

HOSTED BY



ELSEVIER

Contents lists available at ScienceDirect

Alexandria Journal of Medicine

journal homepage: <http://www.elsevier.com/locate/ajme>

Original Article

Public and private surgeon attitude towards informed consent

Saadoun Faris Alazmi



Department of Medical Records, College of Health Sciences, Public Authority for Applied Education and Training (PAAET), Kuwait

ARTICLE INFO

Article history:

Received 5 June 2017

Revised 17 October 2017

Accepted 3 November 2017

Available online 16 November 2017

Keywords:

Informed consent

Attitude

Surgeons

Public

Private

ABSTRACT

Background: Informed consent ranks as one of the most prominent issues in the recent bioethics literature due to increasing number of medico-legal cases and, the introduction of new national guidelines.

Objectives: The aim of this study is to examine the attitude of surgeons working in public and private hospitals towards informed consent.

Subjects and methods: This study is a cross-sectional survey that was conducted from January to June 2016 in all five governmental general hospitals, and two private hospitals in Kuwait. A self-administered questionnaire was used to collect data from the surgeons working in the selected hospitals including six domains related to informed consent.

Results: The majority of surgeons believed that informed consent routinely achieved in their current practice and that all doctors should receive formal training on informed consent, though only 35.7% of public surgeon received training compared to 76.7% of private surgeons. Although 82.7% of public surgeons believed that written information leaflets should be provided for patients, only 41.1% provide their patients with these type of leaflets. There was no significant difference between public and private surgeons regarding the purpose of informed consent except that higher proportion of private surgeons believed that informed consent improves the doctor-patient relationship. There was an agreement between public and private surgeons that junior doctors should not conduct the informed consent. Higher proportion of private than public surgeons stated that the content of informed consent was affected by patient's age, gender, and social class whereas level of education was thought by public surgeons.

Conclusion: Private surgeons differ from those in the public hospitals in that they tend to look at informed consent as not only an ethical and legal obligation, but also of benefit to patients. The introduction of formal training on informed consent in both types of hospitals are recommended.

© 2017 Alexandria University Faculty of Medicine. Production and hosting by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

The right of patients to make decisions about their medical care without coercion by health care provider is called patient's autonomy which is very important issue in health care service.¹ The autonomy of patient is defined as the legal incorporation of the idea that each patient has the right to make decisions that affects his/her health.² It is an opportunity to be an informed participant in his/her health care management plan. So, it acts as a safeguard to ensure the preservation of individual rights.³

For a consent to be effective, it should be informed. Medical intervention consent exceeds the relationship between patient and physician as a mere signature on an acceptance form.⁴ The World Medical Association Declaration of Lisbon on the rights of the

patient has had defined the main components of informed consent. The patient has the right to make decision that affect his health, patient has the right to give or withhold consent to any health management procedure and has the right to get the necessary information that help him make his decision.⁵ The interest in informed consent has been increased among the medical profession and public media due to the increased number of medico-legal cases and, the development of new guidelines. Doctors must adhere to the new guidelines for consent.⁶ Informed consent is now considered as one of the most prominent issues in the recent ethics.⁷

In general, complete informed consent should include a discussion of certain items as the nature of the therapy or procedure, an alternatives to the determined procedure, the expected risks, benefits, suspicion of each alternative,⁸ and assessment of the patient's awareness; and the patient's willing to accept procedure.⁹ Informed consent is a professional ethics emerging from the responsibility of the physician to the patient. Nowadays, informed consent for medical procedures has become a standard procedure,

Peer review under responsibility of Alexandria University Faculty of Medicine.

E-mail address: drsaadoun@yahoo.com<https://doi.org/10.1016/j.ajme.2017.11.001>

2090-5068/© 2017 Alexandria University Faculty of Medicine. Production and hosting by Elsevier B.V.

