



PATIENTS PERCEPTION ON QUALITY OF CONSENT FOR CAESAREAN SECTIONS IN A TERTIARY HEALTH FACILITY IN PORT HARCOURT, SOUTHERN NIGERIA

¹Joyce Okagua and ^{*2}Kenneth E. Okagua

¹Department of Paediatrics, University of Port Harcourt Teaching Hospital, Port Harcourt, Rivers State, Nigeria.

^{*2}Department of Obstetrics & Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Rivers State, Nigeria.

Corresponding author: Dr Kenneth E. Okagua; **Email:** kokagua@hotmail.com

ABSTRACT

Background: Informed consent should be viewed as a process and not just a signature on a form as is commonly seen in most cases. It is very important not just to minimise conflict/medico-legal issues but as a tool for better communication between the physician and the patient on diagnosis, treatment risks and alternatives. In order to improve acceptance and minimise conflicts from Caesarean Deliveries, which are increasingly being performed globally, it is important to assess patients perception on quality of consent obtained, as previous studies have demonstrated poor quality of consent for various surgical procedures.

Objectives: To assess patients perception on quality of informed consent for caesarean sections in a tertiary health facility in Port Harcourt, South-South Nigeria.

Method: Across-sectional study was carried out in Braithwaite Memorial Specialist Hospital (now Rivers State University Teaching Hospital), in Port Harcourt between January 2016 to June 2016, using an

interviewer based previously validated structured questionnaire on women who had caesarean section. Data analysis was done using SPSS software version 21.0. Bivariate analysis was done with chi-square (X^2) test and significance was considered at p value of < 0.05 .

Results: Three hundred and forty eight women who had caesarean section were recruited for the study. They were aged between 20 and 42 years with a mean age of 31.74 ± 4.39 years. Majority (67.5%) of the women had tertiary level of education, 30.2% had secondary level of education while 2.3% had primary level of education. 94.8% of the women were married while 2.3% were single and the remaining 2.9% were co-habiting.

Two hundred and twenty (63.2%) of respondents studied had emergency caesarean section while 128 (36.8%) had elective caesarean section. 313 (89.9%) had knowledge of the diagnosis and 313 (89.9%), were not aware of possible complications indicating very poor consent quality. 324 (93.1) were not aware of alternative procedures. 194(55.7%) of the consents were





obtained by nurses and 84(24.1%) by junior resident doctors. 70(20.1%) were not aware of who obtained the consent while 181(52%) of the women were satisfied with the consent procedure.

Conclusion: The quality of consent for obstetric surgeries is still poor. Nurses who are not involved in the surgical procedure

obtained majority of the consents partly explaining the unsatisfactory consent quality. Doctors especially consultants need to be more involved in the process to improve its quality. Future studies should focus on communication skills of nurses and junior resident doctors.

Key Words: Caesarean Section, Perception, Quality, Informed Consent, Rivers State.

INTRODUCTION

Caesarean section can be defined as delivery of the foetus(es) through a surgical incision into the uterine wall after the 28th week of gestation¹. As is mandatory for all procedures to be performed on any patient, an informed consent is a pre-requisite. The informed consent is an important part of communication between the physician and the patient². The informed consent process has evolved from simple consent; in which the surgeon needed only to obtain the patient's permission for a procedure, to informed consent; in which the surgeon provides the patient with information about clinically salient features of a procedure, the patient understands this information adequately and the patient voluntarily authorizes the surgeon to perform the procedure³. Informed consent is based on the knowledge of the nature, consequences and alternatives associated with the proposed therapy⁴. Consent practices are influenced by the level of education, extended family system, urbanization, religious practices and healthcare financing options available⁵. Various researchers^{6,7} have studied the quality of informed consent for various procedures. Complex decisions such as

surgery require a discussion of uncertainties⁸. With better access to information and increasing awareness of patients especially in developing countries, there will be an attendant increase in patient expectation and possible conflicts/resort to litigation when these expectations are not met. Patients' perceptions/understanding especially of uncertainties is critical in avoiding unnecessary conflicts. It is therefore imperative to regularly evaluate patients' perception/ satisfaction with the given information and consent process for surgical procedures especially caesarean section which is increasingly being performed globally.

This study aims to assess patients' perception on quality of consent for caesarean sections at a tertiary health facility.

METHODOLOGY

Materials and Method

A descriptive cross sectional study was carried out at Braithwaite Memorial Specialist Hospital (now Rivers State University Teaching Hospital), Port Harcourt; a tertiary health facility using a structured questionnaire based interview between



January 2016 to June 2016.

