It Takes a Village: Reforming Law to Promote Health Literacy and Reduce Orthopedic Health Disparities

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Over the past two decades, health care researchers have documented the low state of health literacy of consumers and cultural competency of providers.¹ These

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studies have also explained how low health literacy and low cultural competency have caused tragic individual health outcomes and contributed to the overall health care crisis in the United States. In a path-breaking report on health literacy, the Institute of Medicine offered the following example, among others, of tragic results caused by low health literacy and ineffective communication:

A 29-year-old African-American woman with three days of abdominal pain and fever was brought to a Baltimore emergency department by her family. After a brief evaluation she was told that she would need an exploratory laparotomy. She subsequently became agitated and demanded to have her family take her home. When approached by staff she yelled, "I came here in pain and all you want is to do is [sic] an exploratory on me! You will not make me a guinea pig!" She refused to consent to any procedures and later died of appendicitis.

Another example of a devastating health care outcome resulting from low emergency department and hospital use, less screening for cervical cancer (through a Pap test) and breast cancer (mammography), lower influenza immunization, and less access to insurance." Id. at 30. In one study of adults in primary care clinics in Shreveport, LA, Jackson, MI, and Chicago, IL, 63% of adults with inadequate literacy skills misunderstood one or more prescription drug instructions, while only 38% of adults with adequate literacy skills had similar difficulty with such instructions. Id. at 94. See also Brietta Clark, Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, & Cost, 20 ANNALS HEALTH L. 253, 259-60 (2011) (asserting low health literacy amounts to "silent epidemic"). The health care crisis poses issues of poor access and quality coupled with high costs. Clark, supra, at 253. The dominant discourse surrounding these problems focuses on the need to ration health care and to reduce our high rate of health care consumption. Id. An emerging discourse, however, focuses on improving literacy rates to reduce the money patients, providers, insurers, and the government must spend on inappropriate treatment. Id. at 254-56. In 2003, the National Assessment of Adult Literacy "found that of 19,000 adults surveyed, only twelve percent were proficient in health literacy, while fifty-three percent had intermediate health literacy, twenty-two percent had basic health literacy, and fourteen percent had below basic health literacy." Id. at 260. Comprehensive health communication between patient and provider can increase advocacy for appropriate health care, while simultaneously decreasing the waste of resources on inappropriate and unnecessary health services. Id. at 267. For a source explaining the importance of cultural competence in serving populations with low health literacy, see Raquel R. Ingram, Using Campinha-Bacote's Process of Cultural Competence Model to Examine the Relationship Between Health Literacy and Cultural Competence, 68 J. OF ADVANCED NURSING 695, 696 (2012).

3 COMM. ON HEALTH LITERACY, BD. ON NEUROSCIENCE & BEHAVIORAL HEALTH, INST. OF MED., HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION 31 (Lynn Nielsen-Bolhman et al. eds., 2004).
health literacy and a lack of communication is described in the California case of Truman v. Thomas, in which a woman died from cervical cancer at the age of 30, after failing to undergo a Pap smear—a routine screening for cervical cancer.\(^4\) Her children brought a wrongful death action against her physician, asserting that the physician breached his duty of care by failing to ensure that she understood the risks of not undergoing a Pap smear.\(^5\) The Supreme Court of California reiterated that, to ensure a patient can make an informed choice about health care, a physician has a duty to inform the patient of “[a]ll information material to the patient’s [health care] decision,” which could include the material risks of not undergoing a diagnostic test such as a Pap smear.\(^6\)

\(^4\) Truman v. Thomas, 611 P.2d 902, 904 (Cal. 1980).
\(^5\) Id. at 904-05.

Although Dr. Thomas saw Mrs. Truman frequently between 1964 and 1969, he never performed a [P]ap smear test on her. Dr. Thomas testified that he did not “specifically” inform Mrs. Truman of the risk involved in any failure to undergo the [P]ap smear test. Rather, “I said, ‘You should have a pap smear.’ We don’t say by now it can be Stage Two (in the development of cervical cancer) or go through all of the different lectures about cancer. I think it is a widely known and generally accepted manner of treatment and I think the patient has a high degree of responsibility. We are not enforcers, we are advisors.” However, Dr. Thomas’ medical records contain no reference to any discussion or recommendation that Mrs. Truman undergo a [P]ap smear test.

\(\ldots\) Dr. Thomas also testified that on at least two occasions when he performed pelvic examinations of Mrs. Truman she refused him permission to perform the test, stating she could not afford the cost. Dr. Thomas offered to defer payment, but Mrs. Truman wanted to pay cash.

\(^6\) Id. at 905-07.

Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient’s position when deciding to accept or reject the recommended medical procedure. To be material, a fact must also be one which is not commonly appreciated. If the physician knows or should know of a patient’s unique concerns or lack of familiarity with medical procedures, this may expand the scope of required disclosure.

\(\ ld at 905-06\) (citations omitted). The court reversed the jury’s verdict in favor of the physician, noting that the trial court’s refusal to provide a requested jury instruction on the physician’s duty “meant that the jury was unable to consider whether Dr. Thomas breached a duty by not disclosing the danger of failing to undergo a pap smear.” Id. at 908, 909.
In this article, we focus on joint and bone health and describe how low health literacy and cultural competency contribute to orthopedic health problems and disparities. We describe and assess legislative reforms adopted by states and the federal government to address health literacy and cultural competency and the problems caused by the interaction between consumers and health care professionals who do not understand each other. We also describe the health problems that result from scarce consumer resources, limited health insurance coverage, and legal restrictions that prevent health care providers from delivering better care. We conclude by discussing the recent trend of statutory and regulatory reforms enacted in the past decade that strive to improve health relationships and outcomes. We argue that significant barriers to effective decision-making continue to exist in part due to the medical and legal visions of informed consent as a legal requirement mandating a ritualistic but limited communication between physicians and patients. We contend that this view of consent sets forth an essential type of communication but does not preclude developing a more effective patient-centered communication process that invokes shared decision-making among patients, health care providers, family members, and community health workers, all of whom need to be involved in consent for care.

The Patient Protection and Affordable Care Act ("PPACA") offers new opportunities to embrace expanded visions of health and health care decision-making. The legal system of the states provide the environment in which the decision-making takes place and has tremendous impact on behavior of both consumers and health care providers. The legal rules must rest on a vision of decision-making that goes beyond a focus on individual patient autonomy and endorses consumer empowerment in a shared decision-making process. Such a change in the law does not require disregarding individual autonomy as an important value. However, it does require acknowledging that health maintenance and disease prevention decisions are improved when the decision-making is shared and supported by others, and that respect for individual autonomy does not preclude vigorous efforts of persuasion. We join with others who view shared decision-making and motivational interviewing as vital strategies that may help reduce disparities and improve the orthopedic health of members of minority communities. For this reason, we advocate the passage of state statutes that provide safe harbors for physicians, nurses, community health workers, and others who engage in good faith efforts to provide accurate information, counseling, and motivational support to individuals making decisions about orthopedic health and health care.

7 For a few specific provisions, see infra notes 88-100 and accompanying text (noting key provisions of PPACA that encourage health literacy and cultural competency).
I. Orthopedic Health and Health Disparities

More than one in four Americans suffers from some form of musculoskeletal disorder, making musculoskeletal disorders the leading cause of disability in the United States. As in other areas of health care, minority and female populations within the United States experience disparities in musculoskeletal care. Researchers have documented such disparities in spine surgery, joint replacement, pain management, treatment for osteoporosis and fragility fractures, diabetic foot management, amputations, rehabilitation after a stroke, management of congenital and developmental disorders, and treatment for metastatic prostate cancer.

African Americans, Hispanics, Pacific Islanders, and American Indians experience disparate health outcomes and decreased access to effective operative procedures as compared to other Americans. For example, despite a higher incidence of osteoarthritis, African Americans and Hispanics receive proportionally fewer total knee and total hip replacement procedures than non-Hispanic white patients. Studies

12 Nelson, supra note 10, at S14.
have revealed that “African Americans were nearly 50% less likely than whites to perceive the benefits of total joint [replacement] and 70% more likely than whites to recognize barriers to total joint [replacement].” In fact, lower extremity amputation for the management of diabetic foot ulcers is the only surgical intervention in which minorities receive treatment at a disproportionately high rate. For instance, due to disparities in care, African Americans and Mexican Americans with diabetes have an increased risk of more severe health consequences, leading to amputation rather than treatments to preserve limbs. Health disparities also impede access to emergency care. Studies comparing Hispanic and non-Hispanic white patients who sought emergency care for long-bone fractures found that the Hispanic patients waited longer to receive pain medication and were half as likely to receive pain medication at all. The Patient Protection and Affordable Care Act provides opportunities for new approaches to health care and decision-making about health, which may reduce such disparities.

Improving the health of large segments of the community and building a sustainable health care system requires reducing the cost of care. Effective approaches to reducing health care costs must include strategies that address prevention and early detection of injuries and diseases. Consumers often make poor choices concerning lifestyle and when and how to use the health care system, while providers – whether consciously or unconsciously – demonstrate bias when treating patients of different

14 Nelson, supra note 10, at S14.
16 Id.
17 Id.
19 See id. at 36 (asserting “American health care is in crisis”). The United States has one of the most costly health care systems in the world, yet only 18% of the American public believes that the system works well. Id. Even with heavily used expensive and invasive treatments, the United States still falls short in comparison to other industrialized countries vis-à-vis treating chronic illness and improving quality of life. Id.
20 Abbott, supra note 18, at 59 (asserting that conventional medicine is not only route to achieving lower health care costs). For example, complementary and alternative medicine (CAM) therapies are generally non-invasive. Id. Although not mainstream, the use of CAM can help to avoid the human and economic costs of adverse effects from medical treatment, as well as the legal and administrative costs associated with conventional therapies. Id.
races and gender. The result of uninformed consumer choices and provider bias is preventable illness and disability. Failure of individuals to take effective steps to

21 COMM. ON HEALTH LITERACY, BD. ON NEUROSCIENCE & BEHAVIORAL HEALTH, INST. OF MED., supra note 3, at 8, 11-12 (estimating “90 million adults . . . lack the needed literacy skills to effectively use the U.S. health system”). The behavior of providers and consumers is impacted by a “lack of mutual understanding” as to such things as prevention and illness. Id. at 11. See generally R. Brian Haynes et al., Helping Patients Follow Prescribed Treatment: Clinical Applications, 288 JAMA 2880 (2002) (discussing low adherence among patients to prescribed treatments, particularly lifestyle changes, and failures to seek care when needed); AUGUSTUS A. WHITE III WITH DAVID CHANOFF, SEEING PATIENTS: UNCONSCIOUS BIAS IN HEALTH CARE (2011) (detailing race and gender biases in health care and recounting personal efforts as physician to reduce such biases). A personal example involved Dr. White meeting a woman “neatly dressed, very polite” on a plane, who ultimately mentioned her body was covered with tattoos except for her face and hands. WHITE WITH CHANOFF, supra, at 195. In reflecting on the woman’s statement, Dr. White illustrated how appearances may shape judgment because in the physician’s office, where the tattoos would have been exposed, the woman might not be perceived as “normal,” leading to “stares, the amazement, [and] intrusive questions.” Id. at 196-97.

