MEDICAL-LEGAL

Cuan Util Es El Consentimiendo Informado en Otro Idioma?

How Good Is Informed Consent in Another Language?

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Resumen

El consentimiento informado es importante en la practica medica actual. Este documento pone de manifiesto la dificultad que representa la barrera idiomatica.

Esta manana temprano, una paciente hispanica de nustro consultorio, cuatro semanas luego de un parto vaginal espontaneo se presento al departamento de emergencies refieriendo dolor addominal. Habia tenido un parto vaginal sin complicaciones, sin ligadura de trompas, un puerperio sin problemas tales que la senora habia sido dada de alta a su domicilio. La paciente desarrollo un cuadro de dolor en el cuadrante inferior derecho del abdomen con nauseas, vomitos, 101 grados F de fiebre y distension abdominal. Las radiografias simples de abdomen revelaron un ileo versus obstruccion del intestine delgado. La tomografia computada de abdomen mostro un apendice cecal inflamado con un coprolito en su interior, ambos rodeados de liquido. Con el diagnostico presuntivo de apendicitis, un cirujano general de la escuela de medicina fue oportunamente consultado. Ni la paciente ni ningun miembro de su familia alli presentes hablaba Ingles. El cirujano no hablaba Espanol tampoco. Usualmente un estudiante de medicina o un residente de nuestro servicio que hablan fluidamente Espanol suelen estar presentes, pero eso no ocurrio hoy. Finalmente, un interprete fue localizado en el hospital y el consentimiento informado fue obtenido. La paciente fue sometida a una laparotomia y apendicecetomia sin complicaciones. Pero, cuan utile es el consentimiento informado en otro idioma?

Abstract

Informed consent is an important part of medical care today. This paper discusses the difficulty with informed consent when there are language barriers.

Case Report

Early this morning an Hispanic patient from our clinic, four weeks postpartum from a spontaneous vaginal delivery, presented to the emergency department with abdominal pain. She had had an uncomplicated vaginal delivery, no tubal ligation, an uneventful postpartum course thus far, and went home. She developed right lower quadrant abdominal pain with nausea, vomiting, fever of 101 degrees F and abdominal distention. Flat films of the abdomen showed an ileus versus a small bowel obstruction. CT Scan showed a swollen appendix with a fecolith, all surrounded by fluid. With a diagnosis of probable appendicitis, a medical school general surgeon was appropriately consulted. Neither the patient nor her family members present spoke any English. The surgeon did not speak Spanish. Usually, there is a medical student or resident on our service who speaks fluent Spanish, but not today. An interpreter was finally located in the hospital and informed consent was obtained. The patient underwent an uneventful open laparotomy and appendectomy. But how good is our informed consent, even with an interpreter?

During high school and college, I had to choose a foreign language to study. I selected Latin because I wanted to go to medical school. I thought that a lot of medicine was probably in Latin. Spanish appeared useless because I would never have the need to use it . . . I was wrong. Today, the number of Hispanics in the United States has surpassed the number of African-Americans. In some parts of the United States, growth of this minority is exponential. Most days I wish that I were fluent in Spanish because of the many Hispanic patients that we care for at our medical school clinic.

Because most Hispanic pregnant patients do not initially qualify for the Medicaid program, as they are not U.S. citizens, they receive charity care in medical school teaching programs. Our medical school clinic and teaching hospital have interpreters to effectively communicate with these patients. But what about informed consent?

Informed consent is an important part of the delivery of health care. Quoting from the Compendium of Selected Publications, 2005, from the American College of Obstetricians and Gynecologists:

Informed consent laws have evolved to the "materiality or patient viewpoint" standard. A physician must disclose to the patient the risks, benefits and alternatives that a reasonable person in the patient's position would want to know to make an informed decision. Throughout this process, the patient's autonomy, level of health literacy, and cultural background should be expected. It is often helpful, for example, to ask the patient to explain in her own words her understanding of the essential elements of this patient-physician exchange of information. As is frequently emphasized, informed consent is a process and not a mere document. The election by the patient to forgo an intervention that has been recommended by the physician constitutes informed refusal.[1]

Informed consent is an important part of medical care today. We go to great lengths to inform the patient about what we, as physicians, think is the appropriate treatment. We document what we say and hear, and this becomes part of the permanent medical record. A big part of informed consent is my perception of what I think the patient understands by what she asks, how she acts, and her family's responses. It is my job to explain it in a way that the patient and her family can understand. I test that with directed questions. I answer their questions and ask if they understand what I have explained. I get some feeling from this process about how good is my informed consent. My interpretation of this process then leads me to treating the patient.

It is not enough to assume that just because this Hispanic patient came to the emergency room with pain, it would be all right to proceed with whatever is deemed necessary by the medical staff, in this case an exploratory laparotomy with appendectomy. It is not good enough to assume that, if the patient did not bring someone to explain in English what was going on, it would be satisfactory to do anything to care for the patient. There are always exceptions to this, as in the case of a patient brought to the emergency department by ambulance in full cardiopulmonary arrest with cardiopulmonary resuscitation in progress or massive bleeding from trauma.

Even with an interpreter exchanging words between English and Spanish, it is that look on the patient's and family members' eyes that tells me that this is not true informed consent. The lack of opportunity to exchange questions and get the feeling of understanding leaves me feeling the inadequacy of giving informed consent when the process crosses language borders. It is that uneasiness about the process that makes me feel that it needs to be better. When the results are good, the problem seems less important. When the results do not turn out as expected, I wonder if the patient and family understood that as a possibility.

Early on I went into an Hispanic patient's room and did what I thought I needed to do to take care of the patient's needs. If there was no interpreter, I really said very little, hoping for the best. Our practice at the medical school has a full-time interpreter, whom the patients get to know and she gets to know them as well. Most hospitals have various interpreters on call. Telephone companies have interpretation services available by phone. Our teaching hospital has interpreters, usually in-house, available as needed. Usually our OB/GYN service has at least one student or resident who is fluent in Spanish. Our clinic interpreter probably affords the best attempt at achieving informed consent, when the process occurs in the clinic.

True informed consent crossing language barriers needs continued effort. Patients, no matter what language they speak, can give informed consent only if they understand what is explained to them.

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Reference

1. American College of Obstetricians and Gynecologists. Informed Refusal. In: Compendium of Selected Publications. 2005. p. 80-81.