

Original Research Article

Attitude of Patients towards Anaesthesia: Comparing the Use of a Single Consent for Anaesthesia versus the Combined Surgical and Anaesthetic Consent

Niew YL, Magdalene Chee MX, Juanita J, Nurul Ezzati AK, Mohd Sharol AW, Azarinah I, Choy YC

Department of Anaesthesiology and Intensive Care Unit, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Jalan Yaacob Latif, Bandar Tun Razak, 56000 Cheras, Kuala Lumpur, Malaysia.

Abstract

Anaesthesiology is a specialty which is less well known and the public usually have little knowledge regarding anaesthesia and the roles of Anaesthesiologist. Many hospitals now use a single dedicated consent for anaesthesia. This study was conducted to compare the effectiveness of a single consent for anaesthesia with the combined surgical and anaesthetic consent. A total of 109 patients, scheduled for elective surgery requiring anaesthesia were interviewed with a standardised questionnaire. Patients were divided into two groups, where one group used a single anaesthetic consent while the other used a combined surgical and anaesthetic consent. A single consent for anaesthesia was found to be more effective than the current combined surgical and anaesthetic consent ($p < 0.05$). Regarding information about anaesthesia, 89.91% respondents agreed that the Anaesthesiologist should tell them all material risks of anaesthesia, no matter how serious it is and 81.65% respondents would like to meet Anaesthesiologist every time prior to the operation. In terms of knowledge, 94.5% patients recognized that Anaesthesiologist is the one who delivers anaesthesia during surgery. However, patients had little knowledge regarding the extended roles of Anaesthesiologist. The present study confirmed that a single consent for anaesthesia was better than the current combined surgical and anaesthetic consent.

Keywords: Anaesthesia, attitude, knowledge, consent, Anaesthesiologist

Correspondence:

Dr. Choy Yin Choy, Department of Anaesthesiology and Intensive Care Unit, Faculty of Medicine, Universiti Kebangsaan Malaysia Medical Centre, Jalan Yaacob Latif, Bandar Tun Razak, 56000 Cheras, Kuala Lumpur, Malaysia. Tel: +603-91455865 Fax: +603-91456585 Email: choy@ppukm.ukm.edu.my

Date of submission: 20 Jan, 2014

Date of acceptance: 21 May, 2014

Introduction

In current medical practice, patients sign a written consent form giving permission for surgery and anaesthesia, even though anaesthesia is associated with different risks and potential complications that are dissimilar to those resulting from surgical operations. Consent is an important issue that involves the patients and their respective doctors. Therefore, consent for anaesthesia should always be obtained from patients as agreement to a specific treatment.

There is a growing threat to anaesthesia practice from consumerist litigation. Consumerist litigation means that, individual autonomy, which is defined by the rights of self determination for the procedure that he/she will be experiencing. The details of anaesthesia and any potential adverse outcomes are commonly explained together with routine information related to surgery. However, anaesthesia is associated with its own risk and consequences, which is entirely different from the risk related to the surgical procedure. Therefore, it is essential for the Anaesthesiologist to

inform and advise patients as they have better knowledge and experience about the types of anaesthesia which the patient will receive later during the surgical procedure. This is very relevant in major surgical procedures involving critically sick patients, where explicit communications over possible adverse outcomes may often avoid the occurrence of legal proceedings against the doctors or hospitals when there is morbidity or mortality.

In July 1999, the Association of Anaesthesiologists of Great Britain and Ireland published guidelines entitled "Information and Consent for Anaesthesia", which reflect current legal opinion, but provide no discussion on why Anaesthesiologist should obtain separate consent (1). Therefore, the importance of obtaining separate consent should be highlighted as a way to honour the autonomy of each individual. In clinical context, signing a written consent allows an individual patient who has normal mental faculties to independently decide in favour of his/her own will and prevent unlawful physical harm from any external source (1). According to law, consent is a device which protects autonomy from any third party interference.

