Barriers to Communication in the Clinical Consultation: How Language Barriers can Affect Consent

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ABSTRACT
Communication forms an essential basis to the doctor-patient relationship, fostering trust and improving patient care. Patient autonomy has been at the forefront of Western medicine for decades, with informed consent playing a vital role in ensuring patients are at the centre of their care. However, there are also large populations of patients who do not speak a common language with their healthcare providers, and may rely on ad hoc interpreters - such as family members - or professional interpreters for consent and medical information. This presents an ethical, practical, and cultural issue to the idea of informed consent and patient autonomy, and thus must be dealt with systematically to prevent patient outcomes from being impaired.

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INTRODUCTION
Communication is undoubtedly the most fundamental aspect of any patient-doctor relationship. It forms the basis to trust, improved patient outcomes and increased patient safety. This lattermost notion is arguably most important; clinicians are likely to make human error, thus optimal communication is essential to reduce these mistakes (Khan, 2012). A fairly contemporary principle of Western medicine is the notion of patient autonomy, where patients make decisions about their own healthcare through the use of informed consent, thereby taking a more patient-centred approach to care (Gillon, 1994, Sakellari, 2003). Consent itself has three primary uses: ethical, legal and administrative (Hall et al., 2012; see Figure 1). The ethical aspect is to protect patient autonomy in their own healthcare, therefore supporting a progression from old-fashioned doctor-centred care to contemporary patient centred care. In terms of legality, implementing informed consent would help to prevent errors such as the wrong procedure taking place, and legal issues can be avoided by safeguarding the patient with consent. The final aspect, administration, relates somewhat to practicality; by documenting consent and those involved in gaining it, clinicians can ensure legality and a ‘paper trail’ if any issues arise.

The concept of informed consent is therefore protective and parallels autonomy, allowing patients to decide their own best interests and ensure their goals of care remain patient-defined rather than physician-defined (Hall et al., 2012). This encourages shared decision-making and fosters trust between patients and their healthcare team. According to the General Medical Council’s guidance on good practice, doctors must gain consent before any examination, investigation, treatment or involvement of the patient in education and research (GMC, 2008). Essentially, if a patient is to give informed consent, they must receive accurate information about the treatment, advantages and risks of the treatment, any alternative interventions, and what would happen if the treatment does not take place (NHS: Consent to Treatment). Additionally, the patient must have capacity to give consent, by retaining and understanding the information given, weighing it up and arriving at their own conclusion (Mental Capacity Act 2005, Selinger,
Importantly, this decision must be fully voluntary and not coerced, avoiding manipulation by relatives, carers or clinicians (Sakellari, 2003). Thus, even if their final choice disagrees with the clinician’s recommendations, patient autonomy should still be respected as the foundation of patient-centred care (Haddad and Vernarec 2001, Habiba 2001).

Under the umbrella of informed consent are the different forms of giving this permission. Consent can be implied, oral or written. Implied consent is often suitable for smaller, low risk procedures, which occur routinely. An example given by the GMC is of a patient being asked for permission to take their blood pressure and rolling up their own sleeve in response (GMC, 2013). Oral consent is acceptable for other routine and low risk procedures, such as physical examination, as long as the patient is informed beforehand. Both implied and oral consent open up a ‘grey area’ of informed consent, as neither are documented and it is difficult to monitor how different clinicians gain this kind of consent. However, as these procedures are low risk and low impact for the patient, it could be argued that this is a non-issue as long as patient safety and autonomy are not endangered. For procedures that carry risk, have potential consequences for the patient, or are non-routine and complicated, written consent is necessary, stating that they are giving their informed consent. Regardless of the subtype of permission, it is important that the patient remains informed (Khan, 2012). Thus it is clear in modern western healthcare that patient autonomy and informed consent go hand in hand, with dependency on unhindered communication between patients and clinicians.

