

**Zeitschrift:** Studies in Communication Sciences : journal of the Swiss Association of Communication and Media Research

**Band:** 5 (2005)

**Heft:** 2

**Artikel:** Health literacy : more than reading a prescription label

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**DOI:** <https://doi.org/10.5169/seals-790936>

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## HEALTH LITERACY—MORE THAN READING A PRESCRIPTION LABEL\*

In this issue of the *Studies in Communication Sciences* “health literacy” is studied like a disease under a microscope, put through the CAT scanner, and dissected by the authors. Much like physicians on morning rounds at the bedside of a sick patient, the authors each provide different perspectives from their specialties about the problem of low health literacy. Although the “doctors,” the authors, agree that the patient’s diagnosis is either “illiteracy” or “low health literacy”, they do not define the diagnosis in the same terms. Given this difference in opinion, the authors suggest differing interventions and “treatment plans” or solutions. They are unsure where low health literacy should be addressed—in a physician’s office, in the community, or perhaps in the school setting? Should their energies be focused on all those with low health literacy, or should they first try to teach those who are disenfranchised—the poor or those who do not speak the native / predominant language where they live?

Not only do our authors disagree on the “diagnosis”, they disagree about whose responsibility it is to cure the illness of low health literacy. Is it the physician, who must present material in a manner which the patient can understand? Is it the responsibility of the media to seek out physicians willing to assist in the presentation of technical health information for public consumption? Is it the consumer who must know where to find material and use it effectively? Is it an issue of empowerment so consumers may better utilize information since most physicians are woefully inept at communication and need to be directed to share information, or power, in the relationship? What sources of information are consumers currently utilizing and what is most effective in increasing knowledge? Finally, what are the barriers to achieving health literacy?

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Several definitions of “health literacy” are presented by this group of “diagnosticians”. Specialists from academic and community medicine, communications, information studies, business, and marketing begin the discussion by defining the problem in varying terms.

- Representing the medical community, Schwartzberg, Fleming, Van Geest, Vergara, and Oliver and the American Medical Association define health literacy in the publication *Health Literacy: A Manual for Clinicians* as “the ability to read, understand, and use health information to make appropriate healthcare decisions and follow instructions for treatment”. The AMA health literacy kit assumes that physicians, and their staffs, bear responsibility for ensuring that the patient *understands what is presented in the medical office*. Therefore, it follows that the route to increasing health literacy is through increasing physician skills in this area and that lack of literacy is the responsibility of the health care providers. The cure is more information delivered more effectively!
- Dr. Eriksson-Backa, Information Studies, defines health literacy as “knowing when health information is needed, how and where to find information about health, and how to evaluate and use this information in everyday life”. This definition moves the patient out of the clinic or doctor’s office and assumes there are other venues by which health literacy can be increased. It is the responsibility of the consumer to *attain optimum health self knowledge*. Responsibility is placed squarely on the shoulders of the individual. The solution is patient, or consumer empowerment! This solution is especially difficult for those with low general literacy to embrace.
- Several authors focus on the use of media. Others focus on the use of the web, describing inherent dangers of information presented to the consumer via the Internet. Stokes agrees with Backa, noting that the “patients who are empowered believe they can adequately cope with a health situation, “take charge” and accept responsibility for their own health, and enter into a more partnership based relationship with their physicians.” Patients are consumers who must be savvy in their quest for knowledge. Tedesco and Holloway warn us that “health web sites” are thinly viewed advertising venues. Vested interests of pharmaceutical companies may suggest that a specific medication is the only path to health. These authors highlight the importance of consumer awareness of tricks employed by sponsors of websites. Consumers must be warned about advertising masquerading as unbiased health information!

