

AN AUDIT OF ASPECTS OF INFORMED CONSENT AND PAIN RELIEF IN GENERAL SURGICAL UNITS OF KORLE BU TEACHING HOSPITAL

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SUMMARY

There is the need to adequately inform patients about their disease, treatment options, surgery and post-operative complications. Adequate pain relief after surgery leads to less morbidity. Two important aspects of surgical practice are being addressed in this paper, the need for informed consent and post operative pain relief.

A questionnaire survey was carried out in 100 patients on the four general surgical wards of the Korle Bu Teaching Hospital, just before they were discharged from hospital. They were asked what they knew or had been informed about their diagnosis, operation and complications of surgery. On pain relief, patients were asked about their experiences on the first post-operative day and what relief they had from analgesics.

Twenty four did not know the diagnosis and 36 were not told what operation they were going to have before surgery. Although 75 were eventually told what operation they had, only 64 said they *knew* the operation. Sixty eight did not know what to expect after surgery; 87 did not know about possible complications. On the first post-operative day there was significant pain (scores 4 and 5) felt by 24 patients at rest and 46 on movement. The most frequently prescribed analgesic was pethidine.

Patient information in General surgery at the Korle Bu Teaching Hospital is unsatisfactory. Post-operative analgesia is also poor. There is the need for surgeons to either train doctors to administer consent or administer it themselves. Anaesthetists should assume a leading role in managing post-operative pain.

Keywords: Consent, post-operative analgesia, patient information, complications, surgery, Korle Bu

INTRODUCTION

Patients need to be well informed about their diagnosis and available treatment options. Doctors have sometimes been accused of arrogance by dictating treatment even when there are other available options. It is quite common to find patients who do not know what operations they have had in the past. This may be due to poor education but sometimes it is because doctors have not made the information available to patients.

There is an increasing awareness among patients that they can now take on the medical profession when they feel they have been mistreated. With the liberalization of the airwaves in Ghana people have been encouraged to express their unhappiness with treatment they receive from health personnel. Some of the complaints patients make could easily have been avoided if they were better informed. Whenever information is not fully shared with patients, there is room for suspicion.

Pain relief after surgery should be effective as it leads to a reduction in the complications of surgery^{1,2}. There is the perception that patients in our hospitals are not given sufficient pain relief following surgery for a number of reasons.

We set out to determine how much patients knew about their illnesses and the operations they underwent at the Surgical Block of the Korle Bu Teaching Hospital. We also enquired about their experience of pain and pain relief after surgery from the same group of patients.

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METHODS

A questionnaire survey was carried out in 100 patients on the four general surgical wards of the Korle Bu Teaching Hospital. The questionnaires were served to patients who had been discharged and were "waiting to go home". To ensure that patients felt free to speak their minds, national service personnel, student nurses and a ward clerk administered the questionnaire.

The questions asked included the following: "Do you know the diagnosis?", "Do you know what operation you have had?", "Were you told what operation you were going to have – before or after surgery?", "Were you told what to expect before surgery?" and "Are you aware of any complications that can follow your operation?"

On pain relief, the first question was: "Describe your experience of post-operative pain, day after surgery". Patients were made to use a numeric scale of 1 to 5. Those who had difficulty with numbers used a visual analogue scale which was then converted to a numeric scale. They were also asked about whether their pain was "as expected", "less than they had expected" or "more than they had expected". The last question was "Were you satisfied with your pain relief?"

RESULTS

There were 100 questionnaires administered, to 58 males and 42 females. Their ages ranged from 16 to 80 years (mean 35.6, median 34 years). They were from varied backgrounds – professionals, traders, artisans, etc. (Table 1).

Table 1 Occupation of respondents

Occupation	Number
Trader	21
Students	16
Professionals	16
Artisans	15
Low-skilled	15
Unemployed	10
Retired	4
Businessmen	3
Total	100

Table 2 shows the number (percentage) of patients who responded 'yes' or 'no' to various questions. Twenty four percent did not know the diagnosis. Thirty six (36%) did not know what operation they had had. The same number (36) was not told what operation they were going to have before surgery.

Twenty five (25%) were never told what operation they had had, before or after surgery. As many as 68 were not told what to expect and 87 did not know the complications that could follow their operation.