Herein lies the problem. The 2011 UK Census noted that 138,000 people in Britain speak no English and 800,000 struggle with the language, with this figure increasing as immigration continues to rise (Office for National Statistics, 2011). Language is a major communication barrier in healthcare, which greatly compromises the patient-physician relationship (Cohen et al., 2005). When there are language barriers between
the patient and healthcare team, the principal concepts of patient autonomy and gaining informed consent may be undetermined. This also introduces an ethical issue of disparity in the care provided for those from different backgrounds, something that contradicts the basic principles of equality in care within medicine (Human Rights Act 1998; Equality Act 2010; Social Value Act 2012). For example, when administering medication or conveying information about procedures, a simple miscommunication due to a language barrier could have very adverse consequences for the patient (van Rosse et al., 2015). Furthermore if a patient cannot understand the purpose of their treatment plan, they are less likely to comply and manage their condition as well (Timmins, 2002). The disparity in care can be especially appreciated when trying to gain informed consent, as even if a patient can understand a little of the language, it is less likely that clinicians will be thorough trying to explain the medical intervention, either due to their own time constraints or through the assumption that the patient will never understand. Furthermore, clinicians may not provide opportunities for questions, or may adjust their approach to paternalism as they feel this would suit the patient’s culture better, even though this undermines the idea of patient-centred care. With such vast numbers of people in the UK, let alone other western countries with large immigrant populations not able to speak the same language as clinicians, several will receive reduced quality of care and are at risk of diminished patient safety. Moreover, the cultural differences, which are often interlinked with language barriers, provide an additional avenue for error, as misunderstanding a patient’s cultural background could have deleterious effects on the patient-clinician relationship (Schyve, 2007). The issue of language barriers in healthcare should therefore be dealt with systematically to prevent these adverse cases from arising. This can be done through the use of interpreters and a better understanding of how to practice medicine in a multicultural society. To explore this further, solutions for the aforementioned concerns surrounding language barriers and gaining informed consent will considered solely in the context of western healthcare and patients of Limited English Proficiency (LEP).

BRIDGING THE GAP: INTERPRETERS

It could be argued that these issues of reduced patient care and safety of LEP patients could simply be solved with the optimal use of interpreters, whether familial or professional. With regards to family involvement in a patient’s care, it is important to remember that a patient cannot always be considered as one person. Whether there are language barriers or not, patients will often be accompanied by family members who are concerned for their welfare, and these relatives are sometimes essential for providing support and helping them to reach decisions about their healthcare (Sedig, 2016). This is increasingly evident as patient autonomy takes precedent, because some patients prefer family involvement in the decision-making process. With LEP patients, family members can additionally be useful to clinicians, doubling as informal interpreters in the consultation (Meyer et al., 2010). As they know the patient, they can adapt their language to convey the information in a way that suits them personally. Practically, the use of relatives or friends as interpreters may also save time in the consultation, as opposed to booking professional interpreters or calling them for phone consultations, therefore cutting down costs of interpreters. While the latter argument may seem less important, the NHS and other western healthcare systems such as the US system, have major national healthcare expenditure issues relating to decreased funding and overspending (Centers for Medicare and Medicaid Services 2016, HM Treasury 2017). Family interpreters are thus a valuable tool in the clinical consultation, especially in instances of lower risk procedures that only require implied or verbal consent. These procedures often do not take long and calling a professional interpreter would unnecessarily prolong the consultation on an occasion when patient safety and care are not severely compromised.

