Informed consent in Indian patients

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J R Soc Med 1996;**89**:196–198

Keywords: *medicolegal; informed consent*

SUMMARY

It is commonly believed that patients in India do not need to be told about their operations as they are unable to understand the complexities and forget the salient facts soon afterwards. Obtaining informed consent is therefore considered to be an unnecessary ritual.

We studied 100 consecutive patients undergoing elective major abdominal operations and asked them 5 days after their operations to recall certain details about the procedure which had been explained to them preoperatively.

Seventy per cent of the patients recalled the relevant data. The ability was the same in males and females (67% and 69%) but the older, less educated and poorer patients performed worse than the others. Ninety-eight per cent of the patients appreciated being given the information as it reduced their anxiety about the operation.

Indian patients are able to comprehend and should be informed about the details of their operation. Particular care should be taken during explanation to the old, poor and illiterate. In these informed consent should be a continuous process rather than a single event and the information should also be given to a younger and more educated relative.

INTRODUCTION

A statutory legal obligation in India specifies that surgeons should explain to a patient the nature, purpose, risks and benefits of a proposed operation as well as alternatives to the surgical procedure. However, the process of obtaining consent for operation is usually treated as a ritual in which patients are presented with complex information that they cannot understand and duly sign or place their thumb prints on the dotted line. This is particularly true in developing countries like India where many patients are poor and illiterate and put themselves entirely in the hands of their doctors whom they consider to be next to God. Under these circumstances many Indian doctors adopt highly paternalistic attitudes and see informed consent as directly interfering with patient care by wasting their scarce and valuable time and sometimes frightening patients into rejecting treatment which may be life saving. When the doctor carries out what he or she believes is in the patient's best interest and the patient concurs, is it necessary to go through this meaningless ritual of obtaining informed consent? Recently, Indian doctors have come under the purview of the Consumer Protection Act which makes them liable to malpractice suits. Thus the doctor–patient relationship will become much more equal and patients will themselves demand more information about their treatment.

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As most complaints in western countries are provoked by doctors failing to communicate adequately with patients[1], we investigated whether Indian patients understood and were able to recall the information about their operation which had been carefully explained to them preoperatively. We also assessed whether the ability to recall the information was influenced by their age, sex, education and income and also whether or not they wished to be given the details about their operative procedure.

PATIENTS AND METHODS

We studied 100 consecutive patients admitted to the 20-bedded Department of Gastrointestinal Surgery at the All India Institute of Medical Sciences excluding those who were less than 10 years and above 75 years of age, those who were very sick and those who were undergoing emergency operations.

On the evening before surgery, the senior resident on duty carefully told the patients

1 The diagnosis
2 The organ involved
3 The operation proposed
4 The major and minor risks
5 The prognosis with and without the procedure
6 The alternative treatments available

The patients were then asked whether they felt such explanations were useful and whether all patients should be given similar information.

On the fifth postoperative day the patients were asked to recall the facts about their operation that had been explained to them earlier. All the details were recorded on individual proformas and the recall was classified as total (if all the facts were repeated), partial (if the important facts were remembered) and none (if the patient could not recall anything he or she had been told or gave wrong answers).

Statistics

The differences between the groups was assessed by use of the χ^2 test with Yates' correction.

RESULTS

There were 56 males and 44 females whose ages ranged from 10 to 74 years (mean 37 years). Twenty-four were illiterate or had had only a primary school education, 34 had matriculated from secondary school and 42 were college graduates. Forty-six had an income of less than 15 000 rupees (US$650 a year) and 54 an income greater than this amount.

The operations they underwent are listed in Table 1.

Overall recall

Table 2 lists the recall by the patients of the individual items of information provided preoperatively. There was good (total and partial: 70%) recall of diagnosis, organ involved and operative procedure. For instance, 87% of patients remembered being told the diagnosis but they were not as good at remembering the major and minor risks of the operation and the prognosis without the procedure.