Even though anaesthetic consent is vital to be obtained prior to any surgical intervention, however, according to Irwin, a study in Hong Kong which entitled: 'Patients' knowledge of and attitudes towards anaesthesia and anaesthetics in Hong Kong', it clearly showed that there was scanty knowledge on Anaesthesiologists' perioperative role or their role in other aspects of patient care such as pain management, intensive care, resuscitation, research, and teaching (2). Furthermore, patients feel that it is important to inform them about the anaesthetics, and they were also keen to see their anaesthesiologists preoperatively and postoperatively. From this study as well, only 60% of patients knew the actual qualifications as fully trained medical doctors who are specialists in their field. Ninety-four percent of the respondents from this study thought that anaesthesiologists only involve in giving anaesthetics in operation and did not have other roles such as counselling, as consultant to medical doctors, looking after patient in intensive care unit and other commitments (2).

Since, the involvement of Anaesthesiologists in medical services is so wide and important, it is crucial for anaesthesiologist to have their own written consent as the first step to approach patient holistically so the patient can acknowledge the effort of anaesthesiologists. This survey aimed to evaluate the value of a single written anaesthetic consent.

Materials and Methods

This study was conducted using a cross sectional design. The study was ethically approved by the Research and Ethical Committee, Faculty of Medicine, Universiti Kebangsaan Malaysia (UKM) (FF 365-2010). The research was carried out for five months from October 2010 to February 2011 in Universiti Kebangsaan Malaysia Medical Centre (UKMMC). Target population for this research were patients who were planned for anaesthesia in UKMMC especially those who were listed for elective surgery.

A total of 109 patients were interviewed using a standardized questionnaire. The questionnaire was prepared with reference to a similar study and modified to suit the Faculty of Medicine, UKMMC academic system and population background. Patients were divided into two groups, where one group used a single anaesthetic consent while the other group used the current combined surgical and anaesthetic consent.

Data was collected by assessing the questionnaire given to the patient and were analyzed using Statistical Package for Social Service (SPSS) version 19. Paired comparison was by independent T test. The exclusion criteria in this research were patients less than the age of 18 years or more than 80 years, illiterate, blind, deaf and had mental illness.

Results

Figure 1 showed that, generally both groups had positive attitude towards anaesthesia and anaesthesiologists. This was reflected by few of the responses to questions in our questionnaire regarding their knowledge and attitude towards anaesthesia and Anaesthesiologists. More than 77% of our respondents would like to meet Anaesthesiologists before having surgery and more than 80% of our respondent would like to know their Anaesthesiologists if they need any surgery in the future. Almost 90% of the respondents thought that Anaesthesiologists' and Surgeons' cooperation in the surgery is an important factor for a successful outcome. More than 90% of our respondents preferred the Anaesthesiologist's personal explanation rather than reading anaesthetic brochures by themselves. Only less than 28% of the respondents claimed that Anaesthesiologists did not take time to explain to them.

Figure 2 showed that, overall those who received a single anaesthetic consent had no significant difference in scores (in percentage, total 100%) compared to those who received the combined surgical

