TO EXAMINE THE RELATIONSHIP BETWEEN KNOWLEDGE LEVELS REGARDING THE INFORMED CONSENT PROCESS AND PSYCHOLOGICAL READINESS FOR SURGERY IN PATIENTS BETWEEN THE AGES OF 20 TO 49 YEARS AT MPILO CENTRAL HOSPITAL.

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Abstract

Psychological readiness for surgery has a critical impact on the patient as it helps to reduce anxiety and stress (Sharma, 1996). At Mpilo Central Hospital complaints have been leveled against doctors and nurses that they hurry patients into agreeing to undergo surgery without providing adequate information and preparation prior to the procedure. With 10 to 20% out of all surgical cases patients have been reported to withdraw from surgery (Mpilo Public Relations, Officers Report, 2009). The purpose of this study was to examine the relationship between knowledge levels regarding the informed consent process and psychological readiness for surgery. The study utilized Peplau’s Interpersonal Process Model. A descriptive co-relational design was used. Eighty subjects aged between 20 and 49 years were selected using systematic random sampling. Data was collected using a structured interview schedule, consisting of demographic section, knowledge on the informed consent process section and psychological readiness for surgery section. Data was analyzed using descriptive statistics, Pearson correlation coefficient test and simple regression analysis. The findings of the study showed a Pearson coefficient test ($r=0.375$, $p<0.01$) and a regression of $0.014$, $r^2 0.01$. This shows that there was a positive correlation between knowledge levels regarding the informed consent process and psychological readiness for surgery. Results have shown that there were generally low levels of knowledge regarding the consent process with a range of between 2-12 points from a possible 35 and results also showed lack of psychological readiness for surgery. Implications for Medical surgical Nursing are that there is need to reinforce the psychological preparation of patients for surgery to reduce the number of patients who withdraw from surgery.
DEDICATION

To my late father Andrew Mayitukashe Nyandoro Unendoro, I wish you were here to see my achievements. Thank you for encouraging me to do good. I love you. To my mother Loriene Ntozini Nyandoro. At least you are alive to see what achihoro has done. You are my pillar of strength. I could not have asked for a better mother. God bless you. I love you. To Lindsay and Leeroy, this is for you my dear children.
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CHAPTER 1

BACKGROUND INFORMATION AND ORGANISING FRAMEWORK

Introduction

The American College of Surgeons (1998) adopted a statement in principles guiding the care of a patient prior to surgery, one of the aspects was to recognize and address psychological, social and spiritual problems which led to the importance of psychological stability prior to surgery. According to Foreman (2005), lack of psychological readiness of a patient prior to surgery has a critical impact on the emotional state and postoperative state of that patient. Studies done in America on elective patients for various surgeries revealed that (78%) of those patients who were not psychologically ready for surgery and had various forms of stress, had a weakened healing process of wounds post operatively as their wounds took 9 days longer days to heal (American Medical Association, 2007). Another study done by Sharma (1996) revealed that ongoing psychological support helped the patient and family to manage their pain better which is not just physical but can be psychological too and can be anticipated negatively.

No research has been done in Zimbabwe to determine the psychological readiness of patients prior to surgery, as most of the time readiness is determined using the physiological status of the patient like blood pressure, pulse, respirations or blood or radiological results. This study therefore sought to identify levels of knowledge regarding the informed consent process and psychological readiness for surgery.

The consent process play a major role in the management of surgical patients, as it helps understanding the type of surgical information and procedure to be performed. It also lessens preoperative anxiety and fear of the unknown concerning the possible
outcome of surgery and also lessens the liability of the nurse or Doctor to legal litigation, if the procedure does not go well (Worthington, 2002). The informed consent process for surgery usually begins long before the patient enters the operating room with the patient first visit to the surgeon’s office (Van Norman, 2008).

While the ultimate duty rest upon the operating surgeon , to explain the or procedure, risks, alternatives and so on ,a separate discussion of an anesthesia risks, nursing procedure and other preparations needs to be considered also (Van Norman,2009).

According to Robbam and Parves (2009) the informed consent process involves five major components which are voluntarism or autonomy , adequate disclosure of all relevant information about the procedure , understanding the of information by the patient , competence of the patient to grant consent and consent signing its self . All these components are meant to assist the patient to make an informed decision.

