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INFORMATION ABOUT THE NIGERIAN RESEARCH JOURNAL OF CLINICAL SCIENCES (NRJCS)/INSTRUCTIONS FOR AUTHORS (NRJCS)

The Nigerian Research Journal of Clinical Sciences (ISSN: 2276-6995) is the official journal of the Faculty of Clinical Sciences, Delta State University, Abraka, Delta State, Nigeria. The Editorial Board, which consists of distinguished academics in the clinical sciences, is committed to the publication of peer reviewed scientific articles of the highest quality. Currently, two editions of the journal are produced annually in April and December.

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Acknowledgements. Contributors who do not meet the criteria for authorship, such as technical assistants, writing assistants or heads of departments who provided only general support should be listed here. Financial and other material support should be disclosed and acknowledged.

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NIGERIAN SURGEONS' PERSPECTIVES ON INFORMATION DISCLOSURE FOR INFORMED CONSENT FOR SURGERY

¹* OKONTA. P. I., ²OTENE. C. I., ³UMEORA. O.U.J

¹Department of Obstetrics and Gynaecology, ²Department of Surgery, Faculty of Clinical Sciences, Delta State University, Abraka, Delta State, ³Department of Obstetrics and Gynaecology, Ebonyi State University, Abakiliki, Ebonyi State

***Corresponding author:**

Email: patrickokonta@yahoo.com, Tel: 08036863224

ABSTRACT

Background: There is generally consensus on some minimum threshold of information to be provided to the patient in the informed consent process; however, there is some debate on whether other information would be important to the patient in making an informed decision.

Objective: To document the opinion of surgeons on the extent of information disclosure in the informed consent process.

Method: A descriptive questionnaire based survey of surgeons who attended the annual scientific meeting of the Nigerian sector of the International College of Surgeons (ICS) in Asaba, Delta State, Nigeria.

Result: About 90% of all surgeons either 'agreed strongly' or 'agreed' that providing the following information to patients is mandatory when obtaining informed consent from them: Diagnosis of pathology; description of surgical procedure; risks/complications of the surgery; alternative treatment(s); implication of not having the planned surgery; type of anaesthesia and complications of anaesthesia. A much lesser percentage agreed that, informing the patient of the name of the surgeon; disclosing the surgeon's scorecard to the patient; and disclosing the HIV or hepatitis B status of the surgeon should be mandatory disclosure during informed consent process. None the less, many surgeons agreed that this information would be of assistance to them in making an informed choice about undergoing a surgical procedure if they were patients.

Conclusion: Surgeons in Nigeria are aware of the relevant information that should be disclosed in the informed consent process.

However, some of them desire more information to be provided if they were patients.

Key words: Nigerian surgeons, information disclosure, informed consent.

INTRODUCTION

Obtaining informed consent for surgical procedures is an important aspect in offering health care to patients. It recognizes the right of the patient to accept or reject any surgical procedure deemed appropriate for management of the patient's condition. It is the expression of the ethical principle of autonomy and reflects the paradigm shift from paternalism to patient centered care.¹⁻³ The process of obtaining informed consent from surgical patients involve, providing information about several aspects of the intended surgery. These include the diagnosis of the surgical condition; the surgical procedures; the risks and benefits of the procedure, the alternative therapy if any; the risk of not having the surgical procedure; the type of anaesthesia and possible risks of anaesthesia and the name of the surgeon or surgical team.^{2, 4, 5} This information is considered important in order for the patient to make an informed opinion whether to undergo the surgery or not. While there is generally consensus on some minimum threshold of information to be provided to the patient in the informed consent process, there are some debates on whether other information would be important to the patient in making an informed decision about undergoing the surgical procedure.⁶ Over the years, there appears to be a

