

## COUNTRY REPORT

# LOCAL ATTITUDES, MORAL OBLIGATION, CUSTOMARY OBEDIENCE AND OTHER CULTURAL PRACTICES: THEIR INFLUENCE ON THE PROCESS OF GAINING INFORMED CONSENT FOR SURGERY IN A TERTIARY INSTITUTION IN A DEVELOPING COUNTRY

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### Keywords

consent,  
surgery,  
local moral obligation,  
customary obedience,  
cultural bioethics

### ABSTRACT

*The process of obtaining informed consent in a teaching hospital in a developing country (e.g. Nigeria) is shaped by factors which, to the Western world, may be seen to be anti-autonomous: autonomy being one of the pillars of an ideal informed consent. However, the mix of cultural bioethics and local moral obligation in the face of communal tradition ensures a mutually acceptable informed consent process. Paternalism is indeed encouraged by the patients who prefer to see the doctor as all-powerful and all-knowing, and this is buttressed by the cultural practice of customary obedience to those 'above you': either in age or social rank. The local moral obligation reassures the patients that those in authority will always look after others placed in their care without recourse to lengthy discussions or signed documentation, while the communal traditions ensure that the designated head of a family unit has the honor and sole responsibility of assenting and consenting to an operation to be carried out on a younger, or female, member of the family. Indeed it is to only a few educated patients that the informed consent process is deemed a shield against litigation by the doctors. This paper later addresses the need for physicians to update their knowledge on the process of informed consent through the attendance of biomedical ethics courses, which should highlight socio-cultural practices that may make this process different from the Western concept, but perfectly acceptable in this setting.*

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## INTRODUCTION

The Residency Training Programme in Surgical specialties at the University College Hospital in Ibadan, Nigeria takes between five to eight years to complete, depending on how successful or otherwise a resident is in the fellowship exams. Up till now, biomedical ethics has not been included in the curriculum of the training programme.

Recently efforts have been made, under the auspices of the West African Bioethics Initiative (WABIN), to champion this cause to the Faculty of Surgery of the West African College of Surgeons (WACS). An inaugural symposium was held in February 2005, at the 45<sup>th</sup> annual conference of the WACS, to sensitize surgeons to this important subject of bioethics. It is likely to be a slow process, as many hurdles have to be crossed before bioethics is fully accommodated into the residency programme. In the surgery department of the hospital, every consultant, resident and house-officer knows that it is essential to obtain consent from patients before surgery. The rationale, if asked, is for legal reasons: usually a defense against malpractice. Many are not aware that it is a unique opportunity to interact with a patient and allow him/her to exercise the right of self-determination. The process of obtaining informed consent is, at the moment, no more than asking patients to sign on the dotted line, a small hurdle to be surmounted so that an operation can proceed. Very few of these practitioners are conversant with the evolution of this process, its current controversies, its innate usefulness in the bioethics process, and the fact that it is not just a 'defense against litigation'. Having said that, one should also be aware of the local cultural practices and moral obligations in this locality that tend to confound the process of a proper (Western orthodox) informed consent, which may exasperate even the most well-meaning physician. Nevertheless, a deeper knowledge of this interesting principle of informed consent and its history may reshape the whole process of informed consent for surgery in the University College Hospital, Ibadan for the better.

It is hoped that by identifying the scope of understanding of this process by senior members of the hospital, that areas which require strengthening may be addressed by suitable workshops on the subject.

## MATERIALS AND METHODS

A questionnaire was developed to seek opinions and attitudes about the process of informed consent (see Appendix 1), and this was first administered to 12 senior residents in the Department of Surgery, University College Hospital, Ibadan, noting their responses and discussing questions that required clarification. Senior residents are the lieutenants of consultants, and they ensure the smooth running of the wards, clinics and seminars according to the instructions of the consultants; they feature prominently in obtaining consent from the patients. The questionnaire was then circulated to consultants in various specialties of surgery in the hospital. These unique groups of specialists undertake research, train medical students and resident doctors and operate on patients.

The administration of the questionnaires was carried out personally where possible, with a clear message of the voluntariness of the participation and the anonymity of the responses. Where consultants were not engaged in their offices, their questionnaires were passed to their secretaries for delivery. Forty-seven questionnaires in total were delivered: 30 personally and 17 through secretaries.

