



## Informed consent: myth or reality in the surgical units of Yaoundé Central Hospital?

Le consentement éclairé : mythe ou réalité dans les services chirurgicaux de l'Hôpital Central de Yaoundé ?

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### Original Article

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### ABSTRACT

**Introduction:** Our study aimed to evaluate the practice of informed consent among patients undergoing surgery.

**Patients and methods:** This cross-sectional survey was conducted in seven surgical units at Yaoundé Central Hospital (YCH). A 14-item structured questionnaire was administered to explore the content and adequacy of the information provided to patients and the methods used to obtain consent. Data on age, sex, responses to the questions, and adequacy score were collected and analyzed using SPSS.

**Results:** One hundred and fifty-five patients were recruited. The mean age of patients was  $37.38 \pm 21.26$  years, with 80.6% being men. Participants were informed of their diagnosis ( $n=153$ , 98.7%), of the nature and purpose of the surgery ( $n=139$ , 89.7%), of the expected benefits ( $n=150$ , 96.8%), of the type of anesthesia ( $n=137$ , 88.4%), of the anesthetic risks ( $n=127$ , 81.9%), of the need for postoperative medication ( $n=124$ , 80%), and of the outcome if surgery was refused ( $n=132$ , 85.2%). Only 42 participants (27.1%) had been informed of the risks and complications of surgery. The information adequacy score was statistically higher in ENT-HNS units ( $p=0.006$ ) and Maternity ( $p < 0.001$ ). A total of 151 (97.41%) participants had signed a consent form.

**Conclusion:** The process of obtaining consent for surgery was satisfactory, although the information provided to the patient was incomplete.

### RESUME

**Introduction :** L'objectif de l'étude était d'évaluer le processus d'obtention du consentement éclairé chez les patients opérés.

**Patients et méthodes :** Il s'agissait d'une étude transversale menée à l'Hôpital Central de Yaoundé. Un questionnaire structuré de 14 items a été administré afin d'explorer le contenu et la pertinence de l'information prodiguée aux patients, ainsi que les méthodes utilisées pour obtenir leur consentement. L'âge, le sexe, les réponses aux questions et le score d'adéquation de l'information ont été collectés et analysés à l'aide du logiciel SPSS.

**Résultats :** Au total 155 patients ont été retenus. L'âge moyen des patients était de  $37,38 \pm 21,26$  ans et 80,6 % étaient du sexe masculin. Les participants ont été informés de leur diagnostic ( $n=153$ , 98,7 %), de la nature et du but de l'intervention chirurgicale ( $n=139$ , 89,7 %), des bénéfices attendus ( $n=150$ , 96,8 %), du type d'anesthésie ( $n=137$ , 88,4 %), des risques anesthésiques ( $n=127$ , 81,9 %), de la nécessité d'un traitement postopératoire ( $n=124$ , 80 %), et de l'issue en cas de refus de la chirurgie ( $n=132$ , 85,2 %). Le score d'adéquation de l'information était plus élevé dans les unités ORL-CCF ( $p = 0,006$ ) et à la maternité ( $p < 0,001$ ). Au total 151 patients (97,41 %) avaient signé un formulaire de consentement.

**Conclusion :** Le processus d'obtention du consentement pour la chirurgie a été satisfaisant bien que le contenu de l'information prodiguée aux patients soit incomplet.

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## Introduction

The medical field is complex and demanding, inherently involving risk and uncertainty, and closely connected to lifelong suffering and death. Consequently, even minor errors can make a doctor legally responsible [1]. Medical liability encompasses various forms, including disciplinary, administrative, civil, and criminal, with some overlaps between them [1]. In the latter half of the 20th century, the rise of patients' rights prompted notable shifts in medical practice, fundamentally transforming the doctor-patient relationship [2]. Starting in 1960, global protests emerged, marking a shift away from paternalism towards greater respect for patient autonomy, seen as a sign of progress [3].