This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

in many countries, that provide the patients with the suitable information regarding the diagnosis and treatment of his case as well as risks, complications, and alternative treatment. This considerably improve the communication between physician and patient. A signed form is the evidence that their conversation leads to a reciprocal understanding.^{10,11} The specific information needed for by certain patient and methods used to provide this information should be considered. Informed consent should be given by patient after ensuring that the he understood the information by the physician or another responsible individual.¹²

A considerable number of medical researches has been conducted recently on the consent process. Most of them focused on patients – doctors' attitudes towards consent.^{13,14} The notion of informed consent is usually more related to surgical specialties than other clinical specialties because patient should decide to participate into surgery and permissiveness for surgeons to operate on them.¹⁵ Advanced surgery has been practiced for long time in state of Kuwait. Yet, to our knowledge, no studies have been conducted to examine surgeons' attitudes towards informed consent in Kuwait. Kuwait has introduced compulsory medical consent to be given by patients before any procedure. According to the this document, doctors should inform patients about medical protocols and options available for the case before getting patient signature prior to any medical procedure. Doctors also should provide all information, including possible risks. This would be mandatory in public as well as private hospitals and clinics.¹⁶ This has been documented by Ministerial decree No. 307/2015.¹⁷

The aim of this study is to examine surgeons' attitude working in public and private hospitals towards informed consent.

2. Subjects and methods

All five governmental general hospitals, and two private hospitals were randomly selected from 11 private hospitals in the state of Kuwait. This study is a cross-sectional survey that was carried out from January to June 2016. The sampling unit used in this survey was a surgeon working in the selected hospitals during the study period. A self-administered questionnaire about informed consent for surgery derived from different published studies dealing with the same subject as well as from our own experience was used in this study.¹⁸ Surgeons were asked to participate and complete the questionnaire and return it back. In addition to personal characteristics, the questionnaire included 24 items related to surgeons' attitudes towards informed consent categorized as follow: general question regarding informed consent (5 questions), the main purpose of informed consent (5 questions), why of informed consent is not necessary (4 questions), the person who get the informed consent and what should be included (6 questions), and factors affecting the quantity of information given to patients before giving informed consent (4 questions). The response to each question was either Yes (agree), No (disagree) or Unsure (not sure).

All the necessary approvals for carrying out the research were obtained. The Ethical Committee of the Kuwaiti Ministry of Health approved the research. The permission of the Deputy Ministry of Health in Kuwait as well as head of each selected hospital were obtained. Complete confidentiality was ensured. A pilot study was carried out on 10 surgeons to the clarity the suitability of the used questionnaire, and test the overall response of the surgeons. This study revealed that, overall, the questionnaire was suitable, and the required modifications of the questions were performed.

2.1. Statistical analysis

Data were revised for completeness. Questionnaire with missing data were excluded, so analysis of results did not contain miss-

ing values. For categorical variables, frequency and percentage distribution were used. For quantitative variables, the mean and standard deviation were used. To test the association between two variables, a bivariate analysis was conducted using Chi-square test.

3. Results

Of the 600 distributed questionnaires, 456 were completely filled and were returned back; with a response rate of 76.0%. Of those, 353 (77.4%) were public surgeons and 103 (22.6%) were private surgeons. Most of surgeons were males 347 (76.1%) and 109 (23.9%) were females. Their age ranged from 25 to 74 with a mean equals 40.4 ± 11.05 years. Years of experience ranged from 1 to 48 years with an average value 14.47 ± 10.98 . Distribution of surgeons according to their professional categories revealed that, 5.9% were trainee, 9% were assistant registrar, 43.8% were registrar, 15.9% were senior registrar, 8.4% were specialist, 6.2% were senior specialist, and 10.8% were consultant. According to specialty, 32.2% were general surgeons, 13.9% were ENT, 1.8% were ophthalmologists, 17.2% were orthopedics, 3.1% were gastrointestinal surgeons, 0.9% were chest surgeons, 1.1% maxillofacial surgeons, 2.6% plastic surgeons, and 7.7% were others.

Table 1 reveals the responses of the public and private surgeons to the general informed consent questions. A significant higher proportion of private surgeons (98.1%) compared to 87.8% of public surgeons considered informed consent routinely achieved in their current practice ($P = .004$). Similarly, 81.6% of private compared to 79.3% of public surgeons thought that all physicians should receive formal training on informed consent ($p < .001$). However, 76.7% of surgeons from private compared to 35.7% from public have received formal training on informed consent ($P < .001$). On the other hand, 82.2% of public compared to 46.6% of private surgeons thought that written information, in the form of leaflets, should be provided for patients during informed consent ($p < .001$) although only 41.1% of public and 30.1% of private surgeons mentioned that they provide their patients with leaflets during informed consent ($p < .001$).

Table 2 shows that the majority of participants agreed about the main purpose of the informed consent without a significant difference between public and private surgeons. However, a significant higher proportion of private than public surgeons believed that the main purpose of informed consent is to protect the surgeon against litigation (86.4% versus 83.0%, $P = .008$).

