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ACADEMY OF
FAMILY
PHYSICIANS

“I Hear You Talking, But I Don’t Understand You!”

MEDICAL JARGON & CLEAR COMMUNICATION

**Presented by Molina HealthCare and
California Academy of Family Physicians**

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I Hear Your Talking, But I Don't Understand You!

MEDICAL JARGON & CLEAR COMMUNICATION¹

Health literacy has been defined by the Partnership for Clear Health Communication as “*the ability to read, understand, and act upon health information.*” While health literacy continues to receive significant attention these days, it is important to recognize that oral communication between doctors and patients can greatly contribute to a patient’s understanding of health information.

Clear and effective communication remains a core element in developing meaningful exchanges between patients and their doctors. Communication is an intricate dance between two parties: a speaker and a listener. In medical interactions, physicians and patients take turns speaking and listening. However, not every conversation is necessarily effective, and there are many barriers that may place clear communication at risk. Some of these barriers include:

1. The anxiety and intimidation associated with the medical interaction between a highly trained medical professional and an unsophisticated patient
2. Patient stress associated with seeking health care services
3. Preconceived patient notions that make them less likely to listen to and understand important health care messages from their doctors
4. Cultural and linguistic differences between physicians and patients created by an increasingly diverse patient population
5. Physician time constraints that often result in brief patient interactions and cross-cultural misunderstandings

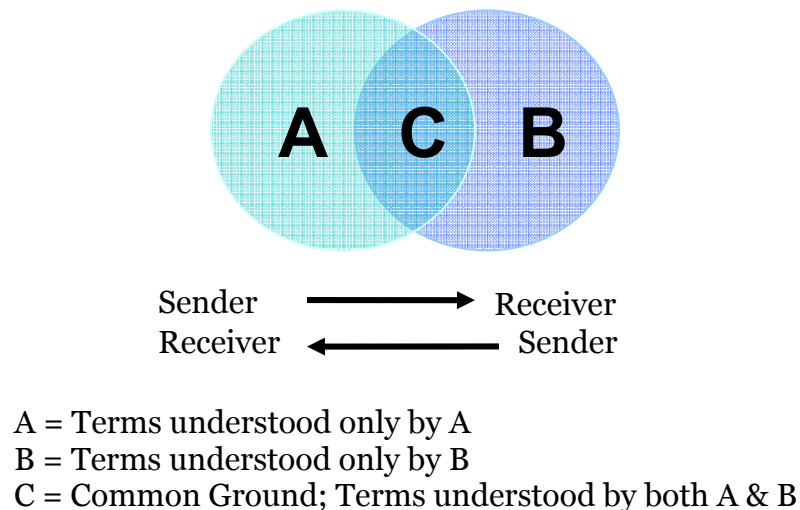
Medical jargon can contribute to poor communication. Webster’s Dictionary defines jargon as “*the technical terminology or characteristic idiom of a special activity or group...obscure and often pretentious language marked by circumlocutions and long words.*”² Medical jargon can therefore be both a tool for effective and efficient communication, as well as a significant barrier to understanding. The sophistication of the audience determines whether jargon can hinder or help communication.

¹ This monograph was based on a roundtable discussion hosted by Martha Bernadett, MD, MBA of Molina Healthcare as part of *Hablamos Juntos*, a project funded by The Robert Wood Johnson Foundation. Please refer to Appendix B for a listing of individual present at the roundtable. This monograph was written by Laura Johnson Morasch, MPH, CAE, of the California Academy of Family Physicians.

² Webster’s Ninth New Collegiate Dictionary, 1990.

Jargon is a language of familiarity. It can be a useful tool when everyone has a common understanding of the terms at hand—it is verbal shorthand. The problems arise when physicians let jargon creep into their every day communications with patients. This is when physician language can separate, insulate, and intimidate. Good communication is the result of the use of common terms that are clearly understood by both parties. Physician-patient communication is represented in Figure 1.