It does not matter how health literacy is defined; the subjects in these studies know where they want to get their health information and how they want it packaged. They know the cure for their low health literacy and it is independent of levels of general literacy. Material must be presented in formats easy to comprehend. Those individuals with lower general literacy improve their health literacy most when information is presented in an easy to digest form such as in the media. Duff, Singhal, and Witte present a fascinating case of utilizing mass media to increase health literacy. For rural Indians watching "Taru," a Soap Opera providing information about contraception, the greatest gains in information about the subject are among those with low general literacy. Isn't this the group we should target for education about health problems?

The approach to increasing health literacy amidst a culture in flux is addressed by Erramilli, Sharma, Chung and Sivakumaran. For women in Singapore, the authors studied the influence of family, health care provider, the media, and the Internet on individual awareness and knowledge of reproductive health and on contraceptive practices. Influence of sources varied according to age, educational level, and work status. For example, most women indicated that health care practitioners were a source of information but younger women relied more on information from friends and colleagues, the Internet and magazines for women. Differing vehicles had differing levels of influence which may be a proxy for alignment with traditional versus modern lifestyles.

Lynn Eagle elaborates on the importance of "approachability" of information in her analysis of sources of health information in the media. Using the simple measure of gobbledegook—SMOG—consumers indicate clearly that, although over 70% identify physicians as reliable sources of health information, they utilize television programs to learn about health problems. Media sources are also identified as useful for those with higher levels of general literacy. For Finns, the study by Eriksson-Backa identifies a group of subjects who are literate yet rely on professional scientific information in the popularized form of health magazines. They are the most literate of her study groups yet they still choose where, and how, they consume information and utilize media sources to increase knowledge.

What about patient empowerment? From a marketing and business viewpoint patients are consumers entitled to knowledge—after all, it's *their* health! An "empowered patient" is better able to communicate with the doctor and thus have better overall health literacy. Complementary

and alternative providers are known for a strong interest in “empowering their patients” and one would expect that they would present health information in a readable, approachable format. Yet in Eagle’s study information presented by complementary and alternative medicine—a system one would surmise operates outside the traditional “medical model”—there is a high level of SMOG. Even when the medical provider gives more than lip service to empowerment, the effect is not realized in sources of information. Instead patients prefer to gather information from the television shows *ER* and *Casualty*. After a topic is presented in a “friendly” form for the consumer, interpretation is provided from a traditionally valued source—a doctor—thus integrating the two sources.

Every patient brings a concept of health and wellness driven by culture, age, ethnicity, educational level, and experience in the health care system. Many of the authors discuss barriers to health literacy, and solutions, including adapting material for those who speak a different language and are from the non-majority culture. Smith and Gonzales provide a practical approach to language barriers. They utilized native speaking health workers to modify materials that were scientifically correct. They then used the Cloze test to evaluate comprehension of materials by Spanish speaking patients. The strength of their approach is specific attention to the reality that “literal translation ignores the differences among cultural groups and subtleties in the language”.

Another “cultural barrier” exists even when physician and patient share ethnicity and language. Physicians have their own culture, and even language, that is a product of experience—rigorous education that extends into the late 20s. Intense hours of study begin in college, extend into medical school, and finish with clinical experiences in hospital and clinical training settings. These experiences usher physicians into their own culture, the “society of healers”. The need for rapid, exact communication of diagnoses and treatment plans, sometimes in intense emergency settings, dictates that medical students learn a language heavily peppered with Latin and medical terms. Physicians are described as arrogant with poor communication skills in the literature review by Eriksson-Backa. The problem may be a simple need for interpretation of this strange language ‘doctors speak’! Patients really do want to hear about their health from their doctors—they just need some help with interpretation of a language which becomes more complex with each advance in medical care. Perhaps this is why even those with higher literacy preferred to receive information from popular media. Even though they are well

educated, they don't understand physician jargon. Over 70% of the subjects in Eagle's work found information from their specialist or general practitioner extremely important. Is there a solution to the cross cultural divide that exists, even when physicians share ethnicity and language with their patients?

