PERCEPTION AND KNOWLEDGE OF PATIENT'S TOWARDS INFORMED CONSENT ON SURGICAL PROCEDURES IN TERTIARY TEACHING HOSPITAL, ADDIS ABABA, ETHIOPIA 2024 BY ENDALE ASCHENAKI

by Endale Aschenaki

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COLLEGE OF HEALTH SCIENCE SCHOOL OF NURSING & MIDWIFERY PERIOPERATIVE & CARDIOTHORACIC GRADUATE PROGRAM

PERCEPTION AND KNOWLEDGE OF PATIENT'S TOWARDS INFORMED CONSENT ON SURGICAL PROCEDURES

IN TERTIARY TEACHING HOSPITAL, ADDIS ABABA, ETHIOPIA 2024G.C

BY ENDALE ASCHENAKI (BSC)

Advisor: Mr. Tigistu Gebreyohannies (Ass. Professor).

A THESIS TO BE SUBMITTED TO THE DEPARTMENT OF NURSING SCHOOL OF NURSING AND MIDWIFERY COLLEGE OF HEALTH SCIENCES ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTERS OF SCIENCE IN PERIOPERATIVE AND CARDIOTHORACIC NURSING

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MASTER OF SCIENCE RESEARCH PROJECT SUBMISSION FORM

Name of investigator	**Mr. Endale Aschenaki (BSc)**
Name of Advisor(s)	**1. MR. TIGISTU GEBRE YOHANNIS (ASS.PROF).** **2. MR. BOKA DHUGASA (MSN)**
Full title of the research project	**PERCEPTION &KNOWLEDGE OF PATIENT'S TOWARDS INFORMED CONSENT ON SURGICAL PROCEDURES**
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Address of investigator	**Endale Aschenaki (BSc)** **0920318412 E-mail: endaleaschenaki7@gmail.com.**

APPROVAL SHEET

ADDS ABABA UNIVERSITY

COLLEGE HEALTH SCIENCE SCHOOL OF ALLIED SCIENCES DEPARTMENT OF NURSING AND MIDWIFERY

I, the undersigned MSc student, declare that I have submitted my original work on the title Perception and Knowledge of Patients towards Informed Consent on Surgical Procedures in a tertiary teaching hospital, Addis Ababa, Ethiopia 2024G for the examination.

Submitted by:

_____	_____	_____
Name of student	**Signature**	**Date**

This thesis work has been submitted for examination with my approval as an advisor.

Approved by:

1. _____	_____	_____
Name of Major Advisor	**Signature**	**Date**

2. _____	_____	_____
Name of Co-Advisor	**Signature**	**Date**

STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis, and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis.

This thesis is submitted in partial fulfillment of the requirement for a graduate degree from Addis Ababa University at the College of Health Sciences, School of Allied Health Sciences Department of Nursing and Midwifery. The thesis is deposited in the Addis Ababa University Digital Library and is made available to the local, national, and international scientific community. I solemnly declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma, or certificate.

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Name: _____Signature: _____Date: _____

RESEARCH ADVISORS:

_____	_____	_____	_____
NAME	RANK	SIGNATURE	DATE
_____	_____	_____	_____
NAME	RANK	SIGNATURE	DATE

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Acronym	
ACS	American Cancer Society
APA	American Psychological Association
ECOMR	Ethiopian Council of Ministers Regulation
ECSAJ	East Central Southern African Journal
ENT	Ear, Nose, Neck, Tongue
FMOH	Federal Ministry of Health
HBM	Health Belief Model
HCW	Health Care Worker
IRB	Institutional Review Board
KAP	Knowledge and Perception
OR	Operation Room/Theatre
PI	Principal Investigator
SIC	Surgical Informed Consent
SoM	School of Medicine
SPHMMC	St. Paul's Medical Millennium College
TASH	Tikur Anbessa Specialized Hospital
WMA	World Medical Association
WW II	World War Two
AML	Above Mean Level
BML	Below Mean Level

Table of Contents

SUMMARY

Background: Surgical Informed Consent (SIC)- is a process of communication between the client and health care provider that often leads to agreement or permission for care, treatment, or services. The aim was to assess the knowledge, perception and associated factors of informed consent among surgical patients.

Methods: A valid standardized interviewer-administered data collection instrument was used to gather data from participants.

Data was entered and analyzed by using Excel word processing, Epi-data version 3.1, and SPSS version 26. Descriptive statistics was used to summarize participants characteristics and linear regression analysis was employed to examine the association between the independent and the outcome variable. The level of Significance was determined at P< 0.05.

Result: A total of 440, participants with a response rate of 100%, were interviewed. Of the total, 222 patients (50.5%) demonstrated good knowledge with a mean level of 1.668 +0.155 SD; and median of 1.71 more than half of 228 (51.8%) patients reported a low level of perceptions about informed consent and 212 (48.2%) had above the mean level 2.55 + 0.17 SD; 2.54 median. There was a statistically significant negative association between patient knowledge and perception of patients toward informed consent for surgical procedures 0.000 (-0.297- -0.131) 95%CI. knowledge vs residency had a significance of 0.001 (r= -0.235, -0.085- -0.023) 95% CI weak negative correlation and knowledge vs specialty 0.000 (0.005-0.016) 95% CI correlated at 0.05 level. However, there is a negative weak correlation between patient understanding and perspective of informed consent for surgical operations and their degree of education (r= -0.049).

Std. residual of residual statistics of -3.519 minimum and maximum 2.253 regression linear value.

Conclusion: This study showed that low level of patients' perceptions and bits of knowledge regarding informed consent. Additionally, a link between patient knowledge and their perspective of informed consent was found, with patients with low levels of education having a favorable view of it.

Keywords: informed consent; knowledge, perception, surgery, surgical patients, educational status.

1. INTRODUCTION

1.1. Background

Surgical Informed Consent (SIC)- is a process of communication between the client and health care provider that often leads to agreement or permission for care, treatment, or services, in which all adult patients are mentally able to make their own decisions and refuse(Sanchez-Sweatman, 1993) . it is an ongoing process of communication that continues throughout preoperative, intraoperative, and postoperative treatment (Bernat and Peterson, 2006).

Medical practice has been guided by ethical principles for centuries, it was only in the 20th century that globally accepted guidelines were produced. Its founding principles were developed in Egyptian, Greek, and Roman civilizations where documents have been found to show how doctors' interventions had to be agreed upon by patients (Nijhawan *et al.*, 2013).

In 1981, the World Medical Association Declaration of Lisbon published the first draft of the WMA declaration. In 2015 this declaration was updated and highlights the duty of surgeons and physicians to ensure autonomy and justice for patients(World Medical Association, 2015). The patient has the right to the information that is necessary to make his/her decisions and the right to give or withhold consent to any diagnostic procedure or therapy. Patients' autonomy should always be respected to respect the patients' rights as an individual but also to make decisions that may affect their lives. It should be noted that one way to respect autonomy is by respecting individuals' rights (Wismayer, 2022).

Nowadays, globally informed consent guidelines and laws studied in the United Kingdom, Australia, New Zealand, Canada, and the United States of America, have been a trend towards a more patient-focused approach. Surgeons are aware of the guidance and legal cases so that they can inform patients fully, and prevent legal problems if outdated practices are followed(McCormack, Gulati and Mangwani, 2018).

Notwithstanding the constraints in a developing country, informed consent is an ethical and legal requirement for research involving human participants, particularly in Africa, the population has low levels of literacy and education, so they have low knowledge and perception of informed consent (Minnies *et al.*, 2008).

Some works of literature stated that patients had poor knowledge and perception about the surgical informed consent process and they had to be informed of the reason for the operation, the success of the operation, alternatives of the treatment, what would happen during the operation, for how much the operation would take, precautions after the operation and information on post-treatment/post-operative/ care and free and willingness of the overall consent before consent is signed, further regulations are based on the western guidelines, which do not necessarily reflect the requirements of the researchers country, the guidelines should be based on complex factors such as culture, level of education, demographics and risks involved during the study (Nijhawan *et al.*, 2013).