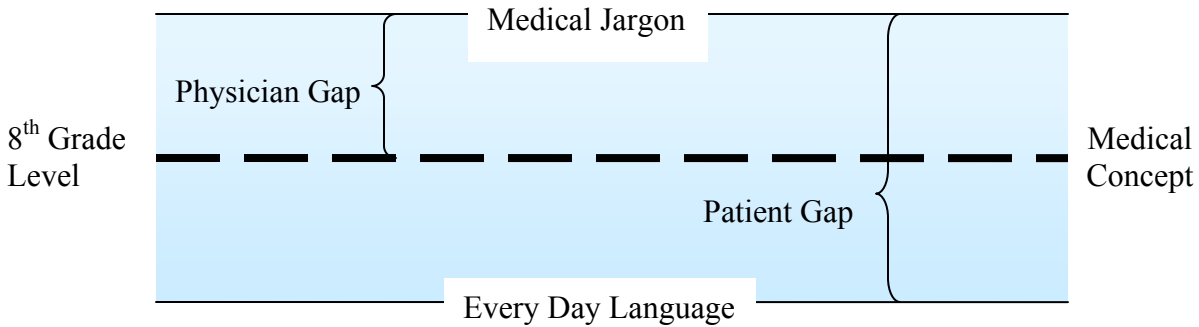
Figure. 1
Communication Venn diagram



Why do we use Jargon?

Jargon is instilled during the years of medical training in highly intellectual and scientific environments. After such an intense professional training, it is easy to forget that the physician's vocabulary is extremely technical. The clinical/medical language ability of the physician may be many grade levels above that of an average patient. Physicians typically have had more than 20 years of education by the time they reach practice, whereas the average American reads and speaks at an 8th or 9th grade level, pointing to a huge disparity in learning and comprehension. Figure 2 suggests that the level at which the physician communicates can be easily adjusted to contribute to greater understanding.

Figure. 2
Communication Disparity



The use of medical jargon can easily -- and unknowingly -- lead to misinformation and incorrect interpretations that may have an adverse impact on a patient's health. Avoiding medical jargon is essential to ensuring the concise exchange of information between patients and physicians. When a patient does not understand the jargon, the quality of that patient's care may be jeopardized and the comprehension of the physician's message is diminished.

The responsibility to ensure that patient and physician understand one another rests with the physician. It is often pointed out that physicians with wonderful bedside manners and poor outcomes are sued less frequently than physicians with poor bed-side manner and wonderful outcomes.

Physicians must be on the lookout continually for the use of overly complicated language in their patient encounters. Some examples of medical jargon include:

- Using medical abbreviations, such as telling a patient they can have a medicine PRN
- Using overly specific anatomical descriptions, such as asking a patient if she has pain in the upper right quadrant
- Using basic descriptions with inadequate context, such as telling a patient a test result is positive, which might be good or bad, depending on the circumstances and test administered
- Using words commonly understood by health care professionals that aren't as well known to patients, as in telling a patient his "mass is benign"
- Using case descriptions to substitute for personal nouns, such as referring to the patient in room 4-07 as "the gallbladder"

A list of words that are particularly likely to confuse patients is included in Appendix A.

Without realizing it, jargon is more likely to creep in during highly sensitive conversations. Why? In difficult situations, it is easy to fall back on jargon as a way to insulate one's self from the full impact of patient emotions and thereby remain more objective. When discussing highly sensitive subjects, or delivering bad news, it is important to keep language simple and clear. For example:

Consents: These forms serve to protect the patient and document that the patient has been informed about his/her options for care; patients commonly misunderstand them as documents that protect the institution or doctor, however. Using jargon such as “coronary bypass surgery due to myocardial insufficiency” may be precise terminology, but may not be the least intimidating way to obtain consent.

Furthermore, patients or their families are often signing for consent at vulnerable times. They may not understand why they need to hear about the worst possible outcomes. People aren’t used to thinking about risk. The concept of risk is best explained when put in terms patients will understand. For example, “you take risks every day, like when you choose to cross a street. You take a risk to cross the street, though you could stay on the other side and have more limited options.”