Perhaps the answer is for physicians to provide information, but accept that they are not the most effective in transferring it to their patients. Physicians must not give up their role in increasing health literacy—rather they should explore the use of other venues of information and accept the role of the “translator”. As illustrated beautifully in the papers by Eagle, Tedesco and Holloway, and Stokes, doctors struggle to communicate with patients watching TV, reading magazines and surfing the Internet seeking health information. Physicians should consider the power of the print and visual media and the growing field of cyberspace and assist the media in presenting correct, scientific information. As busy as they are, physicians must become more media savvy and comfortable with the patients' use of these vehicles for information. For example, pediatricians who read magazines targeted to young mothers and parents such as *Good Housekeeping* or *Parents Magazine* are ready to converse about the health messages presented in this venue. When the parents refer to an article in the lay press, the pediatrician can embellish the message with information, correct misconceptions, and encourage continued acquisition of knowledge from these comfortable sources. In fact, they should empower parents seeking information “on their own” and reinforce these efforts. Of course, the pediatrician would encourage parents to read educational information from the American Academy of Pediatrics (AAP) prepared by the savvy professional staff.

Even though the language may be shared, cultural congruity is not guaranteed. Community health workers, social workers, educators, and nurses have a better track record communicating with our patients. A solution to this type of cultural difference is presented by Howe and the authors at University of South Carolina. They acknowledge the inherent difficulties in communication in a rural primary care setting and take active steps to bridge the gap between the providers and the community. In this model, patients are “empowered” to develop messages that are appropriate for their culture and community. There is a “shared language” between the non-physician staff and patient that is emphasized. This concept combines patient empowerment, use of a “native speaker,” and incorporates information from the physician staff. Notably, social

scientists, health students, and educators are heavily involved in this intervention. Doctors simply assure that material is correct—they are not responsible for communicating.

In another setting with a language barrier, the work presented by Van Leuven in California and Smith in Washington State bring forth the obvious—that those who speak the language must be involved in the development of patient information materials. The strengths of this approach include listening carefully to community and consumer suggestions, use of a multidisciplinary approach with social work and education, and a frank admission that the consumer has something to teach the health care provider. The language spoken is not that of the healer, it is that of the community member.

Finally, what about the emotional context in which human beings experience health problems? Physicians do not provide health care to family members because of the impact of emotion on clinical decision making. In some states a medical license can be removed if a physician writes a prescription for a family member. When faced with devastating health problems, those who are well educated and affluent are no more capable of making decisions than the rest of society. Isn't health literacy about more than reading a prescription bottle, taking a medication appropriately, attending doctor's appointments and following suggested changes in diet, exercise regimen and lifestyle? If health literacy includes the ability to understand pertinent information, interpret it in terms of beliefs, attitudes, culture and experience, and make decisions, the challenge is very great.

Certainly physicians cannot be solely responsible for health literacy when it is defined in these terms. The responsibility for health literacy is shared. Physicians are responsible for assuring that information is correct and becoming more aware of venues outside the traditional clinical setting which deliver health information. Within the clinical setting, physicians should rely more on those who speak the community's language. We would be wise to respect and recognize that sources such as the media can present information in a format that patients often prefer and to ask professionals in marketing, communications, education, and social work to help us to translate information from the language of healers to the language of our patients' culture. Our professional organizations such as the American Medical Association and the American Osteopathic Association have a role in teaching us to be advocates for accurate messages *and* lower levels of SMOG. Media, including the Internet, must

work to present responsible information, clearly acknowledging when the goal of presentation is primarily advertisement of a product. But in the end it is the *consumer* or patient who holds final responsibility to integrate knowledge with their attitudes and beliefs.

The authors in this issue begin to shed light on the subject from wonderfully diverse viewpoints, and all agree that quality of life and health can only be interpreted through the eye of the individual. The consumer tells us how, what, when and where they will learn most effectively about increasing health literacy. As a society of healers we have much to learn from specialists in the fields of communications, information studies, business, marketing, and the media about speaking the language of our patients. We are members of a different culture, the society of healers, and we speak a different language. We need translators!



