Counselling of the Surgical Patient: Opinion of Caregivers

Rex Friday Ogoronte A. Ijah, Friday E. Aaron, Alexander A. Dimoko, Joy O. Dayi, Promise N. Wichendu, and Ebimie M. Eleke

ABSTRACT

**Aim:** The aim of this study was to ascertain the opinion of caregivers on counselling of the surgical patient in tertiary healthcare facilities in Port Harcourt in the months of May and June 2020.

**Background:** The care of the surgical patient partly requires that an informed consent be obtained before a therapeutic or diagnostic surgical objective is accomplished. Surgical counselling should therefore alleviate the fears of patients and relatives on intended surgery and anaesthesia and prepare patient for possible postsurgical deficits.

**Materials and Methods:** All surgical caregivers available at the point in time who gave their consent were recruited for this cross-sectional descriptive study carried out in the wards and specialist surgical outpatient clinics of Teaching Hospitals in Port Harcourt, Nigeria between the months of May and June 2020 using semi-structured questionnaires. Data obtained was analysed using the Statistical Package for the Social Sciences (SPSS) version 20.0.

**Results:** Although 89.8% of respondents affirmed communicating information on the nature and purpose of the treatment to patients, only 161 (56.7%), 158 (55.6%), 156 (54.9%), and 156 (54.9%) responded in the affirmative to discussing the involved risks, potential benefits, available alternatives and the effects of non-treatment respectively. Lack of adequate time for consultation was considered a hinderance by 230 (81.0%) respondents.

**Conclusion:** The challenge most asserted as a hinderance to surgical patients’ counselling was short patient contact time during counselling sessions. The overstretched tertiary health facilities can be decongested if efforts are made by governments to ensure optimum function of the health centers.

**Keywords:** Counselling, caregivers’ opinions, Nigeria, Port Harcourt, surgical patient, tertiary healthcare.

---

I. INTRODUCTION

The care of the surgical patient partly requires that an informed consent be obtained before a therapeutic or diagnostic surgical objective is accomplished. The gateway to achieving this is through adequate counselling of the surgical patient. It has been reported that current counselling and consent processes are probably outdated and requires adjustment to match modern day legislation [1]. It has also been asserted that surgeons are not specifically trained and so lack legal competence to counsel patients through a legally binding surgical informed consent [1], especially as counselling has been defined as a talk-based therapy given by a trained therapist [2]. Informed consent is defined as “voluntary authorization, by a patient or research subject, with full comprehension of the risks involved, for diagnostic or investigative procedures, and for medical and surgical treatment” [1]. It is an action resulting from a talk-based therapy, [2] and the principle has both ethical and legal backing [1].

The counselling process must ensure that the following elements are incorporated and respected: preconditions (competence / capacity, and voluntarism), information (disclosure and understanding), and decision [1], [3], [4]. The scope of information disclosure is individualized and the nature and purpose of the treatment, risks involve, potential benefits, available alternatives, and effect of non-treatment should be discussed during counselling before an informed consent can be achieved [1], [5], [6]. It is also noteworthy that...
counselling of the surgical patient may be dynamic (not only preoperatively or a one-off session), and may also occur in the postoperative period, and sometimes may not end in surgery [2], [7]. The outcome of good counselling/informed consent therefore should be able to alleviate the fears of patients and relatives on intended surgery and anesthesia, and prepare patient for possible postsurgical deficits (disfigurement, cognitive deficits, postsurgical pain, and disability) [2]. In the event that loss of body part / appendage is anticipated, counselling of the surgical patient assumes a more critical outlook requiring more attention especially with the attendant overlapping psychological consequences [8]. Counselling for Cancer Patients, end of life, and breaking bad news are some other areas that require special attention.

