

ORIGINAL ARTICLE

An Audit of Preoperative Counselling and Informed Consent in Four Teaching Hospitals of Lahore, Pakistan

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Surgical consent is not an event or a signature on form but continuous process throughout preoperative, peri-operative and post-operative care. Informed consent & preoperative counseling is very important for patients, their attendants & specially for operating surgeons in present changing environment. This study was designed to evaluate ongoing practice of preoperative counseling & informed consent. The present practice of preoperative counseling & informed consent in our setups is not up to the standards sets internationally.

ABSTRACT

Objective: To evaluate the ongoing practice of preoperative counselling and informed consent in teaching hospitals of Lahore, Pakistan.

Settings: Surgical Units of Jinnah Hospital, Mayo Hospital, Services Hospital and Sir Ganga Ram Hospital of Lahore, Pakistan.

Design: Prospective Observational Study.

Duration: Six (06) Months, January 2011 to June 2011.

Keywords: Preoperative Counselling, Informed Consent

INTRODUCTION

Surgical consent is not an event or a signature on a form but it is an ongoing process of communication that continues throughout preoperative, peri-operative and post-operative care.^{1,2}

Informed consent is a part of preoperative counselling which is necessary to fulfill the demands of standard medical practice and evidence based medicine. The combined written and oral preoperative information presented is well adapted to patients' informative wishes and needs; it allows for a structured conversation and facilitates documentation.³

Preoperative counseling is a second name of opportunity for the patients to allay their anxiety and apprehension by seeking answers to all of questions regarding their pathology and proposed surgery. During this session, operating surgeon can discuss the safety and efficacy of the procedure and also the patients can be offered any suitable alternate treatment options. Patients are the best judge and they must be free enough to say yes or no to any treatment modality which they consider appropriate in the best interest of their health.

This study was designed to evaluate the ongoing practice of preoperative counselling and informed consent related to patients undergoing elective general and special surgical procedures in four teaching hospitals of Lahore, Pakistan. In a nutshell, the information which our patients are provided pre-operatively is merely to fill a medico legal form.

PATIENTS & METHODS

A prospective study was carried out using a structured Questionnaire based interview technique. Patients, who had undergoing elective general and special surgical procedure, were interviewed during six months period from January 2011 to June 2011. All patients were asked a set of standard questions (appendix) post-operatively related to the information they were provided before the procedure as a part of standard few days post-operatively so that patients were able to recall the total information, they received as preoperative counselling.

INCLUSION CRITERIA:

1. Patients undergoing elective general and special surgical procedures.
2. Patients between age groups 18-60 year

3. Gender (male, female)

EXCLUSION CRITERIA:

1. All minor and/or major Emergency Surgical Procedures.
2. Patients admitted for an elective procedure but underwent an emergency procedure.
3. Patients less than 18 year of age group.
4. Patients more than 60 year of age group.

RESULTS

A total of 345 randomly chosen patients (187 males and 158 females) were interviewed post-operatively. The patients who were informed about their disease were 258 (74.7%). Only 66 (19.1%)

patients knew the type of anaesthesia they receive. 97 (28.1%) patients were allowed to ask questions before consent was taken. 09 (2.6%) patients did not give the consent but still they were operated.

All the patients in the study were of adult age but even then only 124 (35.9%) patients signed consent form themselves. Operating surgeon was involved in consent taking in 16 (21.6%) cases. Alternate treatment option was offered to 16 (4.6%) patients. 212 (61.4%) patients were told about the nature and purpose of proposed surgery. 161 (46.6%) patients was disturbed by the information provided preoperatively. (Table-1)

Table 1: Results of questions asked during the interview [n = 345]