22 INST. OF MED., UNEQUAL TREATMENT: WHAT HEALTH CARE SYSTEM ADMINISTRATORS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 3-4, 6 (2002), available at http://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/DisparitiesAdmin8pg.pdf. From the patient’s standpoint, an increase in “culturally appropriate education programs” is needed to enhance patient understanding of accessing health care and the role of the patient in making decisions. Id. at 6. From the physician’s standpoint, uncertainty about treatment can be magnified when physicians are treating racially and ethnically different patients, and this uncertainty may allow stereotypes and bias to play a role in treatment. Id. at 3. Moreover, studies highlight the impact of stereotypes on treatment; for example, a study of hypothetical patients found that when a patient was described with “African-American stereotype-laden words,” this created a more negative evaluation by a provider in comparison to the evaluation of hypothetical patients described with more neutral terms. Id. at 4. For sources detailing the effects of bias and discrimination on health, see CERD WORKING GROUP ON HEALTH & ENVIRONMENTAL HEALTH, UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES: RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE TREATMENT AND ACCESS, THE ROLE OF SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH, AND THE RESPONSIBILITY OF THE STATE 20-21 (2008), available at http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf (asserting adverse impact of discrimination contributes to deterioration of one’s health); Race, Ethnicity, and the Health of Americans, AM. SOCIOLOGICAL ASS’N 2, 5 (July 2005), http://www2.asanet.org/centennial/race_ethnicity_health.pdf (noting racial bias results in unequal access and “unequal treatment for similar severity of illnesses and conditions”). The results of a study by epidemiologists found that White and Asian Americans were more likely than African Americans “to engage in preventive health practices related to diet, smoking, exercise, and use of screening tests.” AM. SOCIOLOGICAL ASS’N, supra, at 5; MOVEMENT IS LIFE: A CATALYST FOR CHANGE, supra note 9, at 11; see also Sullivan & Mittman, supra note 15, at 1810 (demonstrating impact of patient race and ethnicity on clinical decisions). Studies have found that this bias is the greatest when medical professionals “engage in ‘high discretion’ procedures.”
prevent joint and bone disease and damage creates enormous economic and social costs. Effective prevention of illness and accidents requires innovative approaches to educating consumers about risks, benefits, and alternatives to both lifestyle choices, including diet and exercise, and health care choices, including weight reduction medication and joint replacement. Developing and implementing effective approaches to improving the health literacy of residents in the United States may require reconstructing legal rules and precepts to encourage and support shared decision-making among individuals, family members, community activists, and health care providers.

Consumer education must be complemented by culturally competent health care professionals. For clinical medicine to be effective in preventing and treating

Sullivan & Mittman, supra note 15, at 1810.

23 E.g., F.C. Breedveld, Osteoarthritis—The Impact of a Serious Disease, 43 RHEUMATOLOGY i4, i5-i6 (Supp. 2004) (detailing economic and social costs of osteoarthritis); Abbott, supra note 18, at 45 (highlighting statistics supporting cost benefits of preventive medicine). Patients with osteoarthritis (OA) have been found to have a lower quality of wellbeing – on par with patients suffering from depression and advanced cancer. Breedveld, supra, at i5.

The economic impact of OA includes direct costs relating to drugs, medical care, hospitals and research, and indirect costs, such as lost work productivity due to chronic and short-term disability. While treatment of OA may relieve symptoms and therefore reduce the social impact and perhaps some of the indirect costs of this disease, the costs associated with OA therapy itself and the management of possible adverse drug reactions may be substantial. Id. at i5-i6 (citations omitted).

24 See DAVID L. KATZ & ATHER ALI, IOM SUMMIT ON INTEGRATIVE MEDICINE AND THE HEALTH OF THE PUBLIC, PREVENTIVE MEDICINE, INTEGRATIVE MEDICINE & THE HEALTH OF THE PUBLIC 3-4 (2009), available at http://www.iom.edu/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Preventive%20Medicine%20Integrative%20Medicine%20and%20the%20Health%20of%20the%20Public.pdf (detailing primary goal of prevention by subdividing it into three distinct categories). Primary prevention seeks to eliminate causes of disease or to increase disease resistance, precluding the development of disease. Id. at 3. Primary prevention entails both “health promotion,” which includes lifestyle changes such as to diet and exercise, and “specific protection,” which includes unique health care choices for the specific disease or injury, such as vaccinations or wearing a helmet. Id. at 4. Secondary prevention “interrupts the disease process before it becomes symptomatic.” Id. at 3. Finally, tertiary prevention aims to limit the “physical and social consequences of symptomatic disease.” Id.


Health literacy issues and ineffective communications place patients at greater risk of preventable adverse events. If a patient does not understand the
disease in a society that respects the right of individuals to make personal decisions about their bodies, health professionals must have the capacity to understand their patients' perspectives as well as the medicine they hope to use in promoting health. A health care professional who lacks the skill to communicate medical knowledge to lay people of diverse backgrounds has a limited capacity to promote the health of individual patients as well as the health of other members in his or her community.

The legal and medical communities should move from employing a narrow conception of individual autonomy guided by professional advice and instead embrace shared decision-making and active involvement of local communities and organizations in the orthopedic health of society's members. Such community involvement in turn necessitates a reexamination of the function, costs, and benefits of the prevailing standards underlying the judicial conception of informed consent. Obesity and other implications of her or his diagnosis and the importance of prevention and treatment plans, or cannot access health care services because of communications problems, an untoward event may occur. The same is true if the treating physician does not understand the patient or the cultural context within which the patient receives critical information. Cultural, language and communication barriers – together or alone – have great potential to lead to mutual misunderstandings between patients and their health care providers.

Id.; see also ETHICAL FORCE PROGRAM, AM. MED. ASS'N, IMPROVING COMMUNICATION – IMPROVING CARE 9 (2006), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf (emphasizing that understanding culture, language, and literacy skills are essential to effective health care communication). “Communication-vulnerable populations” include those populations where there is a lack of English language proficiency, as well as health literacy, and a lack of culture understanding by the provider. ETHICAL FORCE PROGRAM, supra.

Id. at 7. “Patient-centered communication is respectful of and responsive to a health care user's needs, beliefs, values and preferences.” Id. (emphasis omitted).

Id. at 7, 9, 42. (concluding “clear communication is always important in health care, to every individual and population”). Diversity impacts communication and poor communication impacts health care. Id. at 7. In addition to communication at an individual level, some populations will need communication initiated at the community level in order for changes in belief or behavior to occur. Id. at 42.


See King & Moulton, supra note 28, at 431-32, 436. The current informed consent legal standard needs to evolve to a shared decision-making system that harmonizes patient autonomy
health risks that adversely impact joint and bone health require a village of collaboration amongst health care providers and consumers to appropriately address and minimize health care disparities.

II. Low Health Literacy and Its Impact

"Health literacy" is defined as "[t]he degree to which individuals have the capacity to obtain, communicate, process, and understand health information and services needed to make appropriate health decisions." When people are health literate, they are empowered to actively participate in shared decision-making with their health care provider to determine the appropriate course of treatment. Health literate patients are empowered to make informed decisions and are better prepared "to seek out, access, judge, and use information about their health." Unfortunately, more than forty-six percent of American adults are health illiterate.

In recent years, the prevalence of low health literacy has gained attention in the United States. An estimated 90 million adults in the United States have limited health literacy with physician beneficence, "tip[ping] in favor of autonomy in equally balanced situations." The prevailing legal standard concentrates on disclosure of information but pays little attention to whether the patient comprehends and can make meaningful use of the information. See id. at 431-32; see also, e.g., Complaint, Quinn v. Abiomed, Inc., No. 001524, 2002 WL 34249525 (Pa. Ct. C.P., Philadelphia Cnty. filed Oct. 15, 2002) (asserting physician assigned as "patient advocate" failed to advocate for and help patient with informed consent process); Sheryl Gay Stolberg, On Medicine's Frontier: The Last Journey of James Quinn, N.Y. TIMES, Oct. 8, 2002, at F1 (chronicling Mr. Quinn's serious medical issues and ultimate death vis-à-vis an experimental artificial heart received via clinical trial).

31 Shalowitz & Wolf, supra note 28, at 759-62 (discussing difficulties presented by low literate patients in shared decision-making). "Literacy has important consequences for health services delivery and is a strong predictor of a person's health status." Id. at 759.
33 Id. at 42.
34 See, e.g., Health Literacy, NAT'L NETWORK OF LIBRARIES OF MED., http://nnlm.gov/outreach/consumer/hlthlit.html#A3 (last updated Nov. 20, 2012) (compiling research on health literacy, the prevalence of low health literacy, and its impact); Jillanne M. Schulte, Comment, Health Literacy: Closing the Communication Gap Between Doctors and Patients, 34 HUM. RTS., Fall 2007, at 18, 18 (discussing recent findings from health literacy studies and
Uninsured patients and patients enrolled in Medicare and Medicaid have lower average health literacy than their counterparts with other types of health insurance. Poor health literacy contributes to inadequate informed consent discussions, improper use of medication, inappropriate and decreased health service utilization, reduced self-management, poor response to emergency situations, and social inequities. Low-literate patients often lack knowledge regarding the efficacy of preventive health measures and rely upon emergency care services to serve their health needs.