That being said, the use of professional interpreters has revolutionised the delivery of healthcare in a multicultural, multilingual western society. A ‘professional’ interpreter constitutes someone who is familiar with medical jargon, fluently bilingual and understands the particular dialect of the patient. They must also be registered with a recognised regulator and have undergone safeguarding checks to ensure they can act in the best interest of the patient and appreciate confidentiality (NHS Policy Statement, 2015). Thus, professional interpreters are highly trained
and regulated, ensuring that language barriers are overcome in the most efficient way possible. In the event of cases where interpreters are used over the phone, though face-to-face consultations can be pre-arranged if written consent is required for more complicated procedures. Though over-the-phone interpreters may not be ideal, as some patients would prefer personal contact with an interpreter, they are valuable as they may be used as needed to explain lower risk procedures or less complicated treatment plans to gain informed verbal or implied consent. Aside from gaining consent for complicated procedures, pre-arranged consultations using interpreters can also be useful in cases where a patient requires long-term care. For example, in a GP setting, the same interpreter may be used several times for one patient, thereby fostering trust and improving communication with both interpreter and clinician. In fact, some patients even prefer interpreters to be more active in consultations, helping to guide them through decision-making processes and act as a sounding board (Hadziabdic, 2011).

Interpreters have long been used in clinical consultations, both informally and formally, and their role as patient advocates is becoming clearer in contemporary medicine where patient autonomy is at the forefront. While family interpreters have their limitations with regards to their health literacy, professional interpreters are able to bridge the gap between patient and clinician when language barriers are in place. Their knowledge of medical jargon and training on how best to support the patient are fundamental to the process of gaining informed consent, and they can be viewed as the best possible solution to the issues pertaining to reduced patient safety and care when the patient and clinician speak different languages.

**AD HOC INTERPRETERS: THE ISSUE**

Despite credible arguments for the use of interpreters in clinical consultations and gaining consent, the counterargument circles back to the original resounding issue: human error. A shocking figure from an American study was that on average, 31 errors occurred per clinical encounter when interpreters (both ad hoc and professional) were used (Flores et al., 2003). With the use of family as ad hoc interpreters, who have no training and are unfamiliar with medical jargon, patient care could be compromised by inaccurate translation (Hunt and de Voogd, 2007). Additionally there is the aspect of their own personal view, which could easily influence their interpretation and introduce a conflict of interest (Woloshin et al., 1995). Ordinarily, if a patient’s family disagrees with a patient, the clinician would be an advocate for the patient’s wishes while advising the family on how best to support this decision (Sedig, 2016). However, when there are language barriers, the clinician is unable to take up this role of patient advocate to ensure patient autonomy and informed consent. Another aspect to consider is confidentiality; while the patient has allowed the relative to be present in the consultation, there may be issues when discussing topics such as sexual health, drug use, mental health and cases of domestic violence (Flores, 2006). It could be argued that these kind of issues are relatively rare, as in most cases relatives seem genuine in their concern for the patient’s health and safety. However the use of family interpreters opens the doorway to several safeguarding issues, and in a healthcare system where patient safety is regarded as of utmost importance, these rare cases should be avoided.

Many hospitals do not include family interpreters in their policy for interpretation services. More specifically, the NHS recognises them as ‘inadequately trained’ and a source of high risk, stating that the use of these untrained interpreters could actually pose a higher risk to the patient than foregoing the use of interpreters completely. The official NHS policy is that while family and friends as interpreters should be discouraged, patient autonomy means that they can be used if the patient strongly requests it, as long as the interpreter is above 16 years old and the patient has given informed consent (NHS Policy Statement, 2015). However, this in itself may be an issue if the patient has been coerced or manipulated by their relative or if they cannot understand the consequences of this consent and therefore are not fully “informed.” Furthermore, if a patient refuses a professional interpreter, they may be unknowingly allowing mistakes to occur in the consultation. With a known high error rate when family interpreters are used, at what point does patient autonomy give way to prioritising patient safety? If the patient has to give informed consent for an invasive procedure, they may not be fully informed by their relative’s translation. Moreover, in western hospitals where qualified interpreters are usually easily accessible by phone, it can be ethically difficult for the clinician to support the LEP patient’s autonomy when they are refusing a better quality interpreter – even though hospital guidelines always prioritise...
autonomy when the patient has capacity. Additionally, clinicians are more likely to treat family interpreters as caregivers who are in charge of the patient’s healthcare, which is not always the case and can lead to additional errors whereby the patient’s own concerns are not addressed (Rosenberg et al., 2007). Thus it is clear that while healthcare guidelines regarding interpreters are often very thorough, they cannot account for every possibility and perhaps it is impossible to create the perfect policy regarding family interpreters.