Participants opinion regarding considering informed consent unnecessary was shown in Table 2. A significant higher proportion of private than public surgeons supported the un-necessity of the informed consent because: most patients depend on their doctor to make the decision for them (42.7% versus 24.4%, $p = .001$); included information to patients about potential risks may be worrying for them (48.5% versus 36.3%, $P = .03$); disclosing information about potentially harmful risks may hinder patients from undergoing the operation (58.3% versus 32.3%, $P < .001$). A significant higher percentage of public than private surgeons believed that the informed consent is unnecessary because most patients do not usually remember all the information given to them (41.4% versus 30.1%, $P < .001$).

Table 3 shows that there was a general agreement between participants that the doctor who is going to perform the operation should do the informed consent with a significant higher proportion among public than private surgeons (85.6% versus 62.1%, $P < .001$). Lesser proportions of participants believed that the responsible consultant should do the informed consent (57.2% of public and 58.3% of private surgeons). Less than half of the participants in both groups believed that a junior doctor should do the consent.

Table 1
Responses of the public and private surgeons to the general informed consent questions.

Response to general informed consent questions	Public		Private		χ^2 P value
	No.	%	No.	%	
<i>Is informed consent routinely achieved in your current practice</i>					
Yes	310	87.8	101	98.1	$\chi^2 = 11.18$ P = .004
No	35	9.9	0	0.0	
Unsure	8	2.3	2	1.9	
<i>Do you think that all doctors should receive formal training on informed consent?</i>					
Yes	280	79.3	84	81.6	$\chi^2 = 26.87$ P < .001
No	61	17.3	4	3.9	
Unsure	12	3.4	15	14.6	
<i>Have you received any formal training on informed consent</i>					
Yes	126	35.7	79	76.7	$\chi^2 = 54.18$ P < .001
No	218	61.8	23	22.3	
Unsure	9	2.5	1	1.0	
<i>Should written information leaflets be provided for patients during informed consent</i>					
Yes	290	82.2	48	46.6	$\chi^2 = 120.18$ P < .001
No	48	13.6	7	6.8	
Unsure	15	4.2	48	46.6	
<i>Do you provide your patients with leaflets during informed consent</i>					
Yes	145	41.1	31	30.1	$\chi^2 = 69.52$ P < .001
No	183	51.8	31	30.1	
Unsure	25	7.1	41	39.8	
Total	353	100.0	103	100.0	

Table 2
Responses of the public and private surgeons to questions related to the importance and unimportance of informed consent.

The main purpose of informed consent is to	Public		Private		χ^2 P value
	No.	%	No.	%	
<i>Ensure that the patient has been informed of all potential complications</i>					
Yes	312	88.4	88	85.4	$\chi^2 = 0.65$ P = .72
No	33	9.3	12	11.7	
Unsure	8	2.3	3	2.9	
<i>Provide the surgeon with greater protection against litigation</i>					
Yes	293	83.0	89	86.4	$\chi^2 = 9.77$ P = .008
No	41	11.6	3	2.9	
Unsure	19	5.4	11	10.7	
<i>Respect the patient's right of autonomy</i>					
Yes	316	89.5	98	95.1	$\chi^2 = 3.09$ P = .214
No	25	7.1	3	2.9	
Unsure	12	3.4	2	1.9	
<i>Improve the doctor-patient relationship</i>					
Yes	293	83.0	97	94.2	$\chi^2 = 9.12$ P = .010
No	43	12.2	6	5.8	
Unsure	17	4.8	0	0.0	
<i>Improve the patient's compliance with medical care</i>					
Yes	286	81.0	86	83.5	$\chi^2 = 5.67$ P = .059
No	38	10.8	15	14.6	
Unsure	29	8.2	2	1.9	
<i>Most patients depend on their doctor to make the decision for them</i>					
Yes	86	24.4	44	42.7	$\chi^2 = 14.42$ P = .001
No	240	68.0	56	54.4	
Unsure	27	7.6	3	2.9	
<i>Disclosing information to patients about potentially harmful risks may be worrying for them</i>					
Yes	128	36.3	50	48.5	$\chi^2 = 7.22$ P = .027
No	197	55.8	42	40.8	
Unsure	28	7.9	11	10.7	
<i>Disclosing information about potentially harmful risks may dissuade patients from undergoing the operation</i>					
Yes	114	32.3	60	58.3	$\chi^2 = 25.02$ P < .001
No	197	55.8	40	38.8	
Unsure	42	11.9	3	2.9	
<i>Most patients do not usually remember all the information given to them</i>					
Yes	146	41.4	31	30.1	$\chi^2 = 39.25$ P < .001
No	167	47.3	33	32.0	
Unsure	40	11.3	39	37.9	
Total	353	100.0	103	100.0	

Table 3

Responses of the public and private surgeons to questions on who should do the informed consent and what should be disclosed during the process.