Over 300 studies, conducted over three decades and assessing various health-related materials, such as informed consent forms and medication package inserts, have found that a mismatch exists between the reading levels of the materials and the reading skills of the intended audience. In fact, most of the assessed materials exceed the reading skills of the average high school graduate.


A major impediment to appropriate communication about health is the limitation on provider time that is often required by HMOs, public clinics, and health-care reimbursement plans. For example, most plans do not reimburse for time spent in instructing patients on how to manage diabetes. Ironically, the result of poor communication and abbreviated or no patient education is higher use of emergency services, greater severity of illnesses, failure to follow instructions and use medications properly, and other “errors” which ultimately result in increased health-care costs.
needs. Emergency care is a more expensive and less successful treatment option for low-literate patients. In 2007, researchers at the University of Connecticut reported that the annual health care expenditures attributable to low health literacy ranged from $106 billion to $238 billion.

III. Cultural Competency

The increasing diversity in the population of the United States has intensified the need for cultural competency training for health care providers. While marginal or low-literacy is most prevalent amongst white native-born Americans, “changing demographics suggest that low literacy is an increasing problem among certain racial and ethnic groups, non-English-speaking populations, and persons over age 65 years.”

Cultural competence becomes important to health literacy at the point where language and culture interfere with or support effective communication. While health literacy efforts are not limited to cross-cultural situations, and cultural competence efforts are broader than health literacy, initiatives in both these areas would benefit from coordination with each other. In meeting the health needs of diverse peoples, cultural competency is essential for the development of health literacy.


39 Id. Because individuals with low health literacy tend not to use preventative health measures, their emergency room care is typically more expensive. See id.


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42 HEALTHY PEOPLE 2010, supra note 30 at 11-10. "One study of Medicare enrollees found that 34 percent of English speakers and 54 percent of Spanish speakers had inadequate or marginal health literacy." Id. The elderly population is also suspected to have low health literacy. See id. For instance, "a study of patients 60 years and older at a public hospital found that 81 percent could not read and understand basic materials such as prescription labels and appointments. Id.
This demonstrates an increasing need for culturally competent health care. Patients with low health literacy may experience difficulties in "providing a detailed history, responding to questions from their physicians, and formulating questions to ask their physicians." This is especially difficult for patients with limited English proficiency ("LEP"). LEP patients experience difficulty communicating with health care providers and participate less in health care decisions. A 1995 health literacy survey of patients at two public hospitals found that "35% of English-speaking patients and 62% of Spanish-speaking patients had inadequate or marginal functional health literacy in their native language."

The problems produced by the interactions of consumers with low health literacy and providers with low cultural competency are graphically illustrated in a profound book, *The Spirit Catches You and You Fall Down*. The book offers a troubling and insightful discussion of how the medical profession's cultural incompetence leads to poor patient outcomes. The author describes how a Hmong family from Laos repeatedly sought emergency medical care for their child who suffered from epilepsy. Instead of collaborating to provide care in the best interest of the child, the health care providers and patient's family entered a legal dispute. The lack of communication and cultural divide in this example of medical care illustrates how well-intentioned health care providers and patients exacerbate health problems primarily because they see the world through a different lens and respond to different values. Health care providers' inability to recognize and respond to cultural values remains a pervasive problem in the United States at a variety of levels.

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44 Id. at 105.
45 Id. The study involved "predominantly indigent and minority patients presenting for acute care." Id.
47 Id.
48 Id.
49 Id.
50 Id.
51 Id.
Today, an increasing number of medical professionals appreciate the importance of cultural considerations as a central component of quality medical care. More knowledge of cultural competency skills is being imparted to medical students through the medical school curriculum and to practicing health care professionals through requirements to complete continuing education courses. In the next section of this article, we consider how such education and training may be employed in the field of orthopedic medicine. We then turn our attention to the role the law should or should not play in relationship to health literacy, cultural competency, and informed consent.

IV. Patient-oriented Orthopedic Education and Health Care

Maintaining mobility is a significant key to good health because the sedentary or immobile patient runs a significant risk of being or becoming obese, with all of its associated disease states, such as heart disease, Type II diabetes, and hypertension. Among Americans ages fifty to eighty-four, obesity and knee osteoarthritis (“OA”) constitute two of the most frequent chronic conditions, leading to a substantial loss of quality-adjusted life years. Black and Hispanic women disproportionately experience this loss. Measurable health benefits do result from the reduction of the mean body mass index in these populations. Raising education and public health literacy can help reduce disparities in this area and achieve such goals.

Patients must understand that activity and conditioning help to control weight and can prevent or help treat the many other co-morbid diseases that commonly afflict a large number of obese patients. Treating patients' medical conditions without weight

53 See Joseph R. Betancourt et al., Cultural Competence and Health Care Disparities: Key Perspectives and Trends, 24 HEALTH AFF. 499, 499 (2005).
54 See id. at 501-02.
55 Elena Losina et al., Impact of Obesity and Knee Osteoarthritis on Morbidity and Mortality in Older Americans, 154 ANN. INTERN. MED. 217, 218 (2011).
56 Id. at 217, 221-22. “A quality-adjusted life-year (QALY) takes into account both the quantity and quality of life generated by healthcare interventions. It is the arithmetic product of life expectancy and a measure of the quality of the remaining life-years.” Ceri Phillips, What is a QALY?, WHAT IS...? SERIES (2D ED.), Apr. 2009, at 1, 1, available at http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/QALY.pdf.
57 Losina et al., supra note 55, at 217, 221-22.
58 See id. at 223-24.
59 See Betancourt et al., supra note 53, at 502-03.
60 Breedveld, supra note 23, at i5-i6.

A large proportion of patients with [osteoarthritis (OA)] suffer from
reduction or increased conditioning yields sub-optimal results.\textsuperscript{61} The patient must understand the benefits of weight loss and exercise. The function of the musculoskeletal system must be optimized to allow patients with arthritis to maintain their activity.\textsuperscript{62}

A variety of barriers to specialty care exist, such as insurance co-pays, distance, language, racial non-concordance, and gender non-concordance, limiting patients’ ability to seek and receive adequate medical care from specialists.\textsuperscript{63} A recent study found that, because of the low reimbursement rate, only approximately fourteen percent of comorbidities, including hypertension, cardiovascular disease, peripheral vascular disease, congestive heart failure, renal function impairment, diabetes and respiratory disease. . . . [H]alf of the patients [in a study of 1000 patients undergoing surgery for OA of the hip] had at least one comorbidity, and only 10% of patients had no comorbid disease or history of comorbid disease. In this latter group of patients, 78% were overweight or obese. The reasons for the high incidence of comorbidities in this study's participants are not known, and whether patients with OA are more likely to develop comorbidities or vice versa remains to be established.

\textit{Id.} at i5 (citations omitted).

\textsuperscript{61} See generally \textsc{Disease Control Priorities Project, Musculoskeletal Conditions Are the Most Common Cause of Chronic Disability} 2 (2007), \textit{available at} http://www.dcp2.org/file/84/DCPP-Musculoskeletal.pdf. (noting benefits of weight reduction through physical activity and consumption of balanced diet); Luke B. Connelly et al., \textit{Cost-Effectiveness of Interventions for Musculoskeletal Conditions}, in \textsc{Disease Control Priorities in Developing Countries} (Dean T. Jamison et al. eds., 2d ed. 2006).

\textsuperscript{62} See Connelly et al., \textit{supra} note 61, at 966.

Obesity brought about by increases in sedentary lifestyles and changes in eating patterns is becoming a major problem worldwide. Weight reduction has been demonstrated to reduce pain and disability from [osteoarthritis (OA)] of the knee and other forms of lower limb arthropathy. In OA of the knee, weight reduction will not only reduce pain and improve mobility, but it can put off the time when surgical replacement of the weight-bearing joint is necessary. Obesity can also be associated with back pain, and weight reduction is an important factor in reducing the recurrence of episodes of back pain and in reducing long-term disability and chronic pain. . . . Appropriate nutrition and exercise underpin many of the preventive and treatment strategies for musculoskeletal disease.

\textit{Id.}

\textsuperscript{63} Carlos J. Lavernia et al., \textit{Access to Arthroplasty in South Florida}, 27 J. \textsc{Arthroplasty} 1585, 1587 (2012).
orthopedic surgeons in private practice in South Florida were willing to make an appointment with a patient covered by Medicaid insurance who needed a knee replacement. In comparison, one hundred percent of the surgeons were willing to make an appointment for a prospective patient with private insurance who needed a knee replacement. Another barrier to specialty care can involve abusive marketing practices by Medicare Advantage plan insurers in which Medicare beneficiaries may be misled about a private plan's covered services and participating physicians, leading beneficiaries to join the private plan to their detriment.

A more prominent barrier to specialty care involves the common need for a referral to such care. In many instances, without a referral from a primary care physician, there is no clearly marked door to walk through to get to specialty care. Many primary care providers, however, note their own lack of musculoskeletal training and experience and have serious gaps in their understanding of osteoarthritis treatment. Even with a primary care referral, the patient is being asked to trust that their orthopedic physician will take an unbiased approach to their problem. If the musculoskeletal care

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64 Id. at 1586-87.
65 Id. at 1586.
67 Kristina Akesson et al., Improved Education in Musculoskeletal Conditions Is Necessary for All Doctors, 81 BULLETIN 677, 677 (2003), available at http://www.who.int/bulletin/volumes/81/9/Akesson20903.pdf; MOVEMENT IS LIFE: A CATALYST FOR CHANGE, supra note 9, at 11 (citing Kevin B. Freedman & Joseph Bernstein, The Adequacy of Medical School Education in Musculoskeletal Medicine, 80 J. BONE & JOINT SURGERY (AM.) 1421-27 (1998)).
68 In Dr. Wood's professional experience as an orthopedic surgeon, there are often several components to a successful referral for specialty care: (1) patient trust in the referring physician; (2) positive testimonials from the specialist's previous patients; (3) a positive public perception of the provider and/or hospital - generally, as established through public relations; (4) valid credentials of the specialist, including board certification and fellowship training; and (5) further validation of the specialist by an influential source such as a family member or pastor. For further information on physician-specialty referrals, see, e.g., Christopher B. Forrest et al., Specialty Referral Completion Among Primary Care Patients: Results from the ASPN Referral Study, 5 ANNALS FAM. MED. 361 (2007); Kraig S. Kinchen et al., Referral of Patients to Specialists: Factors Affecting Choice of Specialist by Primary Care Physicians, 2 ANNALS FAM. MED. 245 (2004); Bill Champion, Build Referrals with Nine Milestones in Patient Care: What Does Your Patient Experience
received does not merit the trust, the patient may not return.