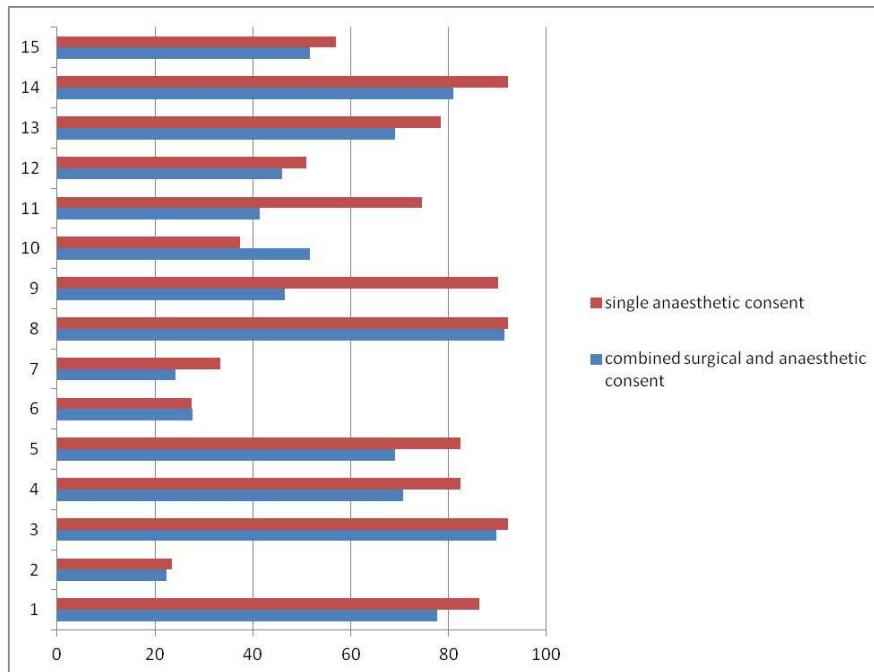


Figure 1: Patients response to questionnaire about attitude.

- 1 = I would like to meet Anaesthesiologist before my operation every time
- 2 = the less I know about anaesthetic for my operation, the better
- 3 = a good operation results requires teamwork from both surgeon and Anaesthesiologist
- 4 = All I need to know about anaesthetic for my operation is what my surgeon tells me
- 5 = I would remember my Anaesthesiologist better if I saw him in office or in the clinic before my operation
- 6 = I am more nervous about the anaesthetic than the surgery itself
- 7 = Anaesthesiologist do not take time to explain what is going to happen to me
- 8 = I prefer to have an Anaesthesiologist explain things to me rather than having to read about anaesthesia form
- 9 = Anaesthesiologist should tell you what all the possible material risk of anaesthetic are, no matter how serious
- 10 = Even if the Anaesthesiologist takes the trouble to talk with me before the operation, it makes no difference to the operation results
- 11 = I would like to see the Anaesthesiologist after the operation so that I could find out how the anaesthetic went
- 12 = I would be happier in paying my bills to Anaesthesiologist if they spent more time with me
- 13 = I do not really care about the anaesthetic as long as my operation turns out well
- 14 = in case of any future surgery I would like to know about my Anaesthesiologist
- 15 = I worried that the Anaesthesiologist fail to manage my pain during and after the surgery

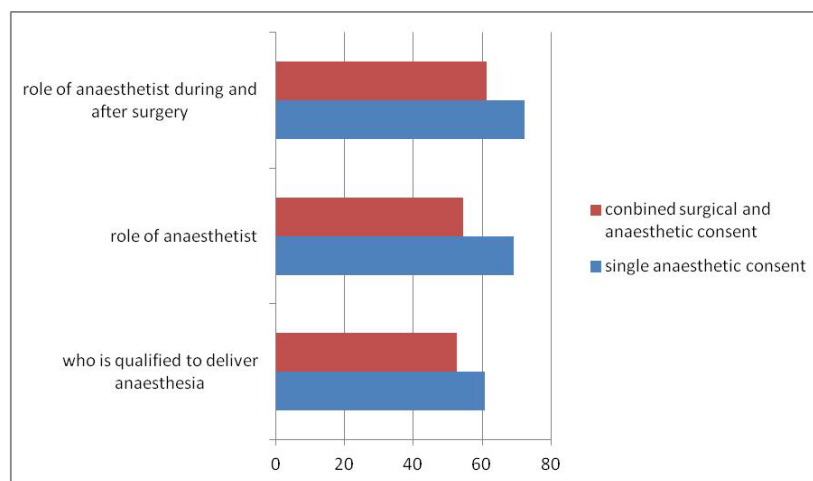


Figure 2: Patient's positive response to the questionnaire.