While there are no widely accepted guidelines or policies for providing information regarding surgery , the accepted standard is to provide information that a reasonable patients would want and would need to know to make an informed consent , but counseling may vary widely by health care professionals, setting and type of surgical procedure .(Porta et al, 2010).

According to White (2007) the procedure consent involves the following ;

1. Surgical counseling, where a surgical counselor discusses the surgical information , procedure , which includes information on reasons for surgery , its benefits , what will be used , who the tea entails , a visit to the theatre , the ward concerned and equipment to be used . The post operative instructors
regarding follow up visits and activities instructions to which the patient will need to consent, a check list on the physiological status of the patients is made this is done by a specialist nurse.

2. The surgeon who will discuss any concerns’ of any potential risks, questions regarding the procedure, the surgical information package, consent form and post operative care are discussed.

3. The patient’s consent form which will need to be signed for prior to surgery. This indicated that the patient is making an informed decision and to undertake the procedure and that all counseling has been done.

Problem Statement

Despite the availability of Mpilo Central Hospital Policy (1991), the Patient’s Charter (1997) and other policies and guidelines that guide client care with respect to preparation for surgery and workshops and hospital meetings held regularly, the gap between patients and Health Care providers continues to widen (Mpilo Public Relations Officer Report, 2008).

At Mpilo Central Hospital the investigator has observed that there are about 10 to 20% cases of surgical patients per month who seek full explanation of the operation performed on themselves, hours to days after surgery. This indicates discrepancies in the way patients are being prepared for theatre, although they would have signed the consent to operate process prior to the procedures. Complaints have been leveled against doctors and nurses that they hurry patients into agreeing to undergo surgery and do not provide
adequate information about the operation, and all the information that is relevant to their care. They are either told that the doctor will soon go on leave or resign, or that the resources in the Hospital are running dry or worse still that nurses and doctors will soon embark on a strike for salaries and better working conditions (Mpilo Public Relations Officer’s Report, 2009).

Also Mpilo Central Hospital has not had the services of a Health Education Officer since 2000, whose duty would be to partially offer guidance on obtaining consent to treatment which would help reduce the number of patients undergoing surgery at Mpilo surgical wards with vague information on the operation or without being psychologically ready for surgery (Mpilo Central Hospital Annual Report, 2009).

The institution has also seen a sharp rise in the number of patients cancelling or not turning up for surgery, or postponing the procedures, for lack of satisfaction, lack of psychological readiness as further consultation would need to be made with other family members from as little as 2.5% patients per month to about 20% patients a month, (Mpilo Outpatients Department Mid Year Report, 2009). This has raised questions as to whether enough time and effort is put to prepare these patients psychologically and physically and to equip them with the necessary information prior to surgery, (Mpilo Out Patients Department midyear report, 2009).

Doctors at Mpilo Central Hospital routinely in process patients about the intention to operate them either during the out patients clinic or during the ward round and with a doctor/patient ratio of 1:200, the doctor spends little time with the patient to fully explain all the detail, (Mpilo Public Relations Officers Report, 2009). The bulk of that work load is left to the nurse who might barely know the procedure and because work has to be
done, she sometimes obtains the consent on the doctor’s behalf without having to think about any consequences of helping out a colleague. Patients are routinely prepared physically then they proceed for surgery. It is the consent process and other laboratory investigations which if they are normal then the procedure goes on.

The Legal Age of Majority Act of 1982 provided the reduction of the legal age of majority from 21 to 18 years indicating that the consent to operate process that is being used in Zimbabwe was originally from the Rhodesian era, which stipulates that those above 21 years can only consent on their own. From then on no amendments have been made at Mpilo Central Hospital to accommodate the new age of majority which is now 18 years. Of all the 100 operations preprocessed in 2009 throughout the Hospital, almost half of those patients who consented on their own were 18 years of age to 21 years of age. This is a clear indication that Health workers and the patients themselves do not understand the legal implications of signing for such a document. The investigator could not however find any previous research locally or regionally regarding the informed consent process or psychological readiness for surgery.