In order to be effective, health care providers must incorporate their patients’ cultural values into their services. By enacting legislation, several states are mandating cultural competency courses that impart a wide array of strategies and techniques to close the health literacy gap.69 For instance, health care providers are trained to refrain from using medical jargon when dealing with a low-literate patient, and to speak slowly, particularly when explaining instructions.70 Offering ancillary patient-centered information such as reading material, videos, and websites can augment physician-patient communication;71 however, any of these approaches require patient interest, understanding, and curiosity to be effective. Written materials should convey medical information at a third to fifth grade reading level.72 Health care providers are encouraged to use pictorials to communicate instructions, to refrain from dismissing or ridiculing a patient’s beliefs, to maintain a neutral stance, and to respect cultural differences.73

In order to build a trusting rapport and have successful communication, physicians must facilitate environments where patients feel at ease.74 It is also critically important to make a patient feel heard.75 Orthopedic practices do not always

70 GLORIA G. MAYER & MICHAEL VILLAIRE, HEALTH LITERACY IN PRIMARY CARE: A CLINICIAN’S GUIDE 41 (Sally J. Barthdyt & Shana Meyer eds., 2007).
71 Id. at 41-43.
72 Id. at 43.
73 Id. at 118-23.

The concept of patient-centered care compels physicians to treat patients as
communicate: “We want to care for you in our clinic.” Providing a welcoming and diverse administrative and paraprofessional staff helps to create a comfortable initial contact. This initial contact must go beyond confirming the patient’s medical problem and approving the type of insurance they carry. The patient’s interaction with a knowledgeable, caring nurse, medical assistant, or physician’s assistant, sets the stage for meaningful interaction with the provider and better utilization of ancillary patient information materials. Treatment options are not one-size-fits-all and should be customized for each patient’s individualized health needs.

Whether or not a provider is communicating successfully with a patient can be difficult to gauge. Yet, a provider must take the time and initiative to ensure that the patient and his or her family understand the message. A provider may, for instance, partners, involving them in decision making and enlisting a sense of self-responsibility for their care, while respecting their individual values and concerns. Specifically, this process includes striving to maintain eye contact; leaning forward; remaining physically calm; avoiding jargon and interruptions; validating the patient’s emotions; learning about the patient’s lifestyle; checking for understanding; and offering support. Effective communication skills allow for more accurate diagnoses, better adherence to treatment plans, decreased medical liability, and better patient outcomes.

Id. at 109 (footnotes omitted).

76 See id. at 109-16 (detailing noted lack of empathy and engagement among orthopedic surgeons and suggesting communication methods to improve patient-centered care).

Consumers favorably rate orthopaedic surgeons on successful medical results, which is the most important factor. However, the interpersonal skills of listening, demonstrating compassion, and spending time with patients also rank very high with patients but much lower with orthopaedic surgeons.

The most common deficiency in daily interviews with patients is the consistent failure of the orthopaedic surgeons to offer empathic responses. Social science research clearly indicates that doctors trained in empathy can improve their ability to make eye contact, appear more attentive, reflect understanding, and express feelings that encourage patients to talk openly.

Id. at 110 (footnote omitted).

77 MAYER & VILLAIRE, supra note 70, at 29-30, 40-41; JOINT COMM'N, supra note 25, at 7 (recommending hiring practices that promote diversity to demonstrate priority of cultural competence).

78 MAYER & VILLAIRE, supra note 70, at 40.

79 See id. at 135 (noting difference between knowing a language and communicating effectively). “Communication issues transcend language. Just because a patient speaks Spanish and his or her nurse speaks Spanish, for instance, does not necessarily mean the two are communicating.” Id.
assess a patient's comprehension during an interaction by asking open-ended questions to facilitate discussion followed by open- and closed-ended questions to ensure the patient understood the conversation. Ensuring successful communication between provider and patient empowers the patient with the knowledge to make informed decisions and helps to reiterate the reasons why he or she is on a particular treatment plan.

With a treatment plan in place, group interaction can help anchor successful adherence, including lifestyle changes. Providers should always suggest a partner to walk the changing road with the patient, whether it involves changes in eating, exercise, or personal appearance. Trusted voices, including those of friends, family, community members, celebrities, and non-profit organizations, can play a significant role in increasing individual health awareness, and, similarly, community health consciousness can be raised through neighborhood activities, employer programs, churches, hospital outreach programs, and other community settings. For instance, church health

80 See id. at 134, 142-43. Common questions and instructions used by health care providers to test a patient's comprehension of their interaction include “Did you understand what I just said?,” “Do you have any questions?,” and “Draw what you think we are doing.” Id. To assess the patient's continuing understanding of his or her medical condition on the day of a follow-up visit or procedure, a provider may ask “What are we doing today?” See id.

81 See MAYER & VILLAIRE, supra note 70, at 143 (finding “teach back” to be an effective means for improving patient's understanding). For instance, after describing in simple terms how to take a prescribed medication, the provider might ask the patient, “Would you tell me how you are going to take this medicine so I can be sure I've told you everything?” Id.

82 E.g., Rena R. Wing & Robert W. Jeffrey, Benefits of Recruiting Participants with Friends and Increasing Social Support for Weight Loss and Maintenance, 67 J. CONSULTING & CLINICAL PSYCHOL. 132 (1999) (correlating long-term weight loss and maintenance with social support and participation of family and friends); Charlotte Huff, Teaming Up To Drop Pounds, MONITOR ON PSYCHOL., Jan. 2004, at 56 (providing overview of studies linking success of weight loss to group participation), available at http://www.apa.org/monitor/jan04/teaming.aspx; see also Exercise: How to Stay Active, NIHSENIORHEALTH, http://nihseniorhealth.gov/exerciseandphysicalactivity/howtostayactive/makeexerciseahabit/01.html (last visited Mar. 29, 2013) (recommending enlistment of friend or family member to help develop exercise as habit); see also Haynes et al., supra note 21, at 2883 (suggesting family support may be useful in promoting patient adherence to prescribed treatment). For a more recent example in popular culture of group interaction to support lifestyle changes, see, for example, The Biggest Loser, About, NBC, http://www.nbc.com/the-biggest-loser/about/ (last visited Mar. 29, 2013) (seeking to inspire weight loss amongst obese adults and children through group interaction and support).

83 See Renjilian et al., Individual Versus Group Therapy for Obesity: Effects of Matching Participants to Their Treatment Preferences, 69 J. COUNSELING & CLINICAL PSYCHOL. 717, 717, 719-20 (2001) (finding “group therapy [may] produce[ ] greater weight loss than individual therapy, even among those clients who express a preference for individual treatment”).

84 See generally NAT'L PREVENTION COUNCIL, U.S. DEP'T OF HEALTH & HUMAN SERVS.,
ministries provide an ideal example of a shared effort to promote community health, often with specific initiatives to maintain mobility by providing programs that encourage community members to remain physically active.\textsuperscript{85} Physician-directed community outreach programs also offer valuable information to community members in an environment that is less formal and threatening than the physician's office.\textsuperscript{86}

\textsuperscript{85} See, e.g., \textit{Health Ministry Program}, ALTA BATES SUMMIT MEDICAL CENTER, http://www.altabatessummit.org/community/hm.html (last visited Mar. 29, 2013). “Health ministry activities can range from meeting the individual needs of the congregation by providing health screenings, to addressing social justice issues for the entire community (safe neighborhoods). Faith communities are vital centers for addressing the well-being of people in their communities.” Id.; see also Rebecca A. Krukowski et al., \textit{Obesity Treatment Tailored for a Catholic Faith Community: A Feasibility Study}, 15 J. HEALTH PSYCHOL. 382 (2010) (finding significant weight loss and high satisfaction among study participants).

V. Law, Health Literacy, Cultural Competency, and Informed Consent

Recent policies and initiatives in both the federal and state arenas have addressed health literacy and culturally competent health care. These approaches take into account the challenges health care providers face in getting informed consent and giving good advice, and the challenges consumers face in abiding by that advice and understanding the consequences of their lifestyle decisions.

A. Health Literacy – Federal Law and Initiatives

While there is no direct federal law on health literacy like the once attempted National Health Literacy Act of 2007, the newly enacted PPACA encourages health literacy and cultural competency in a variety of ways. PPACA makes continual references that health care plans, documents, procedures, and programs are to be carried out in a "culturally and linguistically appropriate manner." For example, PPACA

87 National Health Literacy Act of 2007, S. 2424, 110th Cong. (2007) (as reported by S. Comm. on Health, Educ., Labor & Pensions, Dec. 6, 2007), available at http://www.gpo.gov/fdsys/pkg/BILLS-110s2424is/pdf/BILLS-110s2424is.pdf. In 2007, the National Health Literacy Act was introduced in the Senate to address the need for Americans to “have basic health literacy skills to function effectively as patients and health care consumers.” Id. The Act proposed amending the Public Health Service Act by establishing the Health Literacy Implementation Center which would have focused on eliminating low health literacy through research, development, and making information more available to the diverse public. Id. § 3(b)(1). Among other responsibilities, the Center would have been directed to make health literacy resources more available to providers and the public, to enter partnerships and interagency agreements (such as with the Department of Health and Human Services and the Department of Education), to promote the use of health literacy interventions and tools, and to convene yearly to raise awareness of the issue and of federal and state efforts to address it. Id. §§ 3(b)(2)(A)-(B), (F)-(G), 3(b)(3). The Act also would have required the Health and Human Services Secretary to contract with the Institute of Medicine to identify opportunities within the department itself to improve the public’s health literacy through the Medicare and Medicaid programs and at the Food and Drug Administration. Id. § 4(a). Unfortunately, the National Health Literacy Act never became law and only went so far as to be reviewed by the Senate Committee on Health, Education, Labor, and Pensions. Bill Summary & Status: 110th Congress (2007-2008): S.2424, LIBRARY OF CONG. – THOMAS, http://hdl.loc.gov/loc.uscongress/legislation.110s2424 (last visited Mar. 29, 2013). It has not been reintroduced. See id.