A photocopy of the present consent form used in the hospital was attached to all the delivered questionnaires (see Appendix 2). Informed consent towards participation in the study was implied when the participants agreed to answer the questionnaires. A specimen of the questionnaire is shown at the end of the paper.

## DISCUSSION

Nigeria is a country in which the majority of its people are uneducated. The present style of obtaining consent does not really take into consideration whether the patients understand what the proposed operation entails (i.e. what organs are involved and what repair or removal may ensue), the alternatives available, and the possible complications that may occur from such an operation. Many times this may not be the surgeon's fault, and it is certainly not the patients' fault that Western-type education eluded them: most surgical procedures have no

Table 1. Questionnaire results\*/\*\*

QUESTIONS	YES (Count)	NO (Count)	OTHER
Are you satisfied with the present consent form?	63% (12)	31.6% (6)	One person omitted to fill any of the boxes.
Do you think it is too vague?	58% (11)	42% (8)	
Does it serve your specialty patients' needs?	42% (8)	47.4% (9)	10.5% Uncertain (2)
Do you obtain consent from patients yourself?	10.5% (2)	52.6% (10)	31.6% Sometimes (6). (One person did not fill any box.)
Do you believe patients always know what they are signing for?	15.8% (3)	10.5% (2)	21% Uncertain (4) (Nine consultants omitted to fill any box.)
Do you test patients after consent has been taken by house-officers to ensure comprehension?	26.3% (5)	37% (7)	26.3% Sometimes (5) 10.5% Rarely (2)
Has a patient you thought comprehended ever turned out not to have understood after all?	42% (8)	0%	31.6% Seldom (6) 26.3% Rarely (5)
Do you think it is the doctor they are signing to please?	31.8% (6)	42% (8)	26.3% Maybe (5)
Do you feel patients may be afraid of annoying the doctor by not signing?	37% (7)	26.3% (5)	37% Maybe (7)
Do patients have a choice but to sign?	52.6% (10)	31.8% (6)	15.8% Maybe (5)
Has a ward admission ever refused to sign after a discussion with you?	42% (8)	42% (8)	15.8% Rarely (3)
Has an outpatient ever refused to sign after a discussion with you?	31.6% (6)	63% (12)	5.2% Rarely (1)
Where would you prefer taking consent?	0% (0)	0% (0)	52.6% Wards (10) 47.4% Clinics (9)
Consent form should be printed in major Nigerian languages and pidgin English.	47.4% (9)	15.8% (3)	37% Not sure of advantage (7)
Can consent be taken in patients' mother-tongue if he/she does not understand English?	68.4% (13)	0% (0)	26.3% Maybe with interpreter (5) 5.2% Why bother (1)
Should consent forms be specific for each procedure?	42% (8)	21% (4)	37% Not sure of advantage (7)
Should consent forms be in duplicate so that you keep a copy in case of litigation?	79% (15)	5.2% (1)	15.8% Uncertain (3)
In triplicate? Copies for the case-file, the patient and the surgeon.	37% (7)	26.3% (5)	26.3% Why bother (5) (Two consultants did not answer question.)
Do you believe that as long as a patient comes to you he/she has given moral if not legal consent?	15.8% (3)	84.2% (16)	

\* Nineteen out of 47 questionnaires were retrieved, giving a return rate of 40.4%.

\*\* Participating departments were (1) Surgery – 8, (2) Ophthalmology – 3, (3) Obstetrics and Gynecology – 3, (4) Dentistry – 2, (5) Oral and Maxillofacial surgery – 2, and (6) Ear, Nose and Throat – 1.

translation-correlation in the local language, and when misunderstandings occur post-operatively as a result of a complication that had been previously discussed with the patient (who assented without comprehending), it is difficult to hold any party culpable. The consent form presently used seems to be resigned to the fact that there may be no advantage in trying to offer any more information than is necessary (see Appendix 2). The authors wish to move away from this standpoint and seek the opinion of other senior members of staff in finding a way to include the participation of patients in a decision-making process that may be culturally acceptable and mutually beneficial, ethically speaking, to both parties, and subsequently develop a proper consent form that is appropriate to the socio-cultural environment as well as internationally-accepted standards.

