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Surgeons' opinions and practice of informed consent in Nigeria

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Abstract

Background—Informed consent is perhaps more relevant to surgical specialties than to other clinical disciplines. Fundamental to this concept is the provision of relevant information for the patient to make an informed choice about a surgical intervention. The opinions of surgeons in Nigeria about informed consent in their practice were surveyed.

Methods—A cross-sectional survey of surgeons in Nigeria was undertaken in 2004/5 using self-administered semistructured questionnaires.

Results—There were 102 respondents, 85.3% of whom were men and 58.8% were aged 31–40 years. 43.1% were consultants and 54.0% were surgical trainees. 27.4% were in surgical subspecialties, 26.5% in general surgery and 21.6% were obstetricians and gynaecologists. 54.9% agreed that sufficient information is not provided to patients while obtaining their consent for surgical procedures. They listed medicolegal reasons (70.6%), informing patients about benefits, risks and alternatives (64.7%) and hospital policy (50.0%) as some reasons for obtaining consent for surgical procedures. When patients decline to give consent for surgery, 84.3% of them thought that poor communication between surgeons and patients may be contributory. They identified taking a course in bioethics during surgical training and compulsory communication skills course as some ways to improve communication between surgeons and patients.

Conclusion—Most Nigerian surgeons seemed to have a good knowledge of the informed consent requirements and process but fall short in practice. There is a need to improve the surgeon–patient relationship in line with modern exigencies to provide interactive environments for fruitful patient communication and involvement.

INTRODUCTION

Informed consent ranks as one of the most prominent issues in the contemporary bioethics literature. Most discussions in bioethics revolve around research ethics and informed consent in clinical trials and in other forms of biomedical research involving human participants. Informed consent in clinical activities is well established in law and moral philosophy. It underscores the inputs of patients to decisions about their healthcare. It takes into cognisance patients' views and perspectives and is both a step to and an outcome of a good physician–patient relationship.

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The concept of informed consent is perhaps more closely related to surgical specialties than other clinical disciplines because of the necessity for patients' decisions to participate in surgery and their authorisation of surgeons to operate on them.¹ Fundamental to this concept is the provision of relevant, sufficient and comprehensible information for the patient to make an informed choice about a surgical intervention. To achieve this, the surgeon requires necessary skills to evaluate his/her patient's ability to process and use given information. He/she also needs to be forthcoming in providing unbiased clinical information in a manner that is void of threat or coercion.

Informed consent is part of preoperative routine as a matter of hospital policy, legal requirement and ethical obligation. In surgical practice, the principle behind consent for surgery is essentially the same everywhere but the emphasis placed on it and the process of obtaining it varies from place to place. For example, while consent is obtained in the immediate preoperative period in many places,²⁻⁴ in others structured interviews,⁵ information leaf-lets,⁶ electronic systems⁷ and multimedia tools,⁸ among others, are used to enhance the process. A recent review of the subject showed that the body of literature on surgical informed consent is not robust.⁹ Previous work in Nigeria has focused mainly on the opinions of patients about the informed consent process.²⁻⁴¹⁰ In this paper we report the opinions and practices of surgeons in Nigeria about informed consent in their practice.

MATERIALS AND METHODS

The study took place among surgeons from various surgical disciplines in Nigeria in 2004/5. A cross-sectional survey was performed using a self-administered semistructured questionnaire. The instrument was developed after consulting the relevant literature on the subject and was pretested and reviewed among surgical residents in the Department of Surgery, University College Hospital, Ibadan, Nigeria. Surgeons were contacted on a one-on-one basis by research assistants who went to hospitals in the major cities and towns mainly in the southwestern part of the country.

The questionnaire consisted of two parts. The first elicited general information about demographic and professional characteristics of the respondents, while the second part focused on information about informed consent and was subdivided into four sections: informed consent process, obtaining consent for surgical operations, refusal to provide consent for surgery and how to improve the consent process. For some questions the respondents could select more than one response as applicable. The data were entered into SPSS software version 15.0 and analysed using simple descriptive statistics.

RESULTS

One hundred and two surgeons returned the completed questionnaires (table 1). Only 11.8% of the respondents were from regions outside the south-west of Nigeria. Most were male (85.3%), 58.8% were aged 31–40 years, 85.3% practised surgery within a 150-kilometre radius of Ibadan city and 88.2% worked in tertiary level hospitals. 43.1% were of consultant status while 54.0% were surgical trainees. Most (63.7%) had practised surgery for <5 years and only 2% of respondents had been in surgical practice for >20 years. Only 27.4% were in surgical subspecialties combined, 26.5% in general surgery and 21.6% in obstetrics and gynaecology. Of those in the surgical subspecialties, 10.8% were in orthopaedics and 5.9% in plastics and reconstructive surgery. The others were in paediatric, cardiothoracic, urological and neurological subspecialties.