End of Life: Physicians treating patients at the end of life need to be particularly careful not to use medical jargon. Options and probable outcomes should be explained in a tactful manner that is free of any jargon. If there is a need for interpreter services, the highest level of interpretive skills should be used to avoid any misunderstanding by the patient and his/her family.

Medication Instructions: Prescriptions are often written in medical jargon, so keep patient instructions as simple and clear as possible. Have paper available so that you or the patient can write down the medication procedures for the patient to take home. Instead of instructing the patient to take a prescription BID, explain he/she should take it twice a day while awake. Patients often need more concrete instructions as to when to take medicines than physicians offer. Do you know if your patient is waking up in the middle of the night to take a medicine prescribed every eight hours? If there is an interpreter, have the instructions written in English on top and in the native language on bottom. Have the patient bring the instructions back on later visits.

Jargon and Bedside Manner

Avoiding medical jargon is an important way to improve one’s ability to communicate with patients. Self-awareness is the key to understanding bedside manner. Self-perception may differ from the way your patient sees you. It is also essential to understanding your biases and limitations, and to be mindful of the things that most push your buttons. Avoiding medical jargon and communicating clearly enhances the physician’s effectiveness in providing good patient care.

Martha Bernadett, MD, MBA, comes from a family of physicians. She remembers the special touch that her father had with his patients:

“My father was a general practitioner for many years. He had a real knack for talking to all sorts of people: big, burly truck drivers, senior citizens. He could really speak to all of them effectively. He had communication skills and rapport. More importantly, he had real empathy for people. It was a self-fulfilling cycle: he found the interactions rewarding and was very good at it.”

If you don’t have this natural easy way with patients, do not give up hope. Richard A. Helmer, MD, Medical Director of Molina Healthcare, Inc. says:

“It is too easy to become fatalistic about your interactions with patients. Interpersonal communication can always be improved. You need to learn to pick up cues from your patients and find ways to connect with them. It’s also important to know that you can be empathetic without getting emotionally involved.”

What can be done to ensure that you and your patients are getting through to one another? Here are some tips:

1. Respect is the foundation of a sound physician-patient relationship. Respect means that you value your patient as a person, and it allows you to be a better physician.
2. Non-verbal communication (both yours and the patient’s) is critically important to your interaction. Learn to read your patients’ body language and don’t hesitate to check in about what you’re noticing. Likewise, try to keep open, non-judgmental posture. Smile at patients. Lean forward slightly and nod occasionally when listening.
3. Ask open-ended questions that get real answers. Don’t be afraid to ask for the hard truth. How the question is phrased and the choice of words may influence the patient’s response. For example, ask “How often do you miss taking your medications?” instead of “How often do you take your medications?”
4. When taking a history, try to elicit information in ways that validate, empower and avoid judgment. Ask, “What kind of herbs or other alternative remedies do you take?” rather than “you don’t take herbs, do you?”
5. When explaining a diagnosis, go the extra mile to make sure the patient understands. Ask directly what his or her understanding of the diagnosis is. Try to find out if there are other things weighing on the patient’s mind. For example, many patients hear the diagnosis “diabetes,” and they immediately think of amputation. Asking, “What do you think this might be and what are you most afraid of?” can provide an opportunity to greatly unburden a patient.
6. Elicit all questions or concerns the patient has at the start of the visit. You can triage the patient’s concerns and schedule a follow-up visit if there isn’t enough time for everything. This ensures that the patient feels that his/her concerns are being heard and it also precludes the “hand on the doorknob” question.