Nowadays surgeons are expected to ensure that their patients understand the clinical information given to them to the best of their capacity and then voluntarily authorize the procedure(Dunin De Skrzynno and Di Maggio, 2018). Surgery is an invasive practice with a higher intensity and frequency of association risks and to be role models for their students, surgeons should be well grounded in professional and ethical practice, so best surgical informed practice must imply with the country's consent form guidelines in university tertiary teaching hospitals like in Tikur Anbessa hospital.

According to prior research, patients' comprehension and perceptions of the surgical informed consent process are limited and poor in Ethiopia(Lemmu *et al.*, 2020).

In most setups where surgical services are being provided, most components of informed consent are not always complete. In Ethiopia, informed consent is a legally required procedure for medical or surgical operations; it stated that medical service may not be provided without obtaining the patient's informed consent under the Ethiopian Council of Minister's Regulation 299/2013, article 52 (FDRE, 2014). However, it is not fulfilled in the majority of surgical centers. Therefore, this study outcome is expected to address the majority of surgical centers, enlighten the health care policymakers about any required modification of the current informed consent process to fit in patients' rights, and intended to assess the patient knowledge and perception towards informed consent for surgical procedure in Ethiopian Tertiary teaching hospitals, TASH & SPHMMC 2023 G.c

1.2. Statement of the Problem

In Tertiary teaching hospitals in Addis, Ababa, Ethiopia; the researcher has realized a poor perception and limited knowledge regarding surgical informed consent among patients during the clinical practice as the patients sign the informed consent as a medical obligation for surgery and thought that the decision making regarding their treatment is the physician deal. There is no documented evidence regarding this issue. However, in other countries, studies have been done to show the magnitude of the problem.

Informed consent during surgical or clinical practice is a medical obligation for surgery but the surgical team neglects it and patients think that the decision-making regarding their treatment is by the physicians or surgical team deals, so they do not see consent forms as important (Felix, 2017). Patient and surgical teams have lack of knowledge of the legalities of informed consent(Alfred P. Minei, Rachelyn Ann S. Araña and Ronald R. Roldan Jr., 2018).

However, in other countries, studies have been done to show the magnitude of the problem. A study conducted in India revealed a great misconception and perception of patients towards surgical informed consent. Many of the patients believed that they were not allowed to withdraw after signing the consent and did not believe that detailed explanations were important (Bhardwaj *et al.*, 2020).

Thereafter, informed consent for surgery is expected to be more detailed as compared to general medical care and the appropriate pre-operative counseling during informed consent. Informed consent will not only help to strengthen the patient-doctor relationship but, also protect the doctor against medico-legal risks(Kilmer, 2010).

There is a lack of documented evidence in Ethiopia regarding the issue of informed consent, which makes it difficult for patients to make decisions for themselves. In Ethiopian hospitals, there is a lack of awareness and understanding of the quality of surgical informed consent (Chane W, 2020).

If this situation persists, the quality of surgery will decline, patients won't be able to obtain their legal rights, and they will feel helpless and hopeless. As a result, preoperative expectations must be better managed, patient satisfaction must be raised and informed consent needs improved information on the surgical procedure process for patients, and training needs yearly for the surgical team about the informed consent process and current adequate consent process needs a revisit (Lemmu *et al.*, 2020). Therefore, this study assessed patient's knowledge and perception towards informed consent for surgical procedures in an Ethiopian tertiary teaching hospital, Addis Ababa, Ethiopia 2024 G.c

1.3. Significance of the Study

This study is significant in practice because it will improve the surgical informed consent process by highlighting the patient's roles and responsibilities in the informed consent process. As an education matter, this study will help students, nurses, anesthesia, medical, and other health care providers to learn evidence-based practice in surgical procedures and to recognize surgical informed consent as an autonomous action from the patient. Legal issues emphasized/raised in Ethiopian countries in private and governmental hospitals, clinics, or health care centers will get answered on time.

In research, the data of this study will be used by other health researchers to conduct their studies therefore the cost of their study will be reduced. This study will help to establish the guidelines on informed consent for surgery. This study will be used by the administration and Ministry of Health to establish a surgical informed consent policy and adhere to good clinical practice in African and Ethiopian contexts.

2. LITERATURE REVIEW

2.1. Theoretical Overview

The patient's permission to undergo a medical procedure is the consequence of informed consent, which is a legal and ethical need for physicians to explain to the patient. It is used as a safety tool for the patient and the surgical team(Agu *et al.*, 2014). Legal and ethical principles are the foundation of informed consent (Horton, 2002). The deontological and consequentialist theories explain the moral foundation of informed consent. According to the deontological principle, which Emanuel Kant formulated in the eighteenth century, all doctors should act in the same manner when confronted with the same circumstance or conduct. The consequentialism hypothesis, however, held that a procedure's difficulties determine whether it is correct or incorrect (Martin, 2015).

In the eighteenth century, when a surgeon was charged with performing treatments without a patient's agreement in England, the legal foundation for informed consent was laid (Jameson and Al-Tarawneh, 2022).

The informed consent process starts with an introduction, during which the doctor looks for a peaceful setting for counseling and explains the procedure to the patient, while, the second phase is explanation, in which the doctor gives the patient pertinent information in language they can understand, and the third part is comprehension, in which the doctor determines whether the patient has understood by asking questions or utilizing the teach-back method. The final step is for the patient to ask questions, who then offer consent and signs a consent paper for verification once the doctor has given them time to read it (Tamire and Tesfaw, 2022).

An essential component of patient and surgical team, safety is the significance of informed consent. It demonstrates the patient's active participation in his or her therapy, which is important because

patient-centered care should make the patient educated and accountable for the procedure. When the surgical team is being sued, informed consent can be used as evidence in court(Kinnersley *et al.*, 2011).

2.2. Empirical Overview

2.2.1. Knowledge of patients with regards to informed consent:

A study, which was carried out in India, revealed that patients had little knowledge of informed consent; 75.0% of them believed, incorrectly, that the physician's obligation to obtain the patient's consent is one of law, and 68.8% believed that consent gives the patient the right to some form of compensation. Aside from that, only 17% of patients reported having a poor understanding of what was explained to them during the informed consent process, while 33% of patients reported having an unsatisfactory understanding. Additionally, 63.6% of patients don't care about the specifics of the procedure, 69.2% let their doctor decide their course of treatment and don't require a thorough explanation, and 11.6% prefer to make the final decision themselves. However, the level of knowledge was 44.6% for illiterate patients, 44.6% for those who had only received an elementary education, and 68.2% for educated.(Singh *et al.*, 2012).

According to a study conducted in central Saudi Arabia, 48% of patients believed that by signing the consent form, the surgery would not be performed, and 42% believed that by refusing to sign, their relationship with their doctor would be broken (Abolfotouh and Adlan, 2012).

In a previous study at SPHMMC Ethiopia, 336 (87.3%) of the patients signed consent forms knowing why they were having surgery, 160 (41.6%) with less awareness of the type of operation, 69 (17.9%) with knowledge of its complications, and 153 (39.7%) with knowledge of alternatives to surgery. Overall, only 40 (10.5%) were satisfactory, and 94 (24.4%) were satisfactory. 1/3rd of

199, 133 (34.5%) had poor knowledge regarding SIC, 52 (40%) signed SIC and undergone surgery in the past (Lemmu *et al.*, 2020).

2.2.2. Perceptions of patients towards informed consent for surgical procedures:

According to a Saudi Arabian study on patients' perceptions of the value of clinical informed consent, 65% of patients believed that having this information at hand makes it easier for them to make their own decisions(Hammami *et al.*, 2014). According to the study, men and women had different ideas about informed consent; while women thought it was a way of revealing truths, males thought it gave patients the freedom to make their own decisions (Hammami *et al.*, 2014).