| Questions | Yes n (%) | No n (%) |
|---------------------------------------|----------------------|---------------------|
| Information about Surgery | | |
| Informed about the patient's disease? | 258 (74.7) | 87 (25.3) |
| Nature & purpose of proposed surgery? | 212 (61.4) | 133 (38.6) |
| Expected benefits from surgery? | 164 (47.7) | 181 (52.5) |
| Approximate time of surgery? | 194 (56.2) | 151 (43.8) |
| Complications during & after surgery? | 59 (17.1) | 286 (82.9) |
| Alternate treatment option? | 16 (4.6) | 329 (95.4) |
| Need of blood and their risks? | 136 (39.4) | 209 (60.6) |
| Results of no treatment? | 139 (40.2) | 206 (59.8) |
| Information about Anaesthesia | | |
| Type of Anaesthesia? | 66 (19.1) | 279 (80.9) |
| Complications of Anaesthesia? | 21 (6.0) | 324 (94.0) |
| Question / Answer Session | | |
| Disturbed by the information? | 161 (17.6) | 184 (53.4) |
| Time for questions to be asked? | 97 (28.1) | 248 (71.9) |
| Consent | | |
| Consent taken by operating surgeon? | 61 (17.6) | 284 (82.4) |
| Consent given? | 336 (97.4) | 09 (2.6) |
| Consent signed by patient? | 124 (35.9) | 221 (64.1) |

ORIGINAL ARTICLE**DISCUSSION**

Preoperative counseling is a gateway towards healthy bonding between doctor and a patient. This can be used as an appropriate tool to reduce the patient's phobia of intervention. The idea of preoperative counseling & informed consent is just similar to preemption of pain to reduce post-operative pain⁴. Above all, this question-answer session can be used to educate before undergoing any procedure. All this practice can increase patients' confidence on medical profession and they become an active member of the team. The goal of the patient teaching is to improve patients' understanding of their disease process and the operation that they are about to experience. The additional goal of obtaining informed consent is not only codified in law, but also has become an ingrained component to the current physician-patient relationship. This is very helpful in minimizing post-operative hospital stay and surgical site infections during healing process⁴.

Informed consent is a result of preoperative counselling. It is at present hard to reach a valid level of information, both due to the difficulty to use a language that should be scientific and understandable at the same time, and to all the cultural, social and intellectual characteristics which determine the real state of comprehension of each patient. Every medical act lawfully always comes from a valid consent of the patient.⁵ In this era of evidence based medicine, the medical practice is formalized by advanced documentation in every field. Nixon I⁶ highlighted the importance of a standardized consent form and structured interview technique. In their study, 94% of patients who gave consent on a standardized form knew about post-operative complications (pain) as compared to 82% of the patients who gave consent on general surgical consent form⁶.

In our study, most of the patients gave informed consent just prior to their surgery. Bhattacharyya T elaborated that orthopedic surgeons take consent prior to the surgery but they have very less information regarding effective methods of obtaining informed consent⁷. In this regard, two things are important for the surgeons i.e. documentation of informed consent and taking consent in their offices. Surgeons may be able to decrease the risk of a malpractice claim by obtaining informed consent in their offices, rather than in the preoperative holding area, and by documenting the informed consent discussion within their dictated office or operative notes.

Some surgical procedures result in higher risks of post-operative complications. For example, Patients who receive musculoskeletal allograft may develop severe post-operative infections. Porter SE has⁸ almost the same percentage of patients (32%) who were counselled properly before allograft in teaching hospitals, compared with 28.1% of patients, who were allowed proper time to ask questions about their surgery and its potential complications in our study. This percentage needs to be raised; and it may be possible by obtaining consent on a structured informed consent form.

An improvement issue in preoperative counselling and informed consent is; who is going to counsel the patient and how much information is to be delivered. Unfortunately, in only 61 (17.6%) cases operating surgeon was involved himself in taking the consent. Although this figure is higher than Amin¹ (8%) even then there is need to improve it by involving senior doctors in this process. This will not only fulfill the international standards of informed consent but also will training the junior doctors as a part of their continuing medical education. We were surprised to see that both patients and operating surgeons were not interested in the complications of the anesthesia as, in our study, surgeons provided information regarding complications of anaesthesia to only 6% of the patients which is not appreciable in any sense. In Moores A.'s⁹ Study, the question most commonly asked by patients was related to duration of surgery, with less priority been given to complications of anaesthesia. In his study, the majority of patients (n = 496, 67%) had no further questions at a point when so-called consent could have been obtained, compared with minority of patients (n = 97, 28.1%) who were given time for questions to be asked in our study. This shows the degree of interest of clinicians towards the right of the patients which must be respected to meet international standards of patient care, the other side of the picture depicts that the patients, themselves, are not interested to know about the details of their disease process and the proposed surgery.