Informed consent involves sharing crucial information with patients, enabling them to make informed, rational choices among various options they believe are in their best interests [4]. Over the past 25 years, there has been a growing consensus that the importance of informed consent has increased as medical practice has become more formalized [5]. Its primary aim before an intervention is to uphold and reinforce the patient's sense of autonomy. The process must allow patients to decline and to be informed of alternative options when available. Proper informed consent is key to addressing patients' questions, easing their anxiety, and preparing them for the procedure [6]. The idea of informed consent is especially associated with surgical fields because patients must decide whether to undergo surgery, and surgeons must authorize the procedure [7]. Central to this process is providing relevant, adequate, and clear information so patients can make informed decisions about surgery. To do this effectively, surgeons must have the skills to evaluate whether patients can understand and use the information. They must also deliver unbiased, non-coercive clinical details. For instance, while consent is often obtained right before surgery [8,9], some places use structured interviews, leaflets, electronic systems, or multimedia tools to improve the process. Recent reviews indicate that research on surgical informed consent remains limited and largely unrobust [10-13].

A properly conducted informed consent process for surgery is an interactive, structured process that results in fully informed patients who are capable of making an informed decision about the risks and benefits of treatment, alternative treatment options, or postponing surgery [14]. Inadequate informed consent to surgery compromises patient autonomy, creates potential risks, decreases patient satisfaction and trust in their surgeon, and thus jeopardizes the patient-physician relationship. In addition, breach of informed consent to surgery can result in a disciplinary tribunal, assault or battery [15]. Although improvements in informed consent to surgery

have been achieved in recent years, other studies suggest that implementation of informed consent to surgery is still sub-optimal in surgical practice [16]. Informed consent is not only necessary from an ethical and legal point of view, but also effective in terms of quality of care, patient understanding and cooperation, improved outcomes, and satisfactory medical treatment, and it contributes to the prevention of errors [17] and harmony in the career-patient relationship.

Changes in legal status and new consent guidelines have influenced medical culture, requiring doctors to adapt [18]. Not providing sufficient information can lead to liability for the doctor and may also violate the patient's consent [19]. For many years, doctors in Cameroon experienced virtual immunity. However, medical malpractice lawsuits have recently increased, prompting lawyers and doctors to pay close attention to the issue. This study aimed to assess how informed consent is practiced in the surgical departments of Yaoundé Central Hospital and to raise surgeons' awareness of the importance of obtaining informed consent and of understanding the legal consequences of failing to provide proper information or consent.

## Patients and methods

This was a cross-sectional study conducted from 1st April to 30th June 2024 in seven units providing surgical care at the Yaoundé Central Hospital: Ear, Nose, and Throat and Head and Neck Surgery (ENT-HNS), General Surgery, Traumatology, Maternity, Pediatric Surgery, Neurosurgery, and Urology. This work concerned patients operated on at Yaoundé Central Hospital, selected non-probabilistically. All patients hospitalized after surgery and who had consented to participate were included. Patients unable to give consent were excluded, as those who were unconscious in the postoperative period, and minors whose parents/guardians or careers were absent at the time of our visits. We created a survey form with three sections: one for information and consent to participate; another for collecting sociodemographic and clinical data from daily pre-anesthetic visit forms; and a modified, adapted, and previously tested semi-structured questionnaire [20]. The questionnaire comprised 14 questions to which patients responded 'yes' or 'no'. Questions 2 to 13 pertained to the content of the information provided regarding the surgical treatment (diagnosis justifying the surgery, nature and purpose of the operation, expected benefits, duration of the operation, potential surgical risks and complications, therapeutic alternatives, type of anesthesia, possible anesthetic risks and complications, medication taken in the postoperative period, natural course without surgical treatment, satisfaction with the information given, and opportunity to ask questions). Questions 1 and