Questions related to who should do the informed consent and what should you disclose during the process?	Public		Private		X ² P value
	No.	%	No.	%	
<i>The doctor who is going to perform the operation</i>					
Yes	302	85.6	64	62.1	X ² = 40.02 P < .001
No	38	10.8	38	36.9	
Unsure	13	3.7	1	1.0	
<i>The responsible consultant</i>					
Yes	202	57.2	60	58.3	X ² = 7.60 P = .022
No	121	34.3	42	40.8	
Unsure	30	8.5	1	1.0	
<i>A junior doctor who is not going to perform the operation</i>					
Yes	154	43.6	47	45.6	X ² = 0.67 P = .716
No	170	48.2	50	48.5	
Unsure	29	8.2	6	5.8	
<i>Should disclose the possibility of death if present</i>					
Should be included	271	76.8	73	70.9	X ² = 10.52 P = .005
Not necessary	52	14.7	10	9.7	
Uncertain	30	8.5	20	19.4	
<i>Should disclose all major risks with incidence > 1%</i>					
Should be included	305	86.4	101	98.1	X ² = 11.18 P = .004
Not necessary	34	9.6	1	1.0	
Uncertain	14	4.0	1	1.0	
<i>Should disclose all minor risks with incidence > 5%</i>					
Should be included	240	68.0	76	73.8	X ² = 5.20 P = .074
Not necessary	89	25.2	16	15.5	
Uncertain	24	6.8	11	10.7	
Total	353	100.0	103	100.0	

The vast majority of participants believed that all major risks should be disclosed in the consent with a higher proportion among private than public surgeons (98.1% versus 86.4%, $P = .005$). A lesser proportion of surgeons believed that the minor risks should be disclosed. On the other hand, 76.8% of public compared to 70.9% of private surgeons thought that they should disclose the possibility of death if present ($P = .005$).

Table 4 shows participants' response regarding factors affecting the amount of information given to patients during the informed consent. Patient age (85.4% versus 70.5%, $P = .01$), gender (79.6% versus 41.1%, $P < .001$) and social class (78.6% versus 49.9%, $P < .001$) were believed by significant higher proportions of private than public surgeons respectively. Contrary, a lesser significant proportion of private than public surgeons believed that patient level of education (58.3% versus 70.3%, $P = .01$) has an effect.

4. Discussion

The participating surgeons in the current study could be considered as a representative sample of surgeons in public and private hospitals as they were of different levels of seniority and varied specialties.

Most public and private surgeons stated that informed consent was a routine process in their practice. This was obvious and significant among private surgeons. They believed that all surgeons must receive informed consent training. However, only a third of public surgeons declared that they had this type of training. Physicians in the USA, UK, and Canada are well trained on how to obtain informed consent due to the possibility that patients usually make legal claims in case of complications.¹⁹ It is well defined by law in these countries which procedures patients should give written

Table 4

Responses of the public and private surgeons to questions on what affect the amount of information given during informed consent.

Questions related to factors affecting the amount of information given to patients during informed consent	Public		Private		X ² P value
	No.	%	No.	%	
<i>The patients age</i>					
Yes	249	70.5	88	85.4	X ² = 9.22 P = .010
No	95	26.9	14	13.6	
Unsure	9	2.5	1	1.0	
<i>The patients gender</i>					
Yes	145	41.1	82	79.6	X ² = 47.42 P < .001
No	201	56.9	20	19.4	
Unsure	7	2.0	1	1.0	
<i>The patients level of education</i>					
Yes	248	70.3	60	58.3	X ² = 10.02 P = .007
No	91	25.8	42	40.8	
Unsure	14	4.0	1	1.0	
<i>The patients social class</i>					
Yes	176	49.9	81	78.6	X ² = 27.34 P < .001
No	169	47.9	20	19.4	
Unsure	8	2.3	2	1.9	
Total	353	100.0	103	100.0	

consent.²⁰ Even in less developed countries like Nigeria, surgeons defined courses of bioethics and communication skills during surgical training as a way to improve surgeons-patients communication.⁷