According to a study done in Uganda, patients had a negative perception of informed consent because they were unaware of the most important component, shared decision-making, and more than 20% of the participants expressed dissatisfaction with the explanations provided by the doctor during the informed consent process. Many patients have different ideas about what constitutes informed consent, and many people have surgery without knowing who the surgeon is or why they are having it. Improved patient involvement in informed decision-making is required, and doctors' ongoing education can help them do this (Ochieng *et al.*, 2015).

According to a prior study at SPHMMH in Ethiopia's capital city of Addis Ababa, roughly 59.6% of post-surgical patients said that the consent form did not make them aware of the operation's risks during the consent process, when they evaluated this outcome in light of another research, with a 95% confidence interval of (59.4, 66.3) (Yesuf *et al.*, 2019).

2.2.3. Studies on the relationship between perceptions and knowledge regarding informed consent of surgical patient

Hana Gebrehiwot and colleagues conducted a study at Wollo University College of Medicine and Health Sciences. The results showed that rural residence (AOR 3.71; 95% CI: 1.94-7.07), being widowed and divorced (AOR 3.85; 95% CI: 1.83-8.08), not being able to read and write, and having a language of written informed consent other than one's mother tongue (AOR 4.196) was all 1.31–4.24), and poor knowledge of surgical informed consent (AOR ¬ 3.05; 95% CI: 1.56–5.97) were significantly associated with poor perception of surgical informed consent (Gebrehiwot *et al.*, 2022).

According to research done in three villages in south-eastern Nigeria, replies ranged from the "philosophical" (leaving everything to God) to the seemingly "logical" (putting all of one's faith in one's doctor's expertise over a procedure). However, it should be noted that among those with formal education, tertiary, 30 (36.1%); secondary, 80 (20.1%); primary, 14 (24.1%) as opposed to those without 7 (10.8%), believe in the doctor's thorough knowledge of the surgery was also cited as a factor more frequently. This distinction was statistically significant (P 0.01).

The individuals without a formal education had the greatest difficulty understanding the process. Across all education cadres, a large majority of respondents provided justifications for deferring to the decision-maker that weren't included in the list above (Agu *et al.*, 2014).

Nurhusien Nuru Yesuf and his team's investigation at Gondar University Comprehensive and Specialized Hospital in Ethiopia also supported the existence of a strong correlation between patient knowledge and their prior surgical experiences. According to this finding, patients who had prior surgical history were almost twice as likely to have good knowledge compared to those who didn't [AOR=2.2; 95%CI (1.39, 6.42); p=0.005]. The cause may be related to preoperative health instruction during their prior surgery. This finding contrasted with a study by Kalala Tshimanga conducted in South Africa, where participants' prior surgical experiences did not provide an advantage over those who did not in terms of patients' understanding of informed consent. Patients undergoing surgery might not have received informed consent instructions before the procedure (Yesuf *et al.*, 2019).

The study found that urban patients were 2.07 [AOR=2.07;95%CI (1.06,4.04); p=0.033] times more likely to have a favorable perception of surgical informed consent than patients undergoing surgery in a rural context. This study's findings also showed a strong relationship between the participants' educational status and how patients perceived their ability to give informed consent for surgery (Yesuf *et al.*, 2019).

Another element that influences patients' perceptions of surgical informed consent is the type of procedure. Based on these findings, orthopedic patients had 91% lower odds of having a positive perception of surgical informed consent [AOR=0.09; 95% CI (0.03, 0.32); p=0.000] than ophthalmologic surgical patients. It might be because preoperative health instruction was different. This result was in line with research conducted in Nigeria by Sulaiman A. et al.

The type of surgery and patients' perceptions of surgical informed consent had a statistically significant relationship (p=0.006). The above finding, however, diverged with investigations conducted in Jerusalem, Israel by Brezis M. et al (Yesuf *et al.*, 2019).

Mbonera F. et al. indicated in Rwanda that there was no variation in the patient's perception of the various surgical specialties. The outcome of this research nevertheless indicated a substantial relationship between the HCW profession from which the patient had obtained informed permission and patients' perceptions of SIC (surgical informed consent). Based on this data, patients who received SIC treatment from intern practitioners were 55% less likely [AOR=0.45;95%CI (0.26,0.96); p=0.024] to have a positive opinion of SIC than patients who received SIC treatment from physicians (Teshome *et al.*, 2018). Forty-six percent (46.9%) stated that their relatives can sign the consent form on their behalf and (43.5%) of patients believed that the operation cannot take place without informed consent. These results were different from Hammami et al where nearly all participants (95.7%) were aware that their next of kin could sign on their behalf. The results of this study revealed that there is a significant weak positive correlation between patient's knowledge and perception of patients towards informed consent for surgical procedures, (r = 0.487), (-1≤ r ≤1, p=0.00), (83%) had low knowledge, 12% moderate and only 5% had a high level of knowledge, (23%) had low perception, 50% moderate and 31% had a high level of perception towards informed consent for surgical procedures. knowledge contributing variance of 23.7% (R Square=0.237). This means that as the patient's knowledge increases the perception also increases toward informed consent for surgical procedures (Mbonera and Chironda, 2018).

Surgical informed consent in obstetric and gynecologic surgeries: experience from a comprehensive teaching hospital in Southern Ethiopia, 40% of respondents were aged between 25 and 29 years (M = 28.2; SD = 7.9). Nearly a quarter (22.6%) had no formal education, while 20.9% have attended only primary school. Nearly all (92.2%) of the women involved in this study were married and more than half (53%) were housewives. The average monthly income of the respondents was 3690.7 Birr, A majority of the women (70.4%) involved in this study were referred from other health facilities for service. More than 1/3 (36.6%) of respondents do not know the role of the person who conducted the SIC counseling session. The remaining participants reported having received SIC counseling from resident physicians (27.3%), nurse-midwives (21.3%), or

obstetrician-gynecologists (18.4%), A slight majority of study participants (54.3%) had undergone emergency surgical procedures, while the rest received elective procedures, More than 2/3 (70.4%) of women reported to have received SIC counseling immediately before their surgery, while 8.8% (2% among elective surgical clients and 14.8% among emergency surgical clients; $p < 0.001$) reported to have received counseling on the operation table. Meanwhile, 12% of women reported that they had received counseling 1 day before their surgery, and 8.8% reported having received counseling on the same day, The odds of receiving SIC on the operation table rather than receiving it 1 day before the date of surgery was lower among clients who had an elective surgery than those who had an emergency surgery service, almost all (99.6%) of the respondents or their family members were asked to provide written consent, and all agreed. Most women (87%) reported that they received information about the indication(s) for undergoing the surgical procedure. Only 14.3% of the respondents were informed about the expected duration of their surgery. Nearly three-quarters (73.9%) of women were not informed about possible alternatives to surgical intervention; 71.4% were among elective and 76% among emergency clients ($p = 0.09$). Few (11.3%) respondents were informed about the type of anesthesia to be administered. Only 3 (1.3%) women reported being given counseling aids to help them make decisions about their surgery; receipt of counseling aids did not vary with clients' educational status ($p = 0.30$). Most (87.4%) (OR: 0.02; 95% CI: 0.01–0.10), The multivariate logistic regression analysis revealed that none of the sociodemographic and service-related characteristics of clients, except the timing of counseling, were found to be associated with receipt of the minimum (at least six) components of SIC(Teshome *et al.*, 2018).

There are 369 responses, ranging in age from 18 to 82 (mean: 44.1 17.7 years). Of these, 207 (56.1%) are under 45, 173 (46.9%) are women, and 279 (75.6%) have at least a secondary education. They are predominantly Igbo people living in Nigeria's south-eastern region, where 99.7% of them are Nigerians, in general, 78.3% of the 369 respondents correctly identified the disease condition, 63.7% correctly identified the planned surgery, and only 21.7% identified the risks associated with the planned surgery. Seventy-one percent (71.0%) of those under 45 years old (n = 207) 63.6% of those under 45 years old (n = 162), 74.0% of females (n = 173), and 62.2% of males (n = 196), 50.0% those with no or primary level of formal education (n = 90) and 73.5% of those with the post-primary level of formal education (n = 279) affirmed that their concerns were satisfactorily addressed (Nnabugwu *et al.*, 2017).