The interview questionnaire applied was that previously validated and used by Brezis *et al*⁹ which was slightly modified, pretested with 20 patients in a different facility and found satisfactory. Questions asked include patient's age, occupation, educational qualification, marital status, spouses' employment status and knowledge of diagnosis. Knowledge of complications and alternative procedures were asked to assess quality of consent. The place, time and staff obtaining the consent as well as patients' satisfaction with the consent process were also asked. Based on an assumed 50% level of patients' satisfaction toward informed consent for Caesarean Sections, 7% precision, and 95% confidence interval, the calculated sample size was 196 patients. All the 348 patients who delivered by Caesarean section within this period and who agreed to participate formed the sample size and were interviewed within 72hrs of caesarean section. Women who were unconscious pre- and post-operatively, were excluded from the study.

Data Analysis

Data entry and analysis was done using SPSS software version 21.0. The patients' satisfaction with the consent process (answer of yes/no) and their knowledge of risks of the procedure were used to assess the overall perception/quality of informed consent using percentages.

These results are presented in tables and charts. The data fields were checked for accuracy using visual checking technique to

eliminate possible data entry errors or inconsistencies of information. Bivariate analysis was done with chi-square (X^2) test to examine the relationship between the variables. In all cases, a probability value (p value) of < 0.05 was regarded as statistically significant.

RESULTS

Three hundred and forty eight women were recruited for the study aged between 20 and 42 years with a mean age of 31.74 ± 4.39 years.

Majority of the women (131 or 37.6%) were traders followed by teachers (67 or 19.3%). Only 23 (6.6%) were full time housewives (see table 1).

Table 1: Occupation of respondents

OCCUPATION	FREQUENCY	PERCENT
Accountant	12	3.4
Caterer/Nutritionist	11	3.1
Corper	7	2.0
Teacher	67	19.3
Engineer	7	2.0
Environmental Health Scientist	7	2.0
Hair Dresser	7	2.0
Housewife	23	6.6
Lab Technician	4	1.1
Legal Practitioner	4	1.1
Media Practitioner	7	2.0
Photographer	3	0.9
Receptionist	4	1.1
Seamstress/Stylist	19	5.4
Secretary/Typist	7	2.0
Student	28	8.0
Trader	131	37.6
TOTAL	348	100.0

One hundred and forty two (40.8%) of the women were self-employed, 89 (25.6%) were unemployed, 87 (25%) worked for private firms while 30 (8.6%) were public servants (see Figure 1).

EMPLOYMENT STATUS

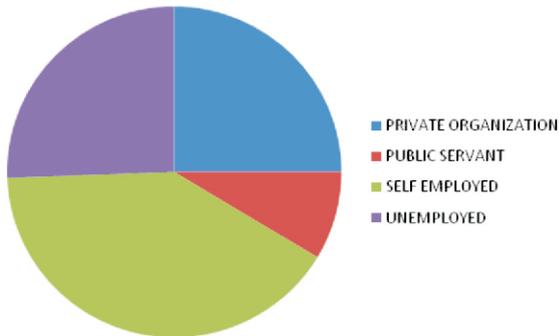


Figure 1: Employment status of respondents

Three hundred and thirty (94.8%) of the women were married while 8 (2.3%) were single and the remaining 10 (2.9%) were co-habiting.

Majority of the women (235 or 67.5%) had tertiary level of education, 105 (30.2%) had secondary level of education while 8 (2.3%) had primary level of education. None of them had any formal education (figure 2).

EDUCATIONAL STATUS

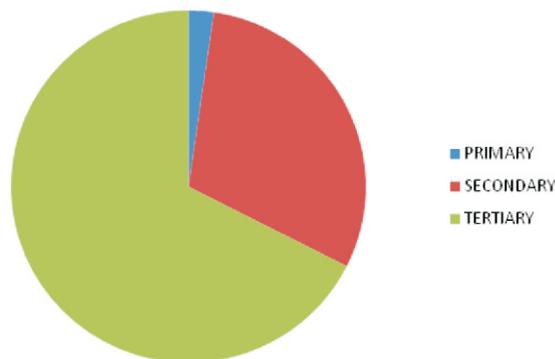


Figure 2: Educational status of respondents

Eight (100%) of the women with primary level of education were satisfied with the quality of consent, 44(41.9%) of the women

with secondary level of education and 129(54.9%) of the women with tertiary level of education were satisfied with the quality of consent (see table 2). This observed difference was statistically significant (chi-square=12.460, P-value=0.001)