From the results obtained, it was seen that the majority of the consultants were satisfied with the

present consent form (63%); however, many agreed that it is too vague (58%) and may not serve the needs of patients in their specialty (47.4%) (see Table 1). This suggests that since many consultants are willing to use the consent form as it is, even though they know it does not contain enough information for patients, the full importance of the consent form in the informed consent process may be unknown or trivial to the consultants.

To be of benefit to the physician, the consent forms must help him in meeting his duty to inform the patient or in protecting him from a patient's claim that his was not an informed consent (or both). Consent forms are of no benefit to the physician or the patient if they are worded poorly or put to poor use.<sup>1</sup>

<sup>1</sup> R.M. Moore Jr. Consent Forms – How, or whether, they should be Used. *Mayo Clin Proc* 1978; 53: 393–396: 393.

Table 2. Refusal of consent\*

	You scared them off with too much info	They had no confidence in you despite detailed discussion	Traditional medicine was preferred	Don't know	Don't care
For patients who refused consent, the cause might have been. . .	10.5% (2)	0% (0)	0% (0)	42% (8)	0% (0)

\* Nine consultants omitted to answer this question.

Thus, the ethical thing to do is to find a way to improve on the present form so that it benefits both the doctor and patient.

Most consultants in the UCH, Ibadan do not routinely obtain consent from their patients and this duty is left to the residents or house officers. It has been shown in a study that residents, especially first year residents, are unable to provide patients with correct appraisals of the risks, extent of surgery, alternatives and complications whilst taking informed consent.<sup>2</sup> Thus, it is advisable that consultants take the trouble to have these informed consent discussions with their patients as this fosters a good doctor-patient relationship, which many believe goes a long way in preventing malpractice suits.<sup>3</sup>

A proper informed consent process requires information or disclosure (from doctor to patient), comprehension (by the patient), voluntariness (lack of coercion or persuasion), agreement or assent (in principle after opportunity to ask questions and ruminant), then consent.<sup>4</sup> This process is difficult to achieve, as many studies have shown.<sup>5</sup>

<sup>2</sup> P. Angelos et al. Residents Seeking Informed Consent: Are they Adequately Knowledgeable? *Curr Surg* 2002; 59: 115–118.

<sup>3</sup> P.A. Plumeri. The Gastroenterologist and the Doctrine of Informed Consent. *J Clin Gastroenterol* 1983; 5: 185–187; D.A. Buehler. Informed Consent – Wishful Thinking? *J Bioeth* 1982–1983; 4: 43–57; H.R. Krause, A. Bremerich & J. Rustermeier. Reasons for Patients' Discontent and Litigation. *J Cranio-Maxillofac Surg* 2001; 29: 181–183; G. Neale. Informed Consent. *Gut* 2000; 46: 5–6.

<sup>4</sup> T.L. Beauchamp & J.F. Childress. 2001. Principles of Biomedical Ethics. 5<sup>th</sup> edn. Oxford: Oxford University Press.

<sup>5</sup> C.W. Lidz, P.S. Applebaum & A. Meisel. Two Models of Implementing Informed Consent. *Arch Intern Med* 1988; 148: 1385–1389; W.S. Edwards & C. Yahne. Thomas G. Orr Memorial Lecture. Surgical Informed Consent: What it Is and Is Not. *Am J Surg* 1987; 154: 574–578; G. Robinson & A. Merav. Informed Consent: Recall by Patients Tested Postoperatively. *Ann Thorac Surg* 1976; 22: 209–212; T.C. Wade. Patients may not Recall Disclosure of Risk of Death: Implication for Informed Consent. *Med Sci Law* 1990; 30: 259–262; D.A. Herz, J.E. Looman & S.K. Lewis. Informed Consent: Is it a Myth? *Neurosurg* 1992; 30: 453–458; S. Layton & J. Korsen. Informed Consent in Oral