This study therefore attempts to unravel some of the issues on counselling of the surgical patient for discussion, and contribute to the body of knowledge on this subject, aiming to ascertain the opinion of caregivers on counselling of the surgical patient in tertiary healthcare facilities in Port Harcourt in the months of May and June 2020: the study investigated the current scope of knowledge of caregivers; determine the opinions of caregivers, and established the challenges encountered by caregivers on counselling of the surgical patient in tertiary healthcare facilities in Port Harcourt within the study period.

II. METHODOLOGY

A. Study Area

The study was carried in Port Harcourt the capital of Rivers State, one of the Niger Delta States in the Federal Republic of Nigeria.

B. Study Place and Period

The place of study were the specialist surgical outpatient clinics and surgical wards of University of Port Harcourt Teaching Hospital and the Rivers State University Teaching Hospital in Port Harcourt from May 2020 to June 2020. Surgeries performed in these government owned tertiary health facilities include but not limited to general surgical, neurosurgical, otorhinolaryngologic, dental/oral-maxillofacial, plastic surgical, cardiothoracic, orthopedic, obstetric and gynecologic, urologic, pediatric surgical, and laparoscopic surgical procedures.

C. Study Design

A cross-sectional descriptive study.

Study Population: The study population was caregivers at the surgery department (comprising surgeons of all specialties, resident doctors, anesthetists, nurses, technicians).

D. Sample Size Determination

The minimum sample size of 284 (more than 2/3rd of the total population) was determined based on a projected total caregivers’ population of about 400.

E. Sampling Technique Procedure

The convenience sampling method was used to recruit respondents among caregivers present at the tertiary health facility who gave consent for inclusion during the period of study. A total of three hundred and fifty (350) self-administered semi-structured questionnaires intended for the study were distributed (with effort made to avoid double administration) between May 2020 and June 2020, and two hundred and eighty-four (284) were retrieved.

F. Data Analysis

Information on socio-demographic characteristics; knowledge of the scope of counselling of the surgical patient; current practice of counselling of the surgical patient; and factors that hinder proper counselling of the surgical patient were collated and analyzed using the Statistical Package for the Social Sciences (SPSS) version 20.0.

G. Ethical Approval

The approval of the Research Ethics Committee of the University of Port Harcourt Teaching Hospital and the Rivers State University Teaching Hospital were obtained.

III. RESULTS

A total of 284 respondents who were surgeons, anesthetists, nurses, technicians, and students, were included in the study. The demographic characteristics of the respondents summarized in Table I indicated that 131 (46.1%) were males while female respondents were 153 (53.9%).

| TABLE I: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF STAFF RESPONDENTS |
|-----------------|--------|-----------------|
| VARIABLES       | FREQUENCY | PERCENTAGE     |
| Sex             |         |                 |
| Male            | 131     | 46.1            |
| Female          | 153     | 53.9            |
| Age             |         |                 |
| Less than 25 years | 30   | 10.6            |
| 25-40 Years     | 169     | 59.5            |
| 41-60 years     | 72      | 25.4            |
| Above 60 years  | 13      | 4.6             |
| Marital Status  |         |                 |
| Single          | 115     | 40.5            |
| Married         | 162     | 57.0            |
| Separated       | 4       | 1.4             |
| Divorced        | 3       | 1.1             |
| Years in service |       |                 |
| Less than 1 Year | 62    | 22.2            |
| 1-10 years      | 131     | 46.1            |
| 11-20 years     | 58      | 20.4            |
| 21-30 years     | 22      | 7.7             |
| More than 30 years | 10  | 3.5             |
| Religion        |         |                 |
| Christianity    | 275     | 96.8            |
| Islam           | 3       | 1.1             |
| Traditional     | 4       | 1.4             |
| None            | 2       | 0.7             |
| Health staff category |     |                 |
| Surgeon (All Specialists) | 85 | 29.9 |
| Anesthetist     | 28      | 9.9             |
| Nurse           | 69      | 24.3            |
| Student         | 6       | 2.1             |
| Others (Technician, House officer) | 96 | 33.8 |
| Place of work   |         |                 |
| UPTH            | 197     | 69.4            |
| RSUTH           | 87      | 30.6            |
| Total           | 284     | 100.0           |