Prosser and Keeton (2004) express that explanations about the nature of the operation are not always done because those offering the treatment are experts who cannot expect those who come to them for help to be in a position to understand as much as they do nor can they be given all the information to make a truly educated or responsible decision.

Foreman (2005) believes that the signing of the consent process should be the last step of the consent process and in cases of elective surgery the doctor should not hurry the patient. A study that was carried out by the Department of Medical ethics at the
University of Pennsylvania (2005) on 100 subjects with regards the consent process prior to elective surgery revealed that 86% of the patients only had the benefits of the operation explained to them and not the risks and that the consent process was signed during the Doctors’ visit just hours before surgery and were required to sign in 3 different places without being afforded enough time to process the information. The study further established that most patients viewed the informed consent process as a ritualistic and bureaucratic hurdle where they felt threatened, frightened and pressured by having to give a informed consent and reported that they did not read or understand the consent process; hence it was to please the health worker and just to get it over with (University of Pennsylvania, 2005).

A research done by the Ministry of Health and Child Welfare, (1997) on communication skills of the health care workers who included doctors and nurses revealed that their attitudes and behaviors were unprofessional and left most clients mistreated, belittled, rejected, used and unsure of their diagnosis making them unwilling to take their medication and the advice offered by the health care worker, and if they took the advice it would only be because they wanted relief from the pain and had fear of the unknown. This is in agreement with Foreman (2005) who also noted that communication is a valid tool in any encounter with the patient to lessen the anxiety brought about by the impending surgical procedure hence the health care workers need to ensure that a therapeutic environment for the healing process is accelerated.

The patient’s charter of 1997 states that with regards to obtaining consent prior to surgery, the client has the right to consultation with the full nature, the risk of surgery explained to them, and that any client who is above 18 years has the right to sign his own
consent process, but does not highlight who obtains the consent from him, (Ministry of Health and Child Welfare, 1997).

A study done by Byrne, Napier and Cushcieri (2000) to determine the patients’ full understanding of the information given to them prior to signing the consent process before surgery revealed that most doctors and nurses were actually not confident enough to provide information to patients and did not want to tie themselves down to giving patients a whole chapter of information lest there were complications and the doctor would be liable to prosecution, instead health workers used a lot of the medical terminology to confuse patients.

On researching if the patients could recall what information they were given 2 to 5 days after surgery, 68% of the patients expressed that they could only remember that they were operated on but could not remember the body parts that was operated on. The wound or the scar was the only guide on where the operation was done. The study also revealed that the communication skills and the experience of the medical attendants were seen to influence the ability of the patient to understand, appreciate and retain the information. The less experienced the doctor was, the less information he was likely to give to the patient, although in terms of spending quality time, the junior doctor would sacrifice his time, just to give reassurance to the patient that the operation would go well.

Humphris, (1994), and Potter and Perry (2001), stated that doctors use a more teleological approach to client care where as long as what would have been done to the patient would bring good results whether or not they were informed about the operation, as long as they got the relief they were looking for.
Potter and Perry (2001) cited the issue of paternalistic behavior which doctors use together with “deception” as a process of manipulation and coercion to induce patients to do what they want them to do. This method is used routinely by the medical staff to make patients compliant to treatment, where they are made to believe that if they do not agree with what the doctor is suggesting, then they are punished by withholding of information and services.

A patient can be starved for more than 24 hours for refusing to go to theatre so that they could toe the line or an immediate discharge is instituted by the doctor with the nurses’ help. Thus adults are treated as children by persons acting as if they had the authority and concern of a parent (Byrne, Napier & Cushieri, 2000).

The investigator sought to find out the reasons for the doctors’ failure to fulfill the clients’ expectations as they have a full right to disclosure of information pertaining to their Health, so that they make informed decisions about their Health and to determine whether patients retain the information after consultation when consent is obtained and understand its role in their treatment.

Theoretical Framework

A theoretical framework is an abstract logical structure of meaning that guides the development of the study and enables the researcher to link the findings to nursing’s body of knowledge (Burns & Grove, 2005). Peplau’s Interpersonal process model was used to guide the conceptualization of the study. Peplau, (1986) developed the interpersonal process model with the main aim of assisting the patient who is experiencing anxiety due to various factors. This model becomes applicable to the study in that according to
Sharma, (2006); Kerrigan, (1993) and Udry, Shelbourne, and Gray, (2003) all the patients undergoing any surgical procedure exhibit some level of anxiety, which necessitates the need for their psychological stability prior to that procedure.