shift in standard concerning the yardstick in measuring the adequacy of information provided to patients in the consenting process. The standards seems to have shifted from the 'Reasonable doctor standard' to the 'Prudent patient standard' and even the 'subjective standard'.⁷ Under the prudent patient standards, a patient ought to be informed of all 'material risks' that a prudent patient would attach significance to in making a choice whether to accept or decline treatment. The prudent patient standards put the criteria for measuring the adequacy of disclosure squarely within the ambit of the patient. To this end, some ethicists have argued that some information not disclosed routinely should become part of the information disclosed to the patient during the informed consent process. One of such is the disclosure of the surgeon's surgical score card. Clarke and Oakley in their seminal article published in 2004 argued that the performance record of a surgeon is a vital information that a patient needs in deciding whether to consent for a surgical procedure or not.⁸ They argue that the outcome of surgery could be impacted by the skills of the surgeons and this risk must be made known to the patient. The examples of the public disclosure of cardiac surgeons performance is readily given to buttress the positive effect of disclosure of surgeon's performance card to quality of care.⁷⁻¹⁰ As persuasive as this may seem, many have disagreed with this. They have argued that disclosure of surgeon's performance cards to patients would have negative effects such as increase in levels of surgeon's anxiety, practice of defensive medicine, and create an ethical problem of justice - where only patients with financial means could access surgeons with better performance cards.^{7, 11, 12} Other debatable items of disclosure in the informed consent process include the name and status of the operating surgeon, and any medical condition of the surgeon for example HIV - that may pose a risk to the patient at surgery.¹³⁻¹⁵ So far the discourse on these aspects of disclosure in the informed consent process for surgery has emanated majorly from the

developed countries. This study sought to document the opinion of surgeons and doctors in the surgical specialties on the extent of information disclosure in the informed consent process. Of particular interest will be their opinion on the inclusion of surgeon's performance score card, name of surgeon and HIV or Hepatitis status of the surgeon as necessary information to disclose in the informed consent process for patients for elective surgeries. It is hoped that findings from this study will add to the growing body of knowledge on the subject. Importantly, it will provide the perspective from a developing country on the subject.

METHODS

The study was a descriptive questionnaire based survey of surgeons who attended the annual scientific meeting of the Nigerian sector of the International College of Surgeons (ICS). The conference held in Asaba, Delta State Nigeria from the 11th - 14th June 2014. All conference participants were invited to take part in the survey. Information concerning the survey was provided in the participant's information page, thereafter consenting participants filled the self-administered questionnaire which was retrieved after completion.

The questionnaire was developed after a review of the relevant literature on disclosure for informed consent for surgery. It contained 3 parts - the first part elicited data about the characteristics of the surgeon; the second part elicited responses on their views of the mandatory information to be disclosed to patients during the informed consent process; and the third part of the questionnaire required the surgeons to assume the role of a patient and indicate how important these same information would be in assisting them make an informed choice about undergoing a surgical procedure. The minimum sample size required for the survey was calculated assuming a 95% confidence interval of 10% and a of 0.05

$$n = 1.98^2 \pi(1-\pi)CI^2$$

Minimum required sample size was 96

respondents. However, a total of 126 questionnaires were distributed to participants at the conference.

Data from retrieved questionnaire was inputted into the computer using the EpiInfo statistical software version 4.5.1 (Center for Disease Control, Atlanta, 2008). The 5 stem likert scale response was analyzed using proportions and presented as percentages. Additionally, responses from the 5 stem likert scale were converted into a 3 stem likert scale response in order to demonstrate better contrast in responses. This was done by merging the responses 'strongly agree' with 'agree' and 'strongly disagree' with 'disagree'.

Ethical approval for the study was obtained from the Delta State University Teaching Hospital Research Ethics Committee.

RESULTS

A total of 126 questionnaires were distributed to all participants at the conference and 105 returned out of which 102 (81%) were completely filled and analyzed. The mean age of the surgeons was 48.5 ± 8.6 years. The youngest surgeon was 34 years while the oldest was 72 years. The respondents belonged to the following surgical specialties: General surgery - 36 (35.29%); Surgical subspecialties - 32 (31.38%); Obstetrics and Gynaecology 20 (19.61%); Orthopaedic surgery 6 (5.88%); Anaesthesia 4 (3.92%); Pathological sciences 2 (1.96%) and Radiology 2 (1.96%). The average duration of practice as a surgical specialist was 10.82 ± 8.57 years, with a minimum duration of practice of 1 year and a maximum duration of practice of 40 years. Sixty-four surgeons (62.75%) practiced primarily in a teaching hospital, 24 (23.53%) practiced in Federal Medical Centres, 8 (7.84%) practiced in Specialist hospitals, 3 (2.9%) practiced in General hospitals and another 3 (2.9%) practiced in private clinics.

Surgeons views on the contents for disclosure for obtaining informed consent from a pre-operative patient.