DOI: http://dx.doi.org/10.24018/ejmed.2022.4.2.715

Vol 4 | Issue 2 | April 2022
One hundred and sixty-nine (59.5%) were between 25 and 40 years old and 13 (4.6%) were above 60 years. One hundred and thirty-one (46.1%) respondents had spent between 1 and 10 years in service, 58 (20.4%) were in service for 11 and 20 years, and 10 (3.5%) had worked for more than thirty years in service. Eighty-five (29.9%) respondents were surgeons (of all specialties), 28 (9.9%) were anesthetist, 69 (24.3%) were nurses, and 96 (33.8%) were other healthcare personnel like laboratory staff, pharmacist, technicians, etc.

Respondent’s knowledge of the scope of counselling of the surgical patient is as indicated in Table II. Two hundred and nine (73.6%) positively affirmed to all the three elements of counselling of the surgical patient for informed consent (precondition like competence/capacity and voluntarism; information disclosure and decision). Two hundred and thirty-four (82.4%) respondents were of the opinion that counselling the surgical patient should be done as often as necessary. Two hundred and seventy-nine (96.1%) respondents asserted that good surgical patient counselling may alleviate the fears of patients and relative on intended surgery and anesthesia; improve patient-doctor relationship; improve compliance with treatment; and result in a legally binding informed consent.

Table III shows respondents’ opinion and knowledge of the content of counselling of the surgical patient. Two hundred and fifty-five (89.8%) respondents affirmed that information on the nature and purpose of the treatment should be discussed with the patients. However, only 161 (56.7%), 158 (55.6%), 156 (54.9%), and 156 (54.9%) responded in the affirmative to discussions of the involved risks, potential benefits, available alternatives, and the effects of non-treatment respectively.

Table IV shows respondents’ opinion on the staff category that currently carry out counselling of the surgical patient at the center. Two hundred and fifty-eight (90.8%) respondents affirmed that the surgeons (residents and consultants) carry out the responsibility of counselling the surgical patient. Other category of staff also asserted to were for nurses - 122 (43.0%), anesthetists - 111 (39.1%), specialist guidance counselor - 85 (29.9%), psychologists – 76 (26.8%) and house officer – 15 (5.3%).

Table V shows the respondents’ opinion on the frequency and duration of counselling session for the surgical patient at the center. Eighty-five (29.9%) respondents indicated that the current duration of counselling session was 5-10 minutes, 62 (21.8%) asserted to 11-30 minutes, 39 (13.7%) indicated more than 30 minutes, while 95 (33.5%) affirmed to variable timing. Two hundred and eleven (74.3%) respondents asserted from their experience that counselling was done as often as necessary. However, 57 (20.1%) indicated the frequency to be twice, while 16 (5.6%) asserted to once.

Table VI displays the opinion of caregivers on challenges that constitute hinderances to proper counselling of the surgical patient, and who should carry out surgical counselling. System factor of not having enough time with the patients due to bulk of work was considered a hinderance by 230 (81.0%) respondents. Patient factors like communication or language difficulties was asserted to by 230 (81.0%) respondents. The authoritarian disposition of the caregiver was indicated by...

---

**TABLE II: Respondent’s Knowledge of the Scope of Counselling of the Surgical Patient**

| Elements of counselling of the surgical patient for informed consent | Frequency | Percentage |
|---------------------------------------------------------------------|-----------|------------|
| Precondition like competence/capacity and voluntarism              | 26        | 9.2        |
| Information disclosure and understanding                           | 38        | 13.4       |
| Decision                                                            | 7         | 2.5        |
| All of the above                                                    | 209       | 73.6       |
| None of the above                                                   | 4         | 1.4        |