Sharma , (2006) further elaborates that any admission by the patient to anxiety is a sign of lack of psychological readiness for the procedure and that these concerns should not be taken for granted as the patient would need “de-stressing” before surgery to have a positive outcome post operatively. Four central components have been developed in this model, namely, the interpersonal process, the nurse, the patient and anxiety.

The interpersonal process is the central component of the model which describes how the nurse formulates the useful transformation of the patient’s anxiety in this regard, about surgery, its benefits, the nature of the disease, risks involved in the surgery and general outcome in terms of recovery. The process consists of four phases in which the nurse and the patient participate where the nurse governs the purpose and process and the patient controls the content.

During orientation, the nurse assists the patient to become aware of the availability of trust in the nurse’s abilities to prepare them psychologically for surgery. In identification, the patient experiences feelings about the condition, and whether or not he understands the nature of the operation, the informed consent process and its uses and is allowed to express self without any objections.

During the exploration phase the patient develops full value of the importance of dealing with the current stresses in his life to reduce the levels of anxiety which are negative to his disease outcome. Lastly in resolution, the patient is gradually freed from dependence from the nurse, which permits the generation and strengthening of the ability
to face the pending surgical procedure with boldness. The nurse as the second component of the model assumes six roles on different intervals. She is the resource person who through her great source of knowledge, provides information to the patient about the consent process, helps the patient understand the importance of surgery as she holds the necessary knowledge and expertise (N.M.C, 2004, & Boston Globe, 2007). She is also regarded as the counselor, which is of major importance on all nurse patient relationships (Peplau, 1986). Through this role, the nurse promotes experiences leading to Health. She shows unconditional acceptance of the patient as he expresses his worries about surgery. The other roles are that of teacher, and surrogate and these roles imply that the nurse has the primary responsibility in reducing anxiety to a healthy level (Peplau, 1986).

The patient is the third component of the interpersonal process whose expression of anxiety is in various ways and affects his/her ability to learn and function effectively. The assumption is that all humans have the potential to change the self and move towards health, in this case which is being psychologically ready for surgery. The nurse affects this health outcome through communication with the patient.

Anxiety is the fourth component in this model and according to Peplau, (1986) there is a direct relationship between anxiety and illness. In illness, the energy from anxiety needed for growth is instead bound in non-healthy symptoms such as headache or suicidal ideation. A major goal of the nurse would be to assess the degree of anxiety existing in the patients’ life the way its communicated by the patient and its effect upon the patient’s ability to learn and maintain healthy behaviour patterns by showing an understanding of their illness and the need for surgery and implement strategies that effectively reduce debilitating levels of anxiety. Through interpersonal interaction with
the patient, the nurse facilitates the patient’s ability to transform symptom bound energy into problem solving energy, and that only the individual can change himself as he deals with his fears.

The four universal concepts of person, environment, health and nursing form the core of the model. Nursing was defined as an educative instrument and that the interpersonal process is organized around the client learning about self, the health problem attitudes and practice. The person according to Peplau is a developing self system composed of biochemical, physiological, interpersonal characteristics and needs. Development of a person occurs with interaction with significant others. The environment was addressed in reference to the external factors essential for development which allow the person to independently make a decision which include the presence of a secure economic status of the family and a healthy family environment. Health was linked to the phenomenon of human development and it was placed on a health illness continuum. This means that the anxieties which any human being faces in their life might well have been conditioned by one’s upbringing and environment and this either has a negative or a positive bearing in the outcome of health.

Anxiety has been seen as a normal response to the presence of a stressor or any threatening situation but how one deals with it would depend on whether its effects are beneficial, that is towards positive decisions about surgery or detrimental as when the person cannot decide what to do about the pending procedure (Sharma, 1996).
Model Concepts

Figure 1: Diagrammatic presentation of Peplau’s Nursing Model: The interpersonal process.

