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Attitudes Towards Informed Consent: A Comparison between Surgeons Working in Saudi Arabia and the United Kingdom

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Abstract

Objectives: Changes in legal standing and new guidelines for consent have generated changes in medical culture that doctors must adhere to. This study aims to highlight the differences in the way the surgeons in the two cultures view the informed consent for surgery processes.

Methods: The attitudes towards informed consent of a group of surgeons working in Saudi Arabia (KSA) were compared with those of a similar group working in the United Kingdom (UK), a country with a longer medical history and a more established medico-legal system.

Results: The study shows that KSA surgeons tend to view informed consent not only as an ethical and legal obligation but also as a benefit to patients. In addition, KSA surgeons are more likely to adopt a paternalistic attitude during informed consent. They believe that information about harmful risks may dissuade their patients from undergoing the operation and they admit that the amount of information they provide to their patients is significantly influenced by a number of patient and non-patient related factors.

Conclusion: It is concluded that surgeons in KSA should be more aware of the informed consent guidelines and they should adhere to them. In addition, there is room for the introduction of formal training on informed consent in both countries and for making written information more widely available particularly in KSA.

Keywords: Informed consent, medical ethics, surgical risk, Saudi Arabia, United Kingdom.

Introduction

The principle of informed consent rests on the autonomy of the patient which is explained as being the legal embodiment of the idea that each has the right to make decisions affecting his/her well-being. The basis of the concept is related to self-preservation and could be considered religious in its origin. Religions placed importance on the self-guarding of life as it is considered a gift from God. Islam in particular, has placed the preservation of human life second in rank to preservation of religion. [1]

Changes in legal standing and new guidelines for consent have generated changes in medical culture that doctors must adhere to.[1,2] Informed consent has become a topic of heightened interest and debate, not only within the medical profession but also in the public media. Advanced surgery has been practiced for almost four decades in the Kingdom of Saudi Arabia (KSA), yet there have been no reports examining the surgeons' attitudes towards informed consent. In addition, there are no studies in the literature that have looked at how the informed consent process is viewed by surgeons working in different parts of the world. In this study, the authors examine the attitudes towards informed consent of a group of surgeons working in KSA, and a similar group working in the United Kingdom (UK), a country with a longer medical history and a more established medico-legal system. The aim is to highlight the differences in the way the surgeons in the two cultures view the informed consent for surgery processes.

Methods

A custom designed questionnaire about informed consent for surgery was completed by a randomly selected cohort of surgeons working at a tertiary care hospital in Jeddah, KSA, and a similar hospital in Nottingham, UK. The questionnaire was made up of 30 questions that were developed to examine the surgeons' attitudes towards informed consent. The participants, who were working as consultants, registrars and senior house officers in the various surgical specialties in the two hospitals, were made aware that the emphasis was on the verbal or written information about the operation they provide their patients with and not merely about the signing of the consent form which could take place at the same time or later. They were asked to respond to each question by Yes (agreeing) or No (disagreeing) or Unsure (neither). The responses of the surgeons working in KSA and UK to each statement were calculated, analyzed and compared statistically using a chi-squared test with significance (Sig) achieved at $p<0.05$.

The reliability and validity of the questionnaire was assessed by calculating the correlation statistics for the intra-questionnaire

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groups of questions. The Pearson product moment correlation coefficient was calculated using the number of responders from KSA and UK who agreed with each statement within each group of questions.

Results

Of the 188 questionnaires distributed, 141 were returned; with a response rate of 75%. KSA surgeons completed 82 (58%) and UK surgeons 59 (42%). Ninety percent of the KSA surgeons were Saudi nationals and 50% of them were holding a Western board certification while the others were Arabic-speaking doctors from Middle Eastern countries and the Indian sub-continent. The respondents were working in general surgery, orthopedics, ophthalmology, ENT, urology, neurosurgery, pediatric surgery, plastic surgery and vascular surgery. The hospital rank and specialty of the participating surgeons were comparable in both groups. The questions, responses and statistical analysis are summarized in Tables 1-5. The intra-group correlation coefficients were 0.9 for Table 1, 0.94 for Table 2, 0.17 for Table 3, 0.74 for Table 4 and 0.8 for Table 5.