Another useful tool for improving communication is through the acronym BATHE³. This tool is a way to learn how a patient’s background and upbringing may impact his/her view on health. Under this model:

- **B**ackground provides the context for the visit: “What is going on in your life?”
- **A**ffect helps identify the feeling state: “How do you feel about that/how does that affect you?”
- **T**rouble gets to the subjective state: “What about the situation troubles you most?”
- **H**andling provides an assessment of functioning: “How are you handling that?”
- **E**mpathy legitimizes the patient’s reaction: “That must be very difficult for you.”⁴

³ Lieberman JA 3rd. BATHE: an approach to the interview process in the primary care setting. *Journal of Clinical Psychiatry*. 1997; 58 Suppl 3: 3-6; discussion 7-8.

⁴ Adapted from Lieberman, Stuart, and Robinson. Enhance the patient visit with counseling and listening skills. *Family Practice Management*. http://www.aafp.org/fpm/961100fm/suite_2.html. Accessed September 9, 2003.

An added benefit to spending more time talking to the patient is the opportunity to gauge the level of understanding. In some cases, using jointly understood jargon may be appropriate. In other cases, you may need to simplify your speech to a very basic level. Either way, you are more likely to satisfy the patient and improve your bedside manner by paying greater attention to listening and counseling during patient visits.

Communicating Across Cultures

- In a southern California hospital, a monolingual Spanish-speaking patient was scheduled for heart surgery. The research nurse needed to take blood samples from heart patients to use as a control group for a study on brain surgery patients. Working through an interpreter, the research nurse sought the patient's consent to draw blood, but the patient got really upset. The more the researcher tried to explain, using the interpreter, the more the patient got upset, so she decided to wait until the patient's family got there. When the research nurse met the family they said, "You're the person who wants to draw blood from our mom's brain."

While communicating between two individuals who speak the same language is difficult enough, issues of clear communication and medical jargon take on heightened importance when physicians are communicating with patients from a different culture, and/or patients who don't speak the same language as the doctor.

It is very important to make no assumptions about the patient based on ethnicity or cultural background. It is just as important to go the extra mile to learn about patient preferences and customs. For example, in some cultures direct eye contact or physical touch can be offensive. For an excellent overview of cross cultural issues in health care, visit the *Providers Guide to Quality and Culture* at www.erc.msh.org.

Whether you're talking to a patient who speaks English fluently as a second language, working with an interpreter to communicate with a patient who doesn't speak any English, or speaking with a limited English proficient patient:

- There is an added risk of terminology being misconstrued as jargon, because non-native speakers may make very literal interpretations when thinking in another language; and
- The stress of the physician-provider encounter may temporarily diminish the patient's language skills and lead him/her to speak in the native language as a natural, comfortable fall-back.

When it comes to patient communication across cultures, the goal should be to arrive at a shared understanding of health, disease, and what it will take to stay healthy or get better. To arrive at this shared understanding, physicians and patients need to respect and trust one another so that information can flow freely. Establishing this trust and respect can be a time consuming process but is a basic requirement of effective communication.

Models and tools exist to help providers improve their ability to communicate with patients from other cultures. For example, the following list of questions can help a provider to better understand the patient's perception of his/her illness:

- What do you call your problem (sickness)? What name does it have?
- What do you think caused your sickness?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Do you think it will last a short or long time?
- What do you fear most about your sickness?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?⁵

Speaking clearly, slowly, and repeating key messages often are key to communicating with patients from other cultures. Speaking loudly, however, does nothing to improve physician-patient communication.

Another model, ETHNIC⁶, helps physicians identify with the patient's perspective of illness and provides a framework to broker a care plan that meets the needs of both the patient and the physician:

- **E**xplanation: What do you think may be the reason you have these symptoms?
- **T**reatment: What kinds of medicines, home remedies, or other treatments have you tried for this illness?
- **H**ealers: Have you sought any advice from alternative/folk healers, friends or other people who aren't physicians?
- **N**egotiate: Negotiate options that will be mutually acceptable to you and your patient and that incorporate, not contradict, your patients' beliefs. Ask what are the most important results your patient hopes to achieve from this intervention.
- **I**ntervention: Identify an intervention for your patient. This may include alternative treatments, healers, and/or spirituality, along with traditional medical solutions.
- **C**ollaboration: Collaborate with the patient, family members, other health care team members, healers, and community resources.