**TABLE III: Respondent’s Knowledge of the Content of Counselling of the Surgical Patient**

| Scope of information on to be discussed during counselling before informed consent can be said to be achieved | Yes | No |
|------------------------------------------------------------------------------------------------------------|-----|----|
|                                                                                                             | Freq | %  |
| Information about the nature and purpose of the treatment                                                 | 122  | 45.1|
|                                                                                                             | 70   | 26.8|
| The risks involve                                                                                            | 209  | 73.6|
|                                                                                                             | 72   | 26.0|
| The potential benefits                                                                                        | 161  | 56.7|
|                                                                                                             | 63   | 22.6|
| Available alternatives                                                                                        | 156  | 54.9|
|                                                                                                             | 95   | 33.8|
| The effects of non-treatment                                                                                | 156  | 54.9|
|                                                                                                             | 95   | 33.8|

**TABLE IV: Respondents’ Opinion on the Staff Category that Currently Carry Out Counselling of the Surgical Patient at the Center**

| Staff that should carry out surgical patient counselling | Frequency | Percentage |
|--------------------------------------------------------|-----------|------------|
| The surgeon (Residents and Consultants)                 | 258       | 90.8       |
| The Anaesthetist                                       | 111       | 39.1       |
| The Nurse                                              | 122       | 43.0       |
| The Specialist Guidance Counselor                      | 85        | 29.9       |
| The Psychologist                                       | 76        | 26.8       |
| House Officer                                          | 15        | 5.3        |

**TABLE V: Respondents’ Opinion on the Current Duration and Frequency of Counselling of the Surgical Patient at the Centre**

| Average timing of counselling the surgical patient | Frequency | Percentage |
|----------------------------------------------------|-----------|------------|
| Less than 5 minutes                               | 3         | 1.1        |
| 5 - 10 minutes                                    | 85        | 29.9       |
| 11 - 30 minutes                                   | 62        | 21.8       |
| More than 30 minutes                              | 39        | 13.7       |
| Variable timing                                   | 95        | 33.5       |

**TABLE VI: Respondents’ Opinion on the Frequency and Duration of Counselling Session for the Surgical Patient at the Center**

| Frequency of counselling the surgical patient in practice | Frequency | Percentage |
|----------------------------------------------------------|-----------|------------|
| Once                                                      | 16        | 5.6        |
| Twice                                                     | 57        | 20.1       |
| As often as necessary                                     | 211       | 74.3       |

**TABLE VII: Respondents’ Opinion on the Frequency and Duration of Counselling Session for the Surgical Patient at the Center**

| Average timing of counselling the surgical patient | Frequency | Percentage |
|----------------------------------------------------|-----------|------------|
| Less than 5 minutes                               | 3         | 1.1        |
| 5 - 10 minutes                                    | 85        | 29.9       |
| 11 - 30 minutes                                   | 62        | 21.8       |
| More than 30 minutes                              | 39        | 13.7       |
| Variable timing                                   | 95        | 33.5       |
102 (35.9%) respondents, while 115 (40.5%) were of the opinion that doctors do not have enough knowledge on counselling to communicate to patients. Two hundred and forty-six (86.6%) respondents asserted that the surgeon (residents and consultants) were the right persons to carry out counselling of the surgical patient. Another staff category mentioned were the Specialist Guidance Counselor – 180 (63.4%), the psychologist – 152 (53.5%), the nurse – 145 (51.1%), and the Anesthetist – 142 (50.0%).

Majority of the respondents have been in the service of the hospital for varied period of 1 – 30 years, and the study population also has a widespread among caregivers in the surgery department. The opinion of respondents therefore can be assumed to be based on what they know about counselling of the surgical patient in the center. Most respondents positively affirmed to all three elements of the counselling, indicating awareness on the issue by most caregivers. It is the nature and purpose of the treatment should be discussed with the patients. However, about half of the caregivers asserted the importance of discussing involved risks, potential benefits, available alternatives, and the effects of non-treatment with the patient. This disparity in the opinion of caregivers on disclosure of information appear to be different from the expected standard. The likely explanation for this could be the local experiences of the caregivers in which patients’ default from hospital attendance after such counselling/disclosure in favor of alternative care, and latter represent in a worse state. There is a historical transition from a surgeon-based counselling and consent [9]-[11], - “hold harmless document” - to a patient-centered informed consent [1],[12]-[16], with attendant increase in the demand and responsibility from the surgeon. Cases of workplace violence against health workers that were reported in other climes [17]-[21], are also being experienced in our society [22]-[25]. The emerging cases of litigations against health workers [26]-[28], and the recent theme for the Annual Conference of the Nigerian Bar Association focusing on Medical Negligence, brings to the fore the need to pay closer attention to the subject of patient counselling and informed consent in our society.

