

# Empowerment: An Idea Whose Time Has Come in Diabetes Education

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*We have learned much in the past 10 years about how to help patients to acquire diabetes-related knowledge and skills and how to use strategies to help patients change behaviors. However, the application of knowledge and techniques should be guided by a relevant, coherent, educational philosophy. Empowerment offers a practical conceptual framework for diabetes patient education. Empowering patients provides them with the knowledge, skills, and responsibility to effect change and has the potential to promote overall health and maximize the use of available resources. It is an idea whose time has come for diabetes education.*

The value of diabetes education and the role of the diabetes educator have gained recognition over the past 10 years. Standards for education have been developed,<sup>1</sup> behavioral models (eg, health beliefs) have been applied,<sup>2</sup> strategies to increase adherence have been implemented,<sup>3,4</sup> and new technologies have become widely accepted.<sup>5,6</sup> A great deal has been accomplished but, in spite of this progress, many people with diabetes are frustrated and dissatisfied with their care and education.<sup>7</sup> Diabetes educators are also frustrated with their seeming inability to "motivate" patients to comply.<sup>8</sup> We have observed a growing sense of dissatisfaction among both patients and professionals with programs that are not relevant, and an increased awareness of the need to develop programs that are adequate to deal with the complexities of living with a chronic illness such as diabetes.

As part of ongoing model care development for both patients and health professionals, the Michigan Diabetes Research and Training Center (MDRTC) Education Committee has spent a great deal of time considering these issues. Through our discussions, we have concluded that while much had been learned about providing diabetes patient education, the recommended concepts and strategies have not been formulated into an overall conceptual framework. We decided that before we developed further innovative and effective education programs, we needed to adopt and articulate a philosophy of diabetes education that would guide all of our efforts.

## Identification of a Philosophy

A philosophy is both a viewpoint (a perspective on how things are) and a system of values (a perspective on how things should be). Our educational philosophy is important because it influences our professional behaviors, attitudes, satisfaction, and effectiveness.<sup>9</sup> Defining our philosophy would enable us to better articulate the art of teaching to our patients, colleagues, and those unfamiliar with the role of the diabetes educator. Additionally, if the programs we developed were guided by a common philosophical theme, the development process would become easier and our program activities more cohesive.

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The identification of our philosophy grew out of our experience in diabetes education, and the process was actually one of discovery more than of development. Through reviewing the literature identifying the elements of successful education programs and systematically examining our own beliefs and experiences, we recognized that diabetes is an illness that affects all aspects of a person's life. Because diabetes self-care requires balancing many metabolic and life-style factors, each person makes many diabetes-related choices each day. Successful diabetes self-care necessitates that patients be able to make informed choices and decisions that will help achieve their personal diabetes care goals. Knowledge and experience are required to make these choices, as is the ability to take responsibility for one's own care. We also believe that people have an inherent drive towards health and growth, and we recognize the fundamental right of patients to have the power to control their own health care behavior. The purpose of education is to provide a combination of knowledge, skills, and heightened self-awareness regarding values, needs, and goals so that patients can use this power to act in their own self-interest. Together these ideas began to shape a philosophy that we have described as empowerment.

### Definition of Empowerment

Rappaport<sup>10</sup> defines empowerment as a process by which people gain mastery over their affairs. In health education, this increase in power is not a means to dominate or change others, but rather a means to affect change. Empowering patients to affect change can impact more than specific health behaviors. It has the potential to promote overall health and to expand resources in other personal and social arenas.<sup>11</sup> The goal of empowering patients is to promote autonomous self-regulation so that the individual's potential for health and wellness is maximized.<sup>12</sup> We have defined the process of empowerment as the discovery and development of one's inherent capacity to be responsible for one's own life. People are empowered when they have sufficient knowledge to make rational decisions, sufficient control and resources to implement their decisions, and sufficient experience to evaluate the effectiveness of their decisions. Empowerment is more than an intervention or strategy to help people make behavior changes to adhere to a treatment plan. Fundamentally, patient empowerment is an outcome. Patients are empowered when they have knowledge, skills, attitudes, and self-awareness necessary to influence their own behavior and that of others in order to improve the quality of their lives.