Table 2 Knowledge about diagnosis and operation

Question	Yes	No
A Do you know the diagnosis?	76	24
B Do you know what operation you have had?	64	36
C Were you told what operation you were going to have before op?	64	36
D Were you told what operation you had after op?	75	25
E Were you told what to expect before surgery?	32	68
F Are you aware of any complications that can follow your op?	13	87

Table 3 Occupation and "No" responses to questions

Occupation	No.	A	B	C	D	E	F
Trader	21	5	6	10	5	16	18
Students	16	6	9	8	6	13	15
Professionals	16	2	2	2	2	9	12
Artisans	15	3	6	4	3	11	15
Low-skilled	15	5	7	7	6	10	14
Unemployed	10	2	5	2	1	5	9
Retired	4	0	1	3	2	4	4
Businessmen	3	1	0	0	0	0	1
Total	100	24	36	36	25	68	87

Questions A – F are as in Table 2

With regard to pain relief using pain scores of 1 (no pain) to 5 (very severe pain) on post-operation day 1, 24% of patients had severe pain at rest, while 36% of them had severe pain on movement (scores 4 and 5) Table 4.

Table 4 Post-operative pain – Day 1

Pain Score	Pain at rest (Number)	Pain on movement (Number)
1 (no pain)	18	15
2	24	14
3	34	25
4	10	15
5 (very severe pain)	14	31
Total	100	100

Table 5 shows patients' experience of pain in comparison to their expectations. It was "less than

expected" in 19%, "as expected" in 47% and "more than expected" in 28%. As shown in Table 6, 9 patients had very little satisfaction from analgesia. Twenty found it just satisfactory, 59 were satisfied and 9 were very happy with their pain relief.

Table 5 Patients' experience of pain vs expectations

Less than expected	19
As expected	47
More than expected	28
No response	6
Total	100

Table 6 Patients' satisfaction with analgesia

Not at all satisfied	0
Very little	9
Fair (just satisfactory)	20
Satisfied	59
Very happy	9
No response	3
Total	100

The analgesics used were mainly pethidine (in over 80 patients, usually prescribed 8-hourly or on 'as required' basis) and sometimes diclofenac suppositories. The interval of pethidine administration varied from 4 to 12 hours. Tramadol was used occasionally but morphine was prescribed for only one patient.

DISCUSSION

Patients have a right to information about the disease from which they are suffering, including information about diagnosis, prognosis, treatment options, outcomes of treatment (what to expect) common and/or serious side effects, the likely time scale of treatment (e.g. in cancer treatment) and costs involved^{3,4}.

In this study 24 out of 100 patients claimed they did not know their diagnosis. Thirty six did not know what operation they had and the same number was not told what operation they were going to have before surgery. By the time they were ready to go home, only 75 had been told what operation they had.

Patients need to know what to expect after surgery, since it helps to reduce anxiety and deep-seated fears. From our questionnaires, however, as many as 68 patients going for surgery were not told what to expect after surgery. Knowledge of outcome

following surgical procedures may be limited among junior doctors⁵. It has been shown that the more experience a doctor has on a surgical specialty, the better they are at administering informed consent and answering patients' questions concerning outcome following surgery⁶. The onus falls on specialists to ensure that their patients are consented by suitably qualified doctors⁶. Consent must be sought by someone who is capable of performing the procedure in question or who has been specifically trained to seek consent for that procedure; ideally it should be obtained by the operating surgeon⁴.

The worst statistics concerned patients' knowledge of possible complications arising from surgery: 87 patients had no knowledge of complications!

These results clearly show that patients are not being given adequate information. Possible reasons could be that the consenting medical staff are not adequately trained in communication skills, do not have the knowledge/experience, do not make time to speak to patients, or simply have the wrong attitude. Our patients are also not enquiring enough; these patients who were so inadequately briefed included students from the universities and professionals (Table 3). It thus appears that even the well-educated do not ask the relevant questions about their illness. Patients should be encouraged to ask questions, complain or make suggestions as is done in the developed world.

The quality of the consent form currently in use in the department may be partly responsible for the quality of consent obtained. In the current form, the doctor is not even obliged to sign the form. The most a doctor does is to be a witness to the signature of the patient. It is therefore not surprising that nurses administer the consent form in most surgical units. There is a need to introduce a new consent form in which the doctor is required to sign as having explained the procedure to the patient, including the likely complications that could arise.