Table 2: Educational status of respondents and satisfaction with consent process (consent perception)

EDUCATION	SATISFACTION WITH CONSENT PROCESS		TOTAL
	YES	NO	
Primary	8	0	8
Secondary	44	61	105
	41.9%	58.1%	100.0%
Tertiary	129	106	235
	54.9%	45.1%	100.0%
TOTAL	181	167	348
	52.0%	48.0%	100.0%

Chi-Square=12.46, p-value=0.001

Table 3: Spouses' employment status

SPOUSES EMPLOYMENT STATUS	NO.	%
Private Organization	114	32.8
Public Servant	95	27.3
Self Employment	116	33.3
Unemployment	23	6.6
TOTAL	348	100.0

One hundred and sixteen (116 or 33.3%) of the spouses were self-employed, 114 (32.8%) worked in private firms, 95 (27.3%) were public servants and 23 (6.6%) were unemployed.

In terms of marital status, 6 (60%) of the co-habiting women, 171 (51.8%) of the married women and 4 (50.0%) of the single women were satisfied with the quality of consent (table 4). This observed difference was not statistically significant.

Table 4: Relationship between marital status and consent satisfaction

MARITAL STATUS	CONSENT SATISFACTION		
	YES	NO	TOTAL
Cohabiting	6 60.0%	4 40.0%	10 100.0%
Married	171 51.8%	159 48.2%	330 100.0%
Single	4 50.0%	4 50.0%	8 100.0%
TOTAL	181 52.0%	167 48.0%	348 100.0%

Chi-Square=0.274, p-value=0.932

Table 5: Place of consent and consent satisfaction

PLACE OF CONSENT	CONSENT SATISFACTION		
	YES	NO	TOTAL
Theatre	4 50.0%	4 50.0%	8 100.0%
Ward	177 52.1%	163 47.9%	340 100.0%
TOTAL	181 52.0%	167 48.0%	348 100.0%

Chi-Square=0.013, p-value=0.908

Two hundred and twenty (220 or 63.2%) of the surgeries were emergencies while 128 (36.8%) were elective surgeries.

Three hundred and forty (340 or 97.7%) of consents were obtained in the ward while 8 (2.3%) were obtained in the operating theatre.

The women were satisfied with 4 (50%) of consents given when they were in theatre, while 177 (52.1%) of the women were satisfied with consents given while they were in the ward (table 5). This observed difference was not statistically significant (chi-square=0.013, P-value=0.908).

Over a third of the consents, 143 (41.1%) were obtained less than an hour before the procedures while 45 (12.9%) were obtained more than 24 hours before the procedure. The remaining 160 (46%) were obtained

between 1 – 24 hours before the surgery with about half of them 95 (27.3% of total) obtained between 1 – 6 hrs before the surgery (table 6).

Table 6: Interval between obtaining consent and surgery

TIME INTERVAL	FREQUENCY	PERCENT
< 1 hr	143	41.1
> 24 hrs	45	12.9
1-6 hrs	95	27.3
12-24 hrs	35	10.1
6-12 hrs	30	8.6
TOTAL	348	100.0

Of the surveyed women, 313 (89.9%) had knowledge of the diagnosis and the same number 313 (89.9%), were not aware of possible complications. The poor knowledge of possible complications (risks) was adjudged poor quality of consent (Figure 4). Of the 35 or 10.1% who were aware of possible complications, pain was the commonest (see table 7)

KNOWLEDGE OF COMPLICATION

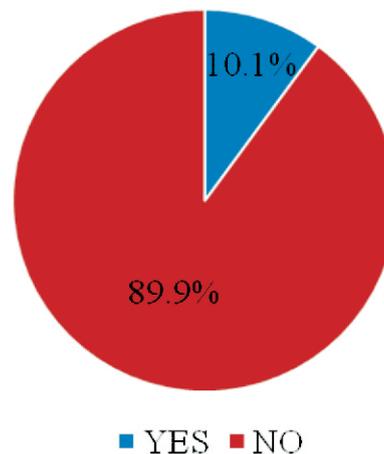


Figure 4: Knowledge of complication (consent quality)

Table 7: Consent quality (knowledge of complications)

COMPLICATION	YES		NO		TOTAL
	N	%	N	%	
Knowledge Of Complications	35	10.1	313	89.9	348
Knowledge Of Specific Complications					
(A)Pain	16	45.7	19	54.3	35
(B)Anaesthetic Complications	12	34.3	23	65.7	35
(C)Bleeding	15	42.9	20	57.1	35
(D)Headache	4	11.4	31	88.6	35