The time spent during counselling sessions with the patient was affirmed to be variable by the highest number of respondents, with some sessions being as short as 5-10 minutes. This may explain why some patients feel that they do not receive satisfactory emotional support, communication, and counselling, as reported in a study in Ghana [29]. This finding of inadequacy of time for counselling agrees with other studies that highlight overcrowding, delay in consultation, lack of proper counselling and consequent patients’ dissatisfaction [30], [31]. In some setting, effort have been made to partly overcome this challenge with student-run free clinics [32], and video consultation for follow up patients [33]. The disproportionately low Nigerian doctor-patient ratio [34]-[36], the burden of inadequacy of time for counselling of the surgical patients for informed consent, brain drain of health personnel, all seem to make matters worse. Many questions, in the light of the above, are begging for answers: who should administer counselling to the surgical patient? The Surgeon, anesthetist, specialist counsellors, psychologists, or all parties? Nearly all caregivers responded in the affirmative that the surgeons were the staff category that carry out the responsibility of counselling the surgical patient, with other category of caregivers having fewer than half responses.

The challenge that constituted hinderance to proper counselling of the surgical patient and attracted the highest number of responses (by majority) was not having enough time with the patients due to bulk of work. This reflects poor doctor patient ratio that is typical of the developing world. There were also some other hindering factors including cultural/religious concerns, communication or language difficulties, authoritarian disposition of the caregiver, and poor knowledge of doctors on counselling, expressed by respondents. Despite the benefits of informed consent[1],[3], it does appear that there are limitations especially as autonomous choices cannot be made when such choice does not exist, and when cultural issues are brought into context [1],[3],[37]-[39]. Reports from some published works demonstrate existence of inadequacies in counselling and informed consent process among doctors and patients [40]-[45].

The awareness of the scope and content of counselling of the surgical patient was high, however the practical application of this knowledge appear to be limited, especially in the areas of disclosure of involved risks, potential benefits, available alternatives, and the effects of non-treatment. The challenge that was asserted the most as a hinderance to counselling of the surgical patient was “not having enough time to spend with the patients” during counselling sessions. Other challenges expressed were cultural / religious concerns, communication or language difficulties, authoritarian...
disposition of the caregiver, and poor knowledge of doctors on counselling. There is need for this issue of short patient contact time to be addressed by governments that run the health institutions. The overstretched tertiary health facilities can be decongested if efforts are made by governments to ensure optimum function of the peripheral health centers, thereby reducing the workload of the attending surgeons at the tertiary health facilities.

ETHICAL CONSIDERATIONS

The approval of the Research Ethics Committee of the University of Port Harcourt Teaching Hospital and the Rivers State University Teaching Hospital were obtained before commencement of study.

ACKNOWLEDGMENT

We acknowledge the department of surgery and the hospital research ethics committee for permission granted to do the study.

FUNDING

The Study was privately sponsored by the researchers.

CONFLICT OF INTEREST

Authors declare that they do not have any conflict of interest.

REFERENCES

[1] Leclercq WK, Keulers BJ, Scheltinga MR, Spaauwen PH, van der Wilt G-J. A review of surgical informed consent: past, present, and future. A quest to help patients make better decisions. World Journal of Surgery. 2010; 34(7): 1406-15.