**CULTURAL INFLUENCES ON LANGUAGE AND CONSENT**

It is clear that the use of relatives or friends as interpreters cannot faultlessly bridge language barriers between patients and clinicians, although they may have their uses in shorter interactions which do not involve informed consent. On the contrary, the use of professional and qualified interpreters certainly does help overcome language barriers in the clinical consultation to a certain extent. There can still be gaps in the way LEP patients are treated. A study by (Schenker et al., 2007) found that even with professional interpreters present, there is significantly less documentation of informed consent from LEP patients than from English-speaking patients. Another important consideration is that even if an interpreter translates the information impeccably, this could be completely ineffective without an appreciation of the patient’s culture. For instance, certain phrases can have a different meaning even when translated word-for-word. In several cases LEP patients will have grown up in another country, immersed in attitudes, traditions and even religion different to western culture. Language and cultural barriers often go hand in hand, but understanding one does not simply translate to understanding the other. Although knowing someone’s language may aid in appreciating their background, cultural differences, while sometimes subtle, can have a huge effect on their experience in healthcare. For example, Islamic women who are used to traditional conservative dress may be confused by the idea of uncovering themselves for examination and are unlikely to do so if an interpreter simply requests it in their language. The interpreter’s own background may also have an influence on gaining consent, as they may have their own cultural preconceptions, or the patient might feel uncomfortable speaking to interpreters from certain regions (British Medical Association, 2012). A relevant example would be if the patient was Palestinian and the interpreter Israeli; even if the interpreter can fluently speak Arabic, tensions in those regions could make communication awkward or introduce cultural prejudices. Thus it is important not to undervalue the effect of a patient or interpreter’s culture when gaining consent in a healthcare setting, while also being careful to avoid stereotyping someone based on this (Schyve, 2007). Doing so would risk damaging the patient-clinician relationship if patients feel they are not being treated as an individual. Hence there is a delicate balance between speaking a patient’s language and showing appreciation for their culture. Although professional interpreters often do the former very well, the latter aspect may be where mistakes occur.

Another aspect of a patient’s culture, which may accompany language barriers, is that perhaps they are used to a different form of communication in healthcare in their country of origin. For example, within Asian, African and some European subcultures, healthcare is often delivered in a doctor-centred, paternalistic fashion (Macer 1999, Yousuf et al., 2007). LEP patients who have immigrated from these areas may actually prefer this kind of patient-clinician relationship, whereby the patient has a far more passive role in decision-making (Rodriguez-Osorio and Dominguez-Cherit, 2008). Even if language barriers are overcome by using an interpreter, it can be hard to explain the central role of patient autonomy in western medicine to these patients, who may have previously experienced paternalistic healthcare. If a patient does not understand that they are autonomous, or perhaps prefers all decisions to be made by the healthcare team, the purpose of informed consent is weakened. This could also put undue stress on the patient, if they are unused to shared decision-making and view this as a burden, especially in an environment where they may already be anxious because they cannot speak the language (Madlom, 2015). Moreover, clinicians often expect professional interpreters to act as a mediator between the two cultures, but unless the interpreter is highly skilled in facilitating the shift from doctor-centred to patient-centred care for the patient, communication will be negatively affected (Rosenberg et al., 2007). In a hectic working environment, clinicians may be spontaneously compelled to accept this culture difference and treat the patient in a paternalistic
manner. This could be because they have a pre-assumption that the patient will prefer it, or they do not have time to practice shared decision-making when a language barrier is present (Schenker et al., 2007). Additionally, the clinician’s own background may have an influence on the way they communicate (Ong et al., 1995). Older doctors or those from Asian, African or European subcultures are more likely to use a paternalistic approach, and this can affect the way they gain informed consent. These clinicians may possibly take a more doctor-centred approach and be less thorough when gaining informed consent, through an understanding that some patients favour this approach (Carrillo et al., 1999). Either way, the ideas of autonomy and informed consent are undermined, and though the patient may prefer this, it poses another challenge to the way we bridge language barriers in healthcare (Krumholz, 2010). Perhaps the black and white idea that autonomy and informed consent promote patient satisfaction and welfare is actually more fluid, whereby patient-centeredness means they can be treated in the way they prefer. However, this can introduce risks for these patients, as treating them in a paternalistic manner with less of a focus on informed consent removes the safeguarding aspect of consent when they, as LEP patients, are already vulnerable to errors in healthcare. Thus cultural influences on communication and gaining consent pose a complex challenge to the ideals of patient autonomy and overcoming language barriers.