Paternalism in medicine has been said to be an inseparable part of the practice,<sup>6</sup> yet how much of this affects the informed consent process is yet to be concisely determined. In Nigeria, the medical doctor is accorded the status of a deity (a lesser God who is only surpassed by the almighty creator). This stems from the first democratic era when independence from British rule was granted in 1960. Whenever the governor of a state went on vacation, the commissioner of health (who was invariably a medical person) took over governance of the state. Thus, to most patients the word of a doctor was law, and he/she had the power of life and death. To have a doctor discussing the merits and demerits of a particular treatment procedure and inviting a patient's feedback may be too much for the patient to come to terms with. Many would accept whatever outcome an operation brings as the 'Will of God' or 'In shah Allah', depending on their religion. A study carried out previously in Nigeria suggested that some patients may lose faith in the doctor during this informed consent process, thinking he or she may be incompetent if he or she mentions all the things that may go wrong with a surgical procedure<sup>7</sup> (see Table 2). The UCH consultants who felt that patients may sign these forms just to please the doctor (yes – 31.8%; maybe – 42%) are in greater number than those who do not agree. Similarly, the

and Maxillofacial Surgery: A Study of the Value of Written Warnings. *Br J Oral Maxillofac Surg* 1994; 32: 34–36; R.J. Hekkenberg et al. Informed Consent in Head and Neck Surgery: How Much do Patients Actually Remember? *J Otolaryngol* 1997; 26: 155–159; C. Lavelle-Jones et al. Factors Affecting Quality of Informed Consent. *Br Med J* 1993; 306: 1273.

<sup>6</sup> J. Katz. 1997. Reflections on Informed Consent: 40 Years after its Birth. American College of Surgeons Committee on Ethics. Ethics and philosophy lecture. Available at: <http://www.facs.org/education/ethics/katzlect.html> [Accessed 18 Apr 2007].

<sup>7</sup> K.A. Agu. Informed Consent Policy and Surgeons in Southeast Nigeria. *Nig J Surg* 2003; 9: 39–41.

Table 3. The value of the consent form\*

	<i>Satisfies your conscience</i>	<i>Medico-legal document</i>	<i>Doubtful value, just one of those forms</i>	<i>Necessary minor hurdle before operating</i>
What is your opinion of the value of the consent form?	10.5% (2)	68.4% (13)	0% (0)	5.2% (1)

\* Three consultants did not state their opinions.

fear of annoying the doctor by not signing is recognized by most (yes – 37%; maybe – 37%) (see Table 1). This underscores the influence the doctor has on the patients' consent to surgery, whether they have understood the risks and ramifications of the operation or not.

Another probable reason for such patients' behavior (apart from paternalism) may be the tradition of customary obedience. This attitude militates against active authorization (or to autonomously consent) to a procedure. The background to such attitudes is traceable to the age-group system tenable in most African countries, including Nigeria. Those in the upper age groups protect the interests of those in the lower groups. In return, those in the lower groups defer, pay unreserved loyalty, show respect to those in the upper group, and regard them as authority figures. Hence, such patients traditionally expect doctors to look after their interests and welfare without the need to document oral agreements. This means the importance of signing a consent form is not uppermost in the minds of patients and doctors in Nigeria; rather, it is regarded merely as performing a token ritual before an operation can take place (see Table 3).

A slightly increased number of consultants preferred to take consent on the wards (52.6%) rather than the outpatient clinics (47.4%) (see Table 1); this is probably the best option as informed consent is a process and not a one-off action. Thus, having frequent access to the patient may enable clarification of doubts and improvement of the rapport between physician and patient. In support of out-patient clinic discussions is the fact that patients who would not assent to surgery after having full disclosure can be identified, thus saving them time and money and giving them an opportunity to seek alternative treatment without having to admit them.

It has been shown that too much disclosure may scare patients off,<sup>8</sup> yet one is required to inform the patient as much as possible. This dilemma is yet to be fully reconciled and it is on record that different countries may interpret this concept of disclosure differently.<sup>9</sup>

The majority of the consultants would like the consent forms printed in the three major Nigerian languages. This may facilitate one of the components of full informed consent regarding comprehension<sup>10</sup> and may also acknowledge, culturally, the impact a recognized language has in making a rural Nigerian feel at ease. The greatest benefits are derived when bioethics is employed within historical, ideological and social contexts, in what is often referred to as cultural bioethics.<sup>11</sup> The moral obligation for Nigerian surgeons towards their patients is to be able to secure first-person voluntary informed consent, while at the same time remaining conscious of the attendant cultural implications. For instance, how a surgeon secures first-person consent from a married African (Nigerian) woman is bound to be very different from how such consent is secured from a married European woman. This is because the principle of autonomy, as it relates to a married European woman, applies differently to a married African (Nigerian) woman.

