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A Prospective Survey on Adequacy of Information Conveyed to Consenters Prior to Obtaining an Informed Consent for Anaesthesia

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ABSTRACT

Background: Ensuring adequate information conveyance to consenters prior to obtaining consent for anaesthesia is an ethical necessity.

Objective: To ascertain the adequacy of information conveyed to consenters prior to obtaining informed consent for anaesthesia, in the University of Port Harcourt Teaching Hospital (UPTH).

METHOD: Ethical clearance secured and written consent obtained, 385 subjects, aged ≥18 years, were served questionnaires addressing 19 points totally, 5 of which (section A) elicited socio-demographic data, while 14 (section B) assessed the comprehensiveness and adequacy of information conveyed prior to obtaining consent. A **"yes, very much"** option score ≥80%, or combined **"yes, very much" and "yes, but little"** options score ≥90%, was considered adequate information in each of the 14 points addressed in section B.

Results: There was less than 80% score of the **"yes, very much"** option, and <90% combined score from the **"yes, very much" and "yes, but little"** options under knowledge of involvement of anaesthesia for the planned surgery, reason, type, advantages, problems, alternative forms of anaesthesia, sufficiency of time spent and information conveyed, as well as under allowance of expression, ease of understanding of language used and satisfaction; the combined proportion of consenters who chose the **"yes, but very little"** and **"no, not at all"** options ranged 16.88 - 78.44%.

Conclusion: Adequacy of information conveyed to consenters for obtaining informed consent was <80% in the depth of information conveyed, allowance of expression, ease of understanding of language and satisfaction.

KEYWORDS: Anaesthesia, Adequacy of information, Informed Consent.

I INTRODUCTION

Over the years, with a rising number of patients becoming more aware of their rights, there has been an increasing number of litigations against medical practitioners.[1] Documented evidence corroborates the fact that the cardinal subject fundamental to most malpractice lawsuits is a breach in the patient-physician relationship, most often emanating from poor patient-physician communication.[2]

Available literature emphasizes a good patient-focused communication, which has been described as an intelligent, sincere dialogue that builds trust and promotes healing, as being the basis of the patient-physician relationship.[2, 3] Such communication favourably modifies patients' behaviour, improves patient care outcomes and satisfaction; consequently, it reduces the incidence of malpractice litigations as patients are very unlikely to sue doctors they like and trust even in the event of substantial medical errors or misjudgements.[2] It is, therefore, imperative that prior to undergoing anaesthesia patients give an 'informed' consent.

By definition, informed consent is an ethical and legal doctrine based on the assumption that all interventions, ranging from diagnostic to scientific studies in the medical field, should only be performed after the purpose, nature, consequences, planned intervention and its alternatives, and risks of the intervention have been made known, not only to a patient or research participant but also to any family members who must give consent on the patient's behalf, and that consent has been granted without coercion.[4] It is, therefore, a necessity that such information being conveyed for obtaining informed consent is comprehensive, adequate, accurate, truthful and faithful, made clear and understandable to the consenter, guaranteeing a proper and valid doctor-patient

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interaction.[5] Given the need to evaluate the content of the process of informed consent for anaesthesia, especially in low- and middle-income settings, this survey was designed to assess the adequacy of information provided prior to obtaining an informed consent for anaesthesia, in UPTH.

II MATERIALS AND METHODS

After securing Institutional ethical approval (UPTH/ADM/90/S.II/VOL.XI/1060) for a prospective, cross-sectional survey, 385 eligible subjects were served a well-structured questionnaire preoperatively, while in their hospital wards, for the collection of relevant data. The questionnaire had two sections, A and B, and addressed a total of 19 points in the respondent: section A featured 5 questions that elicited socio-demographic information; in section B, 14 questions focused on eliciting the comprehensiveness and adequacy of the information conveyed to consenters prior to their granting consent; the subjects were instructed to choose only one option in each of the questions.