Informed consent process

Most of the respondents (61.8%) were of the opinion that surgeons do not provide sufficient information to patients about their illnesses before commencing them on treatment. More than half of them (54.9%) agreed with the concern that sufficient information is not provided to patients while obtaining their consent for surgical procedures (table 2). Furthermore, most agreed that, as practised, informed consent amounts to a mere medicolegal ritual (42.2%) rather than a truly participatory decision making process (51.0%) which is most often done as a momentary preoperative routine (41.2%). Concerning the consent form, many did not think that informed consent is equivalent to signing a consent document. They also did not think that signing the consent form is as important as the consent process. Most respondents thought that informed consent was alien to the African psyche, although the majority would not agree that insisting on it by surgeons amounts to being insensitive to the African culture. However, most of them agreed that consent ensures patients' voluntary decision making and provides their authorisation to proceed to treatment.

Obtaining consent for surgical operation

When asked to choose from a list the very important reasons for obtaining consent before surgical procedures, they chose the following in decreasing frequency: medicolegal reasons (70.6%); informing patients about benefits, risks and alternatives (64.7%); informing the patient in order to take a decision about the planned procedure (56.9%); hospital or unit policy (50.0%); and surgical tradition (19.6%). Only a few (5.9%) responded 'yes' to the question whether they provided adequate information to their patients to consent for or against surgery. Moreover, they were asked to choose what they considered to be very important to the consent process. Their responses in decreasing order of importance were the provision of relevant information and its comprehension by the recipient (74.5%); ability to understand relevant information and appreciate consequences of one's decisions (70.6%); understanding given information and being able to process it (65.7%); making a voluntary decision to proceed with treatment (66.7%); and signing the consent document (59.8%). When obtaining consent for surgery, the information the surgeons frequently discussed with their patients included therapeutic options (38.2%), special ways to minimise the risks of operation (36.3%) and detailed explanation about the diagnosis (table 3).

Refusal to provide consent for surgery

Most of the surgeons said that patients seldom refuse to give consent for surgical operations. When it occurs, 84.3% of them thought that poor communication between surgeons and patients may be contributory to a patient's refusal. Asked if they thought that patients had the right to refuse to give consent to proposed surgical treatment, 2.9% responded in the affirmative while 92.2% said they did not know. When asked to choose from a list of responses what they would do if their patient declined to provide consent for a proposed procedure, 41.2% were most likely to abide by the patient's wish, 56.9% were less likely to refer to the hospital ethics committee and 89.2% were most likely to threaten the patient (table 4). In their comment, however, most of them suggested that one way of dealing with such a situation is to provide more information to patients.

Improving surgeon-patient communication

Asked about how to improve the informed consent process and enhance the communication skills of surgeons, the surgeons listed the following factors as very important: adequate understanding of details of surgical procedures by junior surgical staff; incorporating bioethics into surgical residency training; expanding the consent form to include specific benefits, risks and alternatives; and compulsory communication skills course for surgeons (box 1).

DISCUSSION

This study surveyed the opinions of surgeons in south-west Nigeria about informed consent in surgical practice and how to improve the surgeon–patient communication process. It has shown that most surgeons fall short in providing necessary information to patients about their illnesses and when obtaining consents for surgical interventions. Although their responses seemed to indicate a basic knowledge of the precept and an understanding of their moral obligations, they were deficient in the practice of truly informed consent. Moreover, they acknowledged poor communication as mostly responsible for patients' refusal of necessary surgical procedures and suggested that providing more information in such a situation was an appropriate step. Overall, they identified a course in bioethics during surgical training and a compulsory communication skills course as some of the ways to improve communication from surgeons to patients.

Informed consent has two fundamental components—information and consent—and both components illustrate the process as a collaborative one in which a surgeon provides adequate information to elicit the voluntary consent of the patient for a surgical procedure. The information component involves disclosure of essential facts and details, and comprehension of what is disclosed. The consent part entails coming to a voluntary decision and an authorisation to proceed. Both require time and, on the part of the surgeon, adequate knowledge of the material information, appropriate communication skill and the competence to bring the values and interests of the patient to bear on the decision making process. Conceivably, the time pressure on the surgical staff in many hospitals and the lack of significant oversight or regulation of the process make obtaining surgical informed consent by these surgeons less than optimum. Another reason might be the fact that medical practice is still largely paternalistic and doctors still assume significant responsibilities for making medical decisions. Akin to this, perhaps, is the apparent undervaluing of medical ethics in surgical training curriculum. Previous studies in postoperative patients have demonstrated the necessity for surgeons to spend more time and provide more information to their patients preoperatively.²³¹¹ This is a surgeon's moral obligation and one way to avoid situations where patients are 'feeling afraid or nervous'¹² before surgical operations.

