

Obtaining valid consent

Eva Jungmann

Background

It is a requirement of good practice of every health professional¹ to seek informed consent from a patient prior to starting treatment or offering an intervention. Cultural and language barriers may sometimes make it difficult to be confident that a patient is competent to give valid consent.

Clinical scenario

You are a clinician in reproductive health, working in a community family planning clinic. A 28-year-old woman of Asian origin comes to the clinic to have an intrauterine device (IUD) inserted as a contraceptive method. She finds it difficult to express herself in English and you have concerns that her command of the language is not sufficient to consent to the procedure. She refuses to be seen with an interpreter, as she fears her confidentiality might not be respected and her use of a contraceptive be disclosed to her husband and/or her community. What would you do?

The panel

Three professionals (detailed in Box 1) were invited to give their view on how to manage this situation in practice.

Box 1 Invited discussants for the clinical scenario

- Senior consultant in reproductive health care
- General practitioner
- Ethicist

Senior consultant in reproductive health care

There are a few issues to be addressed here, firstly that of communication, as I feel that her command of English is not sufficient. She has, however, been able to relay her fears regarding confidentiality and thought about her future contraceptive method.

It is paramount to stress that the duty of confidentiality applies to all health care professionals including interpreters. Is there a leaflet in her language explaining our duty of care, or is it possible to use Language Line? (a telephone interpreting system that often has a trained interpreter available within minutes). This could be used to allay her fears with an 'invisible' interpreter on the end of a telephone line. If this were available then I would also use this opportunity – once she is satisfied with the confidentiality issues – to address her contraceptive choice.

Why has she chosen the IUD? Is this the most suitable method for her and is she aware of other available forms of contraception? Has she been using any form of contraception until now? Is there actually a hidden agenda and is she seeking emergency contraception? Are there cultural issues relating to the IUD? Is she embarrassed as regards the actual fitting? Is she worried that the interpreter may be male or is it frowned upon in her culture to use

contraception? Why is she not able to discuss this with her husband? Are there perhaps issues of domestic violence? Or pressure to conceive from her husband, extended family or community?

General practitioner

Initially, you could establish whether she is concerned about being seen with a professional interpreter or a member of her family/community. You could reassure her about the professionalism of the former and their duty to maintain confidentiality. Of course, this might be difficult if her understanding, as well as her command of English, is limited. Perhaps she would agree to a telephone interpreter, as this is more anonymous.

If she refuses to have any interpreter you will have to decide whether her understanding of English is sufficient to enable you to gain valid consent for the procedure. You have to be convinced that the patient is competent, uncoerced and fully informed about the procedure before consent is considered to be valid. Just getting the patient to sign a consent form is not sufficient. The concern in this scenario is that you may not be able to successfully inform the patient about the risks and benefits and potential side effects of the procedure on account of her limited English.

However, you could view gaining consent as a process rather than a one-off event, and support and help the patient through this process by spending time trying to explain things clearly, using diagrams and leaflets, and bringing her back for another consultation to check her understanding. Of course, whether this works or not will be dependent on her having a certain basic level of English.

These requirements might seem rather frustrating for both you and the patient, and it might be tempting to fit the IUD as this is what the patient wants and you will want to do what is in her best interests, especially as a problem is only likely to arise if something goes wrong. But if something does go wrong and it can be proved that the patient has not been 'fully informed' then it is possible for you to be charged with negligence. This is why it is worth making every effort to fulfil the requirements for valid consent before you go ahead with the procedure.

Ethicist

I would first do some/all of the following:

- Try to locate a member of staff who spoke her, or a similar, language.
- Try and locate a leaflet in an appropriate language.
- Draw a lot of diagrams and try to satisfy myself that she understands.
- Ask another member of staff for their opinion of her understanding.

If none of these options were possible, I would not be happy to continue and must try to reassure her about our interpreter's confidentiality. She seems to have conveyed her concerns about this to us so she must have some communication ability.

I must also balance my decision against her obvious desire for effective contraception. The scenario suggests that the patient seems to know her own mind, so I have a feeling that we would probably convey enough information between us to be able to proceed with a fitting. I would insist on a chaperone being present throughout the consultation and insertion though, and would use her as detailed in the fourth option above.

J Fam Plann Reprod Health Care 2006; **32**(4): 259–260

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CLINICAL CONUNDRUM/BOOK REVIEWS

Discussion

"A patient is competent if he/she can comprehend information, it having been presented to them in a clear way; believe it; and retain it long enough to weigh it up and make a decision".¹ There are many different ways to improve communication between health care professionals and patients and to provide information in a culturally sensitive manner. Approaching 'obtaining consent' as a process and involving other professionals may be sufficient to prove competence in most cases. Although providing contraception may sometimes be considered as working in 'the best interest of the patient', it is ultimately the responsibility of the health care professional who is looking after the patient to ensure that informed consent was given and legal advice should be sought if in doubt.

Acknowledgements

The author would like to thank the panel members for their input. A listing of the individual panel members who have contributed to the Clinical Conundrum section of the Journal in 2006 appears on this page.

Reference

- ¹ General Medical Council (GMC). *Seeking Patients' Consent: The Ethical Consideration*. London, UK: GMC, 1998.

Journal of Family Planning and Reproductive Health Care

CLINICAL CONUNDRUM CORRESPONDENTS

The editorial team would like to thank the individual panel members listed below who kindly contributed to the Clinical Conundrum section of the Journal in 2006.