For those who had difficulty in understanding the content of the questionnaire, which was written in English Language, translation into the language they best understood was done, by staff not involved in the study which was conducted from October 2022, to December 2023, at the University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria. Age ≥ 18 years, cognitive, capable and responsible patient/spouse/close relative of patient as well as responsible parent/guardian (of children), who granted consent for anaesthesia and for the study comprised the inclusion criteria, while the exclusion criteria consisted of refusal to give consent for anaesthesia/study, age < 18 years, cognitive impairment, presence of psychiatric illness, sensory disability impairing written or verbal communication, emergency anaesthesia and healthcare professionals.

A. *SAMPLE SIZE*

Sample size was computed using the Fisher's formula for infinite population:[6]

$$N = Z^2 \times P \times \frac{(1 - P)}{M^2}$$

where,
N = sample size for infinite population,
Z = z score for a given confidence level; using 95% confidence level for this study, Z = 1.96;
P = population proportion; assumed as 50% for this survey, P = 0.5;
M = margin of error; set at 5% for this study, M = 0.05.
Substituting, $N = \frac{(1.96)^2 \times 0.5 \times (1 - 0.5)}{(0.05)^2} = 384.16.$
Therefore, 385 subjects were recruited.

B. *DATA ANALYSIS*

All data were handled with strict confidentiality. Collected data were entered on a spread sheet and exported for analysis using Statistical Products and Service Solutions (SPSS) version 20.0. Results were presented in numbers and proportions within tables.

III RESULTS

A total of 385 questionnaires were filled by the respondents; sociodemographically,170 (44.16%) were males while 215 (55.84%) were females, giving a female to male ratio of 1.26:1. Respondents within the age range of 30 – 39 years constituted the majority, recording 152 (39.48%), followed by those who were ≥50 years old [85 (22.08%)]; 75 (19.48%) and 68 (17.66%) respondents were aged 40 – 49 and 20 – 29 years respectively. Those in the age category of less than 20 years recording 5 (1.30%) constituted the least in number. All the respondents had a minimum of basic (primary) education: 2 (0.52%), 135 (35.06%) and 248 (64.42%) respectively attained primary, secondary and tertiary as their highest level of education. Amongst the respondents, 205 (53.25%) were the patients themselves, 70 (18.18%) were relatives/guardians, 62 (16.10%) were parents and 48 (12.47%) were spouses of the patients. While 145 (37.66%) respondents had consented to anaesthesia previously, 240 (62.34%)] had not **(Table I).**

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Table I. Consenters' Socio-Demographics, Relationship to Patient and Status of Previous Consent for Anaesthesia.

Parameter	N	%
Sex		
Male	170	44.16
Female	215	55.84
Total	**385**	**100.00**
Age (years)		
< 20	5	1.30
20-29	68	17.66
30-39	152	39.48
40-49	75	19.48
≥ 50	85	22.08
Total	**385**	**100.00**
Highest educational level attained		
Primary	2	0.52
Secondary	135	35.06
Tertiary	248	64.42
None	0	0.00
Total	**385**	**100.00**
Relationship to patient		
Self	205	53.25
Spouse	48	12.47
Parent	62	16.10
Relative/Guardian	70	18.18
Total	**385**	**100.00**
Previous consent for anaesthesia		
Yes	145	37.66
No	240	62.34
Total	**385**	**100.00**

Data are expressed in number (N) and percentage (%)