2.2.4. CONCEPTUAL FRAMEWORK FOR SURGICAL INFORMED CONSENT

According to the health belief model (HBM) (Abraham and Sheeran, 2016), the relationship arrows in the above diagram demonstrate how independent variables, such as socio-demographic factors, clinical & service factors, ethical and legal factors (Hall, Prochazka and Fink, 2012), typically have an impact on knowledge and perception. Perception can affect knowledge because it is the source of knowledge and good knowledge results from good perception vise verse.

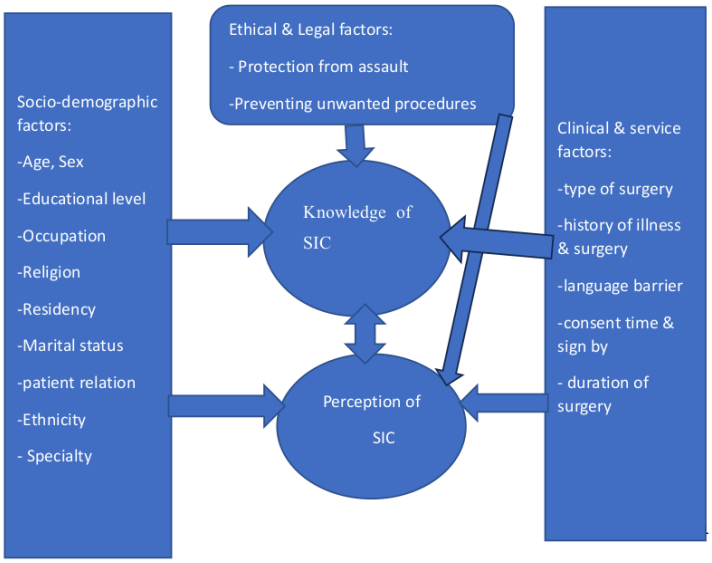

Figure 1: Conceptual framework for informed consent process

3. OBJECTIVES OF THE STUDY

3.1. MAIN OBJECTIVE

The aim the study was to assessed the surgical patient's perception,s and knowledge and associatedfactors towards informed consent for surgical procedures at Tertiary Teaching Hospitals:, Tikur Anbessa Specialized Hospital, and St. Paul Millennium Medical College, Addis Ababa, Ethiopia 2023G.c.

3.2. SPECIFIC OBJECTIVE

1. To determine the Knowledge level of surgical informed consent the among surgical patients's surgical informed consent was determined, in Tertiary Teaching Hospitals, Tikur Anbessa Specialized Hospital, and Sent Paul Millennium Medical College in, Addis Ababa, Ethiopia 2023 G.c
2. To explore Surgical patients' perceptions towards informed consent were explored, in Tertiary teaching hospitals, Tikur Anbessa Specialized Hospital, and Sent Paul Millennium Medical College, in Addis Ababa, Ethiopia 2023 G.c
3. To identify Ffactors associated with surgical patients' knowledge towards informed consent were identified, in Tertiary Teaching Hospitals, Tikur Anbessa Specialized Hospital, and Sent Paul Millennium Medical College ,in Addis Ababa, Ethiopia 2023 G.c
4. To identify Ffactors associated with surgical patients' perception towards informed consent were identified, in Tertiary Teaching Hospitals, Tikur Anbessa Specialized Hospital, and Sent Paul Millennium Medical College, in Addis Ababa, Ethiopia 2023 G.c

4. METHODOLOGIES AND MATERIALS

4.1. Research Area and Period

The study was conducted in Tertiary teaching hospitals at, TASH and SPHMMC, from March 8 to April 15/2023 G.c

The chosen hospitals were purposefully chosen with the expectation that there would be a large patient flow, more specializations, and specialists in these study settings. Federal hospitals.

Dedicated to delivering healthcare services, the TASH has 115 additional health professionals, 627nurses, and 200 doctors, 370,000-400,000 patients annually received and cared for in the hospital by the many departments, faculties, and residents undergoing specialist training in the School of Medicine. To support hospital operations, the hospital employs 950 administrative staff members on a permanent and contract basis. Currently from 850 beds, 181 beds are for surgical, 169 specialists, 65 non-teaching doctors, 138 are OR nurses (62 major OR, 36 orthopedic, 16 labor ward, 18emergency OR and 8 minor OR) with 2perfussionist and 36 anesthetists (major OR nursing office, TASH Human resource office). There are 20 significant operating rooms, with 8698 (54.1%) annual surgical admissions, 4706 (54.1%) elective admissions, and 3992 (45.9%) were emergency admissions in basin 2018G.c. With adequate equipment and skilled staff, the emergency room sees about 80,000 patients annually.

This hospital receives patients from various surgical specialties and catchment areas, in the daily /24-hour work schedule, and serves as a training facility for undergraduate and postgraduate medical students, dentists, nurses, midwives, pharmacists, and others who shoulder the health problems of the community and the country at large (Hospital and Ababa, 2018).

St. Paul's Millennium Medical College (SPHMMC), has more than 2800 clinical, academic administrative, and support staff that provide medical specialty services to patients who are referred from all over the country, teaching medicine and nursing students and doing basic and applied research. While the inpatient capacity is more than 700 beds, the college sees an average of 1200 emergency and outpatient clients daily. The Department of Surgery is staffed with more

than thirty (30) surgeons from different specialties. On average 200 to 250 adult patients are operated every month (9). The study period is from March 10 to April 10/2023 G.C

4.2. Research design

Institutional-based cross-sectional, study designs were utilized to collect data from surgical patients at a single point in time and describe the patient's associations with knowledge and perception on surgical informed consent.

4.3. Study population

All adult surgical patients who were signed and postoperative patients would make up the entire study population at, Tertiary Teaching Hospital, TASH, and SPMMCH Addis Ababa, Ethiopian 2023 G.c

4.3.1. Inclusion criteria

All adults aged 18 years old and above admitted to a surgical ward (General surgery, Orthopedic, Obstetrics and Gynecology, Open and Indo-urology, ENT, Chest, labor ward, and Neurology wards who all performed elective (planned) surgery and who had willingness for interview questionnaires was included.

4.3.2. Exclusion criteria

Patients who underwent emergency surgery, were critically ill and mentally incompetent, or a delayed surgery; painful patients, and patients with postoperative complications were excluded.

4.4. Sampling Strategy

For each of the two hospitals, the sample size was allocated by using probability proportionate to the average monthly major surgical client flow (N1), This will be n1=392 for TASH during the actual data collection period, take a representative entry from the registration book and n1= 200 for SPMMCH(9). Then, based on strata that divide surgical patients into different surgical specialties (ENT, Cardiac/chest, Vascular, Neurology, General Surgery, Gyne and Obs, Open and Endo urology, Labor ward, and Orthopedics).

The study units were chosen by using proportionate and simple random sampling techniques, which were used to identify each stratum in each post-surgical patient. According to their sequence

of operations timetable for each room over the course of a month, study participants were interviewed every day during the study collection, including on weekends.