14 concerned obtaining consent (verbal agreement, signing a form). The adequacy of the information provided to the patients was evaluated using a score validated in a prior study [21]. One point was awarded for each positive response to questions 2-13. The information was deemed unacceptable for a score below 4 points; acceptable for a score between 4 and 7 points; and suitable for a score between 8 and 12 points. On the first postoperative day, during ward visits, interviews were conducted with the patients, their parents or guardians, and careers. Three categories of data were gathered: socio-demographic details (age, sex, department of origin), responses to the questions, and the score assessing the adequacy of the information provided. Statistical data analyses were performed using SPSS version 22.0 software (SPSS Inc., Chicago, Illinois). Quantitative variables were described by their mean and standard deviation, or by their median and interquartile range. Qualitative variables were described by giving their numbers and percentages. Student's t-test and Chi-square test were used to compare variables. The significance threshold was set at a p-value of <0.05.

## Results

The sample included 155 participants: 125 men (80.6%) and 30 women (19.4%). The mean age was 37.38 with a standard deviation of 21.26 years, ranging from one week to 87 years; 126 participants (81.29%) were 20 or older (Table 1).

**Table1:** distribution of general characteristics of participants (N = 155)

Variables	n	%
<b>Age ranges (years)</b>		
0-9	17	11.0
10-19	12	7.7
20-29	29	18.7
30-39	27	2717.4
40-49	24	15.5
50-59	18	11.6
60-69	14	9.0
70-79	10	6.5
≥80	4	2.6
<b>Gender</b>		
Female	30	19.4
Male	125	80.6
<b>Surgical unit of origin</b>		
Neurosurgery	37	23.9
Traumatology	34	21.9)
Urology	26	16.8
Digestive surgery	25	16.1
ENT-HNS	22	14.2
Maternity	6	3.9
Paediatric surgery	5	3.2

ENT-HNS : Ear Nose and Throat and Head and Neck

Although most participants knew their diagnosis, and the nature and purpose of the operation were explained in nearly all departments (about 94% in Traumatology, Neurosurgery, ENT-CCF, and Urology), there were notable gaps in essential information, as shown in Table 2:

**Table 2:** distribution of answers to questions 2 to 13 among the study population (N = 155)

Questions	Yes n (%)	No n (%)
2. Have you been informed of the diagnosis?	153(98.7)	2(1.3)
3. Have you been informed about the nature and purpose of surgery?	139(89.7)	16(10.3)
4. Have you been told what benefits you expect at the end of this surgery?	150(96.8)	5(3.2)
5. Have you been informed about the approximate duration of the procedure?	32(20.6)	123(79.4)
6. Have you been informed of possible complications and risks during and after surgery?	42(27.1)	113(72.9)
7. Have you been informed about the existence of alternative treatments?	19(12.3)	136(87.7)
8. Have you been informed about the type of anaesthesia for this surgery?	137(88.4)	18(11.6)
9. Have you been informed about the complications and risks of anaesthesia?	127(81.9)	28(18.1)
10. Have you been informed about the need for medication after surgery?	124(80)	31(20)
11. Have you been informed of the evolution of your disease if you choose not to have surgery?	132(85.2)	23(14.8)
12. Are you satisfied with the information you have been given?	148(95.5)	7(4.5)
13. Did you have the opportunity to ask any questions?	147(9.8)	8(5.2)

- In 79.4% of cases (123 participants), information about the duration of the operation was missing.

- In 72.9% of cases (113 participants), information regarding the risks and complications of the surgery was absent.

- Information about alternative treatments was absent in 87.7% of cases (136 participants).

- Information about complications and risks was significantly lacking in Visceral (92% uninformed,  $p = 0.025$ ) and ENT-CCF (36.4% uninformed,  $p < 0.001$ ).

- The Maternity ward notably lacked information on the type of anesthesia, with 83.3% not informed ( $p = 0.001$ ), and on its complications, with 83.3% not

informed ( $p = 0.001$ ).

- Information regarding the progression of the pathology without surgery was significantly missing in the Maternity Unit, with 50% not being informed ( $p = 0.043$ ).

**Table 3:** distribution of the adequacy scores of the information provided to the participants among the surgical units.