That anaesthesia was to be administered for their surgery was "**very much known**" by 248 (64.42%), "**little known"** by 96 (24.93%), "**very little known"** by 36 (9.35%) and "**not known at all**" by 5 (1.30%) respondents; 170 (44.15%) "**knew very much"** why anaesthesia was to be administered, 150 (38.96) "**knew little"** why, 55 (14.29%) "**knew very little**" why and 10 (2.60%) did **"not know at all"** why. The type of anaesthesia was **"not known at all"** by 30 (7.80%); 108 (28.05%) "**knew very little"** and 141 (36.62%) "**knew little"**, with 106 (27.53%) who responded that they **"knew very much"** concerning the type of anaesthesia intended for them. While the reason for the very type of anaesthesia to be administered was "**very much known"** by 95 (24.68%), **"little known"** by 125 (32.47%), "**very little known"** by 98 (25.45%), and "**not known at all"** by 67 (17.40%), concerning any problems that might be caused by the type of anaesthesia a total of 114 (29.61%) were **"not at all"** told, 131 (34.03%) were told "**but very little"**,104 (27.01%)were told **"but little"** and only 36 (9.35%) were told **"very much"**. During the process of obtaining consent 174 45.19%) were **"not at all"** informed about alternative types of anaesthesia, 128 (33.25%) were given "**very little**" information, 54 (14.03%) got "**little**" information while only 29 (7.53%) stated they were **"very much"** informed (**Table II**).

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Table II. Opinion On Depth of Information Conveyed by Doctors Obtaining Consent for Anaesthesia.

Question	Response			
	Yes, very much	Yes, but little	Yes, but very little	No, not at all
	N (%)	N (%)	N (%)	N (%)
Has your doctor told you that anaesthesia is to be administered for this surgery?	248 (64.42)	96 (24.93)	36 (9.35)	5 (1.30)
Do you know why anaesthesia is to be administered?	170 (44.15)	150 (38.96)	55 (14.29)	10 (2.60)
Do you know the type of anaesthesia to be administered to you?	106 (27.53)	141 (36.62)	108 (28.05)	30 (7.80)
Do you know advantages of this very type of anaesthesia you are to undergo?	95 (24.68)	125 (32.47)	98 (25.45)	67 (17.40)
Have you been told any problems you may have as a result of this type of anaesthesia?	36 (9.35)	104 (27.01)	131 (34.03)	114 (29.61)
Were you informed about other types of anaesthesia that can be used for this surgery?	29 (7.53)	54 (14.03)	128 (33.25)	174 (45.19)

Data are expressed in number (N) and percentage (%)

By specialty, 130 (33.77%) of the doctors who conveyed information for informed consent were **Anaesthesiologists only**, 120 (31.17%) were **Anaesthesiologists and Surgeons**, 101 (26,23%) were **"Surgeons only"** while the specialty of 34 (8.83%) was unknown by the consenter. The method of information conveyance for consent was mostly **"orally only"** [382 (99.22%)], and 3 (0.78%) consenters were "**not at all"** given information by any method. "**Written method**", and combination of "**written and oral method**" were each 0 (0.00%) in this survey. Joint decision on choice of anaesthetic technique without any coercion by the doctors recorded 142 (36.88%), joint decision on choice with little coercion felt by the consenter was 43 (11.17%); as many as 145 (37.66%) reported the anaesthetic techniques were chosen unilaterally by the doctors and 55 (14.29%) consenters did not know at all how the choice of anaesthetic technique was made (**Table III**).

Table III. Specialty of Doctors, Method Used for Obtaining Information, And Consenters' Participation in Choice of Anaesthetic Technique.

Question	Response	
	N	%
Which doctor(s) conveyed information to you to obtain your consent for anaesthesia?		
Both Surgeon and Anaesthesiologist	120	31.17
Anaesthesiologist(s) only	130	33.77
Surgeon(s) only	101	26,23
I do not know	34	8.83
Total	**385**	**100.00**

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Which method was used by the doctors to tell you the much you needed to know to grant consent?		
Both written and oral	0	0.00
Written only	0	0.00
Oral only	382	99.22
None **at all**	3	0.78
Total	**385**	**100.00**
How was the type of anaesthesia chosen for you?		
By the doctor(s) and I, and I was not forced	142	36.88
By the doctor(s) and I, but I felt a little forced	43	11.17
By the doctor(s) alone	145	37.66
I do not know at all	55	14.29
Total	**385**	**100.00**