requires the language in a summary of insurance benefits and coverage to be "presented in a culturally and linguistically appropriate manner and [to] utilize[] terminology understandable by the average plan enrollee." PPACA also requires the Secretary of Health and Human Services, along with the Secretary of Labor, to develop guidance on the best practices of plain language writing and requires health plans seeking certification as qualified health plans to utilize plain language. PPACA defines "plain language" as language that "the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

PPACA also establishes the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality. Among its many responsibilities, the Center must disseminate research findings "to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy." PPACA also addresses the necessity for a patient's informed decision-making by requiring patient decision aids. It calls for health care providers to "present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy." In addition, the Secretary of Health and Human Services is required to consult experts in health literacy when considering promotional labeling and advertising of prescription drugs. The Secretary also has authority in awarding grants...
to give priority to qualified applicant accredited schools of medicine or osteopathic medicine, pediatric, or public health dentistry that provide cultural competency or health literacy training and educational activities.98

Section 5307 of PPACA amends Section 741 of the Public Health Service Act by relabeling the heading as “Cultural Competency, Prevention, and Public Health and Individuals with Disability Grants” and by emphasizing collaboration between several entities, such as community-based organizations, health professions schools, and licensing and accreditation entities, to develop research and curricula that further culturally competent measures.99 Therefore, PPACA’s health care reform seems to address the goal of strengthening cultural competency training for health care providers and requires the use of language services and community outreach in underserved communities.100

The National Plan to Improve Health Literacy released by the Department of Health and Human Services in May 2010 also offers potential to help bridge the communication gap.101 The plan proactively sets out seven goals for creating accessible and understandable health and safety information. Each goal includes different strategies for the various sectors of the health care system.102 For instance, goal number one is to develop and disseminate health and safety information that is accurate, accessible, and actionable.103 The plan lists strategies for organizations and individuals,

In making [this] determination . . . the Secretary shall review all available scientific evidence and research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women’s and pediatric health.

Id. § 3507(b).

98 Id. § 5301, 124 Stat. at 617 (to be codified at 42 U.S.C. § 293k(b)(3)(H). PPACA requires the Secretary to give priority to applicants that “provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies.” Id.

99 Id. § 5307(a)(1)(A), (B), 124 Stat. at 628 (amending 42 U.S.C. § 293e(a)).

100 See Garth Graham, Closing the Gaps in Health Disparities, HEALTHCARE BLOG (Apr. 8, 2011), http://www.healthcare.gov/blog/2011/04/disparities04082011.html (explaining that PPACA offers potential to address needs of racial and ethnic minorities).


102 Id.

103 U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL ACTION PLAN TO IMPROVE HEALTH LITERACY 18 (2010), available at
The strategies, depending on the sector, range from improving health literacy training in schools to involving members of the target population in spreading information to using local or community media to raise awareness. The action plan takes on a holistic approach to improving health literacy, and it stresses the importance of all parties involved within the health care system becoming active in addressing the issue.

In addition, several federal statutes address language-access services. Title VI of the Civil Rights Act of 1964 addresses federal fund recipients, stating "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The Supreme Court has interpreted this statutory language to include proxies for national origin. In a 1980 notice, the Department of Health and Human Services extended this notion to the health care sector, stating that "[n]o person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.

Title VI was further clarified by President Clinton in 2000 when he issued Executive Order 13166 - Improving Access to Services for Persons with Limited English Proficiency. Title VI and E.O. 13166 reiterate the necessity for individuals across cultures to be health literate by addressing the importance of better communication between providers and

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104 Id. at 25.
105 Id. at 48.
106 Id. at 45.
108 Lau v. Nichols, 414 U.S. 563, 566-67 (1974). A school system that receives federal financial assistance cannot fail to attempt to accommodate non-English-speaking students. Id. at 565-69. Such a failure "denies [non-English-speaking students] a meaningful opportunity to participate in the educational program" and, thus, violates section 601 of the Civil Rights Act of 1964, which "bans discrimination based 'on the ground of race, color, or national origin,' in 'any program or activity receiving Federal financial assistance." Id. at 565-67.
109 Nondiscrimination on the Basis of Race, Color, or National Origin Under Programs Receiving Federal Financial Assistance Through the Department of Health and Human Services, 45 Fed. Reg. 82,972 (Dec. 17, 1980) (providing notice of HHS's intent to develop regulations, for codification at 45 C.F.R. Part 80, in accordance with Title VI of the Civil Rights Act).
patients. Soon afterwards, the Office for Civil Rights ("OCR"), charged with overseeing the enforcement of acts such as the Civil Rights Act or the Hill Burton Act, issued OCR Policy Guidance to help health care providers and other federal fund recipients in meeting their obligations to LEP individuals.

Further addressing language services, the Department of Health and Human Services' Office of Minority Health developed National Standards for Cultural and Linguistically Appropriate Services ("CLAS standards") from 1997 to 2000. The CLAS standards provide mandates, guidelines, and recommendations directed at health care organizations and individual providers to reduce inequities in the delivery of health care services. CLAS mandates, which involve Language Access Services, require recipients of federal funds to provide such services in a manner that communicates medical information effectively. Despite these steps towards improvement, there are no federal standards governing certification of health care interpreters or interpreter competency.


114 Office of Minority Health, supra note 113, at 3. The HHS Office of Minority Health developed fourteen total standards, "organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14)." Id.

115 Id. at 3, 10-13, 65-82 (detailing mandatory requirements for Language Access Services (Standards 4-7)).

116 Chen, supra note 111, at 364-65; see also Janet Bonet, Full Circle: The Qualified Medical Interpreter in the Culturally Competent Healthcare System, in Cultural Proficiency in Addressing Health Disparities 103, 107-09 (Sade Kosoko-Lasaki et al. eds., 2009) (noting mere bilingualism as insufficient for appropriate interpreting services in a health care setting).
B. Cultural Competency – State Laws and Language Initiatives

Individual states have passed statutes encouraging multicultural education for future health care professionals and for medical school students.\(^\text{117}\) California, New Jersey, and Washington have enacted laws mandating that cultural competency training be incorporated into the curriculum of medical students and health care professional education programs as a licensing requirement.\(^\text{118}\) New York and Ohio have bills pending that would mandate the same.\(^\text{119}\) Maryland has also passed significant legislation with its Health Care Services Disparities Prevention Act, which requires its Office of Minority Health and Health Disparities to work collaboratively with universities and other health care institutions to develop courses regarding "cultural competency, sensitivity, and health literacy that are designed to address the problem of racial and ethnic disparities in health care access, utilization, treatment decisions, quality, and outcomes."\(^\text{120}\)

The most significant state legislation responds to changing demographics and aims to enhance language access services. In 2002, at least 26 states and the District of Colombia had enacted legislation requiring health care providers to have some form of language assistance services for LEP individuals.\(^\text{121}\) As of 2006, this number nearly doubled with 43 states enacting one or more laws requiring language assistance services in health care settings.\(^\text{122}\) California itself has over 70 laws directed towards improving access to translated health information.\(^\text{123}\) In fact, its Health Care Language Assistance Act was trailblazing legislation for requiring health plans and insurers to provide their enrollees with language interpreter services.\(^\text{124}\) Individual states have also begun

\(^{117}\) Medical Cultural Competency Legislation and Regulation, supra note 69 (providing overview of states with continuing medical education requirement laws enacted and pending).

\(^{118}\) Id.; CAL. BUS. & PROF. CODE § 2190.1 (West 2012); N.J. STAT. ANN. § 45:9-7.3 (West Supp. 2012); WASH. REV. CODE ANN. § 43.70.615 (West Supp. 2013).


\(^{122}\) Chen, supra note 111, at 363-64.

\(^{123}\) Id. at 363.

addressing interpreter competency by requiring a certain degree of training and assessment; for example, Washington, Oregon, Indiana, and North Carolina are among those that have begun to develop their own certification standards for health care interpreters.\textsuperscript{125}

A major impediment, however, is reimbursement for language access and translating services.\textsuperscript{126} Medicaid and the State Children’s Health Insurance Program (“\textit{SCHIP}”) suggest they could offer reimbursement for interpreting and/or translating services; however, this is heavily reliant on the state’s determination of whether and how to provide reimbursement.\textsuperscript{127} Ultimately, legal obligations vary in scope and impact from state to state, depending on various factors within the state itself, such as political climate, advocacy groups, and demographics.\textsuperscript{128} Nevertheless, the increased measures for cultural competency training and interpreter services suggest a hopeful trend towards enhancing health literacy among diverse populations within various states.

to develop regulations to require health plans to provide translation and interpretation services); Bobby Caina Calvan, \textit{New State Law Requires Translators For Patients: Aim Is To Topple a Barrier To Good Medicine}, SACRAMENTO BEE, Jan. 3, 2009, at A1 (detailing law and regulations, noting that a moratorium and political wrangling delayed implementation several years).

Millions of Californians with limited English proficiency now have the right to an interpreter from their commercial health and dental plans – made possible by a first-in-the-nation law aimed at dismantling the language barriers that get in the way of good medicine.

The new regulation – implemented New Year’s Day after five years of hearings, delays and wrangling among insurance companies, regulators and consumer advocates – is widely hailed as a milestone in reducing mistakes because of miscommunication.