Source: Adopted and adapted from Peplau’s Nursing Model (1996).
Conceptual definition of terms

It is confident understanding of a subject with the ability to use it for a special purpose if appropriate (Wikipedia, 2009)

Knowledge levels

It is awareness of information, understanding acquired through learning or experience. It is the ability to regurgitate definitions or descriptions and to have some sense of what information is relevant or not (Day and Howells, 2001). In this study it meant the ability of the patient to understand and comprehend the type of surgical intervention to be processed and to make an informed decision on whether to undergo surgery or not.

Consent process

The consent process is a legal document which is used to inform a person about the hazards and potential dangers of a particular. it is the permission do to something which is given to complete knowledge of all relevant facts such as rules involved or the available alternatives (Webends, 2006).

Informed consent process

It’s a standard or guidelines used to prepare a patients for a particular procedure , which involves a surgical information package , which entails counseling ,physical and psychological preparation and the signing of the consent form (White, 2007).
In this study it refers to steps taken to provide the patient with information about surgery, its benefits, risks as well as counseling done to prepare the patient psychologically.

**Psychological readiness for surgery**

According to Sharma (1996) psychological readiness for surgery is any inference made on a person’s capacity or propensity to act or react in particular way that enables the individual to undergo surgery without any reservations about it. In this study it refers to the ability of the patient to recognize the presence of stressors that affect the pending surgical procedure and be able to deal with them so that they are ready for surgery.

**Purpose of the study**

The purpose of the study was to examine the relationship between the knowledge levels regarding the informed consent process and psychological readiness for surgery in patients between the ages of 20-49 years Mpilo Central Hospital.

**Research objectives**

1. To determine the extent of psychological readiness for surgery in patients aged 20 to 49 years.
2. To establish the knowledge levels of patients aged 20 to 49 years regarding the informed consent process.
3. To examine the relationship between the knowledge levels of patients aged 20 to 49 years regarding the consent process and their psychological readiness for surgery.

Research Questions

1. What is the extent of psychological readiness for surgery in patients aged 20 to 49 years prior to surgery?
2. What are the knowledge levels of patients aged 20 to 49 years regarding the consent process?
3. What is the relationship between the knowledge levels of patients aged 20 to 49 years regarding the consent process and their psychological readiness for surgery?

Significance of the study to nursing

The study identified gaps in knowledge levels regarding the consent process and psychological readiness for surgery and helps to add to the body of knowledge of medical surgical nursing. The consent process plays a major role in the management of a surgical patient as it helps them to understand the type of surgical intervention and procedures to be undertaken on them. It also lessens preoperative anxiety and fear of the unknown concerning the possible outcome of surgery and also lessens the liability of the nurse or doctor to legal litigation if the procedure does not go well (Worthington, 2002).

The objective of the preoperative preparation is for the patient to sign a process whose information they would be comfortable with and thus “enjoy surgery”. It plays an important part in achieving emotional satisfaction and can contribute to the physical and psychological well being of the patient. The nurse plays a major role of being a teacher or counselor and an advocate for the patient where the services are needed, so that the
patient fully participates and cooperates and is fully empowered and knowledgeable about her condition (Sullivan, 2008). This is important for the nursing profession because since the patient is unique, they have a right to receive quality medical and nursing care and to fully participate in their care. Findings of the study will add to the body of knowledge of nursing science, as psychological stability plays a major role in the surgical management of the patient.

The knowledge will be used in clinical practice to enhance the patient’s knowledge levels on the consent process prior to surgery which will lead to high quality nursing care, client satisfaction and early recovery.

Nursing practice can only provide quality services if it uses research based knowledge, therefore knowledge on the consent process will empower patients to be able to be psychologically ready for surgery leading to fewer dropouts in the number of patients who have to undergo surgery. The findings of the study may also be used in nurse education to review curriculum and teaching strategies pertaining to psychological readiness for surgery in order to enhance provision of quality patient care, for patients undergoing surgery. The results may also be used as a basis to build a database for further research studies.
CHAPTER 2
LITERATURE REVIEW
INTRODUCTION

Polite and Hungler,(1999) state that literature review assists the researcher as a course of research ideas, orientation to what is already known, provision of conceptual content and information in the research approach.