<sup>8</sup> L.M. Wallace. Informed Consent to Elective Surgery: The 'Therapeutic' Value. *Soc Sci Med* 1986; 22: 29–33; Agu, *ibid*.

<sup>9</sup> R.H. Brown. Consent. *Pediatrics* 1976; 57: 414–416; Buehler, *op. cit.* note 3; Hekkenberg, *op. cit.* note 5; C. Lavelle-Jones et al. Factors Affecting Quality of Informed Consent. *Br Med J* 1993; 306: 1273.

<sup>10</sup> Committee on Bioethics. Informed Consent, Parental Permission and Assent in Pediatric Practice. *Pediatrics* 1995; 95: 314–317; T.J. Weber. *The Expanding Requirement for Informed Consent in the Practice of Dentistry*. Online: Goldberg & Katzman. Available at: [http://www.gkslaw.com/dentistry\\_informed\\_consent.html](http://www.gkslaw.com/dentistry_informed_consent.html) [Accessed 17 Apr 2007].

<sup>11</sup> D. Callahan. 2004. s.v. Bioethics. In *Encyclopaedia of Bioethics*. 3<sup>rd</sup> edn. S.G. Post, ed. London: Macmillan: 281.

The primary reason for this is that bride-price is paid on African (Nigerian) women. The payment of the bride-price, known as 'Lobola' in South Africa, 'Rooru' in Zimbabwe and often referred to as head-money in most West African countries (including Nigeria), has implications for securing first-person consent from this category of patients. This is because a woman concedes part of (if not all) her autonomy to her husband and husband's family members on the payment of the bride-price on her 'head'. This makes it difficult, especially in emergency cases, to obtain consent for surgery in a married woman, as the doctor has to wait for the husband or senior male members of the family to be present before surgery can be undertaken.

The husband (or senior male family member) is the one who gives or refuses consent. It does not matter if the woman is a high court judge or a professor of medicine, she would prefer not to undermine her husband's authority by giving the consent herself. In a polygamous family where one wife requires surgery for infertility, the husband may refuse consent claiming he has other children from the other wives, consequently exposing the childless wife to ridicule and disgrace in the community as barrenness is a serious liability in Nigerian culture. This circumstance controls a woman's reproductive rights (the issue of barrenness and its implication for the Nigerian will not be pursued further in this article as this is not an article on reproductive health, law and ethics).

The argument made here, however, is that while securing consent in the Nigerian context may not be as straight forward as in the Western context, it is nonetheless important for the respect and dignity of patients. This implies that we do not acquiesce to non-procurement of informed consent. Instead, what we argue for is the need to procure informed consent within a cultural context. This is particularly so in the African (Nigerian) situation where there is a wide difference in social and cultural values from those of Western countries. And where there are different ethnic extractions (as is the case in Nigeria), then the need for adequate use of language becomes invaluable if patients (or those to give proxy consents on behalf of patients) are to understand the disclosures and information in consent documents.

Nigeria, for instance, has different ethnic tribes, with over 300 different languages, and many can speak and understand one or more of the three major languages, namely Yoruba, Hausa and Ibo. Those who do not understand any of the three major languages speak what is termed 'pidgin-English', which is a rough form of English spiced with local vernacular. This means that even if one has to use an interpreter to get some medical message across, the consultant may speak pidgin-English to his patients to achieve some modicum of disclosure. Many consultants would also prefer the forms to be specific for each procedure (42%); whether this would be accepted by the hospital management remains to be seen, as this would entail expenses for printing and paper: indeed many are unsure of the advantage and some think it is a waste of paper (37% and 21% respectively). There was almost unanimous agreement that consent forms should be signed in duplicate so that a copy is filed in the case note and so the surgeon can keep one (79%) (see Table 1). A form placed in the patient's chart, which the patient has signed, provides the best defense to an allegation that they were not adequately informed.<sup>12</sup>