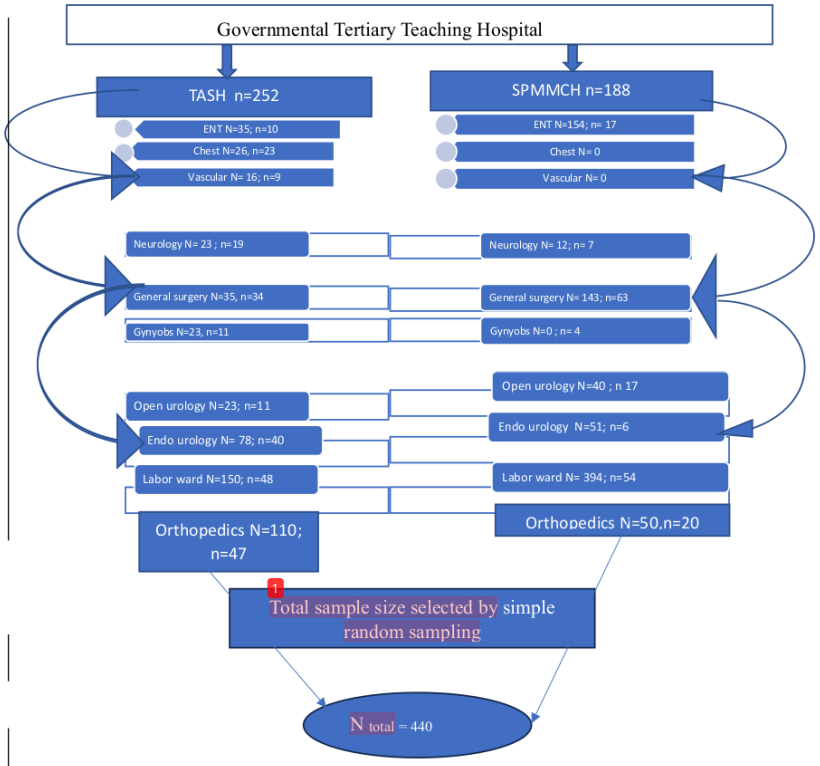

Figure 2. Schematic representation of Sampling technique showing the number of each selected Tertiary Teaching Hospital, in Addis, Ababa, Ethiopia 2023.

4.5. Sample size

The actual sample size for the study was determined by using a single population proportion formula taking a 50% chance proportion to maximize the sample size(Lemmu *et al.*, 2020);with a 95% confidence interval (1.96); α=0.05;5% marginal error area of (5%). Fisher's (1998) formula of N = z2pq/d2 where

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N = (Z ά/2)2 x p (1-p) /d^2; Therefore, n=384.16

N stands for the minimum sample size; Z is the standard normal deviate set at 95% and the confidence limit is at 1.96

P is the prevalence of surgical procedures that required informed consent equal to 0.5 (50%)

q = 1-p (complementary probability) =1-0.5=0.5

d = is the degree of precision (the margin of error) usually at 5% =0.05

Therefore, N = (1.96)2 × 0.5 × 0.5/ (0.05*0.05), = 3.8416 × 0.25/ 0.0025 = 0.9604/0.0025

= 384.16

The proposed study population number is less than 10, 000, so the following formula was applied for the research proposed: - N f =n/1+ (n/N)

Where; N f is the desired sample for a population less than 10, 000

N=desired sample size for a population greater than 10, 000

N= is an estimate of the population size equal to 392.14

Therefore, the desired sample size is 384/1+ (384/392.14)

N f= 384/ (1+0.979591), N f =384/1.979591, N f = 194

Reports on East Central Southern African Journal, on study pattern of surgical admission to Tikur Anbessa Tertiary and Specialized Hospital (TASH) information and statistics center, shows that

from a summary of 8698 (54.1%) yearly surgical admission, 4706 (54.1%) of the surgical admissions were admitted on an elective basis, whereas the rest 3992 (45.9%) were emergency admissions in 2018G.c (Hospital and Ababa, 2018).

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According to the study report, this value is evenly distributed in months; on average 392.14(N) surgical patients will undergo elective surgery in TASH, Hospital within one month.

As N= 392.14, which is <10,000, then by applying reduction formula, N f=n/[1+(n/N)] =

N f = 384/ (1+384/392.14) =194; by adding a 10% (38) non-response rate the final sample size became 232. The researcher applied a 20% attrition rate to calculate the sample size to make it 251. Nineteen more participants were added to improve the power and the validity of the study. Therefore, the sample size for this study becomes 251 by adding 189 SPMMCH, 440 patients per month.

4.6. Variables

Dependent Variables

Knowledge of informed consent

Perception towards informed consent

Independent Variables

Perception towards informed consent vs Knowledge towards informed consent

Socio-demographic variables- age; sex; place of residence; educational level; religion, occupation, marital status, ethnicity; and type of surgery. All these exposure variables are selected based on the literature review. All these variables are used to determine the association between knowledge towards informed consent.

Ethical and legal factors: law enforcement, Protection from assault, preventing unwanted procedures, Protecting autonomous decision-making.

Clinical & service factors: type of surgery, history of illness & history of surgery, language barrier, consent time & sign by duration of surgery.

4.7. Operational Definition

Knowledge: is the fact or condition of knowing something with familiarity gained through experience or association, the fact or condition of being aware of something, the range of one's information or understanding.

The response was rated on a mean level whereby the most favorable answer got a higher score and the less favorable a lower score and the overall score was calculated. The minimum possible total score for the level of knowledge is (1.14) and the maximum possible score is (2.00). Dividing the attained score on this section by the maximum possible attainable score (2.00) and multiplying by a hundred came up with (49.5%) below mean and 50.5% above mean percentage calculate knowledge of informed consent with surgical procedure 218 and 222 respectively.

Perception: perception reflects the patient's attitudes, behaviors, expectations, motivations, and interest factors about informed consent whereas for perception, the minimum possible total score for the level of perception was (2.08) and the maximum possible score was (2.92). Dividing the attained score on this section by the maximum possible attainable score (2.92) and multiplying by a hundred came up with 51.8%) below mean and 48.2% above mean percentage calculated level of perceptions towards informed consent with surgical procedures 228 and 212 respectively.

4.8. Data collection instrument

The structured data collection instrument was adopted from a similar study in the literature review (34), the instrument is open access Likert-scale with three sections:

4.6.1. Section A – demographic data

which captured the personal descriptive data including age, sex, marital status, level of education, religion, occupation, and residential area. This data describes the characteristics of the sample for the study.

4.6.2. Section B- level of knowledge of patients towards informed consent.

The response was rated on the mean level of knowledge 1.668) whereby the most favorable answer got a higher score above the mean and less favorable answers got a lower score below the mean and the overall score was calculated. The minimum (1.14) and maximum (2.00) possible total score for level of knowledge and dividing the attained score on the section by the maximum possible attainable score and multiplying by a hundred was come up with a percentage calculated knowledge of informed consent with surgical procedures. Though absolute Zero and absolute 100

do not exist, as any information was not transparent, there was a certain amount of retention. Independent Knowledge can never be 100 percent, as it also has an impact on previously accumulated information and information-related understanding.

4.6.3. Section C- level of perceptions of patients towards informed consent.

The response was rated on a mean level of perception (2.558), whereby the most favorable answer gets a higher score above the mean and less favorable a lower score below the mean, and the overall score was calculated. The minimum (2.08) and maximum (2.92) possible total score for the level of perception was described. Dividing the attained score on the section by the maximum possible attainable score (2.92) and multiplying by a hundred was come up with a percentage calculated level of perceptions towards informed consent with surgical procedures.

4.9. Validity and Reliability of the research tool

Research Validity and Reliability was ensured by the use of adopted existing data collection instrument (Sulaiman *et al.*, 2015). The reliability coefficient analysis of the research instrument was tested and the instrument measured the concept under the study.

The questionnaire was prepared in the English version and translated to the local language which is Amharic and back to English to maintain its consistency. Data was collected prospectively after surgery but before discharge by the principal and other investigators.

4.10. Data collection Procedure

The principal investigator was taught and certified by SPSS by Nursing and Midwifery school instructors and Dashan bank sponsor and orientation was given for the data collection, two BSc Nurses, one MSc nurse, and one expert for data analysis and data collection respectively. Informed consent was obtained from the postoperative patients, patients were interviewed at their bedside. Data was checked by the principal investigator daily to ensure data completeness.

4.11. Data analysis

Data was collected using an accepted standardized interviewer-administered questionnaire that has been validated beforehand. Excel Word Office and Epi-data 3.1 were used for data entry, and SPSS version 26 was used for analysis. Descriptive statistics was used to analyze data to determine the level of knowledge and perception of patients towards informed consent for surgical procedures

in a Tertiary teaching hospital in Addis Ababa, Ethiopia. Linear regression examined the relationship between the knowledge and perceptions of patients regarding informed consent for surgical procedures in a Tertiary teaching hospital in Addis Ababa, Ethiopia. Regression analysis was used to identify the variance contributed by knowledge towards perceptions of informed consent. The chi-square test was used to find the association between sociographical characteristics and the knowledge and perceptions of patients regarding the issue of informed consent. Data was presented in tables and figures. The level of significance was determined with a p-value <0.05 and 95% CI.