Surgical units	Provided information adequacy Score	p value
	Mean (standard deviation)	
Ear, Nose, and Throat and Head and Neck Surgery (ENT-HNS)	9.6 (1)	0.006
General surgery	8.3 (1,7)	0.227
Traumatology	8.6 (1,3)	0,745
Maternity	6 (3,2)	<0,001
Paediatric surgery	8.6 (2,3)	0.893
Neurochirurgie	8.8 (1,7)	0.589
Urology	8.8 (1,7)	0.646

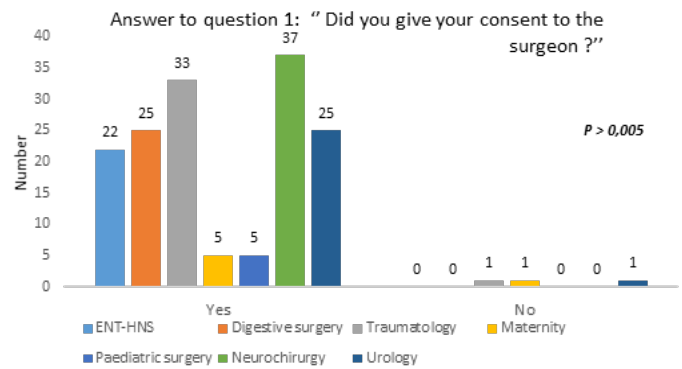
Table 3 demonstrates that the average score for the adequacy of information was high, mostly exceeding 8 out of 10 across nearly all surgical units, except for the Maternity Unit, where it was considerably lower ( $p < 0.001$ ). Most participants expressed satisfaction with the overall information, with over 92% in most departments (Table 4).

**Table 4:** distribution of adequacy levels of information provided to participants among the surgical units (N = 155)

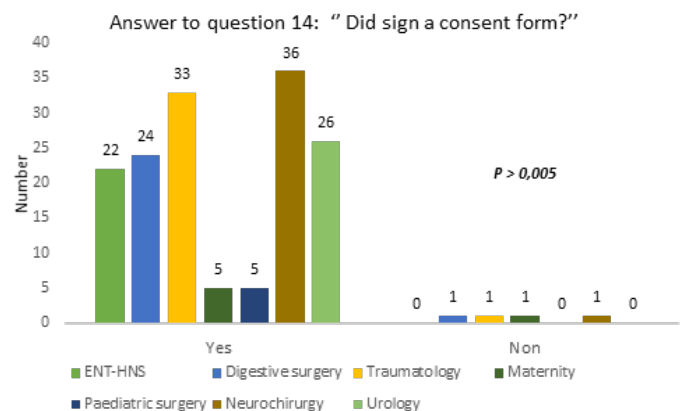
Surgical units	Levels of adequacy of the information supplied			, p-value
	Unacceptable (AS < 4)	Acceptable (AS: 4 to 7)	Good (AS: 8 to 12)	
	n (%)	n (%)	n (%)	
Ear Nose and Throat and Head and Neck Surgery (ENT-HNS)	0(0)	1(4,5)	21(95,5)	0,142
Digestive surgery	0(0)	6(24)	19(76)	0,544
Traumatology	0(0)	7(20,6)	27(79,4)	0,607
Maternity	2(33,3)	3(50)	1(16,7)	<0,001
Paediatric surgery	0(0)	2(40)	3(60)	0,420
Neurochirurgie	1(2,7)	4(10,8)	32(86,5)	0,403
Urology	0(0)	5(19,2)	21(80,8)	0,730

AS : adequacy score

Nearly all participants (152, 98%) provided verbal consent, and a large majority (151, 97.41%) also signed a consent form (Figures 1 and 2).