Table 1: Responses of the KSA and UK surgeons to the general informed consent questions

No	Questions	KSA			UK			*p* value
		Yes	No	Unsure	Yes	No	Unsure	
1	Is informed consent routinely achieved in your current practice?	76 (92%)	3 (4%)	3 (4%)	52 (88%)	0 (0%)	7 (12%)	NS
2	Do you think that all doctors should receive formal training on informed consent?	64 (78%)	3 (4%)	15 (18%)	49 (83%)	2 (3%)	8 (14%)	NS
3	Have you received any formal training on informed consent?	25 (30%)	42 (51%)	15 (19%)	13 (22%)	32 (54%)	14 (24%)	NS
4	Should written information (leaflets) be provided for patients during informed consent?	58 (71%)	8 (10%)	16 (19%)	44 (75%)	4 (7%)	11 (18%)	NS
5	Do you provide your patients with leaflets during informed consent?	17 (21%)	45 (55%)	20 (24%)	28 (47%)	8 (14%)	23 (39%)	Sig

Table 2: Responses of the KSA and UK surgeons to questions related to the main purpose of informed consent

No	Questions *Is the main purpose of informed consent to:*	KSA			UK			*p* value
		Yes	No	Unsure	Yes	No	Unsure	
1	Ensure that the patient has been informed of all potential complications	79 (96%)	1 (1%)	2 (3%)	57 (97%)	0 (0%)	2 (3%)	NS
2	Provide the surgeon with greater protection against litigation	62 (76%)	8 (9%)	12 (15%)	37 (63%)	13 (22%)	9 (15%)	NS
3	Respect the patient's right of autonomy	79 (96%)	0 (0%)	3 (4%)	50 (85%)	1 (2%)	8 (13%)	Sig
4	Improve the doctor -patient relationship	60 (73%)	12 (15%)	10 (12%)	30 (51%)	13 (22%)	16 (27%)	Sig
5	Improve the patient's compliance with medical care	58 (71%)	11 (13%)	13 (16%)	19 (32%)	16 (27%)	24 (41%)	Sig

Table 3: Responses of the KSA and UK surgeons to questions on why informed consent may be unnecessary

No	Questions *Is informed consent unnecessary because:*	KSA			UK			*p* value
		Yes	No	Unsure	Yes	No	Unsure	
1	Most patients depend on their doctor to make the decision for them	19 (23%)	35 (43%)	28 (34%)	11 (19%)	36 (61%)	12 (20%)	NS
2	Disclosing information to patients about potentially harmful risks may be worrying for them	24 (29%)	43 (52%)	15 (19%)	13 (22%)	39 (66%)	7 (12%)	NS
3	Disclosing information about potentially harmful risks may dissuade patients from undergoing the operation	25 (30%)	36 (44%)	21 (26%)	10 (17%)	38 (64%)	11 (19%)	Sig
4	Most patients do not usually remember all the information given to them	24 (29%)	43 (52%)	15 (19%)	13 (22%)	39 (66%)	7 (12%)	NS

Table 4: Responses of the KSA and UK surgeons to questions on who should do the informed consent and what should be disclosed during the process

No	Questions *Who should do the informed consent and what should you disclose during the process?*	KSA			UK			*p* value
		Yes	No	Unsure	Yes	No	Unsure	
1	The doctor who is going to perform the operation	73 (89%)	2 (2%)	7 (9%)	39 (66%)	8 (14%)	12 (20%)	Sig
2	The responsible consultant	52 (63%)	6 (7%)	24 (30%)	16 (27%)	19 (32%)	24 (41%)	Sig
3	A junior doctor who is not going to perform the operation	13 (16%)	53 (65%)	16 (19%)	14 (24%)	29 (49%)	16 (27%)	NS
4	Should disclose the possibility of death (if present)	74 (90%)	4 (5%)	4 (5%)	49 (83%)	3 (5%)	7 (12%)	NS
5	Should disclose all major risks with incidence >1/100	57 (70%)	17 (20%)	8 (10%)	46 (78%)	8 (14%)	5 (8%)	NS
6	Should disclose all minor risks with incidence >1/20	51 (62%)	16 (20%)	15 (18%)	42 (71%)	9 (15%)	8 (14%)	NS