[2] Raju B, Reddy K. Are counselling services necessary for the surgical patients and their family members during hospitalization? Journal of Neurosciences in Rural Practice. 2017; 8(01): 114-7.

[3] Berg JW, Appelbaum PS, Lida CW, Parker LS. Informed consent: legal theory and clinical practice. Oxford University Press. 2001.

[4] Universiteit van Amsterdam. Health Law Section. Promotion of the Rights of Patients in Europe: Proceedings of a WHO Consultation: Kluwer Law International; 1995.

[5] Beauchamp TL, Childress JF. Principles of Biomedical Ethics. Third Edition. New York: Oxford University Press, 1989: 1–470.

[6] Emanuel EJ, Joffe S. Ethics in oncology. Cancer Medicine, Fifth Edition. 2000: 1145 –1163.

[7] Ward E, Hobson T, Conroy A. Pre-and post-operative counselling and information dissemination: perceptions of patients undergoing laryngeal surgery and their spouses. Asia Pacific Journal of Speech, Language and Hearing. 2003; 8(1): 44-68.

[8] Maguire P, Parkes CM. Coping with loss: Surgery and loss of body parts. BMJ. 1998; 316(7137): 1086.

[9] Ajlooni K. History of informed medical consent. The Lancet. 1995; 8980(346): 980.

[10] Vollmann J, Winun R, Baron J. History of informed medical consent. The Lancet. 1995; 347(8998): 410.

[11] Rothman D. History of informed medical consent. The Lancet. 1995; 346(8990): 1633.

[12] Curran WJ, Hall MA, Kaye DH. Health care law, forensic science, and public policy. Little, Brown; 1990.

[13] Powell RE. Consent to operative procedures. Md L Rev. 1961; 21: 189.

[14] Rohde M. Information Overload: How the Wisconsin Supreme Court Expanded the Doctrine of Informed Consent. J Marshall L Rev. 2012; 46: 1097.

[15] Armstrong A, Cole A, Page R. Informed consent: are we doing enough? British Journal of Plastic Surgery. 1997; 50(8): 637-40.

[16] Katz J. Reflections on informed consent: 40 years after its birth. Journal of the American College of Surgeons. 1998; 186(4): 466-74.

[17] Falilahi-Khoshkhab M, Oskouie F, Najafi F, Ghazanfari N, Tamizzi Z, Afshani S. Physical violence against health care workers: A nationwide study from Iran. Iranian Journal of Nursing and Midwifery Research. 2016; 21(3): 232.

[18] Al-Turki N, Afify AA, Alateeq M. Violence against health workers in Family Medicine Centres. Journal of Multidisciplinary Healthcare. 2016; 9: 257.

[19] Phillips JP. Workplace violence against health care workers in the United States. New England Journal of Medicine. 2016; 374(17): 1661-9.

[20] Hesketh T, Wu D, Mao L, Ma N. Violence against doctors in China. BMJ. 2012; 345:e5730.

[21] Sharma DC. Rising violence against health workers in India. The Lancet. 2017; 389(10080): 1685.

[22] Ogbonnaya G, Ukegbu A, Aguwa E, Emma-Ukegbu U. A study on workplace violence against health workers in a Nigerian tertiary hospital. Nigerian Journal of Medicine: The National Association of Resident Doctors of Nigeria. 2012; 21(2): 174-9.

[23] Abodunrin O, Adeoye O, Adeconi A, Akande T. Prevalence and forms of violence against health care professionals in a South-Western city, Nigeria. Sky Journal of Medicine Sciences. 2014; 2(8): 67-72.

[24] Azodo C, Ezeja E, Ethikhamenor E. Occupational violence against dental professionals in southern Nigeria. African Health Sciences. 2011; 11(3).

[25] Ogundipe KO, Etonyekwu AC, Adigun I, Ojo EO, Aladesanmi T, Taiwo JO, et al. Violence in the emergency department: a multicentre survey of nurses’ perceptions in Nigeria. Emergency Medicine Journal. 2013; 30(9): 758-62.