An alternative to ETHNIC is the simpler LEARN model, which includes:

- **L**isten with empathy and understanding to the patient's perception of the problem
- **E**xplain your perception of the problem
- **A**cknowledge and discuss the differences/similarities between the two perspectives
- **R**ecommend treatment
- **N**egotiate treatment⁷

⁵ Kleinman, A, 1980. Patients and healers in the context of culture. Berkeley, CA: University of California Press.

⁶ Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent clinical practice. Patient Care. 2000; 34(9): 188 – 189.

While by no means exhaustive or comprehensive, these tools are mechanisms to improve the ability to communicate with all patients in a way that bridges their understanding of health and disease with your understanding. *The Providers Guide to Quality and Culture* provides extensive information about cross-cultural communication in the health care setting.

Patients as Partners

The patient is potentially the biggest asset to clear and effective communication. A patient who brings in printouts from the Internet or long lists of questions may annoy some physicians, but such a patient is likely to receive better care in the long run. To the extent possible, patients should be encouraged to take an active role in their health care and ask questions so he/she understands the care plan. Encourage the patient to let you know when you have slipped in some jargon that he/she doesn't understand. The Partnership for Clear Health Communication has excellent recommendations for patient involvement:

- Encourage the patient to ask three questions about his/her health care visit:
 - What is my main problem?
 - What do I need to do?
 - Why is it important for me to do this?
- Bring a family member or friend to the visit
- Bring a list of health concerns to the visit
- Bring a list of all medications to the visit
- Write down the diagnosis and recommended follow-up care and any medications prescribed

For a more complete discussion of this topic and for downloadable resources, visit the Partnership's web site at www.askme3.org.

Conclusion

“Even practitioners who have worked with low literacy patients for years are often surprised at the poor reading skills of some of their most poised and articulate patients.”⁸

We cannot afford to use jargon selectively. Rather, we must attempt to reduce it in all settings in an effort to improve communication and with I,t quality and satisfaction. The lawyer who does not understand the word “otitis” and the mother with a sixth grade education who does not understand the word “tympanogram” are both at risk for not understanding conditions that may require them to take action for a good medical result.

The need to address language and cultural needs in our communities will continue to increase and present barriers to clear communication as the diversity of our communities increases. Reducing

⁷ Berlin EA, Fowkes WC. A teaching framework for cross-cultural health care. *Western Journal of Medicine*. 1983; 139: 934 – 938.

⁸ Parker R, Williams MV, and Davis T. *Low Health Literacy – You Can't Tell by Looking*. American Medical Association Foundation, 1999.

medical jargon is the first step in overcoming barriers to clear communication with our patients. Improving communication should improve quality and adherence to prescribed medical regimen.

The final concept that is key to reducing jargon in your practice is to evaluate each patient's understanding. When you are in a hurry, it is easy to fall into the convention of asking the patient if he/she understood. Several acronyms in this monograph describe processes to remind and assist physicians in this regard. The key is to find one that fits your practice. If none fit, at least ask patients to explain to you, in their own words, what is wrong with them and what they are supposed to do about it when they leave your office.

Successful efforts at clear communication, including the reduction or elimination of medical jargon are components of quality that are bound to decrease liability risk and improve both physician and patient satisfaction.

OTHER RESOURCES

Partnership for Clear Health Communication, www.askme3.org

Pfizer Clear Health Communication Initiative, www.pfizerhealthliteracy.com

AMA Foundation Health Literacy Campaign, www.amaassn.org/ama/pub/category/8115.html

Family Practice Management, www.aafp.org/fpm

Provider's Guide to Quality & Culture, www.erc.msh.org

Medline Plus consumer health information, including a medical encyclopedia & dictionary, www.medlineplus.gov

Medical Library Association's Deciphering Medspeak, a medical jargon dictionary, www.mlanet.org/resources/medspeak/medspeaka_d.html

APPENDIX A: WORDS TO WATCH *

Many people, even highly literate people, have trouble understanding words used in health care. This is also true of words in any field outside of our training or expertise, such as computers, nuclear physics, or certain sports. In some instances, a word may be totally unfamiliar. In other cases, a word may be familiar, but the person may not understand it in a health care context. For example, upon hearing, “keep your glucose in a normal range,” people know what normal means about a person, and they may have a range in their kitchen, but they may miss the intended concept in terms of health care. Even people who understand the concept may need more information than the phrase provides. They need to be told what glucose measurements are considered normal.