\textit{Id.}  
\textsuperscript{125} Chen, \textit{supra} note 111, at 364-65.  
\textsuperscript{126} \textit{Id.} at 365.  
\textsuperscript{127} \textit{Id.} at 364. Generally, “hospitals are reimbursed for patient care according to the diagnosis and are not reimbursed specifically for interpreter services.” OFFICE OF MINORITY HEALTH, \textit{supra} note 121, at 18. Although reimbursement issues exist, more and more states have begun requiring health plans to meet the needs of non-English-speaking enrollees under their Medicaid managed care contract provisions. \textit{Id.} As of 2002, approximately “three-quarters of all states require[d] plans and providers to make written materials available in other languages; close to half require[d] language interpreter services for clinical and administrative encounters; and nearly two-thirds of all Medicaid managed care contracts have some cultural competence requirements that are non-language specific.” \textit{Id.} Therefore, state Medicaid policies seem promising in trying to increase public health literacy. \textit{See id.}  
\textsuperscript{128} Chen, \textit{supra} note 111, at 363-64.
C. Shared Decision-Making: Clarifying and Rethinking Relationships and the Role of Law

In 1972, the District of Columbia Court of Appeals rendered a decision that ultimately reshaped physician-patient relationships in the United States.129 Faced with a case involving a 19-year-old male patient who was permanently paralyzed from the waist down after undergoing elective back surgery, the court ruled that the surgeon could be held responsible for the damages sustained by the young man because the surgeon had not advised the patient that the surgery presented a one percent risk of paralysis, even if the operation was done properly.130 Rejecting a then commonly accepted “physician-based” standard of informed consent in which the physician’s responsibility to his patient rested solely on professional standards of care when disclosing risks, the court declared emphatically that because it was the patient’s body, the patient had a right to decide what risks he wanted to incur.131 The right to make such decisions rests on the value society places on individual freedom and autonomy, values that demand respect in the practice of medicine. The court’s opinion in Canterbury invigorated the modern notion of a patient’s right to get enough information from his or her physician to give an informed consent by requiring physicians to disclose any material risk.132 Henceforth, in states that have adopted this “patient-based” standard, a physician must not only conform to professional standards of care when disclosing risks, but must also

129 Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) (holding that principle of informed consent requires physician to disclose material risks, i.e., information that reasonable patient would wish to know in making treatment decisions).

130 Id. at 779.

131 Id. at 786. Prior to Canterbury’s adoption of this “patient-based” standard, states typically employed a “physician-based” standard that “generally require[d] physicians to ‘inform a patient of the dangers of, possible negative consequences of, and alternatives to a proposed treatment or procedure’ to the same degree that a ‘reasonably prudent practitioner in the same field of practice or specialty in [that state]’ would.” King & Moulton, supra note 28, at 441 (providing overview of state medical malpractice actions). As of 2006, twenty-five states still used the physician-based standard in medical malpractice actions, i.e., had not rejected the physician-based standard in favor of a patient-based standard, as the court did in Canterbury. Id. at 441-42.


The current patient-based standard (the objective standard) requires a physician to disclose any material risk. A risk is material if the physician believes that a reasonable person in the patient’s position “would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.”

Id. at 445 (footnotes omitted).
communicate any material risks to his or her patient. Regardless of a state's standard of informed consent, the physician must defer to the patient's judgment, even if the patient's decision clashes with the medical community's collective advice about good health care.

Thus, under any legal doctrine of informed consent, a physician's role is generally to convey information, not to advocate a particular choice. Thoughtful critics, however, have questioned whether the legal doctrine should be built upon a vision that medical decision-making must involve a choice between complete paternalism and individual autonomy. The late Jay Katz, MD, a leading scholar from Yale Law School, argued that the legal doctrine intended to protect autonomy could be

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133 See King & Moulton, supra note 28, at 443, 445 (noting trend toward deference to patient autonomy in adoption of patient-based standard); see also e.g., Cobbs v. Grant, 502 P.2d 1, 10-11 (Cal. 1972) (adopting patient-based standard in California). The Cobbs court further noted that once material risks have been disclosed, a physician's informed consent duty is complete, and the patient bears responsibility for subjectively determining whether to proceed with treatment. Id. As of 2006, twenty-three states and the District of Columbia had adopted the patient-based standard in medical malpractice actions. King & Moulton, supra note 28, at 445.


135 Cathy J. Jones, Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy, 47 WASH. & LEE L. REV. 379, 424 (1990) (noting general deference to patient after disclosure of risks). Although physicians are required to disclose some risks under any legal doctrine of informed consent, physicians may— inadvertently or not— use at least subtle persuasion to attempt to prevent patients from making a "wrong" decision. See id.

Patients, however, in the absence of compelling state interests to the contrary, have the right to act in a manner which others deem to be irrational, foolish, or stupid. . . . Only if physicians believe patients to be incompetent . . . should they decide that patients cannot make decisions for themselves. Even at that point, however, physicians are not entitled to make decisions for patients, but rather they are compelled to follow the informed consent process with a substitute or surrogate decisionmaker—a family member or legal guardian. Those surrogates are entitled to the same information as the competent patient concerning the patient's condition and the risks, benefits, and alternatives to the proposed treatment option. Moreover, they are entitled to receive that information in an objective manner, and by definition, they must understand the information before they can make a decision based on that information.

Id. at 424-25 (footnotes omitted).
Another scholar at Yale, Robert Burt, has contended that total deference to patient decision-making in situations when a patient must accept or reject care to continue living, poses the danger of encouraging the physician to be detached, rather than engaged, with a patient who needs the physician's involvement in the decision-making process. Other scholars contend that patients enter the physician-patient relationship with widely varying values and knowledge, and, consequently, the law should not embrace a legal mandate of communication on the false premise that one size fits all.

The law of informed consent does not take into account two practices in medicine that offer great potential to promote better health among diverse populations, namely, shared decision-making and motivational interviewing. Both practices aim to promote patient collaboration with the health care provider in making informed treatment choices. Health care providers have adopted practices of interacting with...
patients that demonstrate that remaining engaged with a patient and participating in ongoing decisions about the patient's health and health care produce greater patient satisfaction with both the decisions made and care provided. This type of engagement and teamwork stands in stark contrast to the vision the law offers of informed consent.

Court cases addressing informed consent often arise in the context of decision-making about surgery and, in this context, court opinions invite the impression that a physician's duty to a patient is limited to conveying information about risks, benefits, and alternatives. Beyond conveying medical information, the court opinions suggest that a physician should step away and allow the patient to make an autonomous decision. Indeed, a court in Pennsylvania held expressly that because a physician's duty to get informed consent arises from the legal doctrine supporting the intentional tort of battery, a physician's duty to discuss risks, benefits, and alternatives only arises when the medical treatment under consideration entails a physician touching a patient.


See Fitzpatrick v. Natter, 961 A.2d 1229, 1237 (Pa. 2008). The doctrine of informed consent is meant to ensure that the patient has adequate information to make decisions about his or her medical care. Id.; see also Newmark-Shortino v. Buna, 48 A.3d 401, 413 (N.J. Super. Ct. App. Div. 2012) (discussing doctrine of informed consent's requirement that physicians provide adequate information about risks and alternative treatments); Downs v. Trias, 49 A.3d 180, 186 (Conn. 2012) (“In order to prevail on a cause of action for lack of informed consent, a plaintiff must provide both that there was a failure to disclose a known material risk of proposed procedure and that such failure was a proximate cause of his injury.” (citing Shortell v. Cavanagh, 15 A.3d 1042 (Conn. 2011))).

good medical practice,\textsuperscript{143} nor is it mandated by existing law in most states.\textsuperscript{144} However, as the continuing debate over defensive medicine demonstrates, physician perceptions of the law may significantly impact their behavior and their relationships with patients.\textsuperscript{145} Courts and legislatures should clarify the law to encourage shared decision-making and to encourage the development of more effective approaches to health maintenance and improvement.

Dr. Katz in \textit{The Silent World of Doctor and Patient} depicts medical culture historically as struggling with the proper allocation of power between physician and patient, and that struggle continues today.\textsuperscript{146} Nevertheless, the culture of medicine and medical education have changed dramatically in the four decades since the \textit{Canterbury} court announced a shift in consent toward a patient-based standard, requiring that legally acceptable consent be “informed” from the patient’s perspective and not simply from

\textsuperscript{143} See, e.g., \textit{Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship}, supra note 134.

The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. . . . The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

\textit{Id.}

\textsuperscript{144} See King & Moulton, \textit{supra} note 28, at 438-45 (providing overview of state standards of informed consent).

\textsuperscript{145} For articles discussing the impact of “defensive medicine” on patients and health care, see, e.g., Allen Kachalia & Michelle M. Mello, \textit{New Directions in Medical Liability Reform}, 364 \textit{NEW ENG. J. MED.} 1564 (2011) (noting that through defensive medicine “providers avoid high-risk patients or services or order extra tests, referrals, and services primarily to reduce their liability risk”); Michelle M. Mello et al., \textit{National Costs of the Medical Liability System}, 29 \textit{HEALTH AFF.} 1569 (2010); Tara F. Bishop et al., \textit{Physicians’ Views on Defensive Medicine: A National Survey}, 170 \textit{ARCHIVES INTERNAL MED.} 1081 (2010) (finding most physicians studied to “believe that malpractice concerns result in unnecessary testing and procedures’’); Richard E. Anderson, \textit{Billions for Defense: The Pervasive Nature of Defensive Medicine}, 159 \textit{ARCHIVES INTERNAL MED.} 2399 (1999) (asserting that defensive medicine violates the Hippocratic Oath and “does violence to the physician-patient relationship”). Courts have also recognized defensive medicine as an issue. See, e.g., Ferdon ex rel. Petrucelli v. Wisconsin Patients Comp. Fund, 701 N.W.2d 440, 463 (Wis. 2005) (finding practice of “defensive medicine” to avoid malpractice may adversely affect physician-patient relationship); Pin v. Kramer, 41 A.3d 657, 659-660 (Conn. 2012) (holding expert testimony as to need for practice of “defensive medicine” led to mistrial in medical malpractice case).