Table 5: Responses of the KSA and UK surgeons to questions on what affect the amount of information given during informed consent

No	Questions *Is the amount of information you give to your patients during informed consent affected by:*	KSA			UK			*p* value
		Yes	No	Unsure	Yes	No	Unsure	
1	The patient's age	59 (72%)	9 (11%)	14 (17%)	21 (36%)	29 (49%)	9 (15%)	Sig
2	The patient's gender	23 (28%)	39 (48%)	20 (24%)	1 (2%)	53 (90%)	5 (8%)	Sig
3	The patient's level of education	63 (77%)	6 (7%)	13 (16%)	17 (29%)	27 (46%)	15 (25%)	Sig
4	The patient's social class	52 (63%)	14 (17%)	16 (20%)	6 (10%)	43 (73%)	10 (17%)	Sig
5	The patient's s source of funding for treatment	19 (23%)	46 (56%)	17 (21%)	3 (5%)	49 (83%)	7 (12%)	Sig
6	The patient's clinical presentation: whether emergency or elective?	62 (76%)	9 (11%)	11 (13%)	31 (53%)	17 (29%)	11 (18%)	Sig
7	The Complexity and duration of surgery	56 (68%)	8 (10%)	18 (22%)	31 (53%)	20 (34%)	8 (12%)	Sig
8	The timing of surgery	34 (41%)	24 (29%)	24 (30%)	8 (14%)	34 (58%)	17 (28%)	Sig
9	How busy you are at the time	39(48%)	26 (32%)	17 (20%)	5 (8%)	43 (73%)	11 (19%)	Sig
10	The need for referral to another doctor or hospital?	39 (48%)	22 (26%)	21 (26%)	7 (12%)	37 (63%)	15 (25%)	Sig

Discussion

For centuries, medicine was practiced in a very parental fashion. The idea of obtaining a written informed consent from patients was first introduced by Walter Reed in 1900 while he was studying yellow fever in Cuba.[3] Informed consent for research however was defined by the Nuremberg Code of 1947 to ensure that the atrocities that were committed during the Second World War on human beings in pursuit of clinical research were never repeated.[3]

Guidelines related to informed consent had been developed by the Saudi Council for Health Specialties as a part of Ethics of the Medical Profession,[1] the level of awareness and adherence to these guidelines by surgeons in KSA is however is unclear. Based on nationality and command of language it is fair to assume that the participating surgeons in this study were representative of the local culture in both countries. It can be argued that the surgeons' responses to the questions were influenced by codes of practice in their hospital and that the findings in this study represent a comparison of the attitudes of surgeons working in the two tertiary centers in two countries. This would be a fair comment and ideally the opinion of surgeons in other hospitals in both countries should have been sought out. This was not done due to practical difficulties. In addition, we arguably believe that the cohort of responding surgeons could be considered as a fair representative of surgeons practicing in each country because they were chosen randomly, of varied level of seniority, of broad spectrum of surgical specialties and different training background as most of them had worked in many other hospitals in the past. We also believe that the attitude of surgeons practicing in smaller centers is unlikely to differ from those in tertiary centers as a number of our surgeons had worked in smaller hospitals in the past.