This chapter reviewed literature related to psychological readiness for surgery, knowledge of the consent process and the relationship between knowledge levels regarding the informed process and psychological readiness for surgery as well as reviewing of the interpersonal process model.

Psychological readiness for surgery

In this study psychological readiness for surgery refers to the ability of the patient to recognize the preference of stressors that affect the pending surgery and be able to deal with them so that they are ready for surgery.

The American College of Surgeons (1998) adopted a statement in principles guiding care of a patient prior to surgery and one of the aspects that was concluded was the need to recognize, assess and address psychological, social and spiritual problems which led to the need to include the importance of psychological stability prior to surgery.

Studies were done on elective patients prior to surgery to determine their psychological readiness for surgery and these were done by the National Athletic Trainers Association (2009) on the patients who were undergoing anterior cruciate ligament surgery after initial patient education had been done on 125 subjects.
The measures included demographic information an age, sex, ethnicity, previous injury history and surgery, hours of exercising or participation per week as part of validating the sanity and insight of the patient.

Wong’s 30 item processes of change questionnaire (2006), was used to determine how they would cope with the changes, which included changing their behavior like embarking on positive exercising and good eating habits. Decisional balance and self-efficacy and mood disturbances were also used as measures to determine how the patients would cope with the knee surgery and on mood disturbances (98%) expressed tension, fear, depression anger and confusion regarding the operation. On decisional balance, (94%) of the subjects reported that rehabilitation would consume most of their time, hence they were undecided on whether to go ahead with surgery or not, as there was no guarantee for a total recovery, so they did not see surgery as being that important. On self-efficacy, 74% of the subjects expressed that they were not confident about surgery as they felt that the information provided to them was too vague and would rather keep the disability they already had from previous injuries.

Psychology has become an integral part of the medical and nursing profession and most insurance companies and surgeons have demanded that psychological consultation be done prior to major surgery like Bariatric surgery which is a form of lipo suction and partial gastrectomy done on obese patients, (Sowle, 2010).

Another study was done in the United States by Sowle (2010) on the Psychological Consultation prior to weight loss surgery after new protocols were established to ensure the safety and appropriateness of the medical procedure.
The result showed that 74% of the patients who were experiencing current psychological problems and were not on psychotropic medications were not psychologically ready for surgery, and tended not to do well post operatively, so were those who had marriage and family problems. Surgery had to be post-poned until the family issues were sorted out. A supportive family background and source of income was seen to have a positive effect on 68% of the patients as they did not have to worry that much about hospital bills as the medical insurance was enough. The family support in 92% of the patients was seen to play a major role in how well the patient recovered. A good level education in 64% of the subjects was seen to play a positive role in the amount of information that they regurgitated and questions asked both from the doctor, nurses and the counselors provided for surgery.

Eighty three percent of the patients vaguely knew about the risks of the procedure, but 92% of them were well informed about the reasons for surgery and almost all (90%) of the patients knew the benefits of surgery.

While the above measures might not predict absolute certainty that the individual will sail through with the procedure without any emotional complications, nurses are still encouraged to utilize psychological assessment to avoid nervous breakdown associated with surgery even though the actual operation itself is successful, (Sowle, 2010).

Kerrigan (1993) carried out a study on the psychological effects of giving full information to a patient prior to surgery. The abstract was to test the assumption that patients will become unduly anxious if they were given detailed information about the risks of surgery in an attempt to obtain fully informed consent.
Four surgical wards at Sheffield Hospital were used and pre-operative anxiety was assessed before and after patients were randomly allocated information sheets containing either simple or detailed descriptions of possible post-operative complications.

The study was done on 96 men undergoing elective inguinal hernia repair under general anaesthesia. Results showed that detailed information did not increase patient anxiety.

The mean Spielberg score was used. A simple explanation of the facts was provided and the results showed that there was no increase in patient anxiety significantly as shown by 88% of the subjects who remained stable. The advantages were that the information provided pre-operatively allowed the patients to make a fully informed choice before they consented to surgery, thus reducing the potential of subsequent litigation.

In another study on orthopaedic surgical patients by Webster (2007) on whether to adopt the North Americans practice of providing patients with a comprehensive list of the possible complications post-operatively and giving the small detail about their surgery. The study was done at the same Sheffield hospitals in four wards. A concern had been raised by the British doctors that all that information would generate a lot of unnecessary and harmful degree of anxiety.