\textsuperscript{146} See KATZ, \textit{supra} note 136; see also infra note 149 (discussing some evidence of this ongoing struggle).
the physician’s disclosure of risks in satisfaction of a professional standard.147 At the
time of Canterbury, health care providers generally assumed their job was to practice
disclosure of risks to patients); Fredericka K. Shea, Hurricane Katrina and the Legal and Bioethical Implications of Involuntary Euthanasia as a Component of Disaster Management in Extreme Emergency Situations, 19 ANN. HEALTH L. 133, 135-36 (2010) (discussing early common law and Canterbury’s expansion of informed consent). See generally King & Moulton, supra note 28 (arguing for a shift in the legal doctrine of informed consent toward shared decision-making). One significant change in medicine and medical education has been an increasing openness to shared decision-making. The process of shared decision-making has “gain[ed] momentum within the medical community as the most effective way to make the culture of professionalism was nourished by a belief in a hierarchy that placed the power of deciding what to do about medical care rightfully in the hands of licensed physicians. Law changed the power positions, and eventually the culture of medicine transformed itself, albeit begrudgingly, to accept the concept of patient autonomy that gave the patient the ultimate authority to decide what medical care, if any, he or she wants.149

147 See Canterbury v. Spence, 464 F.2d 772, 781-82 (D.C. Cir. 1972) (establishing duty for physicians to disclose material risks of procedures to patients); Fredericka K. Shea, Hurricane Katrina and the Legal and Bioethical Implications of Involuntary Euthanasia as a Component of Disaster Management in Extreme Emergency Situations, 19 ANN. HEALTH L. 133, 135-36 (2010) (discussing early common law and Canterbury’s expansion of informed consent). See generally King & Moulton, supra note 28 (arguing for a shift in the legal doctrine of informed consent toward shared decision-making). One significant change in medicine and medical education has been an increasing openness to shared decision-making. The process of shared decision-making has “gain[ed] momentum within the medical community as the most effective way to make treatment decisions that involve significant tradeoffs, such as elective surgery vs. conservative management.” Id. at 467. Although many scholars have advocated a change in the law to reflect that seen in medicine, the law has not seen a similar trend toward shared decision-making in the doctrine of informed consent. Id. at 462, 467. In advocating for such a change, King and Moulton note, however, that “[t]he procedural and structural changes that must be made within the medical system to implement shared medical decision-making in routine practice . . . have created a great debate amongst scholars regarding the practicality of imposing it as a legal requirement.” Id. at 462.

148 See PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 46-48 (2d. ed. 2001). In Canterbury and other similar cases, courts began to disregard the professional standard of disclosure in favor of a more patient-oriented standard, noting that, in some instances, physicians would not disclose any risks because it was not within the professional standard to do so for certain treatments. Id. In the twenty-five states that still use a physician-based standard of informed consent, a physician who discloses no risks or benefits of a treatment will avoid liability if it is the professional standard to disclose no risks or benefits of that treatment. King & Moulton, supra note 28, at 441.

149 Although the physician’s duty to disclose certain risks already existed as an element of malpractice law, Canterbury marked a change in emphasis toward patient autonomy in the legal doctrine of informed consent, which impacted disclosure practices in the medical community. See Canterbury, 464 F.2d at 782-83; Shea, supra note 147, at 136-37 (discussing impact of Canterbury). In the wake of Canterbury and other significant court decisions reaffirming the focus on patient autonomy, medical ethics codes have been revised to reflect the legal standard. Id. at 136. For instance, see the American Medical Association’s Code of Medical Ethics opinion on informed consent, noting, in part:
The law of informed consent was constructed based on the concept of patient autonomy, meaning that the patient alone would make a decision after being educated by a health care professional. Consequently, the legal doctrine of informed consent developed in response to a perceived patient need for medical information. The premise is that after the autonomous patient receives information, he or she will be in a position to make an informed decision.

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

AM. MED. ASS'N, CODE OF MEDICAL ETHICS 227 (2006); Opinion 8.08 - Informed Consent, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page (last visited Mar. 29, 2013). See also APPELBAUM ET AL., supra note 148, at 53-65 (providing physicians with overview of which information must be disclosed to satisfy patient-oriented standards of informed consent). There is some evidence, however, that physicians “ignore informed consent requirements regardless of the standard applied, perhaps rationalizing that they are acting in the patient’s best interests.” Id. at 52.

As [Dr. Jay] Katz has noted, “the idea of physicians making decisions for, rather than with, patients is still deeply embedded in the ideology of medical professionalism.” One survey found that although most physicians are aware of legal consent standards, they do not apply them properly. The authors suggest that while this may be due to lack of understanding of how to apply the law, it may also result from physicians’ reluctance to allow even competent patients to refuse medically indicated treatment.

Id.; see also supra notes 134-135 and accompanying text (referencing constitutional right to refuse treatment as held in Cruzan and patient's right to make treatment decisions).

150 King & Moulton, supra note 28, at 437-38. “The legal notion of consent to medical treatment was originally derived from the ethical principle of personal autonomy and its subsets: self-determination and bodily integrity.” Id. at 437; see also APPELBAUM ET AL., supra note 148, at 48 (discussing courts’ focus on patient autonomy in development of patient-based standard of informed consent).

151 King & Moulton, supra note 28, at 437-39 (noting that in development of modern negligence-based informed consent doctrines, “judges felt a need to respond to the growing patient demand for information”). Whether a state employs a physician-based standard or a patient-based standard of informed consent, a physician is nevertheless required “to fulfill a duty to provide the patient with sufficient information to make a personal medical decision.” Id. The difference between the physician-based and patient-based standards involves the level of information that must be disclosed to avoid liability. Id. at 438-45.
position to make appropriate health care decisions.\textsuperscript{152} The problem is that patients have different values and personalities that produce differing needs for deferring to, digesting, relying on, or rebelling against suggestions and advice received from health care professionals and others with whom they interact, including family, friends, acquaintances, and strangers.\textsuperscript{153} Some patients need motivation and others need to be left alone.\textsuperscript{154} Health protection and promotion requires a culture of medicine and a system of law that accommodates diverse needs, encouraging shared decision-making in some instances and privacy in others.\textsuperscript{155} In other words, once the information is conveyed to the patient or consumer, health decisions flow from what individuals do with the information.

Recognition of diversity and concern with promotion of public health warrant reexamining the relationships between health professionals and patients and reformulating legal rules and principles to balance the need to protect autonomy and promote public health. A first step in achieving this balance can be taken by distinguishing the relationships involved in decisions to prevent illness or promote health from decisions to immediately intervene with medical therapy of surgery. Treatment decisions demand a culture and legal system that leans toward autonomy, while prevention decisions need a culture and legal system that encourage active engagement of health professionals and others to both inform and educate patients about options and consequences of choices made.\textsuperscript{156} Moreover, improving health literacy requires more than the conveyance of information during a visit with the

\textsuperscript{152} See APPELBAUM ET AL., supra note 148, at 48-49 (noting purpose of informed consent was “to permit patients to make informed choices about their health care”);


\textsuperscript{154} See King & Moulton, supra note 28, at 469 (noting that shared decision-making enables patients to become fully informed and to then choose whether to “defer entirely to their physician, collaborate with him or her, or make the final decision alone”). Patients often vary as to the level of participation they wish to exercise in making their medical decisions, even after being fully informed of their options. \textit{Id}. at 479.

\textsuperscript{155} \textit{Id}. at 479-80, 491-92.

\textsuperscript{156} See \textit{id}. at 463-68 (detailing shared decision-making in the medical and legal contexts).
It requires engagement with health care professionals and others in the community after the patient leaves the physician’s office.\textsuperscript{158}

Professionals have recognized the importance of engagement with patients more deeply and frequently and have begun developing programs to enhance, and in some instances, require cultural competency training.\textsuperscript{159} Employment of the knowledge and skills gained through increased cultural competency will be significantly more effective if the relationships with patients are changed and more health providers become engaged and available to assist patients. Not only will this engagement have a positive impact on health, it is likely to reduce costs.\textsuperscript{160}

There is nothing in existing legal statues or court decisions that precludes motivational interviewing or shared decision-making. However, the concept of the physician-patient relationship as one that should be guided primarily by the importance of deferring to a patient’s autonomy has broad implications that may affect the conduct of health care providers and community health workers in a way that discourages active efforts to influence decision-making and behavior.\textsuperscript{161} The battles over tort reform that have occurred almost continually over the past four decades show that many physicians perceive themselves as unfairly under attack by a legal system that renders irrational and uniformed judgments about their professional care,\textsuperscript{162} and these physicians often engage in defensive tactics that undermine the public policy goal of the legal system – promoting access to good medical care as defined by the medical profession.\textsuperscript{163}


\textsuperscript{158} See generally \textit{JOINT COMM’N}, supra note 25 (providing recommendations for improving health literacy, noting that communication issues increase risks of adverse events).

\textsuperscript{159} Betancourt et al., supra note 53, at 499-503 (presenting overview of cultural competency efforts in health care across multiple perspectives including managed care, government, and academe).


\textsuperscript{163} Madelynn R. Orr, Comment, \textit{Defense of Patient’s Contribution to Fault in Medical Malpractice Actions},
The easiest and most effective way to remove the cloud of concern that privacy and medical malpractice liability dictate leaving a patient on his or her own to make treatment decisions is to pass a statute at the state level or to amend PPACA. Such laws or amendments should identify motivational interviewing and shared decision-making as preferred strategies to reduce health disparities and should provide immunity against tort claims for professionals who provide counseling and advice, so long as they act in good faith and are not engaged in conduct that is willful, wanton, or reckless.

Today, with the country facing a crisis in efforts to build a fair and sustainable system of health care delivery, it is important to reexamine the fundamental nature of relationships among consumers and physicians, as well as the relationships of physicians to other health care providers. Studies have shown that consumer illiteracy with respect to health is widespread and that educating consumers about health matters such as diet, exercise, smoking, alcohol, and drugs is an essential component of a sustainable health care system. Developing and implementing effective approaches to improving consumer health literacy may require rethinking and reconstructing legal rules and precepts to encourage and support shared decision-making among individuals, family members, community activists, and health care providers. The legal system may have to move beyond a focus on individual autonomy and embrace legal rules that emphasize consumer empowerment in a way that increases health literacy and thus shared decision-making. This does not require disregarding individual autonomy as an important value or preclude vigorous efforts of persuasion. It does, however, require acknowledging that health maintenance and disease prevention decisions are improved when the

25 Creighton L. Rev. 665, 699 (1992); see sources cited supra note 145 (noting defensive medicine creates issues of access to care).

decision-making is shared and supported by others.

Decisions about how to prevent or lower the risk of joint and bone injuries and diseases are illustrative of the need for a different analysis than the traditional physician-patient decisions about a potential medical intervention. Obesity serves as a good example. Being overweight contributes to the risk of bone injury and disease. In light of this knowledge, as well as knowledge of the risks that obesity poses to a variety of other health conditions, good medical care requires a treating physician to measure a person's weight and to counsel the patient about the potential impact that his weight may have on his or her health in the future.