CONCLUSION

It is evident that addressing language barriers in clinical consultations is more than just translating language for a patient and clinician. The use of interpreters, both ad hoc and professional, introduces a new opportunity for human error and influence, and the impact of different cultural backgrounds change the way informed consent is viewed in healthcare. Though in an ideal situation, interpreters would have a full understanding of a patient’s culture to enable perfect translation, this is logistically impossible with the wide range of patients seen in western healthcare. Instead, it is important that both clinicians and interpreters understand that translation has its limitations in order to prevent errors whereby assumptions are made about the patient’s culture or preferences. Although it is true that some LEP patients will favour paternalistic care and may even have increased patient satisfaction with this approach, two of the three major aspects of informed consent have practical purposes which cannot be ignored: legality and administration (Figure 1). The use of informed consent safeguards the patient, prevents errors, documents the patient’s involvement and ensures legality of the procedure. Therefore, clinicians must always pursue informed consent, even if this may take more time in the consultation, as it is protective for both them and the patient. The ethical aspect of informed consent could be seen as more fluid, as the definition of patient-centred care includes the idea of respect for the patient’s preferences, so it could be inferred that if they prefer a paternalistic approach, this should be respected (Rodriguez-Osorio and Dominguez-Cherit, 2008). However, the basis of patient-centred care includes information and education, as well as support for patient values guiding clinical decisions (US Institute of Medicine, 2001, Paparella, 2016). Paternalistic communication does not foster this idea of shared decision-making and patient autonomy, and the ethical purpose of informed consent clearly encourages these values of patient-centred care (Krumholz, 2010). Thus, it is important to respect all three aspects of informed consent, especially with LEP patients, to prioritise their safety and quality of care, even if cultural barriers are present in the form of preference for paternalism.

With regards to language barriers in medicine, only western healthcare has been considered so far. However, similar issues may arise in the developing world too. While it is likely that clinicians and patients share a language that is not English, they may speak different dialects. A pertinent example would be China, a country with the world’s largest population of 1.4 billion and seven main dialects, each with sub-dialects and variants too. Linguists class these dialects as mutually unintelligible, meaning that speakers cannot understand each other. Therefore the problems arising from language barriers, including reduced patient safety and quality of care, can occur in developing countries too and may perhaps be more pronounced due to poorer infrastructure. In healthcare in the developed world, it has been discussed that while professional interpreters have their limitations, they are readily available. In developing towns and cities it is unlikely that interpreters are easily accessible, and if there are any available at all, they are more likely to be ad hoc or family members. Communication can be severely debilitated with no translation available, and even
with ad hoc interpreters, the error rate is so large that patient safety may be very compromised (Flores et al., 2012).