About 90% of all surgeons either 'agreed strongly' or 'agreed' that providing the

following information to patients is mandatory when obtaining informed consent from them: Diagnosis of pathology; description of surgical procedure; risks/complications of the surgery; alternative treatment(s); implication of not having the planned surgery; type of anaesthesia and complications of anaesthesia (Tables 1 and 2). However, the number that either 'agreed strongly' or 'agreed' reduced to 62.75% when it concerned informing the patient of the name of the surgeon. It further reduced to 49.02% when it concerned disclosing the surgeon's scorecard to the patient and to 27.45% when it concerned disclosing the HIV or hepatitis B status of the surgeon (Tables 1 and 2)

Surgeons' view of the necessary information they would need to make an informed choice about undergoing a surgical procedure if they were patients.

The surgeons were asked to assume the role of a patient scheduled for a surgical procedure and indicate the extent to which certain information would be of assistance in making a choice about undergoing a surgical procedure. The response showed that when surgeons assumed the role of patients, they would like more information to assist them in making an informed choice about undergoing a surgical procedure. About 84% of the surgeons either 'strongly agreed' or 'agreed' that knowing the name of the surgeon would assist them in making an informed choice about undergoing the surgery (Table 4). Similarly 76.47% of the surgeons either 'strongly agreed' or 'agreed' that knowing the score card of the surgeon would assist them in making an informed choice.

Furthermore, the value of this information appeared greater as a patient (Tables 3 and 4). For example while only 13.73% of the surgeons 'strongly agreed' that providing information on the diagnosis of the pathology to patients is mandatory in order to obtain an informed consent. On the other hand when the surgeons were asked to assume the role of a patient, as high as 93.14% 'strongly agreed' that having the information about the diagnosis would assist them in making an informed choice (Tables 1 and 3). Tables 5 and 6 shows the

difference in responses when surgeons assume their professional roles as surgeon compared to if they were patients. The positive sign indicate that the difference is an increase, while the negative sign indicate that the difference is a decrease. The difference in the 5- level likert scale (Table 5) highlights a shift from 'agree' to 'strongly agree'. Furthermore, the 3-level likert scale (Table 6) highlights the fact that both as surgeons and 'patients' there was agreement on the value in providing the following information in the informed consent process, hence there was little difference in the response.

These information are: Diagnosis, description of surgical procedure, risks/complications of surgery, alternative treatment(s), implication of not having the surgery, type of anaesthesia and complication of anaesthesia. On the other hand, there was considerable difference in the value placed on the following information: Name of surgeon conducting the surgery; the performance scale of the surgeon and the HIV or Hepatitis b status of the surgeon. As 'patients' they would like to have this information as part of the disclosure for informed consent.

Table 1: Surgeons' view on the information that is mandatory to provide to patients when obtaining an informed consent for surgery

INFORMATION	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Diagnosis of pathology	14 (13.7%)	88 (86.3%)	Nil	Nil	Nil
Description of surgical procedure	67 (65.7%)	29 (28.4%)	2 (2.0%)	4 (3.9%)	Nil
Risks/complications of surgery	78 (76.5%)	22 (21.6%)	1 (1.0%)	1 (1.0%)	Nil
Alternative treatment(s)	61 (59.8%)	41(40.2%)	Nil	Nil	Nil
Implications of not having the planned surgery.	80 (78.4%)	21 (20.6%)	1 (1.0%)	Nil	Nil
Type of Anaesthesia	70 (68.6%)	25 (24.5%)	7 (6.9%)	Nil	Nil
Complications of anaesthesia	52 (51.0%)	39 (38.2%)	9 (8.8%)	2 (2.0%)	Nil
Name of Surgeon conducting the surgery	31 (30.4%)	33 (32.4%)	12(11.8%)	22 (21.6%)	4 (3.9%)
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	20 (19.6%)	30 (29.4%)	22(21.6%)	27 (26.5%)	3 (2.9%)
HIV or Hepatitis B status of the surgeon	19 (18.6%)	9 (8.8%)	26 (25.5%)	27 (26.5%)	21 (20.6%)