Recent studies have shown that African American patients receive less counseling about the health risks of obesity than white patients. Correcting this

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167 E.g., Sara N. Bleich et al., Impact of Patient-Doctor Race Concordance on Rates of Weight-Related Counseling in Visits by Black and White Obese Individuals, 20 OBESITY 562 (2012); Jennifer K. Carroll et al., Getting Patients To Exercise More: A Systematic Review of Underserved Populations, 57 J. FAM. PRAC. 170 (2008). "[B]lack obese patients receive less exercise counseling than white obese patients in visits to white physicians and may be less likely than white obese patients to receive weight-reduction counseling in visits to black physicians. Further research is needed to understand how to improve counseling, particularly for black obese patients." Bleich et al., supra, at 569.

According to the latest National Health and Nutrition Examination Survey (2007-2008), the prevalence of class II and III obesity[i.e., a body mass index >35 and ≥40, respectively] was 14.3% of the US population 20 years or older. Women have a higher prevalence (17.8%) than men (10.7%), and non-Hispanic blacks have a higher prevalence (21.9%) than non-Hispanic whites (13.6%), with non-Hispanic black women having the highest prevalence reported (27.9%).

imbalance of counseling is important. Treatment or prevention of obesity may be more effective if a patient engages others in decision-making about lifestyle choices, particularly diet and exercise.\(^{168}\) To effectively assist a person trying to control his or her weight may require sharing information in a person’s medical history and follow-up observations about behavior with, and by, nurses, physician assistants, family members, school teachers, administrators, and community members.\(^{169}\) In other words, good health decisions are promoted by acknowledging the appropriate role of people who are respecting a person’s autonomy, but who are doing much more than informing about risks, benefits, and alternatives.\(^{170}\) The other participants are trying to go beyond

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\(^{169}\) Although this assertion is based on Dr. Wood’s professional experience as an orthopedic surgeon, the American Medical Association supports community engagement to improve health outcomes, as discussed *infra* in note 170. *ETHICAL FORCE PROGRAM, supra* note 25, at 41-46. A small number of schools have begun sharing students’ body mass index (BMI) on their report cards to parents. Susan R. Tortolero et al., *Improving Information on Public Health Law Best Practices for Obesity Prevention and Control*, 37 J.L. MED. & ETHICS (SUPP.) 99, 100, 104 (2009) (recommending that schools explore implications of providing health evaluations to students and parents).

\(^{170}\) *See* *ETHICAL FORCE PROGRAM, supra* note 25, at 42.

Improving health outcomes in the 21st century is increasingly dependent on systemwide efforts to improve health care access, disease prevention and the promotion of healthy lifestyles. Leading causes of death in the United States in 2004 included heart disease, cancers, stroke, and chronic lower respiratory disease, each of which often result from or are made more severe by health behaviors such as improper dietary habits, lack of physical activity or smoking.
informing to persuading. This objective is much more easily embraced in the context of prevention than it is in the context of treatment, but it has a role in both.

As previously discussed, common law informed consent doctrine generally recognizes either physician-based or patient-based standards. Both standards strictly adhere to principles of patient autonomy and self-determination. In either case, however, the legal doctrine of informed consent may impede shared decision-making. The common law of torts generally holds a physician responsible for harm suffered by a patient based on a lack of informed consent when the patient submits to a medical intervention. Generally, however, no liability attaches based solely on a failure to persuade a patient to undergo a test or procedure. A surgeon who persuades a patient to try preventive measures such as losing weight in an effort to avoid surgery, or to increase the chance of a successful surgery if it becomes necessary, may later face a claim, however, that the surgery should have been done at an earlier time. In other words, even though a potential for financial gain may not exist in prevention decision-making, the adequacy of the communication process may remain subject to second guessing in court. Although the likelihood of such a claim prevailing seems minimal

Managing chronic diseases is also increasingly important as the population ages and people with chronic illness survive longer. Health professionals and organizations can influence these trends by helping the people they serve understand how specific behaviors affect their health and that of their families and communities. While some of this information can be conveyed during individual clinical encounters and in the materials provided by hospitals, clinics, health plans, pharmacies and others, changing a population’s beliefs and behaviors requires communication efforts at the community level.

Community engagement allows [a health care] organization to interact with individuals, their families and support structures, well beyond the few opportunities when the individuals encounter the organization as patients, customers or enrollees.

*Id.* (citations omitted).

171 See supra notes 129-135 and accompanying text.

172 See supra notes 134-135 and accompanying text.


174 See generally John H. Derrick, Annotation, *Medical Malpractice: Liability for Failure of Physician to Inform Patient of Alternative Modes of Diagnosis or Treatment*, 38 A.L.R. 4th 900 (1985). *But cf.* Truman v. Thomas, 611 P.2d 902, 904 (Cal. 1980) (holding physician’s duty to provide material information to inform patient’s health care decision may include obligation to inform patient of material risks of refusing diagnostic test such as a Pap smear).
because, similar to the risks associated with smoking or eating unhealthy fast food, juries tend to reject these types of claims and view the consumer as personally responsible for his or her own injuries, many health care providers will remain unwilling to become active participants in shared decision-making and motivational interviewing if they may later have to prove the appropriateness of their conduct in a tort case.

The law of informed consent should not be constructed or interpreted in a way that erects a barrier to active efforts of persuasion by physicians. However, because the law has placed such heavy emphasis on protecting patient autonomy, physicians may perceive that they are legally obliged to ignore a patient's decision to engage in destructive health activities because the law says that each patient has a right to decide what is to be done with his or her own body. The law should provide a space that encourages active efforts at both education and persuasion on the part of the health care provider.

The opportunity and responsibility to counsel on important prevention measures that may prevent serious diseases and injuries should be protected by clear standards of care developed by the medical profession. The adoption of practice

175 See Neil Vidmar & Valerie P. Hans, American Juries: The Verdict 270-271 (2007) (indicating jurors regularly worry that plaintiffs attempt to blame others for problems they brought upon themselves).
176 See Nadia N. Sawicki, Informed Consent Beyond the Physician-Patient Encounter: Tort Law Implications of Extra-Clinical Decision Support Tools, 21 Annals Health L. 1, 4 (2012). “Articles in both legal and medical journals advocating the use of [shared decision-making (SDM)] and patient decision aids typically cite the possibility of physician liability as a barrier to implementation.” Id. The state of Washington has enacted legislation to protect physicians who engage in SDM by establishing a legal presumption in favor of the physician when SDM is used[,] . . . providing that a patient's signature on an “acknowledgement of shared decision making” constitutes prima facie evidence of informed consent that can only be rebutted by clear and convincing evidence. In contrast, a patient who signs a traditional informed consent form need only satisfy a preponderance of evidence standard to rebut the presumption of consent. As commentators have noted, Washington's approach provides physicians who use decision support tools in accordance with SDM “significant legal protection” above and beyond that provided by traditional informed consent laws.

Id. (footnotes omitted) (citing Wash. Rev. Code § 7.70.060(3) (2011)); see also Moulton & King, supra note 161, at 92-95 (arguing for more states to adopt legislation like Washington's and for federal laws and policies to be modified to promote shared decision-making).
177 See supra notes 134, 149 and accompanying text.
standards that reflect current medical knowledge and embrace cultural competency techniques will advance public health goals and minimize the risks of tort litigation. A physician, nurse, or health worker who makes a good faith effort to communicate risks, benefits, and alternatives, and then undertakes the additional burden of helping an individual to make a decision in his or her best interest by sharing in the decision-making, deserves encouragement and protection by the law.

VI. Conclusion

Joint and bone health, among numerous other musculoskeletal issues, provide an interesting lens to view various strategies to improve prevention and early detection of injuries and disease. Successful prevention and reduction of health disparities among diverse groups requires innovative approaches to educating consumers about risks, benefits, and alternatives to both lifestyle choices, such as diet and exercise, as well as health care choices, such as medication and joint replacement. Ultimately, consumer education may prove to be the most effective way to improve health and reduce costs. To provide this education requires a village of cooperation and collaboration between consumers, the community, lawmakers, and health care providers.

According to multiple studies, “literacy is a stronger predictor of an individual’s health status than income, employment status, education level, and racial or ethnic group.” Health literacy among diverse populations has become increasingly acknowledged as critical to improving the U.S. health care system. The statistics reveal a vast amount of the U.S. population face difficulty in finding, understanding, or accessing health information. The numerous severe consequences, including an increase in significant health disparities, a lack of shared decision-making, poor responses to emergency situations, and financial burdens on individuals and society, are devastating to society’s overall public health. Federal and state initiatives have progressively tackled the obstacles that serve as barriers to successful communication between patient and health care provider. It is important to supplement existing

178 BARRY D. WEISS, HEALTH LITERACY AND PATIENT SAFETY: HELP PATIENTS UNDERSTAND 13 (2nd ed. 2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf. Note that “education level is a poor surrogate for general literacy skills and for health literacy [because] education level only measures the number of years an individual attended school—not how much the individual learned in school.” Id.
179 See supra notes 1, 30-40 and accompanying text.
180 See supra notes 1, 33-38 and accompanying text.
181 See supra notes 36-40 and accompanying text.
182 See discussion supra Part V; see also supra note 176 (discussing state legislative efforts to protect
legislation by rethinking and restructuring legal rules and precepts to encourage and support shared decision-making among individuals, family members, community activists, and health care providers.

The authority and responsibility to make decisions about a person's health and health care represent both an opportunity and a burden, with ramifications to the individual and the community within which he or she resides. At some point in time the law will have to reflect a trust in the capacity of patients and health care providers to engage in decision-making guided by mutual respect for each other. Dr. Katz concluded his probing analysis of informed consent, by posing the question, "Can patients be trusted to participate more fully in decisions that affect their well-being?" He followed this question with another: "Can physicians be trusted to make decisions for patients?" He concluded that "both must be trusted, but . . . they can only be trusted if they first learn to trust each other."

Our review of evolving medical practices and culture has led us to conclude that safe harbors for informed consent conversations may promote not only good health but also healthy relationships between professionals and lay people. We agree with the American Medical Association's belief that "health care professionals have an ethical obligation to seek changes to laws when such changes would improve health care," and we believe those in the legal profession should similarly strive to achieve much-needed change to current informed consent doctrines.

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183 KATZ, supra note 136, at 229.
184 Id.
185 Id.
186 ETHICAL FORCE PROGRAM, supra note 25, at 19.