Table 1: Comparing mean score for knowledge about anaesthesia, between groups given single anaesthesia consent or the current combined surgical and anaesthesia consent

	N	Mean	P Value
Combined surgical and anaesthetic consent	58	19.24	0.00001
Single anaesthetic consent	51	25.76	

and anaesthetic consent. To both the questions 'role of Anaesthesiologist' and 'role of Anaesthesiologists during and after surgery' the response showed insignificant difference (14.76% and 11.01%, respectively) whereas the question 'who is qualified to deliver anaesthesia' also showed an insignificant difference in marks scored of 8.02%.

Table 1 showed independent T-Test comparing mean scores for knowledge, for group using single anaesthetic consent against group using combined surgical and anaesthetic consent achieving significant difference ($P < 0.001$). Therefore, it showed that single anaesthetic consent was better than the current combined surgical and anaesthetic consent.

Discussion

The emphasis over written and informed consent has gained wide acceptance by healthcare providers all over the world, as well as in Malaysia. Informed and written consent has also been established as a legal requirement in our country. In cases involving patients who are critically ill and may suffer from poor outcome, they should be given clear and explicit information including possibilities of permanent disability or even death. Jones advised that separate written consents for surgery and anaesthesia would be required and the Anaesthesiologist must personally explain the risks to the patients (3).

Does patient's knowledge and attitude regarding anaesthesia improve with the use of a dedicated consent for anaesthesia rather than combined surgical and anaesthesia consent? In the present study, we showed that a single consent for anaesthesia was more effective than the current combined surgical and anaesthetic consent in several aspects. We believe that most of the hospitals in Malaysia now practice the use of a single anaesthetic consent. A dedicated, single anaesthetic consent form, together with personal visit by the Anaesthesiologist would provide patients more detail information such as the possible risk of complication, details of anaesthetic techniques, effect of the anaesthesia and some other information that individual patients may request.

Jathar et al. studied 600 patients, 270 of these had previous experience of anaesthesia but their past exposure to anaesthesia did not make any significant changes in their scores where their knowledge regarding anaesthesia remained low (4). Another study by Hariharan claimed that passive learning from previous anaesthetic experience did not confer advantage in term of knowledge regarding anaesthesia (5). In the present study, we found that there was no relationship between patient's previous experiences of anaesthesia with patient's knowledge regarding anaesthesia. The reasons for this have not been investigated much further. They also showed that, patient's educational background had a direct relation and did change the level of patient's knowledge regarding anaesthesia (4). Baaj et al. showed that people with higher income correlate well with better knowledge as evidenced by the high scores compared to those from lower income groups (6).

The present study showed that 81.65% respondents would like to meet Anaesthesiologist every time before operation. From the study done by Irwin and Nightingale et al. also showed that 77.6% respondents agreed to meet their Anaesthesiologist every time before operation (2,7). It was because by meeting Anaesthesiologist, they were able to establish a good contact with the patient and explain the possible risk and complication that might happen and more importantly to clear all the doubt of patient regarding anaesthesia. Moreover, it also strengthens the bonding and builds the trust between them.

In the present study, we observed majority of the respondents agreed that Anaesthesiologist should reveal to them all material risks of anaesthesia, no matter how serious it may be. It is also reflected from the study by Irwin where 92.5% respondents agreed to a similar sort of statement (2). Kain et al. found that, over 90% of their studied patients would like to be told about every reported adverse outcome whether they happen very often or they may be potentially life threatening (8). Patients claimed that legally they have the right to be informed of all material risks of potential complications and felt also that with this information it would be easier for making decisions regarding whether or not to accept anaesthesia.

Irwin found that, 88.3% of their respondents would prefer oral than written information (2) as a combination of oral and written information given by Anaesthesiologist will be more effective from the patient's perspective. The results of the present study showed that most the respondents preferred the Anaesthesiologists to explain to them regarding the information about anaesthesia, rather than reading

