Teaching About Health Literacy and Clear Communication

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Physician-patient communication is considered a fundamental aspect of medical care; yet, research shows that patients commonly have difficulty in understanding medical instructions from physicians.[1,2] Physicians often use medical jargon, deliver too much information at a time, and do not confirm patients' understanding of what was discussed.[3,4] At the end of the medical encounter, patients remember less than half of what the physician tried to explain, and they may be uncertain about what steps to take next.[3,5,6]

Low health literacy contributes to the communication gap between physicians and patients.[4,7] Patients with low health literacy may have less familiarity with medical concepts and vocabulary, and they ask fewer questions (S. Kripalani, unpublished data). They may also hide their limited understanding out of shame or embarrassment.[8] Research shows that physicians commonly overestimate patients' literacy levels, and they rarely consider limited literacy skills in their assessment of whether patients understand what they need to do.[9,10] Furthermore, when provided information about patients' literacy levels, physicians appear ill-prepared to communicate effectively.[11]

In their reports on health literacy, the American Medical Association (AMA) Ad Hoc Committee for the Council on Scientific Affairs, the National Work Group on Literacy and Health, and the Institute of Medicine each called for greater efforts to educate physicians and other health professionals about issues related to health literacy, including techniques to communicate more clearly.[12–14] In this article, we describe effective strategies for teaching about health literacy and clear communication. We highlight the most important educational content areas and discuss methods for teaching about health literacy through both clinical precepting and more formal curricula. While the focus of this article is on teaching medical students and residents, its lessons could be applied to developing programs for practicing physicians. Indeed, some of the methods outlined in this article are used in the AMA's health literacy training program for physicians.[15] The approach described in this article is also applicable to the training of students and practitioners in all of the health care professions.

DEVELOPING A HEALTH LITERACY WORKSHOP

If the goal is to raise awareness about low health literacy, then a short didactic lecture may suffice. However, a smaller, but longer and more interactive session, such as a 90 to 120 minutes workshop, offers a better forum not only to review basic information about health literacy but also for hands-on practice with recommended communication skills.

Considering that entire books have been devoted to health literacy and patient education,[16,17] where is the educator to begin when teaching about health literacy? It is useful to first define the concept, describe the scope of the problem, and emphasize that low health literacy affects all segments of society, not only those with limited educational attainment or socioeconomic status.[12,14,18,19]

A powerful means of describing the health care experiences of patients with low health literacy is to invite local patient advocates or adult literacy students to provide first-hand information about their experiences with the health care system.[20] If this is not feasible, then showing selected patient testimonials from the AMA's or Institute of Medicine's health literacy video is also an effective technique. Many of the patients featured in these videos are intelligent and articulate, and their stories help emphasize that low health literacy can be present in any patient.

A brief review of the association between low literacy and health outcomes is also helpful. The 2004 systematic review by DeWalt et al.,[21] commissioned by the U.S. Agency for Healthcare Research and Quality, provides an excellent synthesis of the pertinent information that educators can use. This review describes the relationship of literacy with knowledge, screening behaviors, immunization, health care utilization, and control of several chronic diseases, including HIV infection and depression. Some of the latest research on health literacy, published in this special issue of *JGIM* or presented at the 2006 Society of General Internal Medicine annual meeting, also demonstrates an association of low health literacy with comprehension of informed consent documents and a variety of health outcomes, including control of hypertension and asthma.[22–25] Importantly, 2 of these studies reveal an independent association of limited literacy skills with higher mortality rates.[26,27]

Having set the stage by informing learners about the scope of the problem, the health care experiences of patients with low literacy, and the association between literacy and health outcomes, educators should next empower their trainees by teaching them how to communicate more clearly with patients. Most health literacy experts emphasize several important behaviors to foster clear communication (Table 1).[7,15,28,29]

These strategies should be effective with all patients, but they will be of particular benefit when communicating with patients who have limited literacy skills. Most of the strategies are based on clinical observation and expert opinion, but evidence of their effectiveness is emerging. For example, a study of patients who have diabetes revealed that when physicians used the teach-back technique, patients had better glycemic control.[30] The teach-back is also recommended as a top patient safety practice by the National Quality Forum.[31]

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Table 1. Strategies Recommended for Clear Communication