[26] Ushie B, Salami K, Jegede A, Oyetunde M. Patients’ knowledge and perceived reactions to medical errors in a tertiary health facility in Nigeria. African Health Sciences. 2013; 13(3): 820-8.

[27] Chukwuneke F. Medical incidents in developing countries: A few case studies from Nigeria. Nigerian Journal of Clinical Practice. 2015; 18(7): 20.

[28] Obafemi KAR. Medical Negligence Litigation in Nigeria: Identifying the Challenges and Proposing a Model Law Reform Act. Trinity College Dublin; 2017.

[29] Clegg-Lamptey DN, Dakubu JC, Attoboa YN. Psychosocial aspects of breast cancer treatment in Accra, Ghana. East African Journal Medical. 2009; 8(7).

[30] Iliyasu Z, Abubakar IS, Abubakar S, Lawan UM, Gajida AU. Patients’ satisfaction with services obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. Nigerian Journal of Clinical Practice. 2010; 13(4).

[31] Ogungwonowon O, Mora M. Time, expectation and satisfaction: patients’ experience at National Hospital Abuja, Nigeria. African Journal of Primary Health Care & Family Medicine. 2012; 4(1).

[32] Lawrence D, Bryant TK, Nobel TB, Dolansky MA, Singh MK. A comparative evaluation of patient satisfaction outcomes in an interprofessional student-run free clinic. Journal of Interprofessional Care. 2015; 29(5): 445-50.

[33] Barsom EZ, Jansen M, Tanis PJ, van de Ven AW, van Oud-Alblas MB, Buskens C, et al. Video consultation during follow up care: effect on quality of care and patient-and provider attitude in patients with colorectal cancer. Surgical Endoscopy. 2020: 1-0.

[34] Oche M, Adamu H. Determinants of patient waiting time in the general outpatient department of a tertiary health institution in northwestern Nigeria. Annals of Medical and Health Sciences Research. 2013; 3(4): 58-92.

[35] Umar I, Oche M, Umar A. Patient waiting time in a tertiary health institution in Northern Nigeria. Journal of Public Health and Epidemiology. 2011; 3(2): 78-82.

[36] Ibor UW, Atomode TI. Health Service Characteristics and Utilization Outcomes from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. Annals of Medical and Health Sciences Research. 2013; 3(4): 58-92.

[37] Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation: benefit or harm? Jama. 1995; 274(10): 826-9.

[38] Blackhall LJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. Jama. 1995; 274(10): 820-5.

[39] Pang M. Protective truthfulness: the Chinese way of safeguarding patients in informed treatment decisions. Journal of Medical Ethics. 1999; 25(3): 247-53.

[40] Issa MM, Setzer E, Charaf C, Webb AL, Derico R, Kimberl L, et al. Informed versus uninformed consent for prostate surgery: the value of electronic consents. The Journal of Urology. 2006; 176(2): 694-9.

DOF: http://dx.doi.org/10.24018/ejmed.2022.4.2.715
[41] Skene L, Smallwood R. Informed consent: lessons from Australia. *BMJ*. 2002; 324(7328): 39-41.

[42] Schouten B, Hoogstraten J, Eijkman M. Dutch dental patients on informed consent: knowledge, attitudes, self-efficacy and behaviour. *Patient Education and Counselling*. 2002; 46(1): 47-54.

[43] Angelos P, DaRosa DA, Bentram D, Sherman H. Residents seeking informed consent: Are they adequately knowledgeable? *Current Surgery*. 2002; 59(1): 115-8.

[44] Leeper-Majors K, Veale JR, Westbrook TS, Reed K. The effect of standardized patient feedback in teaching surgical residents informed consent: results of a pilot study. *Current Surgery*. 2003; 60(6): 615-22.

[45] Lavelle-Jones C, Byrne DJ, Rice P, Cuschieri A. Factors affecting quality of informed consent. *BMJ*. 1993; 306(6882): 885-90.