It seemed more likely it was the doctors who were more afraid of fully informed consent than the patients they were treating. A screen for pre-existing anxiety and descriptive state was done using the hospital anxiety and depression scale (HADS) where patients over the few weeks before admission had assessment of the current state of anxiety using the Spiel Berger Score (Merriam-Webster, 2007). The researcher could not
how ever use the same assessment scale as elective patients are only admitted a day before surgery and it was not readily available for use by the researcher.

The sequence of change in anxiety noted was analysed by the students paired tests. The relationship on individual baseline anxiety and changes in anxiety obtained after the information was examined using scattered plots and by calculating the Pearson’s correlation coefficient. Results showed that 86% of those patients who received detailed information did not have anxiety, but those who received less information showed anxiety which had a negative effect on their psychological readiness for surgery.

Seventy-two percent of the patients felt that they had received too much information. The study also revealed that 85% of the patients, could not absorb verbal information and that a better quality of informed consent can be obtained by comparing oral and informed information using short sentences, personal pronouns and avoiding technical terms.

The study also revealed that full explanation of the facts allowed the 88% of patients to make fully informed decision about their surgery which might reduce the number of cases of litigation, arising from misunderstanding about the purpose and nature of any planned treatment. Ninety two percent, of the patients were visited by the anaesthetist in the ward together with the nurse anaesthetist to check for the physical fitness and for those who expressed anxiety, appropriate medication the night prior to the operation was given.

Knowledge on the informed Consent Process

The informed consent process is a standard or guidelines used in preparing a patient for a particular procedure, which involves a surgical information package
(counseling, physical and psychological preparation)and the signing of the consent form (White, 2007).

Wikipedia (2009) define the informed consent process as a document describing a medical treatment or research project, including proposed procedures, risks, and alternatives that are to be signed for by an individual or the individual’s proxy. This indicates his or her understanding of the document and a willingness to undergo the treatment or to participate in the research.

Webends (2006) also defines it as a document used to inform a person about the hazards and potential dangers of a particular activity. Its legal definition is the permission to do something which is given with complete knowledge of all the relevant facts such as the risks involved or the available alternatives. This means that no matter how minor or major the surgery might be, or the risks involved, the patient still has the right to know so that a free decision is made without any regrets.

Appelbaum (2009) further states that patients have a fundamental legal and ethical right to determine what happens to their bodies, meaning that the consent process or the consent to operate process is a legal document. There is a legal and an ethical reason to obtain the consent before carrying out any medical or dental treatment. The legal reason is to avoid a criminal charge of battery or a civil claim of trespass to the person. The ethical reason is that the understanding, cooperation and confidence of the patient are important to help ensure a successful outcome, (Appelbaum 2009). This is also in agreement with the RCN’s (2004) study which identified two frameworks that bind the informed consent, namely the ethical and legal framework.
The core ethical principle in patient care is the respect for every individual (RCN, 2004) taking into account ethnicity, gender, disability, religious beliefs, culture, language and level of understanding, as these areas might be sensitive when going through the process of gaining consent prior to surgery. No studies were obtained on the above concepts in relation to surgery but they need to be considered seriously when attending to every patient. It is a legal requirement if any procedure is to be carried out on any patient for consent to be obtained. If that procedure proceeds without the individual’s informed consent, then legal action can be taken against the Hospital for Battery, (RCN, 2004).

**Cases laws on consent**

Case laws on consent in the United Kingdom and United States established three requirements to be satisfied before a potential research participant or an individual prior to surgery may give consent, firstly the inform should have the mental ability to do so. Sufficient Information must be given and understood by the patient. Consent must be given freely (RCN 2004).