Data are expressed in number (N) and percentage (%)

The time spent by consentees explaining about anaesthesia was categorized as **"very much"** sufficient by 125 (32.47%), "**little**" sufficient by 105 (27.27%), **"very little**" sufficient by 98 (25.45%), while by 57 (14.81%) respondents it was "**not at all"** sufficient. To 45 (11.69%), consenters questions and expression of doubts and fears were **"very much"** allowed, to 167 (43.38%) they were **"little"** allowed, 143 (37.14%) stated they were "**very little**" allowed, and 30 (7.79%) declared they were "**not at all**" allowed. **"Very much"** sufficient information was conveyed to 125 (32.47%) for obtaining informed consent; to 184 (47.79%) and 66 (17.14%) respondents respectively, it was "**little**" and "**very little"** sufficient, and 10 (2.60%) stated it was **"not at all"** sufficient. While 138 (35.84%) judged the language of communication used as **"very much"** easy to understand, 102 (26.49%) and 131 (34.03%) respectively considered it to be "**little"** and "**very little"** easy, with 14 (3.64%) stating it as "**not at all**" easy. Of the respondents, 162 (42.08%) expressed **"very much"** satisfaction with the process of information conveyance, for obtaining consent, 158 (41.04%) expressed their level of satisfaction as "**little"**, 57 (14.80%) expressed they had "**very little"** satisfaction and 8 (2.08%) stated they were **"not at all"** satisfied **(Table IV).**

Table IV. Consenters' Opinion on Sufficiency of Time Spent and Information Conveyed, Allowance of Expression, Ease of Understanding of Language Used and Satisfaction.

Question	Response			
	Yes, very much	Yes, but little	Yes, but very little	No, not at all
	N (%)	N (%)	N (%)	N (%)
Did the doctor(s) spend enough time explaining about anaesthesia during the process of obtaining consent?	125 (32.47)	105 (27.27)	98 (25.45)	57 (14.81)
Did the doctor(s) allow you to ask questions to express your doubts and fears before you gave consent?	45 (11.69)	167 (43.38)	143 (37.14)	30 (7.79)
Was the information given to you sufficient for obtaining your consent?	125 (32.47)	184 (47.79)	66 (17.14)	10 (2.60)

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Was the language used to give you information easy for you to understand?	138 (35.84)	102 (26.49)	131 (34.03)	14 (3.64)
Were you satisfied with the way you were given information to obtain your consent for anaesthesia?	162 (42.08)	158 (41.04)	57 (14.80)	8 (2.08)

Data are expressed in number (N) and percentage (%)

IV DISCUSSION

In this prospective, cross-sectional survey, a gross inadequacy in information conveyed by the doctors obtaining consent was made evident: that anaesthesia was going to be required for the surgery, the reason, type, advantages and associated problems of the type, as well as the alternative forms of anaesthesia were very much known by <80% of respondents, with 114 (29.61%) not at all told of any associated problems, and as many as 174 (45.19%) not at all informed about alternative forms of anaesthesia; by specialty, though the conveying of information for consent was dominantly undertaken by Anaesthesiologists, a greater proportion of consenters (51.95%) reported not being actively involved in taking the decision on the choice of anaesthesia, and only 162 (42.08%) were very much satisfied with the consent process.