Informed consent should be balanced with the abilities of the patients to understand their disease and its outcome. In our study, 161 (46.6%) patients were disturbed by the information provided pre-operatively. Mishra PK [10] has touched the same issue in his study. This disturbance can be bilateral either due to patient's inability to understand the

confronted situation or at the behalf of attending doctor who is not skilled enough to justify the patients' queries about the proposed surgery. Sometimes, information passed to the patient regarding the surgical risks results in an important stress for the patient and modifies the patient-surgeon bonding due to the information, a non-neglectable group of patients regarding the surgical risks results in an information, a non-neglectable group elicit not to follow the advice of the surgeon. Various measures are discussed since the information on the surgery related risks is a must from a legal point of view but is also highly appreciated and requested by most of the patients. This can be extrapolated back to the way of describing the disease to a patient or the amount of information provided [11, 14].

CONCLUSION

A total of 345 randomly chosen patients (187 males and 158 females) were interviewed post-operatively. Marked number of patients as indicated in our results were not informed about their surgery and type of anesthesia.

In this study, it has been noted that the most junior medical staff is involved in preoperative counseling and informed consent. This reflects our concern in providing health care to the patients which is below international as well as ethical expectations. This state can be improved by empowering ourselves with good communication skills.

REFERENCES

1. Amin MF, Jawaid M, Rehman S, Muddasir, Hina & Zakai SB. An audit of information provided during preoperative informed consent. *Pak J Med Sci.* 2006; 22(1):10-13
2. Bernat JL, Peterson LM. Patient-centred informed consent in surgical practice. *Arch Surg.* 2006Jan ; 141(1):86-92.
3. Ghulam AT, Kessler M, Bachmann LM, Haller U, Kessler TM. Patients' satisfaction with the preoperative informed consent procedure: a multicentre questionnaire survey in Switzerland. *Mayo Clin Proc.* 2006 Mar ;81(3):307-12
4. Whyte RI, Grant PD. Preoperative patient education in thoracic surgery. *Thorac Surg Clin.* 2005 May; 15(2):195-201.
5. Rossi G, Manicone PF, Pescolla A, Raffaelli L, Rossi Iommetti P. Experimental evaluation of informed consent supplied by dental hygienist. *Minerva Stomatol.* 2006 Oct; 55(10):541-9.
6. Nixon I, Balaji N, Hilmy O, Fu B, Brown C. A prospective study comparing conventional methods against a structured method of gaining patients' informed consent for tonsillectomy. *Clin Otolaryngol.* 2005 Oct;30(5):414-7.
7. Bhattacharyya T, Yeon H, Harris MB. The medical-legal aspects of informed consent in orthopaedic surgery. *J Bone Joint Surg Am.* 2005 Nov;87(11):2395-400.
8. Porter SE, Stull D, Kneisl Js, Frick SL. Informed consent is not routinely documented for procedures using allografts. *Clin Orthop Relat Res.* 2004 Jun;(423):287-90.
9. Moores A, Pace NA. The information requested by patients prior to giving consent to anaesthesia. *Anaesthesia.* 2003 Jul;58(7):703-6.
10. Mishra PK. Detailed preoperative information – cruelty or improving quality of informed consent. *Eur J Cardiothorac Surg.* 2005 Dec;28(6):910-11.
11. Ivarsson B, Larsson S, Luhrs C, Sjoberg T. Extended written preoperative information about possible complications at cardiac surgery – do the patients want to know? *Eur J Cardiothorac Surg.* 2005 Dec;28(6):910-1. Epub 2005 Oct 19.
12. Scerrino G, Paladino NC, Cocorullo G, Salamone G, Scarpinata R, Gulotta G. Informed consent in thyroid and parathyroid surgery. *Ann Ital Chir.* 2005 May-Jun;76(3):287-90.
13. Laccourreye O, Cauchois R, Touraine P, Garay A, Bourla A. Preoperative oral information prior to planned thyroid surgery: the surgeon, physician, lawyer and judge's point of view. *Ann Chir.* 2005 Sep;130(8):458-65. Epub 2005 Mar 11. French.
14. Sugimoto Y, Baba M, Aishin K, Nishimura M, Makii S, Mizukawa S, Kobayashi Y. Questionnaire survey about an anaesthesia information sheet. *Masui.* 2005 Jan; 54(1):73-6. Japanese.