Sarah Cunningham-Burley, Lana Haslam, Barbara Hollingworth, Hilary Howard, Jane Kavanagh, Brigid Molloy, Rakesh Patel, Radhika Shah, Alison Warner, Christine West

Book Reviews

Emotional Intelligence in Couples Therapy: Advances from Neurobiology and the Science of Intimate Relationships. B Atkinson. New York, NY: WW Norton and Company Ltd, 2005. ISBN: 0-3937-0386-X. Price: £21.00. Pages: 321 (hardback)

This is an essential read for anyone involved in relationship therapy and of interest to anyone involved in clinical work with patients presenting with sexual problems, where there are often co-existing relationship issues. It takes a dedicated read, but the serious subject matter is presented in easily readable style with a huge amount of illustrative casework.

In the first of the book's two sections, the author presents the latest from the fields of affective neuroscience and the science of intimate relationships. Details of the neuroscience studies that have identified the brain's neural response circuits are outlined. These circuits are 'wired' into the brain very early in life and persist throughout life, with automatic activation when an individual is presented with certain circumstances. This may explain why individuals persist with ways of acting and thinking, even when they know it would be in their own best interests to change. It is also suggested as part of the reason why sometimes psychotherapies do not produce lasting change. The new studies in relationship science outline the detail of what people who have successful relationships do differently from those who do not. Atkinson connects these advances in scientific understanding with the processes of change in interpersonal interactions for improvement in intimate relationships.

The second part of the book gives a very detailed and practical account of Pragmatic/Experiential Therapy for Couples (PET-C), with frequent and useful illustrative reference to cases. Broadly, couples are helped to identify their internal mood states and habits of interaction and then helped through a programme of 're-wiring' these response states for greater flexibility and activation of more positive emotional responses that are predictive of relationship success.

Although not likely to be high on the priority reading list for the busy doctor, unless with a special interest in the field, the book does provide a

fascinating insight into the attempts to understand the emotional brain and does present a new approach in couple therapy – a thought-provoking read.

Reviewed by **Gillian Flett**, FRCOG, MFFP, Consultant in Sexual and Reproductive Health, Grampian, UK

Conception and Pregnancy Over 35: Expert Advice for Every Stage, From Planning a Baby to Giving Birth. L Goetzl, R Harford. London, UK: Dorling Kindersley, 2005. ISBN: 1-405-3063-94. Price: £12.99. Pages: 160 (hardback)

This book's lofty aim is to give women over 35 all the information they require to prepare them for conception, pregnancy, birth, and adjusting to motherhood. The book is divided thematically and chronologically into pre-pregnancy planning, each trimester, and motherhood. It is about the size and weight of a glamorous women's magazine, and would fit perfectly into this season's slouchy leather bags. It is very definitely aimed at the professional woman who has delayed childbirth and actively seeks pregnancy. The photographic illustrations are all of slender, well-groomed, smiling women (although the few illustrations of men are more realistic – scruffy, chunky, balding; all seem age-appropriate) but the text is full of useful information about planning a pregnancy, managing common complaints, the benefits of exercise and other things you would hope to be included, presented in a straightforward way. I particularly liked the hints on 'what's safe to use' in pregnancy, and suggestions for healthy eating and exercise in each trimester. The diagrams and line drawings are excellent, especially those relating to antenatal testing and methods of delivery. The authors are based in the USA, but it has been carefully adapted to reflect UK practice. It will not be detailed enough for some women's needs, but there is a decent up-to-date list of additional resources at the end of the book. Contraception is not mentioned in the pre-pregnancy or post-pregnancy section, which I think is an unfortunate oversight in an otherwise excellent resource for older parents of either gender (glamorous or not). Another potential drawback – I offered it to a pregnant colleague over 35 to review, and she was too exhausted to read it.

Reviewed by **Pauline McGough**, MRCOG, MFFP, Locum Consultant in Sexual and Reproductive Health, Glasgow, UK

Female Genital Mutilation. C Momoh (ed). Oxford, UK: Radcliffe Publishing Ltd, 2005. ISBN: 1-8577-5693-2. Price: £19.95. Pages: 164 (paperback)

This book claims to give health professionals user-friendly, factual information on various aspects of female genital mutilation (FGM).

FGM is still a secret, kept by women, inflicted on their daughters. The authors emphasise that it is performed as an act of love, of deep cultural significance, despite being illegal in most countries and a human rights outrage. The morbidity and mortality of the procedure and its complications are unknown but estimated to be high.

In the UK, infibulation becomes a pressing issue when we care for women with FGM, often refugees who have sporadic, unplanned contact with the health service. Girls are at risk, and the procedure may be performed while they are 'on holiday'. The prevalence in Somalia is close to 100%.

This is really a collection of articles by authors from a variety of backgrounds. It is a tough read, for two reasons. First, it is an uncomfortable subject and its elimination is far off. Second, the book has many technical problems: contradictions and repetitions between chapters, difficult writing styles, unexplained abbreviations and poorly presented numerical information. It would benefit from tighter editing.

The book comprises articles relating to the technical details of the procedure and its sequelae, child protection, distribution of the problem, human rights issues, asylum seekers and the cultural background. There are also interviews with Somali people living in the UK. I recommend Harry Gordon's chapter about a clinician's experience of running a clinic in south London. He gives clear advice about services needed by Somali women. Els Leye writes concisely on European legal strategies.

It behoves those of us working with women and girls affected by FGM to be better prepared. This book makes a contribution that, despite its shortcomings, is an optimistic one.

Reviewed by **Helen Johnston**, MRCGP, DTMH, General Practitioner, Orkney, UK