The true incidence of patients' refusal to consent to surgical procedures is not known but it has not been a common event in surgical practice in Nigeria. One explanation for this might be that those who would refuse consent to surgery do not come to the hospital in the first place so that the degree of non-consent as measured in the hospital environment is probably underreported as a measure of the true incidence in the community or population. In a study by Irabor and Omonzejele, 6/19 surgeons sampled had witnessed a patient refusing to give consent at the outpatient clinic.¹³ In the majority of those who declined surgery, the surgeons could not identify what might be responsible for their refusal. From experience, old age, a poor prognosis and fear are some of the reasons why some patients or their families decline to provide consent for surgical operations. In Kenya, Briesen *et al* reported that the rumour that those who had cataract surgery would be blind prevented many people with cataract from consenting for free surgery.¹⁴ However, it was discovered during interview of these patients that none of them had actually seen anyone blind after surgery but that they heard about it from people who also had heard about it from other people. In their conclusion the authors suggested improved awareness of the general population and appropriate counselling as one of the possible methods to enhance acceptance.

In the present study, poor communication by the surgeons was identified as a major factor for patients' refusal of needed surgery and the solution proffered was to provide more information to patients. Provision of sufficient and relevant information during the surgeon–patient interactions at the outpatient clinic sessions or while on admission would enhance

making informed decisions that are based on facts and not on rumours. The concept of informed consent is not only about consent; it is equally applicable to refusal of consent. In a relationship that is based on trust, honesty and respect for persons, the patient's informed refusal should not only be honoured but alternative treatment plans should be explored with the patient. These and other options are better choices than threat, withdrawal or premature discharge of the patient.

The way information is presented greatly influences what a patient remembers,⁹ and may ultimately affect the choices he or she makes and how he or she responds to a surgical outcome. In many settings, after the initial contact with the consultant surgeon, junior surgical residents are in charge of obtaining consent for surgery from patients. Studies have documented the limitations of resident doctors with informed consent, one of which is their weakness in discussing risks or alternative procedures.^{15–17} Most of the surgeons in our study were surgical trainees and, perhaps cognisant of their limitations, identified adequate understanding of details of surgical procedures by them as the leading way of improving the informed consent process. The bare generic consent form that is currently in use adds little to the information process and to the overall quality of the consent practice. Discarding the old form and expanding it to include more information that is customised to each procedure would elicit more commitment from surgical staff and guarantee that patients are better informed.⁹ It is pertinent that surgeons appreciate the wide range of ethical issues in surgical practice and develop a sound framework for resolving them. It is equally necessary that they develop interactive communication skills and enhance patients' comprehension of information and involvement in clinical discussions and decision making; hence, the relevance of incorporating training in bioethics into the residency training programme. During the professionally formative years of residency training an all-inclusive bioethics module can help shape good practice habits.¹⁸

CONCLUSION

Most Nigerian surgeons whose opinions were sampled demonstrated a good knowledge of the informed consent requirements and process but fall short in practice. There is a need to improve the surgeon–patient relationship in line with modern exigencies to provide interactive environments for fruitful patient communication and involvement. The consent form and the practice of obtaining consent should be upgraded to give room for sufficient details, stimulate productive discussion and make the process truly informative. Formal training in bioethics and a specific communication skills course would add value to practice and ultimately narrow the present communication gap between the surgeons and their clients.

There are many limitations to this study. The number of surgeons practising in the south-west of Nigeria is not known, but not all of them participated in the study. Although a few surgeons from other regions of the country took part in the survey, the opinions expressed by them and indeed by all the respondents might not be generalisable countrywide. Most of the surgeons seemed to have some basic knowledge of bioethics as revealed by some of their responses and their call for including bioethics in their training programme. This could be due to increased awareness consequent on many bioethics and research ethics seminars that have taken place in the south-west in the past 10 years. It is unlikely that the same level of awareness exists among surgeons in other regions of the country and this disparity might constitute selection bias and further limit the generalisability of the responses. Moreover, the information in this report has not been stratified to reveal subspecialty variations in the practice of informed consent. For example, the cardiothoracic and neurosurgical surgeons have been known traditionally to place great emphasis on information dissemination to

patients while obtaining consents for surgery and postoperatively. The small number of participants from these specialties did not allow for such subset analysis.