In developing countries, informed consent often plays a smaller role in healthcare, where a paternalistic approach is more common. However, the notion of informed consent is emerging in healthcare around the world. Using the example of mainland China, where traditional medicine stemmed from Confucian principles of kindness and compassion, communication approaches are largely paternalistic (Guo, 1995). Nevertheless, informed consent has played a role in Chinese medical laws since the early 1980s as awareness of patient entitlement has increased, albeit with a lower level of enforcement than in western medicine (Dai, 2003). Within Chinese healthcare, the idea of being informed when giving consent is recognised, but both patients and clinicians do not fully understand what information is necessary, what rights the patient has in terms of decision-making, and the limitations of consent (Du and Rachul, 2013). A shocking case in a Beijing hospital in 2007 highlighted this confusion about consent law: Xiao Zhijun brought his acutely ill pregnant wife into hospital where doctors decided she required an emergency caesarean. Unfortunately, there was a misunderstanding whereby both clinicians and Zhijun believed his consent was required before they could proceed with the lifesaving procedure, when actually an emergency medical intervention can take place as long as not doing so would severely impede a patient’s survival or quality of life. He refused to consent, and the procedure did not take place; his wife and unborn child both sadly passed away (Qun, 2011). The limitations of when consent applies were not understood, causing public outcry, with many calling for better clarification of laws and training on consent. This case in Chinese healthcare is an apt example of how adapting the long held culture of paternalist medicine to a patient-centred approach may go wrong, even in the absence of language barriers and especially without extensive guidelines and training for clinicians. On the contrary, in western medicine, the regulations on gaining informed consent and patients’ rights are thorough and protective for both patients and clinicians, thus language or culture barriers should, in theory, not severely impact a patient’s welfare. With this context of language and culture barriers as a worldwide issue, perhaps the shortcomings of using professional interpreters for LEP patients are a relatively unimportant problem as long as patient safety is prioritised.

Indeed, in western medicine this is often the case; institutions such as the NHS offer extensive training for professional interpreters and have rigorous checks, to ensure they are qualified before being allowed in clinical consultations, as well as regular monitoring of services. Currently, the NHS is running an initiative for the improvement of interpretation services within primary care, which includes surveys on different aspects for clinicians, interpreters and LEP patients (NHS Commissioning, 2017). There are also courses available for clinicians on how best to work with interpreters and LEP patients and most hospitals have databases of common phrases that can be used in an emergency (NHS Policy Statement, 2015). In the UK, guidelines regarding interpreter training can be trust-specific, but generally include the minimum requirement of being registered to a NHS-recognised agency. Educational courses to become a qualified interpreter include a diploma in Public Service interpretation, which is a course involving learning about language in medical specialties, primary and acute care and common procedures (Institute of Linguists Candidate Handbook, 2017). Thus, qualified interpreters will have a high level of health literacy applicable to all levels of medical care. Though attending training may seem like a simple solution to a large problem, one study found that hours of training negatively correlated with number of errors in translation, suggesting that at least 100 hours are required to create a successful interpreter (Flores et al., 2012). Additionally, most hospitals require annual training to be completed, where interpreters are refreshed on both common and difficult situations they may come across in consultations, such as delivering bad news or gaining consent. With regards to consent, interpreters are taught the same as clinicians. They are taught the information required to label consent as truly ‘informed’, the subtypes of consent and how to handle refusal by respecting patient autonomy (Central Manchester University Hospitals, 2011). By training interpreters in this aspect, they themselves can become patient advocates. For example, they may prompt the clinician for more information, or provide information themselves and discuss treatment and care with the patient within their competency (Clifford, 2005). Therefore, interpreters may have a use beyond overcoming language or cultural barriers by
helping to implement patient-centred care for vulnerable LEP patients.