Although it does not eliminate possible allegations that the patient did not understand the form, or was not given sufficient time to comprehend the nature of the procedure, these allegations are tremendously weakened by proper use of a comprehensive form. The opinion of many consultants as to the value of the consent form seems to be for legal defense only; while that aspect should not be ignored, it is better to think of the informed consent process as 'a wonderful opportunity to communicate their personal concern to the patient as a person, not just a sick gall bladder to remove.'<sup>13</sup>

We believe the process of obtaining operation consent from a patient goes beyond the signing of a form by the patient and requires the active and continued participation of the doctors at a senior level so that this process may be imparted to residents and house officers – even in spite of the socio-cultural and local moral practices. This

<sup>12</sup> Weber, *op. cit.* note 10.

<sup>13</sup> S. Latton & Korsen. Informed Consent in Oral and Maxillofacial Surgery: A Study of the Value of Written Warnings. *Br J Oral Maxillofac Surg* 1994; 32: 34–36.

will require regular training and updates in bioethics for all surgical caregivers. The majority of program directors for general surgery residencies support the teaching of clinical ethics and favor a standardized curriculum. However, most residencies in general surgery do not include ethics instruction as part of their on-going regular educational schedule.<sup>14</sup>

The wave of ethics sweeping over the world in general, and Africa in particular, led to the inauguration of the Pan-African Bioethics Initiative (PABIN) in 2001, which led to the formation in Nigeria of the Nigerian Bioethics Initiative (NIBIN). Having trained ethicists onboard, with backing from the various postgraduate colleges, will also encourage interested clinical consultants to take up the ethics baton and disseminate relevant knowledge. Such interested, but untrained, clinicians can be sponsored for fellowships or formal training in biomedical ethics. This is taking a leaf from the Canadian system where biomedical ethics is taught in every medical school and the various postgraduate medical colleges require ethics training in residency training programs as a prerequisite for accreditation.<sup>15</sup>

Reports suggest that medical graduates in the United States who received ethics training while at medical school revealed that they could better understand ethical issues in clinical practice and would encourage continuation and expansion of ethics training in medical schools.<sup>16</sup> This can also be done in Nigeria, with the significant difference that social norms, cultural practices and local moral values and practices are enmeshed into the ethics training program here. One should be able to extend this knowledge to Western-trained doctors so that they accept that the process of obtaining consent from the husband of a female patient is perfectly in order within the local culture.

<sup>14</sup> M.T. Downing, D.P. Way & D.A. Caniano. Results of a National Survey on Ethics Education in General Surgery Residency Programs. *Am J Surg* 1997; 174: 364–368.

<sup>15</sup> M.F. McKneally & P.A. Singer. Bioethics for Clinicians: 25. Teaching Bioethics in the Clinical Setting. *Can Med Assoc J* 2001; 164: 1163–1167.

<sup>16</sup> T.O. Ogundiran. Enhancing the African Bioethics Initiative. *BMC Med Educ* 2004; 4: 21.

## CONCLUSION

It can be appreciated that the informed consent process in the University College Hospital, Ibadan, Nigeria will continue to be shaped by cultural practices, consciously or unconsciously. Consciously in the sense that not much will be gained by trying to explain detailed operation procedures to an illiterate farmer who totally trusts that the surgeon does not wish him harm – even if you started out doing that, after a while you would end up asking him to put his thumbprint on the appropriate line and assure him that all will be well. Unconsciously, a surgeon will institute processes to keep a female or a pediatric patient who requires emergency surgery alive until the husband or father arrives from work to give or refuse consent. Only with the limited number of educated patients will a signed informed consent really be regarded as being useful for legal defense when complications arise. Whatever the circumstances, the surgeon who practices within the African context in general, and Nigeria in particular, must, in thoughts and in deeds in the course of his/her profession, always remain conscious of the cultural environment in which he or she practices. This translates into a local moral obligation, which each surgeon owes to his patients, an obligation which his or her patients could lay claim to as a moral and indeed legitimate expectation.