4.12. Ethical Considerations

This study followed ethical review board rules from Addis Ababa University College of Health Science School of Nursing& midwifery Ethical Review Committee and each hospital administrative office. The research proposal was presented to a panel of research experts and was ethically approved by the panel members. It covered the concept of informed consent from participants and got authorization from them without coercion. The beneficence principle where the patient's freedom from harm was applied during data collection. The principle of respect for human dignity such as the right to self-determination and full disclosure was considered in this study. This study adhered to the patient rights which are privacy and confidentiality, respect and dignity, patient safety, and information. Participants were allowed to refuse or withdraw at any stage of the study. The researcher ensured that there were no risks or harms associated with participating in this study. Privacy was maintained throughout the study through the use of ID numbers and careful attention paid to the protection of information. Confidentiality was kept as no names appeared on the interview scheduled guide at any a written statement (consent) was included in the introductory part of the questionnaires that further explains the study purpose and the confidentiality of the research information. All requirements of the guidelines and regulations or declaration of Helsinki were followed.

4.13. Data management

Confidentiality was maintained by not writing the patient's name on the interview schedule guide. The interview schedule guide was kept in a locked cupboard and it will be destroyed after 5 years.

The computer was locked with a password to ensure that electronic row data was kept confidentially

4.14. Dissemination

The researcher will send a copy of the thesis to the CMHS library publication in the national journals and then send the copy of the thesis to the supervisor. Addis Ababa University College of Health Science, and other concerned bodies as a partial fulfillment of the requirement for Perioperative and Cardiothoracic specialty certificate. In addition, the result will be shared with TASH, and also the manuscript of the research will be prepared and submitted to appropriate journals for possible publication and copy to the Library of Health Science, and Department of Nursing and Midwifery and for each individual's specialty at TASH.

5. Result Presentation

5.1. Socio-demographic Characteristics of the Participants.

The study included 440 patients, and descriptive statistics were utilized to evaluate the demographic information displayed in tables. When it comes to sex, there were 259 responses (50.8% women and 181 men (41.1%)). For 165 respondents (37.5%), respondents' ages ranged from 18 to 43; for 163 respondents (37.0%), age 44 to 69; and for 112 respondents (25.5%), above 70 years old. 71 people, or 16.1% of the population, worked as merchants, day laborers, and cleaners; 86 people (19.6%) were jobless; and 134 people (30.5%) were housewives. 381 (86.6% were educated, and 59 (13.4%) of the respondents were illiterate, a total of 358 respondents, 81.4% of whom were married. The residency result shows that 263 (59.8%) were urban and 177 (40.2%) were rural. Depending on ethnicity for surgical informed consent language barrier, 231 (52.5%) were Amara, 156 (35.5%) were Oromo, 2.3% were Tigre, and 9.8% were others (Wolayita, Hadiya, Sidama, Gurage, and Somali).

Table 1.5.2.1. Sociodemographic Characteristics of the Participants

Variables	Category	Frequency	%
Sex	Female	259	58.9
	Male	181	41.1
Age	18-43	165	37.5
	44-69	163	37.0
	70+	112	25.5
Occupation	Housewife	134	30.5
	Self-employed	52	11.8
	Governmental	29	6.6
	Unemployed	86	19.5
	Farmer	50	11.4
	Private	18	4.1
	Others	71	16.1
Education	Illiterate	59	13.4
	Literate	381	86.6
Marital status	Married	358	81.4
	Single	82	18.6
Residency	Rural	177	40.2
	Urban	263	59.8
Religion	Orthodox	242	55.0
	Muslim	118	26.8
	Protestant	64	14.5
	other	16	3.7
Ethnicity	Oromo	156	35.5
	Amara	231	52.5
	Tigre	10	2.3
	Others	43	9.8
Specialty	ENT	27	6.1
	Chest	23	5.2
	Vascular	9	2.0
	Neurosurgery	26	5.9
	General surgery	97	22.0
	Gyny Obs	15	3.4
	Open urology	28	6.4
	Endo urology	46	10.5
	Labor ward	102	23.2
	Orthopedics	67	15.2

5.2. Service-related Characteristics of the Participants.

Most of the 379 patients (86.1) knew the consent form requested to be signed by the health professional; they did not know who must request to sign the consent form. Two hundred twenty-six (45.0%) of the respondents gave consent before the day of surgery and 163 (37.0%) during cloth change. 316 (71.85) strongly agreed on the language barrier.

5.3. Ethical and legal characteristics of the participants.

Out of 440 respondents, 270 (61.4%) disagree on consent form fault prevention. 289 (65.7%) knew a doctor could do anything, and 328 (74.5%) did not know their own decision on their surgery; 65% agreed that surgical informed consent protects the patient's rights.

5.4. Clinical-related characteristics of the Participants.

According to this study's findings, the majority (23.2%) of patients had labor ward surgery, and 97 (22%) had general surgery. Nearly one-fourth of the participants (23.0%) had a previous surgical history. 330 (75.0%) know about surgical informed consent from their history and near patient information (Table 2).

5.5. Patient Knowledge of Informed Consent for Surgical Procedures.

The sample size was 440 and the response rate was 100%; 222 (50.5%) above the mean level of knowledge and 218 (49.5%) below the mean level of knowledge for surgical informed procedures.

All 427 respondents (97.0%) and 13 (3.0%) did not know their procedure cost, and 316 (71.8%) did not know who had performed surgery for them. 379 (86.1%) know surgical informed consent (SIC), implied by the health professions before the day of surgery, and 163 (37.0%) know during cloth change. 394 (89.5%) did not know the duration of surgery, and 405 (92.0%) did not know the alternative way of their surgery. 192 (43.6%) know the postoperative surgery and anesthesia risk; otherwise, 56.4% do not know.

The patient's level of understanding of informed consent for surgical treatments 101 people (23.0%) have had surgery in the past, and 330 people (75.0%) are interested in learning more about surgical informed consent. The majority of 328 (74.5%), however, are aware of their right to know about the procedure they are having and the sort of surgery they are having. 312 (70.9%) did not know the legal requirement of informed consent. 289 (65.7%) people didn't know or think the doctor could handle things without their consent. 320 people (72.7%) are unaware of the extra precautions to be followed following surgery and the unique diet to be taken into consideration, and 248 (56.4%) did not know about post-surgery and anesthesia risks, but 192 (43.6%) do.

The mean was 1.66),0.15529 Std.~~Devation~~, the minimum (1.14), the maximum (2.00); the median (1.714), and the model score 1.71) out of 440.

Table 2.5.2.2. Knowledge Result on Surgical Informed Consent (~~N~~n=440)

Variables	**Frequency (yes)**	**%**
Had Surgery history	101	23.0
Know about SIC	330	75.0
Know the legal requirement	3	0.7
Know the right to know about surgery	328	74.5
Know consent refusal	104	23.6
Know Self-decision right	233	53.0
Know relative can sign on behalf	337	76.6
Know what doctors can/cannot do differently from sign	151	34.3
Know about any special precautions and post-surgery diet	120	27.3
Know the days when to resume working	40	9.1
Know who had made surgery	124	28.2
Know about the risks of surgery and anesthesia gives to.	192	43.6
Know the alternative way of surgery	35	8.0
Knowing the duration of surgery would take	46	10.5
Know the time of SIC and by whom requested		
Before surgery day by doctor	47	10.7
Before by health professional	179	40.7
On cloth change by health Professional	163	37.0
On a table by the doctor	14	3.2
On a table by health profession	37	8.4
After the day of surgery By Doctor	61	13.9
After the day of surgery by health professions	379	86.1
Do not Know the surgery's treatment cost	440	100

5.6. Perception related Result on Informed Consent

In this study, the sample size was 440 and the response rate was 100%; 228 (51.8%) patients had a below-mean level of perception towards informed consent and 212 (48.2%) had an above-mean level of perception for surgical informed procedures.

