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## Preoperative consent for patients with limited English proficiency

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### ARTICLE INFO

#### Article history:

Received 30 June 2015

Received in revised form

16 September 2015

Accepted 25 September 2015

Available online 3 October 2015

#### Keywords:

Language barriers

Physician–patient communication

Informed consent

Health disparities

### ABSTRACT

**Background:** Informed consent is important for limited English proficient (LEP) patients undergoing surgery, as many surgical procedures are complicated, making patient comprehension difficult even without language barriers. The study objectives were to (1) understand surgeons' preoperative consenting process with LEP patients, (2) examine how surgeons self assess their non-English language proficiency levels using a standardized scale, and (3) identify the relationship between self assessed non-English language proficiency and surgeons' self-reported use of interpreters during preoperative informed consent.

**Materials and methods:** A thirty-two item survey assessing surgeons' reported preoperative informed consent process, with questions related to demographics, level of medical training, non-English language skills and their clinical use, language learning experiences, and hypothetical scenarios with LEP patients.

**Results:** Surgeons who were not fluent in non-English languages reported they often used those limited skills to obtain informed consent from their LEP patients. Many surgeons reported relying on bilingual hospital staff members, family members, and/or minors to serve as *ad-hoc* interpreters when obtaining informed consent. If a professional interpreter was not available in a timely manner, surgeons more frequently reported using *ad-hoc* interpreters or their own nonfluent language skills. Surgeons reported deferring to patient and family preferences when deciding whether to use professional interpreters and applied different thresholds for different clinical scenarios when deciding whether to use professional interpreters.

**Conclusions:** Surgeons reported relying on their own non-English language skills, bilingual staff, and family and friends of patients to obtain informed consent from LEP patients, suggesting that further understanding of barriers to professional interpreter use is needed.

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 0022-4804/\$ – see front matter © 2016 Elsevier Inc. All rights reserved.  
<http://dx.doi.org/10.1016/j.jss.2015.09.033>

## 1. Background

Informed consent is an integral part of patient-centered health care [1]. It is a dialogue during which information is exchanged between patients and health care providers, requiring at a minimum that both parties are competent and can communicate either directly or with the guidance of an interpreter [2,3]. It is the physician's obligation to ensure that patients understand the purposes, procedures, alternatives, benefits, and risks of medical treatments to make informed decisions about their health care [4,5]. Despite this responsibility, research has shown that physicians dominate informed consent discussions and frequently use more complex medical language than their patients comprehend [6]. Moreover, the informed consent procedure can be further compromised by language barriers [7].

Language barriers are a growing problem in health care as the United States continues to diversify linguistically. Over 60 million Americans speak a language other than English at home, and approximately 8.5% of the American population has limited English proficiency (LEP) or speak English less than "very well" [8]. Language barriers lead to poor comprehension of medical treatments [9,10]. When professional medical interpreters or truly bilingual physicians facilitate communication, LEP patients are more likely to understand their diagnosis and treatment plan and receive care comparable with that of their English-speaking counterparts [9,11,12].

Federal regulations mandate provision of language assistance by a competent interpreter during encounters with LEP patients [13], including the consenting process, yet research has demonstrated that there is little enforcement of these mandates [14]. LEP patients are less likely to have documentation of informed consent for medical procedures [1]. Clinicians often choose *ad-hoc* interpreters, such as family members, bilingual support, or nursing staff, or are "getting by" with their own limited non-English skills instead of using professional interpreters [9,15–17]. Clinicians cite time constraints and lack of interpreter availability as reasons why they underuse professional interpreters [16,18,19]. The underuse of professional interpreters is normalized in medical practice [16], putting patients at risk for consenting to procedures they do not truly understand. Although language barriers are a part of a greater problem of health inequity for patients from the nondominant culture, health disparities due to poor communication are more easily measured and can be successfully eliminated by effective interventions and policy changes.

Informed consent is especially important for patients undergoing surgery, as many surgical procedures are complicated, making patient comprehension difficult even without language barriers. To help inform potential interventions, we focused on the surgical informed consent process and sought to (1) understand surgeons' behaviors surrounding the preoperative consenting process with LEP patients, (2) examine how surgeons self assess their non-English language proficiency levels using a standardized scale, and (3) identify the relationship between self assessed non-English language proficiency and surgeons' self-reported use of interpreters in the presurgical consenting process.

## 2. Methods

### 2.1. Design and participants

We developed a survey assessing surgeons' behaviors during the preoperative informed consent process. The survey was initially pilot tested with five surgeons from diverse specialties who acted as key informants and provided focused feedback on each question to test proper interpretation. They provided feedback on face validity, item phrasing, and guidance on how to assess surgeons' behaviors through LEP patient scenarios. The 32-item survey took approximately 10 min to complete and included questions related to demographics, level of medical training, non-English language skills and their clinical use, language learning experiences, and reactions to hypothetical scenarios with LEP patients (Appendix). The survey was conducted anonymously to decrease response bias because we were asking surgeons about their compliance with hospital policy. The final survey was reviewed and approved by the Partners Human Research Committee. The survey was then administered between October 2013 and January 2014 through a secure online tool, Research Electronic Data Capture (REDCap) [20] and made available via email to the medical staff and trainees of all surgical specialties at an academic medical center in Boston, MA.

The hospital's policy on interpreter services states that family and friends of patients should not be asked, suggested, or encouraged to interpret for LEP patients in non-life-threatening situations, unless the patient declines a professional interpreter. The hospital strictly prohibits the use of minors as interpreters [21]. The hospital provided language services for LEP patients and has a policy in place regarding the use of interpreters. The hospital has 25 staff interpreters who cover the major languages requested by LEP patients (e.g., Spanish, Portuguese, Russian, Chinese, Haitian Creole, American sign language, Somali, and Vietnamese). In addition, the hospital has a contract with a large telephone interpreting company that provides access to interpreters in over 200 languages 24 h per day, 7 d per week. This high-quality service is convenient to access throughout the hospital.

### 2.2. Measures

Surgeons were asked to rate their non-English language skills using the adapted Interagency Language Roundtable (ILR) scale for physicians, which has been described in a previous publication [22]. Participants were considered fluent if they self rated as "excellent" or "very good" and nonfluent if they self rated as "good", "fair," or "poor" [23].

Additionally, the method of language assistance the surgeon selected in the hypothetical scenarios presented was noted. The options included using one's own non-English language skills, calling a professional interpreter, using an *ad-hoc* (untrained) staff member, and, in situations where the patient was accompanied by family, the patient's adult family member or child.

Surgeons were asked how they would obtain informed consent from a patient with no English skills who presented in

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