Effect of age, sex, income and education

These results are provided in Table 3, in which we have compared the recall of the individual items for particular groups of patients.

Approximately two-thirds of both males and females were able to recollect the details of what they had been told before the operation and there was little difference between the sexes. However, older and poorer patients were less able to recall the facts explained to them before operation. Understanding seemed to improve with increasing education.

Patients' preferences

Ninety-eight of the 100 patients appreciated being given the information because they said it reduced their anxiety and gave them greater confidence about the impending operation. Two patients became very upset and depressed after the explanation and resented being told these facts.

Although 98 of the patients agreed that they themselves should be told, only 77 thought other patients should be given similar information. The other 21 felt that this kind of information would make other people nervous and worried and it was not essential for everyone to know

Table 1 **Operative procedures (*n*=100)**

Operation	n
Lienorenal shunt	24
Cholecystectomy	23
Hepaticojejunostomy	7
Vagotomy and gastrojejunostomy	5
Hemicolectomy, total colectomy, ileoanal anastomosis, pancreaticoduodenectomy	4 each
Splenectomy, choledocholithotomy, abdominoperineal resection, ostomy closure	3 each
Others	13

Table 2 **Overall recall of the information**

Information	*Complete*	*Partial*	*Nil*
Diagnosis	54	33	13
Organ involved	47	38	15
Operative procedure	40	35	25
Major and minor risks	12	39	49
Prognosis			
With procedure	36	32	32
Without procedure	25	30	45
Alternative treatment			
Modalities	40	30	30

Table 3 **The effect of age, sex, education and income on the recall**

	Total or partial	*Nil*	
Sex			
Male	67%	33%	
Female	69%	31%	
Age (in years)	35.8 ± 15.0	46.1 ± 18.9 (*P*=0.024)	
Income			
<15 000	62%	38%	*P*=0.045
>15 000	75%	25%	
Education			
Primary	54%	46%	*P*=0.02
Secondary	67%	33%	*P*<0.05
University	81%	19%	*P*=0.03

what was about to happen to them when they had absolute trust in the doctor.

DISCUSSION

Our results indicate that, contrary to popular belief, most Indian patients are able to understand the major facts regarding their operation, especially the diagnosis, the organ involved and the nature of their procedure and could recall most details 5 days afterwards. This was in spite of the fact that the operations undertaken at our tertiary referral centre are generally very complicated. However, patients were less good at recalling the major and minor risks associated with surgery. These figures are similar to those obtained in studies from the USA, where 71% of patients recalled information 4–6 months after cardiac procedures[2] and higher than those from England where only 50% of patients were aware of the basic facts relating to an abdominal operation that they had undergone 2–5 days previously[3]. Interestingly, our patients also selectively recalled favourable outcomes rather than risks.

The ability to recall details accurately did not vary with sex but, as in England[3] (where the patients aged above 60 years performed worse), our older patients (those above 50) did not recall details as well as the younger patients. This has been attributed elsewhere to cerebral atrophy with a loss of memory for recent events aggravated by a general anaesthetic and administration of selective analgesic drugs. However, we also found that our patients who were less educated and had lower incomes were unable to recall the salient facts; and, since many of our older patients fell into these categories, the factor of age may not be as important as it appears.

Nevertheless, in all three countries approximately one-third of the patients probably sign an 'informed' consent form as a meaningless ritual. This group consists mainly of the old, poor and uneducated. In these patients we suggest that the task of obtaining informed consent should not be an 'event' which takes place on a single occasion but should be an integral part of the 'process' of treatment[4], in which younger and more educated relatives (male or female) should be closely and continuously involved.

Our misconception that Indian patients did not wish to hear about the gory details of their operations was belied by the fact that the overwhelming majority, like the patients in the UK undergoing herniorraphy[5], appreciated being told. However, we were a little surprised to learn that as many as a fifth of them had the same misconceptions as we did. They reckoned that although explanation was good for them it was not good for others.

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(Accepted 8 August 1995)