



Editor's Spotlight/Take 5

Editor's Spotlight/Take 5: Patients With Limited Health Literacy Ask Fewer Questions During Office Visits With Hand Surgeons

Seth S. Leopold MD

Shared decision-making, clinical decision-support tools, and patient-centered care can be practice-transforming, or they can be entirely unhelpful if the patient doesn't speak the language. Sometimes the language barrier is obvious—imagine a Farsi-speaking patient who knows not a lick of English. We know what to

do for that patient; a professional interpreter makes all the difference. But what if a patient speaks perfect English, but doesn't "speak the language" of healthcare?

Good evidence suggests that this scenario is both common [9], and a problem [7]. If the physician fails to identify a patient's incomprehension (or incomplete comprehension) in the office, key recommendations will be misunderstood, the patient will be unable to make an informed decision about the risks and tradeoffs involved, and (s)he may not partner fully with the physician, decreasing the likelihood that treatment goals will be achieved [3, 10].

In the local argot, patients who engage in their care—perhaps by asking probing questions of their providers—are "activated" patients, and activated patients get more out of their encounters with the healthcare system [8]. But patients who don't speak the language of healthcare lack the tools to ask good questions. They are at risk.

For that reason, whether or not you are a hand surgeon, I urge you to read the study by Menendez and colleagues in this month's *Clinical Orthopaedics and Related Research*®. The authors analyzed more than 80 recorded office visits by Dr. Menendez's group at Harvard University. They learned that patients with lower levels of health literacy do not engage nearly as actively as other patients, and because of that, those patients miss opportunities to learn more about their conditions, potential treatment options, and how the therapies involved might work for them. With such fundamental gaps, no wonder that less-activated patients do not fare as well under the care of orthopaedic surgeons [2, 13].

Who are these patients, how can we identify them in practice, and—most importantly—how can we better serve them? For answers to those questions and others, I hope you will join me for the Take-5 interview that follows with Dr. Menendez, first author of this fascinating study.

Take Five Interview with Mariano E. Menendez MD, first author of "Patients With Limited Health Literacy Ask Fewer Questions During Office Visits With Hand Surgeons"

A note from the Editor-In-Chief:

In "Editor's Spotlight," one of our editors provides brief commentary on a paper we believe is especially important and worthy of general interest. Following the explanation of our choice, we present "Take Five," in which the editor goes behind the discovery with a one-on-one interview with an author of the article featured in "Editor's Spotlight."

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Seth S. Leopold MD: *Congratulations on surfacing a critically important, but underappreciated topic. For the surgeon, perhaps the first step in addressing health literacy is to identify patients who are having difficulty understanding key elements of their visit. In your article, you suggest that physicians might assume “that patients do not understand unless proven otherwise.” How might the thoughtful provider “prove otherwise” in the course of a busy day at the office?*

Mariano E. Menendez MD: One option is to formally assess health literacy using an available instrument (such as the Newest Vital Sign [11]) prior to the visit. Other factors that give us a sense of a person's health literacy include that person's ability to complete registration forms, give a coherent sequential medical history, list prior treatments and imaging tests, name his or her medications, know what musculoskeletal structure is affected, and ask questions about recovery time. Alternatively, everyone has difficulty comprehending health information when receiving an unexpected or unnerving diagnosis. We recommend taking “universal precautions” to confirm that expressed preferences are not based on misconceptions. There are simple things one can do. For instance, “Do you have any questions?” is a question that may be interpreted as the end, rather than



Mariano E. Menendez MD

the beginning, of a conversation. Instead, try: “Tell me your questions?” or “How does that fit with what you were thinking?”

Dr. Leopold: *You suggested that surgeons prepare and offer simple explanations about common conditions, and ask the patient questions if he or she seems confused. This is similar to what one past Academy president offered in the context of a communications skills program [14]. Yet it seems to me that most providers probably think they already do this, and we also know that even the Academy has trouble delivering materials at a level patients understand [4].*

Put in this context, how can we know when we're really “doing it right”?

Dr. Menendez: It's worth taking the time to craft, and even script, descriptions of common illnesses to raise understanding. Surgeons can then practice these descriptions until they are second nature. Most illnesses can be described in 60 seconds using three to four sentences with a silent pause between each to allow for questions. It's important to avoid technical language and a monologue—the aim is to get a person talking about what matters to them.

It's also helpful going beyond the traditional face-to-face transfer of knowledge that often accounts for the shortcomings associated with expert-to-nonexpert information transfer. Decision aids such as pamphlets, websites, or videos help people determine their preferences by providing appealing, understandable, balanced, and dispassionate information about their illness and the available options.

Dr. Leopold: *You found that patients of nonwhite race asked fewer questions, but the race issue is complicated and seems hard to separate from a number of potentially confounding variables. Even if it is an independent and important factor on its own, you point out that evidence suggests that nonwhite patients may have greater mistrust of physicians [6], and that*

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they may be carrying social role expectations, decreasing the likelihood they will engage as actively in these care settings [1]. How can we start to work our way through this tangled thicket of confounding variables and social norms?

Dr. Menendez: Humans, including physicians, have unconscious race and social class biases. Anticipating these biases helps us develop approaches to limiting health disparities. The evidence that racial and ethnic disparities in healthcare are not entirely accounted for by differences in access to care, health literacy, or patient preferences underscores the obligation of orthopaedic surgeons to become culturally competent in interacting with patients with different backgrounds.

Dr. Leopold: *Even sensitive writers on the topic—such as the writers of the “Ask Me 3” program you cited [5]—risk falling into subtle forms of coercion. For example, one of their three questions is “What do I need to do (about the problem)?” which assumes something needs to be done. However, this is not always the case in the settings they wrote about (family practice) and rarely is the case in orthopaedic surgery [12]. What else might we do to engage patients with limited health literacy in ways that do not push them towards more care than they might want or need?*

Dr. Menendez: It might help to change the way we frame this. People who decide to “do nothing” are choosing resiliency and adaptation. Resiliency can be an appealing option for patients with musculoskeletal illnesses. For any illness with discretionary and preference sensitive treatment options—particularly for age-related changes—it makes sense to anchor on resiliency as the preferred option. That’s the option that most people choose for things like trapeziometacarpal arthrosis. Resiliency is an option that everyone deserves and stands to benefit from.

People don’t seek care for symptoms. Instead, they seek care for concern about symptoms. And the American default is to act, though generally in the form of something passive and external (pill, shot, surgery). Anticipating this bias helps us craft a message of hope based in evidence. Crafted interactions, decision aids, and the assistance of health promoters can give patients with limited health literacy an opportunity to consider their options carefully, reduce decisional conflict, clarify their values, and ensure their preferences are not based on misconceptions.

Dr. Leopold: *Finally, how will you know when you’ve succeeded? Will engagement or patient activation improve care quality? Symptom*

resolution? Or are metrics like those secondary to the premise that whether this does or doesn’t improve care, forming empathic partnerships with our patients is a value worth pursuing for its own sake?

Dr. Menendez: The evidence is consistent that activated patients have better health outcomes and care experiences. But forming empathic partnerships with our patients is also paramount to our well-being as physicians. Greater physician empathy is associated with lower risk for burnout and is the primary determinant of patient satisfaction. It should also not come as a surprise that most malpractice claims arise from ineffective communication and lack of empathy.

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