370 (84.1%) patients perceived that the consent form was unimportant, and 264 (60.0%) disagreed with the consent form clarification of their procedure. 296 (67.3%) believe that if they do not sign the consent, the operation cannot be performed; 130 (29.5%) agreed on consent prevention from fault during surgery; protecting the doctor and hospital; 266 (60.5%) and 99 (22.5%), respectively. 316 (71.8%) perceived that language affects how to understand consent forms during consent signing. The mean was (2.55), the minimum was (2.08), the maximum was (2.92), the median was (2.538), and the mode score was (2.54). The lowest score for perception mean was 2.08 out of 13, and the highest score was 2.92 out of 13. The lowest perception mean score was 228 (51.8%) out of 440 and the highest was 212 (48.2%) out of 440, for informed consent for surgical procedures.

Table 3.5.2.4 Perception Result towards Surgical Informed Consent (n=440).

Variables	Category	Frequency	% ~~Frequency~~
Agree that informed consent is important	Strongly disagree	22	5.0
	Disagree	348	79.1
	Agree	70	15.9
The agreed consent form is to protect the patient's rights	Disagree	71	16.1
	Agree	286	65.0
	Strongly agree	83	18.9
Agree that the consent form made it clear about the procedure	Strongly disagree	3	0.7
	Disagree	264	60.0
	Agree	173	39.3
Agree to that not able to sign the consent form, then the operation cannot take place.	Disagree	30	6.8
	Agree	296	67.3
	Strongly agree	114	25.9
Agree to that by signing the consent form the operation will be preceded	Strongly disagree	1	0.2
	Disagree	24	5.5
	Agree	165	37.5
	Strongly Agree	250	56.8
Agree to that consent form prevents fault	Strongly disagree	40	9.1
	Disagree	270	61.4
	Agree	130	29.5
Agree consent is for a formality	Strongly disagree	338	76.8
	Disagree	102	23.2
Agree that the consent form is to protect the doctors	Strongly disagree	160	36.4
	Disagree	14	3.2
	Agree	266	60.5
Agree that signing the consent to protect the hospital	Strongly disagree	50	11.4
	Disagree	99	22.5
	Agree	291	66.1
Agree informed consent confirms that the operation has been explained	Strongly disagree	4	0.9
	Disagree	307	69.8
	Agree	128	29.1
	Strongly agree	1	0.2
Agree to have the right to change your mind after signing the consent form	Strongly disagree	341	77.5
	Disagree	99	22.5
Agree on the language barrier during the consent sign	Agree	124	28.2
	Strongly agree	316	71.8
Agree to calm and not be anxious	Agree	257	58.4
	Strongly agree	183	41.6

5.7. Predictor of knowledge towards informed consent

Socio-demographic variables such as age, sex, occupation, educational level, marital status, and residency. Thirty percent of variation in knowledge of informed consent can be explained by the model. (R Square =0.29). Keeping constant all other variables in the model, one-unit increase in perception about informed consent decreases knowledge about informed concept by-0.22 (95%CI=-311, -131; P=<.000). The result also showed that, keeping other factors constant being from rural part of the country increased knowledge about informed concept by 0.57 (95%CI= 0.153,0.993, P= .008).

Table 4: Multiple linear regression analysis predicting knowledge of informed consent at TASH.

Variables	**Unit of measurement**	**Unstandardized coefficient**	**Standardized Beta**	**t**	**CI (95%**	**p-value**
Perception	Perception	**-.221**	.225	-4.824	**(-.311, -.131)**	**.000**
	Knowledge	Ref				
Age	18-43	.462	.103	1.635	(-.093, 1.017)	.103
	44-69	-.021	.005	-.079	(-.533 .491)	.937
	>/=70	Ref.	Ref.			
Sex	Male	.023	.005	.093	(-.471 .518)	.926
	Female	Ref.	Ref.			
Occupation	Private	.012	.002	.040	(-.574 .598)	.968
	Government	.231	.049	.831	(-.316, .778)	.407
	Unemployed	Ref.	Ref.			
Educational level	Literate	-.346	.054	-1.164	(-.931, .239)	.245
	Illiterate	Ref.	Ref.			
Marital status	Single	-.094	.017	-.323	(-.665, .477)	.747
	Married	Ref.	Ref.			
Residency	Rural	**.573**	.129	2.680	**(.153, .993)**	**.008**
	Urban	Ref.	Ref.			

5.8. Predictor of perception towards informed consent

Socio-demographic variables such as age, sex, occupation, educational level, marital status, and residency. We also included participants knowledge in the final model. The final model has explained twenty-six percent of variation in knowledge of informed consent can be explained by the model. (R Square =0.26). Keeping constant all other variables in the model, one-unit increase in knowledge about informed consent decreases perception about informed concept by -0.23 (95%CI=-33, -14; P=<.001). The result also showed that, keeping other factors constant being male increased perception about informed concept by 0.54 (95%CI= 0.031,1.04, P= .038).

Table 5: Multiple linear regression analysis predicting perception of informed consent at TASH.

Variables	Unstandardized β	Standardized Beta	t	95% CI for β		p-value
				Lower Bound	Upper Bound	
Knowledge	**-.232**	**-.228**		**-.327**	**-.138**	**<.001**
Age						
18-43	.116	.025	.398	-.455	.687	.691
44-69	-.111	.024	-.415	-.636	.414	.678
>/=70	Ref.					
Sex						
Male	**.535**	**.119**	**2.085**	**.031**	**1.039**	**.038**
Female	Ref.					
Occupation						
Government	.255	.053	.894	-.305	.815	.372
Private	-.315	-.051	-1.033	-.915	.285	.302
Unemployed	Ref.					
Educational level						
Literate	-.107	.016	-.350	-.707	.494	.727
Illiterate	Ref.					
Marital status						
Single	-.098	.017	-.330	-.684	.487	.742
Married	Ref.					
Residency						
Rural	-.287	.064	-1.299	-.720	.147	.195
Urban	Ref.					

6. Discussion

To enable proper decisions and to respect the patient's autonomy and dignity, SIC is intended to sufficiently inform the patient about the procedure to be performed, benefits, alternatives, and any complications [(Alazmi, 2018), (Adisa *et al.*, 2008)]. Additionally, it is an opportunity for the surgical team to build a rapport of transparency and trust with the patient and to foster understanding between the two parties to reduce the likelihood of needless lawsuits in the event of the unexpected. The 2015 Montgomery ruling by the UK Supreme Court established patient-centered care and shared decision-making as the core components of legal consent. Similar to the findings of Leclercq et al. A UK study found that patients had limited understanding of the legal standing of written consent on the dangers associated with surgery (Akkad *et al.*, 2006). This gap may be caused by the study subjects' varying reading levels and the consent procedure, which placed more emphasis on the diagnosis, be in contrast to our study 71% did not well informed.

However, 16% of research participants in the UK thought that it would take away their entitlement to compensation. Compared to our study and other African research, the figure is significantly lower (Ochieng *et al.*, 2015).

According to UK research, 46% of patients stated that the primary objective of the SIC, which is the nearest to ours is protecting hospitals (66.1%) and doctors (60.5%). According to the literature, 8.7% to 20% of patients were unsure as to whether they could withdraw their consent after signing SIC (Ochieng *et al.*, 2015). This is in line with our findings (23.4%), which may be the result of insufficient consent and awareness procedures. Many of our and other participants believed that if they were unable to sign the consent, their relative could do so; (76.6%).