## APPENDIX 1

### QUESTIONNAIRE ON INFORMED CONSENT

1. Are you satisfied with the present consent form/s in your hospital?  
1. Yes    2. No    3. Uncertain
2. Do you think it is rather vague?  
1. Yes    2. No    3. Uncertain
3. Does it sub serve the needs of your patients in your opinion?  
1. Yes    2. No    3. Uncertain
4. Do you routinely obtain the consent from the patient yourself?  
1. Yes    2. No    3. Sometimes

5. If yes, do you believe they always know what they are signing for?  
1. *Yes* 2. *No* 3. *Uncertain*
6. If the consent is taken by your resident or house-officer do you routinely 'test' the patients to ensure they fully understand what they are getting into?  
1. *Yes* 2. *No* 3. *Rarely*   
4. *Sometimes* 5. *Don't care*
7. Have you ever had the experience of a patient asking about the operation after you thought you had gotten through to the patient during the consent process?  
1. *Often* 2. *Occasionally*   
3. *Rarely* 4. *Never*
8. Don't you sometimes feel it is the doctor they want to please by signing and not because they understood your discussion?  
1. *Yes* 2. *No* 3. *Maybe*   
4. *Uncertain*
9. Do you think some patients may be afraid of antagonizing the doctor by not signing?  
1. *Yes* 2. *No* 3. *Maybe*   
4. *Never considered it* 5. *Don't know*
10. Do you really believe they have any other choice but to sign however scanty/cursory the information you give might be?  
1. *Yes* 2. *No* 3. *Uncertain*
11. Has any patient after being admitted onto the ward ever refused to sign consent after you had a discussion with him/her?  
1. *Yes* 2. *No* 3. *Rarely*
12. Has any patient ever refused to sign consent in the outpatient clinic with you?  
1. *Yes* 2. *No* 3. *Rarely*
13. For the patients who refused, do you think the reason might have been. . .  
1. *You scared them off with too much information*   
2. *Traditional medicine was preferred*  
3. *They wanted another doctor*  
4. *Really don't know* 5. *Really don't care.*
14. Where would you prefer taking consent?  
1. *Wards* 2. *Outpatients' clinic*   
3. *Theatre*
15. Would you like the consent form printed in the local languages?  
1. *Yes* 2. *No* 3. *Uncertain*
16. Is it really feasible to obtain informed consent in the patients' mother-tongue if he/she does not understand English?  
1. *Yes* 2. *No*   
3. *Maybe with an interpreter*
17. Would you prefer specific forms for specific procedures?  
1. *Yes* 2. *No* 3. *Unsure of merit*
18. Should the forms be signed in duplicate so that you keep a copy in case the filed one gets lost?  
1. *Yes* 2. *No need*   
3. *Uncertain of value*
19. In triplicate? So that one goes in the case-file, the patient keeps one and you keep one.  
1. *Yes* 2. *No need*   
3. *Uncertain of value*
20. Do you believe that as long as a patient comes to seek your help he/she has already given moral consent even if not legal?  
1. *Yes* 2. *No* 3. *Uncertain*
21. What in your opinion is the value of the consent form?  
1. *Satisfies ones conscience*   
2. *A medico legal document in your defense*  
3. *Unique doctor/patient bonding process*  
4. *Just a hospital form one has to fill*  
5. *A necessary minor hurdle before you can operate*
22. Please indicate your department/division/unit.

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.



APPENDIX 2

SAMPLE OF THE UCH IBADAN CONSENT FORM

**CONSENT FOR OPERATION**

.....  
of.....hereby consent to  
(undergo  
(the submission of my \*(child.....to undergo)  
(ward

the operation of .....  
the nature and purpose of which have been explained to me by

Dr/ Mr.....  
I also consent to such further or alternative operative measures as may be found necessary during the course of the above - mentioned operation and to the administration of general, local or other anaesthetics for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon

Date..... Signed.....  
(Patient/Parent/ Guardian)

Witness .....  
Full Name Signature Title

confirm that I have explained the nature and purpose of this operation to the patient/parent/guardian

Date..... Signed.....  
Doctor

**\*DELETE AS APPROPRIATE**  
**ANY DELETION, INSERTIONS OR AMENDMENTS TO THIS FORM**  
**MUST BE MADE BEFORE THE EXPLANATION IS GIVEN AND THE**  
**FORM SUBMITTED FOR SIGNATURE.**

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