themselves from the anaesthetic form, supporting the same findings. Jamjoom et al. in a study of 234 patients found that 79% of them agreed that the main aim of consent is to respect patient's autonomy. While 55% of the patients admitted that the consent process maybe too simplified as patients do not usually remember all the information given to them. Furthermore, 84% of patients would like to know what were the expected results of the particular procedures planned for them. While as many as 70% agreed that major risks of complications should be adequately and clearly expressed by the healthcare provider (9), Sakaguchi and Maeda reported that in Japan, anaesthesiologists routinely inform patients of risks of dental damage, malignant hyperthermia, and nausea/vomiting. Explanations given to patients about anaesthesia was comparable in 59.0% of hospitals they studied. A written consent was routinely used in 61.3% of the studied hospitals (10). Ahsan et al. in a study done in Pakistan found that 82% of patients knew that the Anaesthesiologist is a qualified specialist doctor. Sixty four percent of the patients wanted to know their Anaesthesiologists before the operation. Sixty percent of patients were afraid of anaesthesia and postoperative uncontrolled pain (11).

Falagas et al. in a review about consent for surgery and research found that, adequate overall understanding of the information provided and of the risks associated with surgery or research was provided in 6 of 21 (29%) and 5 of 14 (36%) studies, respectively. Regarding clinical research, adequate understanding of the aim of the study, the process of randomization, voluntarism, withdrawal, and the risks and the benefits of treatment: about 50% of studies providing relevant information, respectively. Approximately, 58% of the patients were happy with the explanations provided as reported by research articles on clinical practice while reports of satisfaction related to information given prior to surgery were as high as 80% in studies done purely for research and academic purposes (12).

Conclusion

It was clearly shown that there was significance difference in the knowledge where those who received a single anaesthetic consent generally scored higher than those who received combined surgical and anaesthetic consent.

References

1. Association of Anaesthesiologists of Great Britain and Ireland. Information and Consent for Anaesthesia. 1999. <http://www.aagbi.org/publications/guidelines/arc>

2. Irwin MG, Fung SK, Tivey S. Patients' knowledge of and attitudes towards anaesthesia and anaesthesiologists in Hong Kong. *Hong Kong Med J* 1998; 4(1): 16-22.
3. Jones P. In response to 'Consent for anaesthesia', White SM, Baldwin TJ, *Anaesthesia* 2003; 58: 760-74. *Anaesthesia* 2003; 58(11): 1153-4.
4. Jathar D, Shinde VS, Patel RD, Naik LD. A study of patients' perception about knowledge of anaesthesia and anaesthesiologist. *Indian J Anaesth.* 2002;46:26-30.
5. Hariharan S. Knowledge and attitudes of patients towards anesthesia and anesthesiologists. A Review. *Anesthesia en México* 2009; 21(3): 174-8.
6. Baaj J, Takrouri MS, Hussein BM, Al Ayyaf H. Saudi patients' knowledge and attitude toward anesthesia and anesthesiologists--A prospective cross-sectional interview questionnaire. *Middle East J Anesthesiol* 2006; 18(4): 679-91.
7. Nightingale JJ, Lack JA, Stubbing JF, Reed J. The pre-operative anaesthetic visit. Its value to the patient and the anaesthesiologist. *Anaesthesia* 1992; 47(9): 801-3.
8. Kain ZN, Wang SM, Caramico LA, Hofstadter M, Mayes LC. Parental desire for perioperative information and informed consent: a two-phase study. *Anesth Analg* 1997; 84(2): 299-306.
9. Jamjoom AA, White S, Walton SM, Hardman JG, Moppett IK. Anaesthesiologists' and surgeons' attitudes towards informed consent in the UK: an observational study. *BMC Med Ethics* 2010; 11: 2.
10. Sakaguchi M, Maeda S. Informed consent for anesthesia: survey of current practices in Japan. *J Anesth* 2005; 19(4): 315-9.
11. Ahsan Ul-Haq M, Azim W, Mubeen M. A survey of patients' awareness about the peri-operative role of anaesthesiologists. *Biomedica* 2004; 20(1): 5-9.
12. Falagas ME, Korbila IP, Giannopoulou KP, Kondilis BK, Peppas G. Informed consent: how much and what do patients understand? *Am J Surg* 2009; 198(3): 420-35.