The finding of gross inadequacy of information conveyance in this study could be attributed to a failure of complete disclosure of the requisite depth. From a legal standpoint, it is professional negligence, and self-subjection to liability to litigation, on the part of a physician who withholds any facts which are necessary to form the basis of an intelligent consent by a patient to a proposed treatment intervention.[7] In other words, to have a patient who is without knowledge of the relevant risks and benefits to agree to a procedure tantamounts to an ethical misconduct.[8] Therefore, the need for 'informed consent' prior to treatment intervention should be considered as an integral component of modern healthcare, the associated high level significance also invariably necessitating that it is documented.[9]

Failure of complete disclosure of information during an "informed consent process might be indeliberate, owing to frank incompetence on the part of the consentee, as when a Surgeon takes up the process of informed consent for anaesthesia, instead of an Anaesthesiologist, or deliberate, as an act of medical paternalism, in which case the consentee limits the extent of what the consenter ought to know about the procedure, to what is considered favourable and understandable. In this survey, 101 (26.23%) respondents identified that they were engaged in the consent process for anaesthesia by Surgeons, rather than Anaesthesiologists. In their systematic review of 11 records, Cebron et al[10] identified that a paternalistic approach to patient education was the most common barrier to obtaining informed consent, the others including lack of knowledge about ethics among surgeons in low- and middle-income countries, cultural beliefs toward healthcare and language barriers. Such incomplete disclosure of information has a serious implication in the event of any complication ending in litigation, as the consenter could claim that had full disclosure of the risks associated with the procedure been made, the consent would not have been granted. It therefore creates allowance for criticism by legal practitioners, who are prone to judge that the patient's right to autonomy and, consequently, self-determination was violated, hence, the consent obtained was invalidated as the consenter was not "informed".

Different core competencies are acquired by doctors in specialist practice, which vary according to the area of specialisation/sub-specialisation, and are not only necessary for successful interventional patient management but also for the process of obtaining informed consent. To ensure adequacy of depth of information, consent for anaesthesia, ideally, should only be taken by trained Anaesthesiologists. Inferentially, therefore, that consent was obtained by non-Anaesthesiologists from as much as 101 (26.23%) respondents, in this study, implied that failure of complete disclosure of requisite depth of information to consenters was bound to occur, in a proportion not less than equivalent to the proportion of respondents engaged in the consent process by non-Anaesthesiologist consentees. The assumption that an informed consent given for surgery suffices for anaesthesia, or vice versa, really needs to be ascertained because the risks and alternatives for anaesthesia are not the same for surgery.[11] Without doubt, a Surgeon obtaining consent from a patient for anaesthesia and surgery is most unlikely to possess the requisite competence to be able to give sufficient details about the choice of anaesthetic technique/alternatives available, the purpose of that choice as well as the associated benefits/risks to justify that the consent being obtained is an 'informed consent'. Neither is an Anaesthesiologist of adequate competence to obtain consent for surgery instead of a Surgeon. Thus, from the report by Cebron et al[10] and the similar findings in this study, it necessitates in the training of doctors, not only an incorporation of a well-structured course aimed at

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achieving competence in the process of obtaining informed consent, but also continuing update, to keep medical practice ahead of the changing considerations in the ethico-legal arena. The Association of Anaesthetists of Great Britain and Ireland (AAGBI), in recognition of this ethical necessity had published and updated "Informed Consent Guidelines".[9]

Time remains an important factor, very fundamental to the process of obtaining informed consent. While spending long duration with a consenter does not necessarily translate to adequate conveyance of information, to be able to convey the requisite depth of information for informed consent, given its definition, sufficient time is required. In this study, the proportion of respondents who stated that consentees spent sufficient time explaining the much they needed to know was inadequate (<80%). Consentees working under the pressure of insufficient time might be accountable for this observation. In recent times, there has been a remarkable drift of specialist physicians, especially Anaesthesiologists, to regions of the globe where more favourable socio-economic benefits can be earned; the low- and middle-income countries from where the drift occurs suffer consequent depletion of trained workforce, increased patient-doctor ratio and excess clinical workload. Invariably, relatively fewer doctors working in high patient-flow hospitals will come under the pressure of time constraint, due to unavailability of sufficient time to beat clinical deadlines, and become prone to hastening the process of informed consent. The importance of giving sufficient time to allow the consenter take an informed decision without feeling rushed or pressured had been documented by Anderson et al.[12]