Words with a Latin or Greek prefix present special problems. The health science field is full of such words. Here’s a small sampling: pre-op, post-op, prenatal, premature, unsweetened, decontaminate, antibacterial. The risk factor for poor readers [and other patients] is that they may recognize one part of the word, such as the “sweetened” in “unsweetened,” and then ignore the “un.” This kind of guessing can lead to the opposite of the desired behavior.

The following list includes a few examples of prefix words, but the main focus is on difficult words found in a sample of Pfizer materials.

Four kinds of words cause much of the misunderstanding: medical words, concept words, category words, and value judgment words. Often these types of words can be made understandable by explaining them with common words, by an example, or by a visual.

Medical Words

Words frequently used by doctors in health care instructions.

Ailment	Sickness; illness; problem with your health
Alleviate symptoms	Help you feel better
Allergen	Something that causes an allergy
Benign	Will not cause harm; is not cancer
Condition	How you feel; health problem
Directed	Told by your doctor, nurse or other health care provider
Diagnosis	Cause of your illness
Dosage	Dose; how much medicine you should take
Dysfunction	Problem
Edema	When body fluids build up too much, often with swelling; swelling (depending on context)
Fluid level	How much water your body has
Glucocorticoid	Something your body makes that reduces swelling and fever
Inflammation	Swelling and soreness, as when you hit your thumb with a hammer; may refer to organs inside the body, not just arms/legs
Inhibitor	Drug that stops something that is bad for you
Interaction	How things work together; drug interaction: some drugs change the way other drugs work; some drugs do not work well together
Internist	Doctor
Intermittent	Off and on
Lesion	Wound; sore; infected patch of skin

Membrane	Thin covering (over a part of the body)
Mg	Milligram; very small amount used to measure drugs
Nocturia	Going to the bathroom a lot at night
Nonprescription	Over the counter; can be bought without a doctor prescribing it
Nutrient	Something in food that is good for you
Oral	By mouth
Procedure	Something done to treat your problem; operation
Refrain	Stop; stay away from
Restart	Start again
Syncope	Blackout; loss of consciousness
Scored tablet	Tablet with a line that makes it easy to cut in half
Triage Nurse	A person who can tell you the best place for care
Vertigo	Dizziness

Concept Word Examples

Words used to describe an idea, metaphor, or notion.

Active role	Taking part in
Area	Part; patch; place
Avoid	Stay away from; do not use (or eat)
Advocacy	Support
Aspect	Point of view; part; item
Associated with	Goes along with
Collaborate	Work together
Coordinate	Make all parts of your care work together; talk with other doctors, nurses, or other health care providers
Contributes to	Also causes
Diet	What you eat; your meals
Dietary cholesterol	Cholesterol from food
Enlarge	Get bigger
Factor	Other thing
Gauge	Measure; get a better idea of; test (dependent on context)
Intake	What you eat or drink; what goes into your body
Initially	At first; to start with
Landmark	Very important (adj.); Important event, turning point
Monitor	Keep track of
Normal range	Where it should be; common amount
Option	Choice
Prevalent	Common; happens often
Pros and cons	Pluses and minuses
Prioritize	Put in right order; put first things first; put things in order of importance
Referral	Ask you to see another doctor; get a second opinion
Triad	Group of three
Type vs. amount	Kind and how much
Wellness	Good health; feeling good

Category Word Examples

Words that describe a group or subset and may be unfamiliar.