### Education to Empower Patients

Patient education that is designed to empower patients to deal with diabetes in a biopsychosocial context has a very different goal than diabetes patient education that is designed to persuade patients to comply with treatment recommendations of health professionals in order to improve their physical status. If empowerment is the desired outcome, then diabetes patient education becomes a process designed to improve the quality of life of patients by enabling them to take charge of their health through recognition and promotion of individual strengths, informed choices, and personal goals. This is significantly different from the more traditional definition of diabetes patient education, which views

patient education as a process designed to influence the knowledge, attitudes, and behavior of patients to enhance their compliance with the treatment recommendations in order to improve their glycemic control. Table 1 contrasts these two models.

The traditional approach represents the medical disease-as-pathology model in which the professional is viewed as the powerful, expert provider and the patient as the passive recipient.<sup>13</sup> Illness is viewed as a cluster of symptoms with a specific name and treatment program. The medical model often fails to adequately account for the person, his or her social context, or the role of the health care provider.<sup>13,14</sup> Patients often feel awed or resigned and helpless, and tend to withdraw from involvement in their care.<sup>15</sup> Dissatisfaction with the medical model has led to a rise in activation or consumerism among some patients with chronic illnesses.<sup>16,17</sup> The consumer model does provide patients with the ability to become more active participants in their care; however, when patients feel the entire burden of responsibility for their health care, they are often dissatisfied.<sup>15</sup> Providers may view these patients as demanding and manipulative, and the relationship often becomes antagonistic.<sup>16,17</sup>

The empowerment approach is different from either of these models in that it represents a shift in attitude for both patients and professionals. It is more consistent with nursing and counseling (social work, psychology) models of care in which patients are viewed as equal and active partners in the treatment program. The patients are seen as the experts on their own lives, and the professional is seen as the expert on diabetes who serves as a resource. The role of the educator is to help patients to achieve skills and to overcome barriers through education, self-exploration, and emotional support.<sup>14</sup>

Key concepts of empowerment relevant to diabetes education are listed below:

*Emphasis on whole person.* This approach takes into account the cognitive, biophysical, psychological, and social aspects of a person. It assumes that the patient's values, beliefs, and opinions are to be respected and considered. In addition to providing information, the major contribution of the educator is to provide a trusting relationship in which patients feel valued, trusted, and psychologically safe.

*Emphasis on personal strengths, rather than deficits.* Each person has useful knowledge, and there is value in each person's culture and ethnic tradition.

*Patient selection of learning needs.* This helps to ensure the relevancy of the information presented and decreases the likelihood of so-called inert knowledge—that patients will “know” but still not be able to “do.”

*Setting of shared or negotiated goals.* Treatment and behavior-change goals are mutually agreed upon. Behavioral strategies are not used as a way of getting patients to do what the educator wants, but rather as ways to help patients attain their personal blood glucose level, weight, or other goals.

*Transference of leadership and decision making.* Because diabetes education and care are currently delivered in an episodic way with limited follow-up, and because diabetes requires multiple daily decisions, persons with diabetes must assume responsibility for their care to ensure its adequacy.

*Self-generation of problems and solutions.* Problems that are identified and solutions that are chosen by patients tend to be more relevant and meaningful because they are generated

**Table 1. Comparison of Traditional and Empowering Educational Models****Traditional Medical Model**

1. Diabetes is a physical illness.
2. Relationship of provider and patient is authoritarian based on provider expertise.
3. Problems and learning needs are usually identified by professional.
4. Professional is viewed as problem solver and caregiver, ie, professional responsible for diagnosis, treatment, and outcome.
5. Goal is compliance with recommendations. Behavioral strategies are used to increase compliance with recommended treatment. A lack of compliance is viewed as a failure of patient and provider.
6. Behavior changes are externally motivated.
7. Patient is powerless, professional is powerful.

**Empowering Person-Centered Model**

1. Diabetes is a biopsychosocial illness.
2. Relationship of provider and patient is democratic and based on shared expertise.
3. Problems and learning needs are usually identified by patient.
4. Patient is viewed as problem solver and caregiver, ie, professional acts as a resource and both share responsibility for treatment and outcome.
5. Goal is to enable patients to make informed choices. Behavioral strategies are used to help patients change behaviors of their choosing. A lack of goal achievement is viewed as feedback and used to modify goals and strategies.
6. Behavior changes are internally motivated.
7. Patient and professional are powerful.

within the context of their life-styles, values, beliefs, and support systems. The educator facilitates this process by helping patients to explore problems, express feelings, develop alternative options, consider the consequences of various options, and come to appropriate decisions. The educator serves as a sounding board and a resource person. The educator does not try to solve patients' problems for them because this would create an unequal relationship in which the educator would be seen as more powerful and competent. Such a relationship would violate the basic tenets of the patient empowerment approach that views patients as inherently trustworthy and able, with a fundamental drive toward health and growth.