Most cases of litigation have been shown to be due to doctors failing to communicate adequately⁷. Poor handling of the consent process may lead to complaint. This frequently occurs when the task has been delegated to a trainee who is not fully conversant with the details of the intended procedure, the likely outcome and the risks⁴. The results of this study imply that there is a significant risk of litigation from our current practice.

Although 75 patients admitted they had been told what operation they had, only 64 said they knew what operation they had. This means that some did not understand what they were told. The reasons for that could be the use of medical jargons, giving information in haste or giving information when the patient is not in a position to understand. It is important for doctors to make sure they have been understood.

Pain Relief

Effective post operative pain relief should start intra operatively. It is now recognized that tissue damage during surgery can result in a prolonged state of sensitisation and hyperexcitability of the central nervous system to pain¹. The concept of pre-emptive analgesia is based on the fact that if one gives analgesia that blocks the tissue response to pain, post-operative pain can be modulated.¹ In other words, if one can prevent the pain from starting there will be less pain subsequently. This can be achieved by the use of epidural anaesthesia and infiltrating the operation wound with a long-acting local anaesthetic. Although none of the patients interviewed benefited from these methods of pain relief, one cannot draw any conclusions as to the extent of use of these methods in the hospital.

In this study many patients had significant pain the day following surgery. Twenty four had significant pain at rest (scores 4 and 5). Forty six had significant pain on movement. Twenty eight had more pain than they had expected and 29 were less than satisfied with the analgesia they received. (Tables 4, 5, 6)

A number of reasons may explain the unsatisfactory pain relief of patients. First, doctors do not prescribe effective analgesia or give them at too long intervals. An example is the routine prescription of pethidine, sometimes prescribed at intervals of 12 hours. The disadvantages of using pethidine are that not only does it appear to be ineffective as an analgesic in about 50% of the population; it has a very short half life¹. It may have to be given as often as 2-hourly to achieve effective pain relief with the risk of epileptiform reactions from accumulation of its toxic metabolite norpethidine¹.

Another reason for the poor pain relief is the fear doctors and nurses have for opiates like morphine because of the risks of respiratory depression and addiction. The fear of respiratory depression often cited should be discarded since patients are not at risk while their pain remains unrelieved.

Not only were effective analgesics like morphine avoided, the analgesia given were prescribed infrequently on 'when in pain' basis. With the shortage of nursing staff such prescriptions are sometimes not given for very long periods. In our experience it is not unusual to see a post-operative patient in obvious pain who had not had analgesia for several hours. The answer to why the patient is in pain is often, "She has not complained of pain!"

The particular modality or modalities of effective postoperative analgesia (including systemic opioids/ non-steroidal anti-inflammatory agents and regional analgesic options) utilized for a particular patient will depend on the risk-benefit profile and patient preferences. Ideally, analgesic options should be incorporated into a multimodal approach to facilitate patient recovery after surgery⁸. The routine use of pethidine in our patients, however, shows that our practice is very far from this ideal and there remains a lot of room for improvement.

Modern methods of postoperative pain relief include patient-controlled analgesia (PCA) and epidural anaesthesia/analgesia. Apart from its advantage of transferring control of analgesia to the patient, PCA takes off some of the workload from nurses who otherwise need to regularly administer drugs or supplemental analgesia.⁹ Epidural anaesthesia/analgesia has been shown to lead to a significant reduction in perioperative cardiac morbidity (~30%), pulmonary infections (~40%), pulmonary embolism (~50%), ileus (~2 days), acute renal failure (~30%), and blood loss (~30%).²

We suggest that anaesthetists play a more active and leading role in postoperative pain management of patients. Many of the procedures involved - pre-emptive analgesia, epidural anaesthesia, patient-controlled anaesthesia – are best handled by the anaesthetist.

CONCLUSIONS

Patient information with regard to their diagnosis and operation at the Korle Bu Teaching Hospital is very unsatisfactory. Informed consent is poorly administered. There is the need for surgeons to train doctors to administer informed consent or administer the consent themselves. The consent form in use currently needs modification.

The management of postoperative analgesia in Korle Bu hospital is poor. There must be a multimodal approach and an increased use of opiates.

Anaesthetists should assume a greater role in post-operative pain management.

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