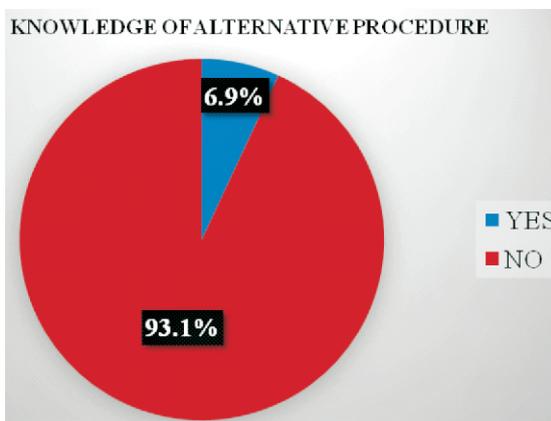


Figure 5: Knowledge of alternative procedure

Of the surveyed women, 324 (93.1%) were not aware of alternative procedures, another indicator of poor consent quality (Figure 5).

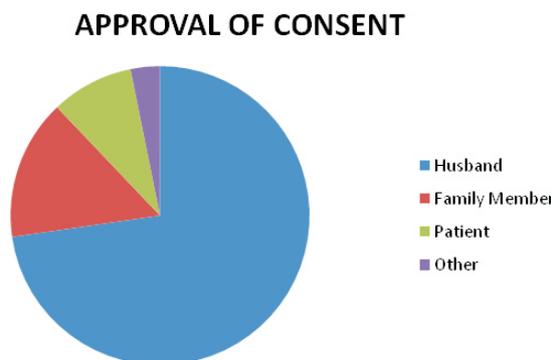


Figure 3: Approval of consent

Less than a fifth of the women, 64 (18.4%), had the consent read to them.

In terms of consent approval, 253 (72.7%) of the consents were approved by the patients' husband and 53 (15.2%) were approved by a family member. Only 31 (8.9%) were given by the patient and the remaining 11 (3.2%) by either their boyfriends or fiancée (figure 3).

Table 8: Consent approval and consent satisfaction

CONSENT APPROVED BY	CONSENT SATISFACTORY		TOTAL
	YES	NO	
Husband	114	139	253
	45.1%	54.9%	100.0%
Family Member	29	24	53
	54.7%	45.3%	100.0%
Patient	31	0	31
	100.0%	0.0%	100.0%
Other	7	4	11
	63.6%	36.4%	100.0%
TOTAL	181	167	348
	52.0%	48.0%	100.0%

Chi-Square=34.252, p-value=0.000

The women were satisfied with 114 (45.1%) of consents approved by their husbands, 29(54.7%) of consents approved by a family member, 31 (100%) of consents given by themselves and 7 (63.6%) of consents approved by their boyfriends/fiancée (table 8). This observed difference was statistically significant (chi-square=34.252, P-value=0.000).

Table 9: Staff obtaining consent and consent satisfaction

CONSENT OBTAINED BY	CONSENT SATISFACTION		TOTAL
	YES	NO	
Junior Resident	45	39	84
	53.6%	46.4%	100.0%
Nurse	108	86	194
	55.7%	44.3%	100.0%
Unaware	28	42	70
	40.0%	60.0%	100.0%
TOTAL	181	167	348
	52.0%	48.0%	100.0%

Chi-Square=5.169, p-value=0.075

A nurse obtained 194 (55.7%) of the consents while 84 (24.1%) of the consents



were obtained by a junior resident. 70 (20.1%) of the women were not aware of who obtained the consent.

Of the consents obtained by a junior resident, 45 (53.6%) were satisfactory to the patient, while 108 (55.7%) of the consents obtained by a nurse and 28 (40%) of consents obtained by unknown staff were considered satisfactory by the women (table 9). This observed difference was not statistically significant (chi-square=5.169, P-value=0.075).

Table 10: Consent read to patient and consent satisfaction

CONSENT READ TO PATIENT	CONSENT SATISFACTORY		
	YES	NO	TOTAL
Yes	52 81.3%	12 18.8%	64 100.0%
No	129 45.4%	155 54.6%	284 100.0%
TOTAL	181 52.0%	167 48.0%	348 100.0%

Chi-Square=26.861, p-value=0.000

Of the 64 women who had the consent read to them, 52 (81.3%) were satisfied with the consent while 129 (45.4%) of the 284 women who did not have the consent read to them were satisfied with the consent (table 10). This observed difference was statistically significant (chi-square=26.861, P-value=0.000).

Overall, the women were satisfied with 181 (52%) of the consents given.