Finally, more than half the respondents were surgeons in training and this might have skewed the information presented and the interpretations proffered. This also explains why, at the time of this study, most of the surgeons had practised for less than 5 years. However, since the residents are the 'lieutenants of consultants'¹³ and they do most of the informed consent, the information in this report can be taken to be a true reflection of the status quo. More research is needed on informed consent in Nigeria to explore the usefulness or otherwise of multimedia tools, customised consent forms and some suggestions that have been raised in this study. After all, surgical informed consent is not a fixed format but is still a developing area of medicine.⁹

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Box 1**Ways suggested by surgeons as very important for improving informed consent process and their communication skills**

1. Adequate understanding of details of surgical procedures by junior doctors (58.8%).
2. Incorporating bioethics modules into surgical residency training (52.9%).
3. Expand consent form to include specific risks, benefits and alternatives of procedures (48%).
4. Compulsory communication skills course for all surgeons (47.1%).
5. Discard generic consent form and customise it for each procedure or group of procedures (28.4%).

Table 1

Demographic and professional characteristics of respondents (n=102)

	Number (%)
Age (years)	
≤30	9 (8.8)
31–40	60 (58.8)
41–50	28 (27.5)
51–60	5 (4.9)
Sex	
Male	87 (85.3)
Female	11 (10.8)
Sex not stated	4 (3.9)
Type of institution	
Tertiary	90 (88.2)
Secondary	6 (5.9)
Private	3 (2.9)
Others	3 (2.9)
Status	
Consultant	44 (43.1)
Senior registrars	22 (21.6)
Registrars	33 (32.4)
Others	3 (2.9)
Duration of practice (years)	
<5	65 (63.7)
5–10	24 (23.5)
>10	9 (8.9)
Duration not stated	4 (3.9)
Specialty	
Surgical subspecialties	28 (27.4)
General surgery	27 (26.5)
Obstetrics and gynaecology	22 (21.6)
ENT	5 (4.9)
Ophthalmology	5 (4.9)
Dentistry	5 (4.9)
Others	8 (7.8)
Specialty not stated	2 (2.0)
Location of practice	
Lagos	11 (10.7)
South-west (outside Lagos)	76 (74.5)
South-east	4 (3.9)
North-central	4 (3.9)
North-east	2 (2.0)

	Number (%)
South-south	2 (2.0)
Not stated	3 (3.0)

Table 2

Response to questions about the current practice of informed consent for surgical operations by surgeons in Nigeria

Concern	Response rate (%) on scale 1–4*			
	1	2	3	4
1. Surgeons don't provide enough information before taking consent	5.9	26.5	54.9	10.8
2. Informed consent as practised is a medicolegal ritual, not a moral obligation	18.6	29.4	42.2	9.8
3. Informed consent is not a truly participatory decision making process	11.8	33.3	51.0	3.9
4. It is most often a perfunctory single-moment preoperative routine	19.6	35.3	41.2	3.9
5. Informed consent is nothing more than signing a consent document	41.2	30.4	23.5	4.9
6. Informed consent is alien to the African psyche	2.9	23.5	49.0	24.5
7. To insist on consent is to be insensitive to African culture	43.1	46.1	6.9	3.9
8. Signing the consent form is as important as the consent process	2.9	17.6	52.0	26.5
9. Informed consent cannot conceivably be sought for every procedure	25.5	25.5	37.3	10.8
10. It ensures patient's voluntary decision and authorisation to proceed	3.9	6.9	43.1	45.1

* Key: 1, strongly disagree; 2, disagree; 3, agree; 4, strongly agree.

Table 3

Information disclosed to patients by surgeons when obtaining consent for surgical operations

Information disclosed	Frequency of how commonly they are disclosed (%)
1. Therapeutic options including surgical operation	38.2
2. Special procedures to prevent or reduce risks	36.3
3. Detailed explanation of diagnosis	31.4
4. Available alternative surgical procedures	29.4
5. Specific operative details	23.5
6. Risks associated with chosen operation	22.5
7. Potential benefits of the operation	19.6
8. Specific information about anaesthesia and immediate postoperative period	19.6
9. Frequency of occurrence of major operative risks	18.6
10. The likely surgeon to perform the operation	4.9

Table 4

Likely response of surgeons to patients who decline to provide consent for proposed surgical operation

Response	Response rate (%) on scale 1 (least likely) to 5 (most likely)				
	1	2	3	4	5
1. Abide by patient's wish	10.8	12.7	18.6	13.7	41.2
2. Talk patient into consenting	32.4	28.4	114.7	11.8	10.8
3. Solicit intervention from colleagues or administrators	31.4	15.7	18.6	16.7	15.7
4. Refer to hospital ethics committee	56.9	17.6	7.8	7.8	6.9
5. Threaten the patient	1.0	1.0	2.9	2.9	89.2
6. Withdraw from treating the patient	6.1	1.0	15.2	11.1	66.6
7. Discharge against medical advice	13.7	10.8	16.7	20.6	33.3