*Analysis of failures as problems to be solved rather than as personal deficits.* This approach helps patients maintain the long-term motivation needed for a lifelong illness.

*Discovery and enhancement of internal reinforcement for behavior change.* One can expect more consistent, long-term adaptations when changes are internally motivated rather than externally imposed and reinforced by others.

*Promotion of escalating participation.* As patients gain control over their diabetes through the acquisition of knowledge, problem-solving experience, and negotiation skills, they are able to assume more and more responsibility for their own care. This responsibility is gradually transferred to the patient through systematic education and support.

*Emphasis on support networks and resources.* Patients are encouraged to develop and nourish both internal and external resources.

*Promotion of patient's inherent drive toward health and wellness.* This philosophy assumes that although most people have learned some behaviors that are barriers to health, they still have a fundamental drive for health and desire to overcome barriers to optimal self-care.

**An Educational Program to Empower Patients**

Because both the fundamental viewpoint and management goals of diabetes are different for the two educational models, strategies and methodologies also differ. If the objective of an education program is to graduate patients who are prepared to make informed choices, solve problems, serve as

fully functioning health care team members, and ultimately take control of their diabetes care, then program activities should be designed to achieve those goals. Table 2 outlines an education program that has empowerment as its goal.

The assessment includes all aspects of diabetes as a biopsychosocial illness and knowledge of diabetes self-care recommendation and practices (eg, annual ophthalmology exams, insulin dose adjustment). Relevant diabetes information is then presented in terms of the purposes, costs, and benefits of each self-care option. Aspects of the regimen, such as diet, monitoring, and medications, are presented as tools that patients can use to care for themselves, rather than as behaviors that must be complied with, that is, as goals in and of themselves. For example, home blood glucose monitoring and record keeping would be taught as a useful tool that patients can use to adjust their diet and medications. The cost of monitoring includes both the monetary expense and the physical discomfort of testing, but the potential benefits include maintaining glycemic control with greater flexibility. This approach is in contrast to the more traditional approach to monitoring and record keeping as recommended behaviors that should be complied with so that the health professional can use the data to make changes in the treatment regimen and to praise or criticize the patient's self-care efforts.

Once patients gain some understanding of diabetes self-care choices and consequences, they can then identify their own goals based on their personal level of responsibility and diabetes-related values and philosophy. Specific diabetes content tailored to the patients' personal goals can be presented. For example, dietary recommendations can be presented as choices to achieve personal goals related to blood glucose goals, weight goals, cholesterol and lipid goals, complications status, nutrition, and general health. At any one time, patients may choose none, one, or all of these aspects as personal goals. Much of the education program is focused on assisting patients achieve their goals using a problem-solving model of goal identification; recognition of strengths and barriers; development of strategies to decrease barriers and maximize strengths; and then the establishment, implementation, and evaluation of a plan. Failure to reach goals is viewed as a prob-

**Table 2. Outline of a Patient Empowerment Education Program**

1. Educator assesses current status (physical, emotional, cognitive, etc).
  - a) Reviews patient's actual self-care practices.
  - b) Reviews recommended self-care practices.
2. Educator provides relevant diabetes information.
  - a) Describes various treatment options.
  - b) Reviews costs and benefits for each option.
3. Educator acknowledges patient's responsibility for self-care.
  - a) Helps patient clarify personal values specific to diabetes.
  - b) Helps patient assess level of personal responsibility for diabetes care.
  - c) Helps patient select diabetes care goals.
4. Patient identifies barriers and strengths related to achieving self-care.
  - a) Assesses diabetes barriers and sources of support.
  - b) Assesses life/social barriers and sources of support.
5. Patient assumes problem-solving responsibility.
  - a) Develops skills to optimize support (eg, develops communication and assertiveness skills to enhance support from family and friends; increases support networks).
  - b) Identifies potential barriers.
  - c) Learns strategies/skills to overcome barriers (eg, negotiation, self-care agreements and plans, conflict resolution).
6. Patient establishes plan with assistance from provider.
7. Patient carries out plan.
8. Patient and provider evaluate and review plan using problem-solving model.

lem to be solved and is dealt with in that framework. Learning what does not work provides valuable information that can be incorporated into a new problem-solving strategy. Specific strategies may include assertiveness training, networking with other patients with diabetes, or holding a family meeting.