Although western medicine has most of the infrastructure and resources necessary to cope with language or cultural barriers in medicine, it is important to not be too idealistic. Even with regulations and safeguarding in place, human error will never be eliminated. While in theory interpretation services are accessible and easy to use, there can still be confusion over translation, and using interpreters often greatly prolongs the consultation (Hampers and McNulty, 2002). For example, if using an over-the-phone interpreter, it could take a while to explain the situation to them so that they understand the context when translating, and if they are not present at the consultation this can be difficult. Furthermore, clinicians are highly pressed for time and spending a disproportionately long time with an LEP patient over other patients could lead to the latter’s care being compromised. There is also the added issue of the cost of interpretation services. The UK is currently in austerity, with depleted funding for health services having severe adverse consequences on public health. A spike in mortality of 30,000 deaths in 2015 was even related to reduced healthcare funding, a figure which caused public outcry (Hiam et al., 2017). Thus, it is fathomable that there is some discontent with the spending on interpretation services and healthcare for non-nationals and LEP patients. It could be argued that this is money should be spent on improving healthcare services for nationals who pay a tax contribution for the service, whereas some non-nationals such as refugees, asylum seekers and their families are exempt from healthcare charges (No Recourse to Public Funds Network, 2017). However, the opposing argument would be that these patients make up a small proportion of immigrants, the vast majority of whom have to pay the Immigrant Health Charge before receiving non-urgent care. Additionally, the controversial proposals discussed by the Department of Health to ask all patients to prove British nationality before receiving free healthcare could actually be disadvantageous to nationals, who would have to undergo time-wasting checks at the point of use. Finally, although vetting patients for eligibility or cutting down on interpretation costs may be economically advantageous, they go against two fundamental principles of medicine: beneficence and non-maleficence (Gillon, 1994).

Overall, it is clear that communication between patients and the healthcare team forms the foundation for their quality of care and satisfaction and significantly improves patient safety. With LEP patients in western medicine, their vulnerability with regards to errors in interpretation or lack of attention to informed consent is a massive factor in reducing their quality of care. This is certainly the case with ad hoc or family interpreters, who are untrained and have low health literacy. The use of professional, qualified interpreters has been shown to improve patient satisfaction and quality of care. Despite the rigorous regulations on training and use of services, even professional interpretation has its limitations (Hornberger et al., 1996; Timmins, 2002). These limitations can include the practical aspects of access to services, cost of interpreters, and the length of time to use them, as well as the cultural limitations of understanding a patient’s background without pre-judgement. It will be interesting to see how treating LEP patients will evolve with modern advances. The use of artificial intelligence offers to revolutionise delivery of healthcare, such as the Google Pixel Buds, which promises to translate language in real time, although implementation of this technology in medicine is in the research stages and may not be well accepted by all patients and clinicians (Sulleyman, 2017, Altman, 2017). Additionally, it is difficult to imagine what role this technology will play in gaining informed consent.

The notion of informed consent came about as a protective mechanism for both patients and clinicians, and to ensure patient autonomy and high quality of care (Hall et al., 2012). However, this has not prevented issues arising around the subject; the landmark Supreme Court ruling over Montgomery versus Lanarkshire Health Board instigated a transformation of what was required to inform a patient. Previously, clinicians would use the ‘Bolam test’ to determine whether a doctor’s actions would be accepted and supported by a responsible body of medical professionals (Sokol, 2015). Following the court ruling, the new test was defined from the patient’s point of view, supporting the idea of patient-centred care. This current test depends on whether a reasonable person who is in the patient’s position would see the risk as significant, or whether the doctor would think the patient would find the risk significant (The Supreme Court, 2015). Therefore, if the risk is significant, even if the chance of it occurring is negligible, a patient must be informed of it before giving consent. To not do so would be deemed clinical negligence. This theory agrees with the GMC guidelines on best practice when
gaining consent, cementing these principles in the law (GMC, 2008). This can only reinforce informed consent as a central concept in healthcare, and one, which must be applied equally to all patients. While it can be hard to monitor this in consultations, the issues regarding a lack of diligence when procuring consent from LEP patients is being tackled by the use of trained interpreters, as well as clinician training on how to gain consent from them. Therefore, the effect of language barriers, often interlinked with cultural differences, on gaining informed consent is being recognised and not overlooked. Though there certainly are limitations in how this can be addressed, at minimum, LEP patients are being treated with the intrinsic medical concepts of beneficence and non-maleficence. To conclude, issues pertaining to language barriers in healthcare are a global problem with a negative influence on gaining consent. However, within western healthcare, the law and principles of medicine safeguard LEP patients, ensuring that even with language barriers, the aim is to prioritise the patient at the centre of their care.

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