The majority of KSA and UK surgeons stated that informed consent was routinely achieved in their practice. They also felt that all doctors should receive formal training on informed consent even though less than a third of them reported that they had such training. In addition, they equally agreed that written information (leaflets) should be given to patients during informed consent; however, significantly more UK surgeons indicated that they were doing that already (47% compared to 21%). This could be a reflection of the practice at that particular Jeddah hospital, but it is more likely that the majority of surgeons in KSA do not give their patients leaflets during informed consent because such leaflets may be unavailable. Written information are useful as they allow the patients learning process to continue in the comfort of their own home and act as a point of reference.[4]

KSA and UK surgeons equally agreed that the main purposes of informed consent was to ensure that the patient is informed of all potential complications and also to provide the surgeon with greater protection against litigation. However, significantly more KSA surgeons felt that the main purpose of informed consent also include improving the doctor-patient relationship and improving the patients' compliance with medical care. This implies that surgeons in both countries view informed consent as a legal and ethical obligation. However, KSA surgeons are more inclined to consider it of benefit to the patient. The latter finding is supported by studies reporting that preparatory information about the procedure and its risks help patients to be more compliant with treatment, make better progress and use less post-operative medications.[5]

The finding that significantly more KSA surgeons who believe that informed consent is unnecessary because disclosing information to patients about potentially harmful risks may dissuade patients from undergoing the procedure is a reflection of paternalistic attitude. This is not totally surprising as KSA surgeons are more likely to deal with patients of a wider range of intellect, health awareness and faith in their medical profession. In addition, it is reported that conveying serious but highly rare complications to patients during informed consent leads to information overload of which there is no guarantee that the patient will retain or correctly understand the risk information.[6]

This study showed that KSA and UK surgeons equally disagreed with informed consent being done by a junior doctor who was not going to perform the operation. This is logical as junior doctors may not be able to provide all the information necessary. In addition, significantly more KSA surgeons believed that informed consent should be done by the consultant or by the doctor who was going to perform the operation. This is in line with the widely accepted policy that the responsibility of obtaining informed consent for a procedure ultimately lies with the health professional carrying out the procedure.[2]

For years the levels of risk to be disclosed during informed consent have been a matter of debate. Many surgeons have taken the 1-2% risk as the cut off point to which operative risks should be discussed during informed consent.[7] The participating surgeons from both countries shared a similar opinion with regards to levels of risk disclosure, this is in agreement with pre-existing practice. It seems that the majority of KSA and UK surgeons agreed with the need to disclose to patients the risk of death (if present) and to disclose all major risks with incidence >1% and all minor risks with incidence >5%.

The issue of who receives the informed consent and signs the form was not addressed in this study. The universal practice amongst all cultures is that informed consent is obtained from the patients themselves if they are of legal age and mentally and physically capable. Otherwise, the informed consent is obtained from a legal guardian or a close family relative. The lineage of who is considered more qualified to give the consent may differ between cultures with priorities given to the paternal side relative in Islamic cultures.

Our results showed that the amount of information KSA surgeons gave to their patients during informed consent was significantly influenced by a number of factors, which were patient and non-patient related. These included; the patient's age, gender, level of education, social class, source of funding for treatment, clinical presentation whether emergency or elective, complexity

and duration of surgery, timing of surgery, how busy the surgeon is at the time and the need for referral to another doctor or hospital. This surprising observation is yet another indication of paternalistic attitude by the KSA surgeons. Such findings are unjustifiable, though the variation in the levels of education, socio-economic status of the KSA patients may be relevant. It is recognized that patients vary in the amount and type of information they want and are able to comprehend and retain and it has been shown that educated patients are more actively involved in decision-making with regards to their treatment.[5] Some also stated that patients' educational status, intelligence quotient (IQ) and age have an effect on information recall and understanding.[8] The influence of the surgeon's command of the local language on the amount of information given during informed consent was not addressed as all the participating surgeons were able to communicate freely with their patients using the local language without a translator. In addition the differences in obtaining informed consent between the local versus overseas trained surgeons practicing in KSA were also not examined as the purpose of the study was to highlight the differences between the practices in two countries.

Conclusion

In conclusion, our study shows that KSA surgeons differ from those in the UK in that they tend to look at informed consent as not only an ethical and legal obligation, but also of benefit to patients. KSA surgeons' approach to consent is more paternalistic compared to UK surgeons. Saudi doctors should become aware of the informed consent guidelines that were developed by the Saudi Council for Health Specialties.[1] In addition, there is room for the introduction of formal training on informed consent in both countries and for making written information more widely available, particularly in KSA.

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