

Addressing Health Literacy for Miscommunication in Dermatology

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To the Editor:

We read with interest the *Cutis* Resident Corner column by Tracey¹ on miscommunication with dermatology patients in which the author highlighted how seemingly straightforward language can deceptively complicate effective communication between dermatologists and their patients. The examples she provided, including subtleties in describing what constitutes the “affected area” for proper application of a topical treatment or the inconsistent use of trade names for medications, underscore how misperceptions of verbal instruction can lead to poor treatment adherence and unintended health outcomes.¹

In addition to how dermatologists deliver treatment information to their patients, a broader aspect of physician-patient communication is health literacy, which is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”² Health literacy involves reading, listening, numeracy, decision-making, and health knowledge; patients who are potentially at risk for having limited skills in these areas include the elderly, those with poor English language proficiency, and those of lower socioeconomic status.³

In 2003, the National Assessment of Adult Literacy found that only 12% of individuals older than 16 years had a proficient level of health literacy.⁴ In an effort to address gaps in communication between health care providers and patients, the American Medical Association, National Institutes of Health, and the US Department of Health & Human Services recommend that educational materials be written at no higher than a 6th grade reading level.^{5,6} Currently, only 2% of dermatology educational materials meet this recommendation; the average reading level of patient dermatology materials is at a 12th grade

level, despite the average American adult reading at an 8th grade level.⁷

It is imperative that dermatologists seek to improve both their verbal and nonverbal communication skills to effectively reach a broader patient population. Visual cues, such as pamphlets to illustrate what is meant by a “pea-sized” amount of adapalene or a photograph demonstrating “border asymmetry” in a melanoma, may be more effective than verbal or written communication alone. In addition, when certain drugs or treatments may be called by various names or when different drug names sound similar, it is crucial to directly point it out to patients; for example, patients may easily confuse the over-the-counter medications Zyrtec (Johnson & Johnson Consumer Inc)(cetirizine, an H₁-receptor antagonist) and Zantac (Chattem, Inc)(ranitidine, an H₂-receptor antagonist), but health care providers can reduce misunderstandings by preemptively discussing differences between these antihistamines with patients.

The visual nature of dermatology creates unique psychosocial scenarios that may inherently motivate patients to understand their cutaneous disease; for example, providing photographs that depict acne improvement at different time points throughout isotretinoin treatment allows for more realistic expectations during therapy. Therefore, it is only fitting that instructive imagery would serve to benefit patient education.

In conclusion, communication between dermatologists and their patients involves multiple variables that can contribute to successful patient instruction for the management of dermatologic disease. Indeed, successful interaction not only includes mutual awareness of words or phrases that can otherwise be misconstrued but also attention to the readability of written materials and the benefits of visual instruction in the clinic setting.

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Integrating these aspects of health literacy can optimize rapport, treatment adherence, and health outcomes.

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