Reply to: "Missing the mark on patient comprehension"

To the Editor: We appreciate the comments by Sanchez et al with regard to our article on patient understanding of medical terminology.[1] Their recent article helps draws much-needed light on the inequalities that exist, particularly with our lower-income, minority, and non—English-speaking patients.[2] This is concerning because these groups often also experience health disparities that place even their ability to access care at risk.[3] To target these vulnerable populations, it is imperative that we propose low-cost and simple solutions that can be widely adopted.

Improving patient comprehension must first start with the physician using patient-friendly terms. This is especially important in busy dermatology clinics, where efficiency must be maintained in a manner that is conducive to patient comprehension of the clinical encounter. Sanchez et al list helpful substitutions for commonly misunderstood terminology. In our study, we had patients self-define terms, and some useful alternative descriptive terms they provided include "cancerous" when defining *malignant* (63.7% of respondents), "spot" when defining *lesion* (46.5% of respondents), "not cancerous" when defining *benign* (38.7% of respondents), and "take sample" when defining *biopsy* (32.6% of respondents) (Table I). We agree that an important next step for future studies would compare patient comprehension of commonly used dermatology terms versus suggested alternate terms.

We also have drawn inspiration from our pediatric colleagues who, in our experience, more frequently and effectively use patient handouts to simplify treatment plans and provide additional information. In our clinic, we have integrated similar patient-directed information for common adult dermatologic diagnoses. Recognizing that many patients will not explicitly express their lack of understanding, we provide this individually tailored information to all patients in physical and electronic forms. This approach is feasible even in resource-limited clinical settings, because nearly all common dermatologic diagnoses have premade resources available without charge on the internet. It should be cautioned, however, that this material is often written above the American Medical Association and National Institutes of Health's recommended sixth to eighth grade reading level,[4,5] and simplifying these handouts whenever possible will likely further improve patient comprehension.

Additionally, our excellent nursing support has been vital for the ability to conduct brief end-of-visit summary sessions. By having nurses return to the patient rooms to review diagnoses, handouts, and treatment plans, patients are offered an additional platform to ask questions and seek clarification. Lack of time was frequently cited by providers as the largest communication barrier in the study

Table I. Common accurate patient definitions

Term	Common accurate definitions*	Percentage of patients with this response†	Percentage of patients with an "NA/I don't know" response
Benign	"Not cancerous"	38.7	16.0
Biopsy	"Take sample"	32.6	16.0
	"Take piece of skin"	12.0	
Excision	"Remove"	16.6	12.9
	"Cut out"	11.1	
Lesion	"Spot"	46.5	14.8
	"Sore"	10.2	
Malignant	"Cancerous"	63.7	20.3
	"Dangerous"	10.2	
Melanoma	"Skin cancer"	44	21.2
Metastasis	"Growing/expanding"	12.9	39.1
	"Spreading"	5.5	
Outpatient	"Not in hospital"	42.1	16.6
	"Go home same day"	27.4	
Pathology	"Test"	15.1	39.1
Precancer	"Before cancer"	13.8	22.5
Topical	"On the skin"	5.5	26.8

NA, Not applicable.
*Common accurate definitions received a physician grading of 4 or 5.
†Responses shared by more than 5% of patients were considered common.

by Sanchez et al, and this approach may be beneficial in reducing this barrier while still enabling our busy clinics to continue at an efficient pace.

Barriers to patient comprehension exist, perhaps more extensively than we had realized, and this has opened an opportunity for improvement within the medical community. Although some of our modifications described have led to anecdotal improvements, we must continue to explore new avenues. We welcome additional future research aimed at optimizing this very important aspect of patient care.

Brett C. Neill, MD, Edward W. Seger, MD, MS, Jace J. Rickstrew, MD, and Anand Rajpara, MD

From the Division of Dermatology, University of Kansas Medical Center, Kansas City, Kansas.

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Correspondence to: Brett Neill, MD, Division of Dermatology, University of Kansas Medical Center, 3901 Rainbow Blvd, Kansas City, KS 66160

E-mail: bcneill6@gmail.com

REFERENCES

1. Neill BC, Golda N, Seger EW, et al. Determining patient understanding of commonly used dermatology terms: a multicenter cross-sectional survey. *J Am Acad Dermatol*. 2020;83(3):933-935.
2. Sanchez D, McLean EO, Maymone MBC, Granados NM, Vashi NA. Patient-provider comparison of dermatology vocabulary understanding: a cross-sectional study in patients from minority ethnic groups. *Arch Dermatol Res*. 2020;312(6):407-412.
3. Jackson C, Maibach H. Ethnic and socioeconomic disparities in dermatology. *J Dermatolog Treat*. 2016;27(3):290-291.
4. Bui TL, Silva-Hirschberg C, Torres J, Armstrong AW. Are patients comprehending? A critical assessment of online patient educational materials. *J Dermatolog Treat*. 2018;29(3):295-299.
5. Stringer T, Yin HS, Gittler J, Curtiss P, Schneider A, Oza VS. The readability, suitability, and content features of eczema action plans in the United States. *Pediatr Dermatol*. 2018;35(6):800-807.

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