DISCUSSION

The quality of consent for surgical procedures continues to remain a challenge in medical practice especially in developing countries like ours. This cuts across medical

practices from the rural to urban areas and from primary to tertiary health facilities as well as private to public health facilities. Patients are increasingly more aware of their rights and expectations and the quality of consent obtained for surgical procedures will go a long way to minimize unnecessary conflicts between patients and their care givers especially when the outcome is below expectation.

Only about half of the patients (52%) were satisfied with the quality of consent obtained in this study. It is similar to findings in other studies^{6,7,10}. About 90% of the respondents knew the diagnosis but the same number did not know of possible complications. This is similar to findings by Jebbin and Adotey well over a decade ago in neighbouring tertiary health facility⁶. That gives a lot of room for improvement and justifies the need for regular evaluation of protocols for obtaining consents. In a survey of surgeons and surgical trainees in Nigeria, 54.9% agreed that sufficient information is not provided to patients while obtaining their consent for surgical procedures¹¹.

It is interesting to note that all the patients who gave the consent themselves were 100% satisfied with the quality of consent obtained compared to only 44.1% patient satisfaction when the consent was approved by their husbands and 54.7% patient satisfaction when the consent was approved by other family members. The common practice in obstetric surgeries is to explain the need and details of the surgery to the patients' husband or in his absence to his/the patients' relations and generally neglecting the



patients views especially in emergency situations. In view of the above findings, this practice needs to be reviewed.

In the present study, there was a significant relationship between educational level and satisfaction of informed consent. All the mothers with primary level of education were satisfied with the consent given. This is contrary to findings by Agu *et al*¹² in South Eastern Nigeria who found better satisfaction of informed consent with higher educational attainment. The difference between the reports could be that the study by Agu *et al*¹² was done in the community outside the hospital in which respondents especially those with poor educational attainment will feel less intimidated^{12,13}. Our finding on significant consent satisfaction with primary level of education may be because they were few compared to others and may not be a true reflection of this class of patients and they possibly lacked understanding of what they are being told. It has been reported that the desire for patient autonomy and readiness to seek consent is directly related to educational attainment of the patient^{6,14}.

Significantly more of the women who had the consent read to them (81.3%) were satisfied with the consent obtained as opposed to 45.5% satisfaction from those who did not have the consent read to them. Reading the consent to the patient clearly gives a better understanding and we advocate explaining the procedure followed by reading out the consent document to the patient to improve the quality of consent obtained.

There was no significant difference in satisfaction between the consents obtained by junior residents (53.6%) and the 55.7% satisfaction for consents obtained by the nurses. One would have expected significantly better quality of consent from resident doctors but in this study, they were involved in only about a quarter (24.1%) of consents obtained as opposed to 55.7% for nurses. They will need to be more involved to improve their communication skills. Although Residents in obstetrics and gynaecology in Nigeria have some knowledge of the informed consent process, this knowledge was found to be deficient in key areas such as competence to give consent, content and scope of information to be disclosed to patients for surgery¹⁵. There was no indication of consultants being involved in obtaining consent although 20.1% of patients were not certain about who obtained the consent from them. It is unlikely that the patients will not know their consultants.

The process of obtaining consent for obstetric surgeries still leaves a lot of room for improvement. Most Nigerian surgeons seemed to have a good knowledge of the informed consent requirements and process but fall short in practice¹¹. A situation in which nurses (or staff) who are not involved in the surgical procedure are left to obtain majority of the consents, can only result in unsatisfactory consent quality⁷. This may explain why the consent quality was so poor that only 10.1% of respondents were aware of possible complications. A South African study¹⁶ revealed 57% awareness of complications suggesting better



communication skills and is buttressed by Falagas *et al*¹⁷ whose study in Greece revealed that improved patient-physician relationship and increased time spent to inform the patient corresponds to more information delivered to the patient and an improved informed consent process. The benefit of increased time spent was corroborated by Sulaiman *et al*¹⁸. Doctors especially consultants need to be more involved in the process to improve informed consent quality.

CONCLUSION

The quality of informed consent has remained poor of the years with only about 50% of patients expressing satisfaction with the consent process. Advocacy on the benefits of a quality informed consent is recommended. The benefits of improved doctor-patient communication skills in improving patients' perceptions and the attendant reduction in conflicts/litigations following negative outcomes cannot be over-emphasized. Doctors especially consultants need to be more involved in the process to improve informed consent quality. Regular studies/reviews of patients' perceptions on quality of consents is strongly recommended in all surgical units until the process is remarkably improved.

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