

## Considering the Potential Impact of Limited English Proficiency (LEP) on Informed Consent

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Consider for a moment the changing cultural landscape of Ohio. According to the 2010 United States Census Bureau data Ohio's population was 11,536,504. This data further reveals that 6.1% of Ohio's population (over the age of 5) reported that they speak a language other than English at home. Additionally, 15% of those reporting that they speak a language other than English at home report that they speak English "not well" or that they do not speak English "at all." Thus, approximately 97,000 Ohioans over the age of 5, qualify as "LEPs" or persons of Limited English Proficiency.

A Limited English Proficient (LEP) individual is a person "who does not speak English as their primary language and who has a limited ability to read, speak, write or understand English." Federal law, pursuant to Title VI of the Civil Rights Act of 1964, requires that language assistance and provision of information and services in languages other than English be provided to persons of limited English proficiency. In 2000, President Clinton further solidified these requirements by signing Executive Order 13166 — *Improving Access to Services for Persons with Limited English Proficiency*. This Executive Order required all agencies that provide federal financial assistance to issue guidance on how recipients of that assistance, including hospitals, can take reasonable steps to provide meaningful access consistent with the Title VI regulations.

All healthcare institutions receiving federal financial assistance through Medicare, Medicaid, federal research grants, and other assistance, are all subject to comply. This is true even if only one part of the institution receives federal assistance and these requirements apply to hospitals, primary care clinics, nursing homes, home health agencies, physicians and other providers. Title VI and Clinton's Executive Order have been further explained by separate Guidelines published by the federal government.

The United States Department of Health and Human Services (DHHS) has issued "guidance" to ensure that providers are ensuring "meaningful access" consistent with the above-mentioned regulations. Pursuant to the Guidance providers need to develop comprehensive written policies, including procedures on providing oral language interpretation and the need for offering trained competent interpreters. The Guidance further suggests that written materials, including consent forms and notices of the

right to free language assistance, should be translated into regularly encountered languages other than English.

All of this historical information is interesting, but doesn't really reflect the significance of the developing issues with LEPs and the topic of informed consent. In Ohio, Revised Code Section 2317.54 provides some protection to the health care provider where documented "informed consent" has been obtained. Specifically, written consent to a surgical or medical procedure shall be presumed to be valid where the elements of the statute are satisfied. There must also be an absence of proof that "the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, **or that person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written.**"

Many consider communication to be the most fundamental element in the relationship between the health care provider and the patient. When accurate communication is not possible, patient care may suffer. Studies report that more than 1 patient in 10 at large urban hospitals cannot understand English. Further, available literature suggests that the use of available interpreter services by hospital clinical staff is suboptimal, despite evidence that trained interpreters contribute to quality of care and patient safety.

Incidents of professional negligence claims on behalf of LEPs continue to increase. Consider for a moment the case of a 34-year-old Hispanic gentleman who presented for ENT surgery related to his obstructive sleep apnea. This gentleman was non-English speaking. Surgical consent was obtained in the ENT clinic in the presence of a trained interpreter;

however, the signed consent form was not executed at that time. This patient was referred for pre-surgical evaluation, including a visit with a member of the anesthesia staff. No interpreter was used at this PSE appointment when anesthesia options, risks and benefits were discussed. At the time of this anesthesia evaluation a family member was present and interpreted for the patient. This patient went to surgery and sustained a catastrophic brain injury related to anesthesia. The lawsuit was filed and, not surprisingly, the family member who had interpreted indicated that she was not proficient in English and did not understand what was explained at time of the informed consent discussion.

Additionally, a problematic case involving a 13-year-old has also been reported. This non-English speaking, young girl reported to the Emergency Room in some obvious abdominal distress. No interpreter was used and the physicians involved mistakenly believed that the patient was pregnant and was suffering from a pregnancy-related issue. Instead, this patient suffered a ruptured appendix and passed away while undergoing unrelated testing in the ED. The lawyer for the family asserted that, had the emergency department staff called for an interpreter, valuable time would have been saved in terms of discovery the nature of the patient's complaints and symptoms.

Both of these reported cases clearly suggest the value in preserving the protections provided to health care providers by Ohio law. In order to take advantage of the protections of Ohio's "Informed Consent" statute, providers must take note to carefully document the use of interpreters, the details of conversations with potential LEP patients and be cognizant of the inherent limitations of using family members rather than qualified interpreters. Practitioners must make themselves aware of the policies and procedures of the hospitals/clinics/facilities in which they practice so as to ensure that their personal practices are consistent with the institutional guidelines and/or requirements. Finally, significant consideration should be given to translating consent forms into frequently encountered languages so as to add an additional layer of precaution. ■

1 Hudelson, P: *Overcoming Language Barriers with Foreign-Language Speaking Patients: A survey to investigate intra-hospital variation in attitudes and practices*. BMC Health Services Research 2009,9:187.

2 Duffy, M: *Overcoming Language Barriers for Non-English Speaking Patients*. ANNA Journal 1999, 507.