Again, the appearance and attitude of the consentee during the informed consent process can impact the time spent either positively or negatively. A doctor wearing a smile, appearing calm, confident and refreshed is more likely to readily create a rapport and establish effective communication, enabling his patient ask questions and express doubts/fears. Samaranayake et al[13] documented, in their qualitative analysis in Sri Lanka, that some of the patients reported an inability to ask questions and express doubts/fears, attributing their failure to do so to the doctors appearing 'busy', 'short-tempered' or 'burnt-out'. Physician burn-out is an entity characterized by cynicism, personal feeling of inefficacy and state of exhaustion affecting the physical, mental/psychological domains of a person, arising from lasting unrelieved stress response to workplace stressors.[14] In their systematic review and meta-analysis of the relationship between burnout, depression and anxiety, Koutsimani et al[15] stated that a burnt-out physician characteristically showed negative professional behaviour such as anger, irritability, decreased productivity and decreased quality of care for a patient. Importantly, it is strategic and imperative during informed consent process to practice a patient-focused communication that involves empathy, attentivity, honesty and respect to patients, providing answers to questions, securing patients' confidence, informing and educating patients about the benefits, problems, treatment alternatives, and actively involving the patients in decision-making processes about their own healthcare as well as demonstrating sensitivity to patients' cultural and religious values.[3]

In accordance with hospital-based protocol, all information conveyance to consenter was done only verbally in this survey. This must have negatively impacted on the adequacy of information conveyed. Ordinarily, the consentee who utilizes a pre-documentation based information conveyance method is less likely to forget and leave out details of what the consenter is required to know and understand; in comparison, a consentee who uses verbal means only to convey information is prone to skipping some pieces of information and end up with failure of complete disclosure. The superior effects of written aids on improving patient understanding compared to the traditional verbal method during information conveyance for obtaining informed consent had been documented in earlier literature.[16]

Similar to its impact on treatment interventions, the environment can significantly affect the process of obtaining informed consent. The subjects in this study were approached preoperatively, while in their various wards, implying that they were unlikely to have had sufficient privacy to the exclusion of distraction or unwarranted interference, or to the enhancement of free expression. In his article titled, "Rethinking Informed Consent", Lenze[17] had opined that obtaining informed consent should preferably be done in the pre-anaesthesia clinic rather than the ward or preoperative holding area, due to the associated advantages of better privacy and sufficiency of time for detailed explanation by the consentee, thereby, enhancing reflection, allowance for questions, and expression of doubts by the consenter.

Although there was an attainment of basic (primary) education by all (100%) respondents, with 135 (35.06%) and 248 (64.42%) reporting attainment of secondary and tertiary level education, respectively, thus, inferentially, assuring an appreciable level of understanding of English language used in communication by the doctors, only 138 (35.84%) and 102 (26.49%), correspondingly, found the language used 'very much easy' and 'little easy' to understand. This finding may be attributed to the inclusion by the doctors of pure medical terminologies beyond easy comprehension by lay population, during communication with

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the consenter. Bar et al[18] had documented in their study that a physician must communicate in a language understandable by the consenter. Also, Shah et al[19] stated that lack of comprehension by consenters often resulted from the use of complex medical jargon, recommending that healthcare professionals communicating in plain everyday language with consenters must be deemed indispensable to ensuring a valid informed consent.

V CONCLUSION

The information conveyed was found inadequate for obtaining informed consent for anaesthesia, owing to an incomplete disclosure of the involvement, purpose, type, advantages, disadvantages and alternative forms of anaesthesia; level of satisfaction amongst the respondents with the consent process was, as well, inadequate.

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DECLARATIONS

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AUTHORS' ROLES

[1*]Study conception, initial study design, data interpretation, manuscript preparation, manuscript intellectual component development, final version approval and corresponding author.
[2]Data acquisition, final study design, manuscript intellectual component appraisal, integrity appraisal, and critical reviewing author.

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