Patients rely on the knowledge and skill of the physician proposing treatment to relay information and inform their decision-making. In the present study, surgeons equally stated that written information in the form leaflets must be given to patients before giving informed consent. However, a significantly higher proportion of public than private surgeons indicated that they usually do this (41.1% versus 30.1%). This could reflect the practice in both public and private hospitals, in which more than half of surgeons do not give their patients written information before giving informed consent or sometimes leaflets may not be available. Although written information are useful for patients, they cannot replace conversation with surgeons.^{12,21,22}

In the present study, 88.4% of public surgeons and 85.4% of private surgeons believed that the main purposes of informed consent were to supply the patient with information regarding all complications and also to protect the surgeon legally (83% versus 86.4%). However, a significantly higher percentage of private than public surgeons believed that the main purpose of informed consent is to improve doctor-patient relationship (95.1% versus 89.5%) and improving the patients' compliance with medical care (83.5% versus 81.0%). Such findings mean that surgeons in both types of hospitals believed that informed consent is a legal and ethical obligation. In a similar study that was conducted in Nigeria, surgeons were asked to state the reasons for obtaining informed consent before surgical procedures. They chose the following reasons in a decreasing proportions: medicolegal reasons, informing the patient regarding benefits, risks and alternatives of the procedure, helping the patient to take a decision about the procedure, hospital standard policy and surgical tradition.⁷ A minority of participants in the present study believed that the written consent was inappropriate because the included information may cause confusion to patients or may prevent them of from undergoing the surgery. This goes against the guidelines and legal issues that patients should be informed about what they want to know.²³ Previous qualitative research has shown that many physicians do not believe that it is necessary to obtain a formal consent after providing the patients with enough information.^{11,24}

The purpose of informed consent is to permit the ordinary reasonable patient to make an intelligent decision, based on the information provided by the physician.²⁵ Aqu et al. in 2014 stated the information to be given to patient as benefits and risk of the procedure, appropriate professional advice, preferred options for the patient, and authorization for the clinician.²⁶ Most participants in the current study, believed that the consent form should include an explanation of the procedure details as one of patients' right to autonomy. Previous studies revealed that information about a procedure and its benefits and risks improve patients' compliance, as well as decreasing post-operative medication care.^{12,27} However, Akkad et al. stated that many patients may not in need to know the procedure details.²⁸ Also, Kocarnik reported that informing the patient with each possible risk of a procedure may not be in his interests.²⁹ Berman et al. in their study reported that there was a substantial variability in surgeons' opinion regarding information that should be included in the consent form. About half of surgeons answered that it was "essential" to discuss risk of the operation. This could be explained by surgeon characteristics. They reported that younger with less experience surgeons would be more cautious about risk estimates, and discuss various risks with the patients.³⁰ The variability noted in this study goes with reports from other studies.^{12,31,32} In the current study, the majority of participating surgeons from both types of hospitals have a similar

opinion with respect inclusion of potential risks in informed consent with higher proportion of public than private surgeons with regards to the risk of death. On the other hand, more private than public surgeons believed that minor risks should be included. Lee Char et al. reported that over 70% of respondents considered the discussion of known and unknown risks as well as benefits of the procedure.³³

The current study showed that less than half public and private surgeons agreed that informed consent may be performed by a junior doctor who will not perform the procedure (43.6% versus 45.6%). This can be justified as a junior doctor has not the ability to provide all the necessary information to patient. Also, private and public surgeons had almost a similar beliefs that informed consent should be done by the consultant (58.3% versus 57.2% respectively), while significantly more public surgeons than private (85.6% versus 62.1%) believed that informed consent should be done by the doctor who will perform the operation. Furthermore, significantly more private surgeons believed that informed consent should be done by the consultant and higher proportion of public than private surgeons believed that the doctor who was going to perform the operation should perform the informed consent. This is consistent with the widely-accepted policy that the surgeon performing the procedure is responsible for the process.⁶ In many health care settings, junior surgical doctors obtain the informed consent for a surgery from the patient after contact between him and the consultant surgeon with the limitation that junior doctors have weakness in discussing risks or alternative procedures.^{34,35} Brewster et al. reported that ensuring that patients are informed of the risks and benefits associated with the surgery is an important responsibility of the treating surgeon.³⁶