1. Assess patients' baseline understanding before providing extensive information
Example for a patient newly diagnosed with hypertension: "Before we go on, could you tell me what you already know about high blood pressure?"
This allows educational content to be tailored to the patient's informational needs
2. Explain things clearly using plain language. Avoid medical jargon, vague terms, and terms with different medical and lay terms
Example: say "chest pain" instead of "angina"
Example: say "hamburger" instead of "red meat"
Example: say "You don't have HIV" instead of "Your HIV test results were negative"
3. Emphasize 1 to 3 key points
Repeat these points throughout the visit
4. Effectively encourage patients to ask questions. Use an open-ended approach
Example: ask "What questions do you have?" instead of "Do you have any questions?"
5. Use a teach-back to confirm patient understanding
Place the burden on your shoulders to have explained the information clearly, normalize the process, and be specific
Example: "I always ask my patients to repeat things back to make sure I have explained them clearly. I'd like you to tell me how you're going to take the new medicine that we talked about today."
Example: "When you get home, your [husband/wife] will ask you what the doctor said. What will you tell them?"
To confirm understanding of a skill, ask the patient to demonstrate the behavior (e.g., use of a metered dose inhaler)
6. Write down important instructions
This lets patients know exactly what they should do after the visit
7. Provide useful educational materials
This gives patients more time to absorb the information. Such materials are accessible to family members who may be helping patients at home

Busy medical residents and practicing physicians may, however, be reluctant to adopt new interviewing behaviors that they believe will lengthen the medical encounter. In our experience, assessing patients' baseline understanding usually takes less than 30 seconds, and the teach-back takes only 1 to 2 minutes.[30] However, time is saved by tailoring information to the patient's individual needs, and by limiting the amount of information provided to the most important points. The net effect on time from implementing the strategies in Table 1 is usually neutral; some physicians actually save time. Furthermore, if improved communication results in better understanding by patients of what they need to do, with resultant improvement in disease control, future office visits may be shorter or needed less frequently.

Like most new behaviors, these communication skills require practice to use them effectively. Structured small group exercises offer a useful venue for skill development, with 1 trainee playing the role of the physician, another trainee playing the patient, and a third providing feedback as an observer. In such groups of 3, students and residents can take turns practicing most of the behaviors listed in Table 1.

Showing a trigger videotape is another effective strategy to engage learners. Such a tape consists of a short physician-patient interaction in which the physician demonstrates poor communication skills. Learners react to the tape, point out the specific elements that could be improved, and model ways to communicate the same information more clearly.

An even more effective technique is to videotape each trainee interacting with a standardized patient who has been trained to play the role of an adult with low health literacy.[32,33] Watching the video with a faculty facilitator provides trainees with an opportunity to reflect on their own communication skills, get feedback from the faculty member, and develop specific areas for improvement.

Educators will note that much of the content and activities described above could be incorporated into existing curricula, such as courses on medical interviewing and physician-patient relationships. In fact, it would likely be more effective to address health literacy longitudinally through multiple established courses than to address the topic in isolated workshops. At 1 institution, health literacy themes have been added to a variety of required classes for medical students, from basic medical interviewing courses to seminars on problem-based learning. A website describes some of the curricular elements and offers resources for other medical schools considering a similar approach.[34]

HEALTH LITERACY AND THE CLINICAL ENCOUNTER

Considering the many ways in which health literacy influences patient care and health outcomes, it is surprising how rarely health literacy is discussed as part of the patient assessment and plan.[10] Clinician educators should take greater advantage of the myriad opportunities to do so when working with medical students and residents in clinical settings.

Low health literacy can be brought up as part of the differential diagnosis (i.e., reason for disease exacerbation), or a factor to consider when selecting treatment. For example, when a patient is readmitted for an exacerbation of heart failure, the assessment could include a determination of the patient's ability to understand complex medication instructions and any recent changes to the regimen. Rather than simply prescribing new medications, a complete plan would include a discussion of how additional help may be provided by using a pill box, providing more extensive counseling, or involving family members. To provide another example, when seeing a patient newly diagnosed with asthma, the physicians should teach the patient how to use an inhaler and ask the patient to demonstrate the skill to confirm understanding. Research indicates that patients with limited literacy skills do not understand how to use inhalers correctly,[35] and instructions that come with inhalers are complicated and written at difficulty levels that exceed the average reading skill of American adults.[36]

In addition to including health literacy in the patient assessment and plan, clinical faculty are in a key position to provide feedback on trainees' communication skills. Whether seeing patients in the clinic or hospital setting, faculty may observe students and residents using complex terminology with patients, trying to cover too much information, not pro-

viding an open opportunity for patients to ask questions, or not confirming patient understanding. Using some portion of the clinical encounter to provide feedback in these areas and others will allow trainees to improve their communication skills continually.

Clinical faculty can also play a vital role by modeling clear communication, including the use of lay language and patient teach-back. Trainees are more likely to adopt such skills long term if they repeatedly see them practiced by a large cadre of dedicated faculty.

CONCLUSION

Almost 10 years have passed since the AMA Ad Hoc Committee on Health Literacy first emphasized the importance of incorporating health literacy training into graduate medical education.[12] While some progress has been made, greater attention to health literacy is still needed in medical education. Many opportunities exist to educate medical students and residents about health literacy and the communication skills recommended for clear communication. We encourage clinician educators to implement health literacy workshops and other curricula, and clinical faculty to role model and reinforce techniques to foster clear patient communication.

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