**Figure 1:** distribution of responses to question 1 among participants in the surgical units



**Figure 2:** distribution of responses to question 14 among participants in the surgical units

## Discussion

Informed consent is a process by which a mentally competent patient agrees to undergo surgery after being informed of indications, alternatives, potential side effects, and complications [22]. The vast majority of patients and their relatives in the current study were over 20 years of age. They were interviewed during the postoperative period, unlike Burkle et al. [23], who administered their questionnaire in the preoperative period. While they argue that their procedure minimizes bias related to the patient's ability to remember the information received [23], we believe that it does not account for the factors that would have led to the decision-making after the patient's personal reflection.

The patient consents to the surgery after receiving complete information about the nature of the procedure, its indications, other available treatment options, its benefits and complications, and the consequences of not having the procedure [24]. The present study shows that 98.7% of the participants had been informed of their diagnosis, 89.7% of the nature and purpose of the surgery, 96.8% of the expected benefits, more than 80% of the evolution of the pathology in the absence of surgery and the need for postoperative medication. We note that the surgeons emphasize explaining the first two elements (diagnosis, nature of the surgery) since



our results corroborate those of Ogundiran et al., for whom 93.75% of patients and their relatives had been informed of their diagnosis and 85% of the nature of the intervention performed [20].

However, many patients in their series were unaware of the expected benefits [25]. We believe this situation results from a misunderstanding on the part of the patient or an omission by the professional responsible for providing information. In this regard, many authors agree that certain aspects of information should be communicated by surgeons with proven experience [26]. Pittalis et al., observed that a detailed explanation of possible complications can scare some patients [21]. This might explain why information as crucial as anesthetic risks is missing in some series. While the type and risks of anesthesia were explained to 80% of the participants in our study, only 15% of the patients benefited from this in the survey by Shafique et al., [27].

The essential pieces of information lacking among the participants in our study were the duration of the surgery in 79.4% of cases, the risks and complications of the surgery in 72.9% of cases and the existence of alternative treatments in 87.7% of cases. Patients in our study seemed to be less informed about these aspects than those in others series. Chia et al., [28] reported that 54% of patients had not received information about potential complications of elective abdominal surgery; Shafique et al., showed that 69.3% of patients had not received any information about surgical risks [29]. It could be that our patients, as well as those in the Dogan et al. study, did not recall receiving information about complications or alternative treatments, due to an omission in the doctor's explanations or difficulties in understanding and assimilating [29]. Although 95.5% of our patients were satisfied with the information received, 94.8% had the opportunity to ask questions. The provision of complete and understandable information can be ensured through audio-visual materials, brochures [30], and asking patients to repeat what they have understood from the information provided [31]. The information provided to the participants in the present study was good/adequate in 80% of cases; almost all (95.5%) were satisfied with it. This is contrary to the result of Aisuodionoe-Shadrach et al., who showed that although the information obtained by patients was considered good, satisfaction with all the information provided was marginal in 35% of cases [31].

Although 98% of participants in our study gave verbal consent for surgery and 97.41% signed a form, we agree with Akkad et al., [32] that patients' needs may not be met, and that some patients may even consent to an operation they do not want. This confirms that patients do not understand the consent process, but accept it.

Our study had some limitations to consider when

interpreting the results. It was carried out only in a few surgical departments at the YCH, which has twelve in total. This reduced the number of patients that could have been obtained, on the one hand, and compromised the representativeness of the sample, on the other. This explains our choice for a non-probability sampling technique.

Patient and/or surgeon-related factors related to understanding the information provided and the communication process were not considered. They would have shed light on specific results. Nevertheless, it merits recognition for having opened up an area for reflection on a delicate subject in surgical practice: the patient-caregiver relationship, which is concretized by the signing of informed consent, and for having identified critical aspects lacking in the information provided to operated patients.

## Conclusion

In the present study, informed consent was obtained satisfactorily: over two-thirds of patients received adequate information. However, the content of the information provided was incomplete, covering only nine out of twelve crucial aspects for informed decision-making. Patients provided their consent both verbally and in writing, demonstrating the surgeons at Yaoundé Central Hospital's commitment to respecting patient autonomy and ensuring informed choices.

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