Activity	Something you do; something you do often, like drive a car
Adverse (reaction)	Bad
Animal product	Food with fat that makes your cholesterol high
Anti-inflammatory	Lowers swelling and fever
Cognitive	Learning; thinking
Coordinate care giving	Plan the right kind of care and how much care; plan and set up help as needed
Good posture	Sitting straight and standing tall
Hazardous	Not safe; dangerous
High-intensity exercise	Use example, such as running
Generic	Product sold without a brand name; like ibuprofen (contrast with brand-name Advil)
Lowest avg. wholesale price	Cheapest (or rephrase to use verb; costs less)
Noncancerous	Not cancer
Poultry	Chicken, turkey, etc.
Prosthesis	Replacement for a body part, such as a man-made arm
Social contact	Staying in touch with family and friends
Support	Help with your needs—for money, friendship or care

Value Judgment Word Examples

Words that may need an example or visual to convey their meaning with clarity.

Adequate	Enough (Example: adequate water is 6 – 8 cups a day)
Adjust	Fine tune; change
Adjustment	A change (Example: sleep on your back instead of your stomach)
Cautiously	With care; slowly (Example: making sure to hold on to handrails)
Considerable	Quite a bit of; a lot of
Excessive	Too much (Example: If blood soaks through the bandage)
Increase gradually	Add to (Example: add 5 minutes of exercise a week)
Moderately	Not too much (Example: don't exercise so much that you get out of breath)
Progressive	Gets worse (or better); ongoing change
Routinely	Often (Example: every day, every week)
Significantly	Enough to make a difference
Temporary	For a limited time; for about an hour, a day, etc. (Example: for less than a week)

* Appendix A is reprinted with permission from Clear Health Communication Handbook, Appendix 5, Words to Watch, published by Pfizer Inc.

APPENDIX B: ROUNDTABLE PARTICIPANTS

Gustavo Estrella, MD, Molina Healthcare, Inc.
Dennis Evans, Molina Healthcare, Inc.
Luis Guevara, PsyD, White Memorial Medical Center
Saji Dias Gunawardane, Molina Healthcare, Inc.
Richard Helmer, MD, Molina Healthcare, Inc.
Gail Margolis, Esq., Scleroderma Research Foundation
Diana Nikas, RN, ACNP, Department of Neurosurgery, Harbor/UCLA
Tom Riley, California Healthcare Interpreters Association
Shelly Rodrigues, CAE, California Academy of Family Physicians
Beverly Treumann, California Healthcare Interpreters Association.

This monograph was written by Laura Johnson Morasch, MPH, CAE, of the California Academy of Family Physicians.

Each of the roundtable participants declared that in the past 12 months neither they nor any members of their families have had a financial arrangement or affiliation with any corporate organizations offering support or grant moneys for this continuing education activity.

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Name: _____

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City/State/Zip: _____

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E-mail: _____

Rating Scale: **4** = fully addressed **3** = mostly addressed **2** = partially addressed **1** = not addressed
Please fill in the circles completely.

	4	3	2	1
Please rate the monograph as it met these objectives:				
After reading this monograph, I am able to:				
Improve understanding of the anxiety and intimidation associated with the medical interaction between a highly trained medical professional and an unsophisticated patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assist in alleviating patient stress associated with seeking health care services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dispel preconceived patient notions that make them less likely to listen and understand important health care messages from their doctors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Address cultural and linguistic differences between physicians and patients created by an increasingly diverse patient population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alleviate physician time constraints that often result in brief patient interactions and cross-cultural misunderstandings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Rating Scale: **4** = fully addressed **3** = mostly addressed **2** = partially addressed **1** = not addressed
Please fill in the circles completely.

	4	3	2	1
Please rate the monograph for:				
It was understandable and easy to read	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It presented information appropriate to the topic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It used examples and patient cases that were informative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It presented useful information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It was engaging and interesting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Final Question:

What do you anticipate you will do differently as a result of reading this monograph?