Table 2: A synthesized 3 level likert item of Table 1

INFORMATION	Strongly agree & Agree	Not sure	Disagree & Strongly disagree
Diagnosis of pathology	102 (100%)	Nil	Nil
Description of surgical procedure	96 (94.1%)	2 (2.0%)	4 (3.9%)
Risks/complications of surgery	100 (98.0%)	1 (1.0%)	1 (1.0%)
Alternative treatment(s)	102 (100%)	Nil	Nil
Implications of not having the planned surgery.	101 (99.0%)	1(1.0%)	Nil
Type of Anaesthesia	95 (93.1%)	7 (6.9%)	Nil
Complications of anaesthesia	91 (89.2%)	9 (8.8%)	2 (2.0%)
Name of Surgeon conducting the surgery	64 (62.7%)	12 (11.8%)	26 (25.5%)
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	50 (49.0%)	22 (21.6%)	30 (29.4%)
HIV or Hepatitis B status of the surgeon	28 (27.5)	26 (25.5%)	48 (47.0%)

Table 3: Surgeons views of the extent to which certain information would assist them in making an informed choice of undergoing a procedure if they were patients

INFORMATION	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
Diagnosis of pathology	95 (93.1%)	7 (6.9%)	Nil	Nil	Nil
Description of surgical procedure	78 (76.5%)	18(17.7%)	3 (2.9%)	1 (1.0%)	2 (2.0%)
Risks/complications of surgery	84 (82.4%)	18 (17.7%)	Nil	Nil	Nil
Alternative treatment(s)	76 (74.5%)	23 (22.6%)	Nil	3 (2.9%)	Nil
Implications of not having the planned surgery.	84 (82.4%)	12 (11.8%)	6 (5.9%)	Nil	Nil
Type of Anaesthesia	84 (82.4%)	13 (12.8%)	3 (2.9%)	Nil	2 (2.0%)
Complications of anaesthesia	60 (58.8%)	35 (34.3%)	3 (2.9%)	2 (2.0%)	2 (2.0%)
Name of Surgeon conducting the surgery	59 (57.8%)	27 (26.5%)	6 (5.9%)	6 (5.9%)	4 (3.92%)
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	50 (48.5%)	28 (27.5%)	16 (15.7%)	6 (5.9%)	2 (2.0%)
HIV or Hepatitis B status of the surgeon	23 (22.6%)	21(20.6%)	30 (29.4%)	17 (16.7%)	11 (10.8%)

Table 4: A synthesized 3 level likert item of Table 3

INFORMATION	Strongly agree & agree	Not sure	Disagree & Strongly disagree
Diagnosis of pathology	102 (100%)	Nil	Nil
Description of surgical procedure	96 (94.1%)	3 (2.9%)	3 (2.9%)
Risks/complications of surgery	102 (100%)	Nil	Nil
Alternative treatment(s)	99 (97.1%)	Nil	3 (2.9%)
Implications of not having the planned surgery.	96 (94.1%)	6 (5.9%)	Nil
Type of Anaesthesia	97 (95.1%)	3 (2.9%)	2 (2.0%)
Complications of anaesthesia	95 (93.1%)	3 (2.9%)	4 (3.9%)
Name of Surgeon conducting the surgery	86 (84.3%)	6 (5.9%)	10 (9.8%)
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	78 (76.5%)	16 (15.7%)	8 (7.8%)
HIV or Hepatitis B status of the surgeon	44 (43.1%)	30 (29.4%)	28 (27.5%)

Table 5: Difference in likert scale responses as a 'surgeon' (mandatory information to give patient) and as a 'patient' (needed information to assist decision)

INFORMATION	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
Diagnosis of pathology	+81	-81	0	0	0
Description of surgical procedure	+11	-11	-1	+3	-2
Risks/complications of surgery	+6	-4	-1	-1	0
Alternative treatment(s)	+15	-18	0	+3	0
Implications of not having the planned surgery.	+4	-9	+5	0	0
Type of Anaesthesia	+14	-12	-4	0	+2
Complications of anaesthesia	+8	-4	-6	0	+2
Name of Surgeon conducting the surgery	+28	-6	-6	-16	0
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	+30	-2	-6	-21	-1
HIV or Hepatitis B status of the surgeon	+4	+12	+4	-10	-10

+ sign indicates increase

- sign indicates decrease

Table 6: Differences in the 3 level likert scale responses (Tables 3 &5) as a 'surgeon' (mandatory information to give patient) and as a 'patient' (needed information to assist decision)