According to an Indian study, SIC confirms to explain surgery by 17%; 69.2% of doctors decided, and 11.6%; self-decision, and in our study 29.1%, 53% (Singh *et al.*, 2012), and 23.4% respectively; to that, the difference was the sample size and education level 68.2% educated and 86.6% ours. Saudi-Arabia study revealed that 48% of respondents believed that; only by signing the operation cannot be proceeded; and 42% refused to sign; surgery could not be done and the pt-doctor-relationship be broken (Abolfotouh and Adlan, 2012). According to Mbonera; the Rwandan study and our study, demonstrated the majority of the subjects knew that SIC was necessary and that it was an obligation to undergo surgery 43.5% and 99.3%. This is primarily related to the culture of surgical treatment in underdeveloped countries, where the patient believes the doctors

make the decisions by 74.5% related to 76.6%.; similar to findings of Leclercq et al (Nnabugwu *et al.*, 2017). This is mainly related to the surgical care culture in developing nations where the patient thinks the doctors decide what to do.

Study shows that in Rwanda; according to Mbonera from 147 respondents 46.9% know a relative can sign on behalf of a patient; relating to ours 76.6% sample size difference. Less understanding was noticed regarding available alternatives to surgery, risks associated with the scheduled procedure, and anesthesia. Literature reported that written information, with good patient education during the consent process, leads to better understanding and postoperative recall. Another study conducted in St. Paul Millennium Medical College revealed that the majority of patients were not told about alternative treatments and potential risks associated with the operation,53 (40%) had signed and undergone surgery in the past, and 69 (17.9%) knew its complications. like our study 92%; 56.4%; and 192 (43.6%) respectively. 316 (71.8%) of our respondents did not know who had done surgery. Many patients have different ideas about what constitutes informed consent, and many people have surgery without knowing who the surgeon is or why they are having it. Improved patient involvement in informed decision-making is required, and doctors' ongoing education can help them do this(Ochieng *et al.*, 2015).

In line with our findings of 28.2%, research from Uganda found that only 22.4 percent of its patients knew the surgeon who performed the treatment(Ochieng *et al.*, 2015). Such lower scores are primarily connected to the patient's understanding of SIC as well as the surgeons' poor technique. This may also be a reflection of the fact that communication skills and bioethics are not taught in our nation's surgical residency program on a formal basis.

The surgical residents in Iran learn these abilities via their professors and senior residents rather than through official education, claim Jarayedi Z and Asghari F. According to a study from Nigeria and Uganda, teaching medical students biological ethics enhances consent procedures(Ochieng *et al.*, 2015). whether 99.3% did not know the legal requirement of SIC; 3 (0.7%) of our patients reported that the SIC was legally required. Studies from Egypt (69.18%), Kuwait (69.9%), India (75%), and the United Kingdom (88%) (Ochieng *et al.*, 2015)have found most of the same results; but different from ours. In a southern Ethiopian study; more than one-third (36.6%) of respondents do not know the role of the person who conducted the SIC counseling session. The remaining participants reported to have received SIC counseling from resident physicians (27.3%), nurse-

midwives (21.3%), or obstetrician-gynecologists (18.4%). Only 14.3% of the respondents were informed about the expected duration of their surgery. Nearly three-quarters (73.9%) of women were not informed about possible alternatives to surgical intervention; 71.4% were among elective and 76% among emergency clients (p = 0.09). Few (11.3%) respondents were informed about the type of anesthesia to be administered and the risk(Teshome *et al.*, 2018). In our study; 379 (86.1%) did not know and they said that health professionals who wear off operation room suet and white gown requested us to sign, before 1 day of surgery and 63 (37%) on cloth change and;47 (10.7%) by doctors before a day of surgery. 394 (89.5%) of our respondent did not know and only 46, 10.5% knew about the expected duration of their surgery. On about possible alternatives they were amazed by us; 92% of respondents did not know the possible surgery alternatives and 43.6% knew the anesthesia to be administered and the risk.

Due to the surgical informed consent perception and knowledge relationship; a study showed that at Wollo University College of Medicine and Health Sciences; (R =3.71; 95% CI: 1.94-7.07), being widowed divorced (R= 3.85; 95% CI: 1.83-8.08), not being able to read and write, and having a language of written informed consent other than one's mother tongue (AOR 4.196) was all 1.31–4.24), and poor knowledge of surgical informed consent (R =3.05; 95% CI: 1.56–5.97) were significantly associated with poor perception of surgical informed consent (Gebrehiwot *et al.*, 2022).

Knowledge vs education toward SIC related; our study revealed that 1.6683±0.15529 and 3.17 ± 1.402SD, knowledge vs specialty and residency (R = 0.224; 95% at CI of (-0.084, -0.025, 0.005, 0.015); p = 0.000 single significant. Unstandardized (Residency B= -0.055 and beta=-0.17, Specialty B= 0.010 and beta= 0.181).

According to research, more than half of consumers and patients believe that the primary goal of SIC is to shield the hospital and the surgeon from legal action.

Strengthens of the study

The strength of this study was that there were no more similar studies done so far in our country, done with our study sample size; Likert scale, and linear regression; therefore, this study shows an index of knowledge and perception of patients toward surgical informed consent in our context, and being a baseline helping for future researchers. The study also tried to include study

participants in all surgery disciplines and as it was conducted at a tertiary care Hospital, so diversity of patients was obtained.

Limitations of the study

The primary limitations of this study are recall bias due to the questions' complete reliance on the remembering abilities of the participants and the omission of key crucial information about the consent process, such as the healthcare provider who got informed consent and counseling. Despite these drawbacks, the survey evaluated our patients' knowledge about and perception of SIC and gave us information to assess our practice.

The reliability of data may also be limited because no more researcher conducts the data.

7. Conclusion and Recommendation

The sample size was 440 and the response rate was 100%. Forty-nine-point five percent (218, 49.5%) had a low level of knowledge, (222, 50.5%) of the research subjects had a high level of knowledge/above the mean level. (228, 51.8%) had a low level of perception/below the mean level and (212, 48.2%) of the patients had a high level of perception towards informed consent for surgical procedures. There is a significant weak negative correlation between patient's knowledge and perception of patients towards informed consent for surgical procedures [(r = -.235), (-1≤ r ≤1), p=.000)]. There is no significant association between the patient's age, marital status, education, occupation, religion, surgery discipline, and knowledge towards informed consent for surgical procedures, but there is a significant association b/n residency being rural. However, there is a significant association between sex being male, and perception toward informed consent for surgical procedures.

8. Recommendations

Nursing practice:

Nurses should make sure that informed consent is given properly and that the patient has sufficient information to make an educated choice. To avoid misunderstandings, permission should be reviewed with patients a few days before surgery. This will give patients the chance to clarify any areas of uncertainty regarding their understanding and views.

Nursing Education

Before undergoing any medical or surgical interventions, informed consent should be considered to be a moral and legal necessity in nursing schools. Nursing professionals should act as the patient's advocate by ensuring that the patient is aware of the process and that there is no coercion during the informed consent process.

Research: A suggestion for the research of local intervention studies on the informed consent procedure is required. Stressing the importance of the patient's knowledge and perception in the decision-making process for surgical operations. While performing informed consent, many community quirks/problems should be taken into account.

Administration Tertiary Teaching Hospital in Addis, Ababa, Ethiopia; should design an informed consent form with the Ministry of Health that contains all the specific information and educates the surgeons and all surgical department health professionals (Resident, Fellow, Nurses, and Anesthetist) and other concerned body improve informed consent.

Legal community:

The hospital's/country's legal community must take concern and add the surgical informed consent right, like the medical right, to the constitution. The patient should know that they have the right to ask questions; clarify any doubts; and have the freedom to revoke it. There must not be any kind of coercion. Consent must be voluntary, consent given under fear of injury, intimidation, misconception, or misrepresentation of facts can be held invalid. No one has the right to even touch, let alone treat, another person. Any such act, done without permission, is classified as "battery" or "physical assault" and is punishable. Hence, obtaining consent is a must for anything other than a routine physical examination.

PERCEPTION AND KNOWLEDGE OF PATIENT'S TOWARDS INFORMED CONSENT ON SURGICAL PROCEDURES IN TERTIARY TEACHING HOSPITAL, ADDIS ABABA, ETHIOPIA 2024 BY ENDALE ASCHENAKI

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