In the present study, higher proportion of private than public surgeons stated that the content of informed consent was affected by patient's age, gender, and social class. The most striking difference was seen regarding gender. This could be attributed to the increased number of females who attended the private sector for delivery. On the other hand, the percentage of public surgeons who believed that education could affect the amount of information in the informed consent was higher than that in the private sector. This could be because public hospitals serve all social classes with a high percentage of public people who tend to be less educated, that might affect their understanding or awareness of the content of informed consent. However, there is no agreement between previous studies regarding the effect of these factors on the content of informed consent. However, Ezeome and Marshall reported that consent practices are influenced by socio-economic status.³⁷ In a study that was conducted in the Czech Republic, younger, highly educated men participants were likely to show the autonomy than older, less educated women.³⁸ On the other hand, another study supported the idea that women tend to be more information-seeking than men in health settings and tend to read the consent forms to alleviate uncertainty and trust concerns.³⁹ Also, in a previous study that was conducted to assess the role of educational status in informed consent, the author stated that poorly educated patients also want to be informed. It has also been shown that education influences the different cultural and social factors that may affect obtaining of informed consent and passing the gap between the doctor and the patient, and encouraging discussion on the procedure.³⁷ On the other hand, Agu et al. showed that the education did not affect patient autonomy about his health.²⁶

This study has some limitations. We did not assess patients' opinion regarding topics to be discussed during informed consent. Many other non-patient-related factors are needed to be studied as type and duration of the surgery, timing of surgery and need for referral to another doctor.

5. Conclusion

This study concluded that private surgeons differ from those in the public hospitals in that they believed that informed consent has benefit to patients, and not mere ethical and legal obligation. Surgeons should become aware of the informed consent guidelines. In addition, introducing formal training on informed consent for surgeons in both types of hospitals are recommended and for making written information more widely available is required.

Conflict of interest

We have no conflict of interest to declare.