INFORMATION	Strongly agree & agree	Not sure	Strongly disagree & disagree
Diagnosis of pathology	0	0	0
Description of surgical procedure	0	+1	-1
Risks/complications of surgery	+2	-1	-1
Alternative treatment(s)	-3	0	+3
Implications of not having the planned surgery.	-5	+5	0
Type of Anaesthesia	+2	-4	+2
Complications of anaesthesia	+4	-6	+2
Name of Surgeon conducting the surgery	+22	-6	-16
The success rate of the surgeon with that particular surgery (surgeons performance scorecard)	+28	-6	-22
HIV or Hepatitis B status of the surgeon	+16	+4	-20

DISCUSSION

The adequacy of information to be disclosed to patients for surgery in the consenting process is very fundamental in making the informed consent valid. The boundaries of what is adequate information for an informed consent sometimes are blurred and determined by professional regulatory bodies and outcome of legal judgments.¹⁶⁻¹⁸ In this study, most of the surgeons agreed that the following information should be mandatorily disclosed to the surgical patient- diagnosis of pathology, description of surgical procedure, risks/complications of surgery, alternative treatment(s), and implication of not having the surgery, type of anaesthesia and complication of anaesthesia. This is in agreement with the core items of information disclosure using the 'reasonable doctor standard'. However as earlier noted, there is a shift from the 'reasonable doctor standard' to 'the prudent patient standard' or even the 'subjective standard' where it is what

matters to the patient that determines the adequacy of disclosure.¹⁹

Results from this study showed that when surgeons assumed the role of patients, the importance of certain information changed - they valued certain information which they had earlier indicated not to be important as surgeons in the consenting process. This finding gives further justification for using the 'prudent patient standard' as a yardstick for assessing the adequacy of disclosure in the consenting process. However, there is need to seek the views of actual surgical patients in order to validate this finding. These studies would take cognizance of the impact of factors such as education and cultural beliefs in determining the amount and type of information that patients want disclosed.^{20,21}

The aspects of disclosure that some surgeons in this study did not see as mandatory are; name of surgeon conducting the surgery; the performance scale of the surgeon and the HIV

or Hepatitis b status of the surgeon. Generally, it appears that the practice of physicians making themselves known to their patient by name is not firmly grounded in Nigeria. Besides formally introducing yourself by name, other methods such as wearing a name badge that also indicates the cadre of physician will make the doctor's name known to the patient. With regards to the consenting process, it is good practice to let the patient know the surgeon that would actually do the surgery. Where the surgery would be done by residents under the supervision of the consultant, this should be made known to the patient in a reassuring way. It is unlikely that providing this information will dissuade the patient from undergoing the surgery. In a study by Wiseman et al,¹³ about 90% of the patient surveyed agreed that residents should perform surgery as part of their training.

Less than 50% of surgeons agreed that the performance scale of a surgeon should be necessary information to be disclosed during informed consent process. This is still a contentious issue even in developed countries despite the success achieved in some specialties like cardiac surgery.^{10, 12} None the less perhaps such information may be useful to patients. About 76% of surgeons agreed that this information would assist them if they were patients to make an informed consent for surgery. The pitfall of using the response of surgeons when they assume the role of patients as reflective of the views of patients in the general population is obvious. The doctor's behaviour as a patient cannot be described as that of a typical patient. Survey of actual patients would help in deciding the importance of such information in the Nigerian context.

While about 27.5% of surgeons agreed that disclosure of HIV or HBV status of surgeon is mandatory as part of the informed consent process, on the other hand about 43.1% agreed that such information would be useful to them in making an informed choice as patients. This is again a very controversial issue. In a landmark judgement in the Kerins v. Hartley case, the court decided that it was mandatory for the surgeon to inform the patient of his HIV status.²²

In a survey of 427 health care workers in Poland in 2009, 16.2% were of the opinion that it is mandatory for HIV infected surgeons to inform their patient of their status before embarking on any procedure.²³ Others have however argued that the risk of infecting a patient during surgery is very low, and if this very small risk must be made known to the patient, it therefore means that all other complications whose risk of occurring is higher than HIV transmission must be disclosed to the patient.¹⁴

CONCLUSION

Surgeons in Nigeria are aware of the relevant information that should be disclosed in the informed consent process. However, some of them desire more information to be provided if they were patients. There is need for studies on what relevant information patients in Nigeria would consider necessary when making an informed decision about undergoing a prescribed surgical procedure for a diagnosed ailment. This information would truly fit into the concept of the 'prudent patient standard' for information disclosure for informed consent.

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