One of the dilemmas that emerges during practice with this model occurs when the goals and priorities of the patient are not similar to or consistent with those of the educator. For example, a patient might not place as high a value on frequent blood glucose monitoring as the health professional thinks is appropriate. Home blood glucose monitoring is expensive, and most patients face competing demands for their financial resources. Once the educator is clear that the patient has consciously made this decision and is aware of the costs and benefits of the choice, the role of the educator is to acknowledge the patient's right to make that choice and go on to other issues.

While the philosophy of empowerment respects the rights of patients for self-determination, patients' choices do not have to be accepted when they are irrational. However, it is important to explore the meaning of the decision, and not to label those choices that are simply an expression of a different philosophy as irrational. It is not appropriate to attempt to dissuade patients from choices that simply express different attitudes, values, and beliefs from those of the educator. Given a patient's beliefs and value system, the choice may be entirely rational from the patient's perspective.<sup>18</sup>

Empowerment can guide the entire educational process for

persons with diabetes including one-to-one and group teaching, and can provide the philosophical framework for programs at both the "home management" level and more advanced "life-style change" level of patient education.<sup>19</sup> While the patient's ability to make informed choices is one of the principal values underlying this philosophy, the educator can plant the seeds of empowerment and begin the gradual transference of responsibility for care to the patient by presenting content and care options in terms of costs and benefits, and choices rather than absolutes, even during the basic or "survival" level of diabetes education.

Learning activities designed to result in the empowerment of the learner can then be said to provide an empowerment context for education. In general, you help to empower your patients at every encounter by enabling them to:

- Explore their feelings about having and treating diabetes
- Develop solutions to their own problems
- Discover their capacity to take responsibility for their health

**Disadvantages of Empowerment Model** One could argue that there are disadvantages to adopting the philosophy of empowerment. Patients who are unaccustomed, unwilling, or unable to take responsibility for their lives in other arenas may find it difficult to begin with their health care. Patients may prefer a more directive or prescriptive approach, particularly those who have not received education in diabetes.<sup>20</sup> In these cases, the patients are transferring the power back to the health professional, or empowering the health professional to make those decisions. The philosophy of empowerment would acknowledge and respect a patient's wish to transfer power back to the health care professional. The choice remains with the patient, even when the choice is to decline power. Patients who choose to remain the passive recipients of care are responsible for that choice and its consequences.

**Advantages of Empowerment Model** Along with the value to patients, this approach offers several advantages to diabetes educators. By acknowledging and transferring the responsibility for daily diabetes care to the patient, the educators can decrease the burden they create for themselves by trying to solve all of the patient's problems; feel less frustrated towards "noncompliant" patients; spend less energy trying to "motivate" patients; and perhaps feel less guilt about asking patients to follow regimens that they themselves might not be able to follow.

**Implementation of Program** The most fundamental aspect of an empowering diabetes education program is that it be presented by health care professionals who believe in the philosophy of empowerment, and who are themselves empowered.

White<sup>21</sup> describes empowerment as a five-step process. The steps are:

1. Healing yourself and your relationships with others
2. Becoming responsible for yourself and your life
3. Becoming empowered
4. Creating a vision of your life as you want it
5. Committing to action by establishing priorities, goal setting, and goal getting.

The more empowered the professional, the greater his or her potential to empower others. Consequently, empowerment-oriented professional education is an important component of patient empowerment.

### Conclusion

Empowerment is a new buzzword for the 1990s. While diabetes educators should not align themselves with an educational approach because it is currently in vogue, the philosophy of empowerment has an appeal in diabetes education because it speaks to issues that are fundamental to diabetes educators and diabetes education. Empowerment is an interactive process of cultivating the power in others through the sharing of knowledge, expertise, and resources. Thus, it is more than just a new approach to patient education. Empowerment represents a conceptual shift in the relationship between patients and educators. The patients are no longer just consumers of our services but active partners in the provision of their diabetes care.

Who better to empower patients than the professionals who have developed expertise in teaching and sharing the knowledge that provides the power? We believe that the time to adopt the philosophy of empowerment in diabetes education has come. It has the potential to strengthen not only the power of persons with diabetes but also diabetes educators and, ultimately, the entire profession.

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