References

1. Beauchamp TL, Childress JF. *The Principles of biomedical ethics*. 4th ed. New York: Oxford University Press; 2001.
2. Al-Freih HM. Ethics of the medical profession. Article (2/11) of the Saudi Council for Health Specialties; 2014:1–32.
3. Bhurgri H, Qidwai W. Awareness of the process of informed consent among family practice patients in parachi. *JPMA*. 2004;54:398–401.
4. Turillazzi E, Neri M. Informed consent and Italian physicians: change course or abandon ship from formal authorization to a culture of sharing. *Med Health Care Philos*. 2015;18:449–453.
5. World Medical Association. WMA Declaration of Lisbon on the rights of the patients. 2017. <<https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/>>.
6. UK Department of Health's. Good Practice in consent implementation guide: consent to examination or treatment. 2001. <www.doh.gov.uk/consent/>.
7. Ogundiran TO, Adebamowo CA. Surgeons' opinions and practice of informed consent in Nigeria. *J Med Ethics*. 2010;36(12):741–745.
8. General Medical Council. Consent: patients and doctors making decisions together. London; 2008: 1–64 accessed on: 12 June 2014. <http://www.gmc-uk.org/static/documents/content/Consent_-_English_0911.pdf>.
9. Jahan F, Roshan R, Nanji K, Sajwani U, Warsani S, Jaffer S. Factors affecting the process of obtaining informed consent to surgery among patients and relatives in a developing country: results from Pakistan. *Eastern Mediterranean Health J*. 2014;20(9):569–577.
10. Wheeler R. Consent in surgery. *Ann R Coll Surg Engl*. 2006;88:261–264.
11. Paterick TJ, Carson GV, Allen MC, Paterick TE. Medical informed consent: general considerations for physicians. *Mayo Clin Proc*. 2008;83:313–319.
12. Turner P, Williams C. Informed consent: patients listen and read, but what information do they retain? *N Z Med J*. 2002;115(1164):U218.
13. Bernat JL, Peterson LM. Patient-centered informed consent in surgical practice. *Arch Surg*. 2006;141:86–92.
14. Krupp W, Spanehl O, Laubach W. Informed consent in neurosurgery: patients' recall of preoperative discussion. *Acta Neurochir*. 2000;142:233–239.
15. Angelos P, Lafreniere R, Murphy TF, Rosen W. Ethical issues in surgical treatment and research. *Curr Probl Surg*. 2003;40:353–448.
16. Arabian business. Kuwait introduces compulsory medical consent forms. <<http://www.arabianbusiness.com/kuwait-introduces-compulsory-medical-consent-forms-615334.html>>.
17. Ministry of Health, Kuwait. Annual Group of the Most Important Ministerial and Administrative Decrees, Group 38; 2015.
18. Jamjoom BA, Jamjoom AA, Sharab M. Attitudes towards informed consent: a comparison between surgeons working in Saudi Arabia and the United Kingdom. *Oman Med J*. 2011;26(1):29–33.
19. Waisel DB, Truog RD. Informed consent. *Anesthesiology*. 1997;87:968–978.
20. Jukić M, Kvolik S, Kardum G, Kozina S, Juraga AT. Knowledge and practices of obtaining informed consent for medical procedures among specialist physicians: questionnaire study in 6 Croatian hospitals. *Croat Med J*. 2009;50:567–574.
21. Pesudovs K, Luscombe CK, Coster DJ. Recall from informed consent counselling for cataract surgery. *J Law Med*. 2006;13:496–504.
22. Deyo RA, Cherkin DC, Weinstein J, Howe J, Ciol M, Mulley Jr AG. Involving patients in clinical decisions: impact of an interactive video program on use of back surgery. *Med Care*. 2000;38:959–969.
23. Smith HK, Manjaly JG, Yousri T, et al. Informed consent in trauma: does written information improve patient recall of risks? A prospective randomised study. *Injury*. 2012;43:1534–1538.
24. Khan RI. Informed consent and some of its problems in Pakistan. *J Pak Med Assoc*. 2008;58(2):82–84.
25. Brown OW. The role of surgeon-specific experience and results in obtaining informed consent. *J Vasc Surg*. 2011;53:545–546.
26. Aqu KA, Obi EI, Eze BI, Okenwa WO. Attitude towards informed consent practice in a developing country: a community-based assessment of the role of educational status. *BMC Med Ethics*. 2014;15:77–84.
27. Dawes PJ, Davison P. Informed consent: what do patients want to know? *J Royal Soc Med*. 1994;87:149–152.
28. Akkad A, Jackson C, Kenyon S, Dixon-Woods M, Taub M, Habiba M. Patients' perceptions of written consent: questionnaire study. *Br Med J*. 2006;333:528–530.
29. Kocarnik JM. Disclosing controversial risk in informed consent: how serious is serious? *Am J of Bioeth*. 2014;14:13–14.
30. Berman L, Dardik A, Bradley EH, Gusberg RJ, Fraenkel L. Informed consent for abdominal aortic aneurysm repair: assessing variations in surgeon opinion through a national survey. *J Vasc Surg*. 2008;47:287–295.
31. Mishra PK, Ozalp F, Gardner RS, Arangannal A, Munday A. Informed consent in cardiac surgery: is it truly informed? *J Cardiovasc Med (Hagerstown)*. 2006;7:675–681.
32. Vohra HA, Ledsham J, Vohra H, Patel RL. Issues concerning consent in patients undergoing cardiac surgery—the need for patient-directed improvements: a UK perspective. *Cardiovasc Surg*. 2003;11:64–69.
33. Lee Char SJ, Hills NK, Lo B, Kirkwood KS. Informed consent for innovative surgery: a survey of patients and surgeons. *Surgery*. 2013;153(4):473–480.
34. Pleat JM, Dunkin CS, Davies CE, Ripley RM, Tyler MP. Prospective survey of factors affecting risk discussion during consent in a surgical specialty. *Br J Surg*. 2004;91:1377–1380.
35. Mc Gaughey I. Informed consent and knee arthroscopies: an evaluation of patient understanding and satisfaction. *Knee*. 2004;11:237–242.
36. Brewster DC, Cronenwett JL, Hallett Jr JW, Johnston KW, Krupski WC, Matsumura JS. Guidelines for the treatment of abdominal aortic aneurysms. Report of a subcommittee of the joint council of the american association for vascular surgery and society for vascular surgery. *J Vasc Surg*. 2003;37:1106–1117.
37. Ezeome ER, Marshall PA. Informed consent practices in Nigeria. *Dev World Bioeth*. 2009;9:138–148.
38. Krizova E, Simek J. Theory and practice of informed consent in the Czech Republic. *J Med Ethics*. 2007;33(5):273–277.
39. Knepp MM. Personality, sex of participant, and face-to-face interaction affect reading of informed consent forms. *Psychol Rep*. 2014;114(1):297–313.