Studies done in the United Kingdom have shown that recent events highlighted by their press and other media regarding the Informed Consent have made the public to be more aware of their right to be involved in the consent process (Freeman, 2005). The idea of consent is based on the principle of respect for the person and thus on the concept of human right or the natural law of life and liberty. This includes care for the individual whom the health care givers would be looking after (Freeman, 2005). The nurse or the doctor is expected to respect the patient’s rights as a person who can make their own choice or decision independently, hence the need for an informed Consent to be obtained, and truthful information so that an informed decision is made based on that truthful
explanation (RCN, 2004). The caregiver is expected not to interfere with the decision making by trying to talk the patient out of the care or coercing them to agree to the treatment offered. Mpilo Central Hospital in Bulawayo, uses two standard consent to operate forms whose origin is unclear and undocumented. The information on the process contains the name of the hospital, the date, and a declaration statement by the patient as the undersigned who hereby consents to the administration of anaesthetics and the performance of any operation upon self, with full name enclosed and the nature of the operation stated, whose nature would have been explained to the patient. It further states that the patient agrees to the performance of any additional or alternative measure that may be considered necessary by the surgeon during the course of the operation. Both the witness and the patient sign. A note well (N.B) sign is placed at the bottom that only those above 21 years although the majority age is 18 years, should complete the process, and in case of a minor, the guardian or parent signs or in terms of the Children’s Protection and Adoption Act (Chapter 5:06) with the consent of a magistrate any other person can sign. The other consent to operate process is on the bottom of the patient’s front sheet or admission sheet with the same information. As a tool to prevent legal litigation against the hospital, it serves as a protective document, but in terms of providing proof of the information that was actually given to the patient prior to surgery none of it exists. The witness who counter signs with the patient is not stated or clear, as it could either mean the doctor, the nurse or the patient’s significant others. The presence of the date is important in that according to Mpilo Central Hospital Policy (1991), a consent to operate process is valid for a week after the initial signing of the document,
meaning that if surgery is not performed within that period a new process has to be signed for.

However, countries like the United Kingdom utilize the service of the department of Health Care education to process, guide and disseminate information to the patients prior to any surgical intervention or research. They also make use of the standardized consent process for competent adults which is informed in English, for general surgery. They have come up with a different consent process for various forms of surgery, namely general surgery, gynaecology, ophthalmology, urology, and so on. (Cadena 2007) This is due to the fact that each category of surgery has its own areas that need stressing on, and risks which do not occur in every operation. Not much research has been done on patients retention of information after consultation when consent is obtained or their understanding and knowledge of the consent process and its role (Cadena, 2007). Most researches have been done by doctors and fewer of them were done by nurses. Previous work has shown that many patients tend to view the informed consent as a ritualistic and bureaucratic hurdle, may feel frightened, and pressured by having to give an informed consent and reported that they did not understand or read the consent process as they wanted to get it over with. One thousand and forty patients were approached by the University of Pennsylvania (2005), and the response rate was 71% with regards knowledge of the legal status of the consent process. Most participants (646), 88% believed that it was a legal requisite to sign a consent process before surgery. One hundred and eighteen (16%) incorrectly thought that signing a consent process removed their right to compensation. More than 33% of the respondents were unsure whether an operation could be done without them signing the consent process, and many patients
517 (71%) were unaware that their next of kin could sign on their behalf if they were unable to sign for themselves. Two hundred and ninety-two (40%) signed the consent process so that they could just have their operation and 46% believed that signing of the process helped to protect the hospital from litigation and 71% thought that it gave the doctor control over what happened.

Although patients want to know their legal rights in hospital, their awareness of legal and ethical issues related to the consent process is often limited (Worthington, 2002). Researches done previously have shown evidence that although the consent process satisfied administrative and legal requirements, patients’ needs may not be met and some patients may even consent to surgery they do not want, (RCN, 2004).

Most patients (78%) did not see the signing of the consent process as functioning primarily in their interests or as a way of making their wishes known, many thought the primary function was to protect the hospital (Akad, et. al., 2004). Although there was no straightforward relationship between knowledge of rights and the ability to exercise them, a lack of awareness of the limits and scope of the consent is clearly undesirable, potentially causing patients to feel disempowered and lacking control. (Byrne, Napier, & Cushier, 2000). Seventy-seven percent reported that it made them aware of the risks of the operation they were to undergo and 36% saw it as a safeguard against mix ups in the operation theatres. Studies done in the United States of America (USA) have shown that freely given consent is central to patient care and helps them to understand what is being done, helping to ensure that they are not deceived or coerced into participating in any procedure. (University of Pennsylvania, 2005). In another study done by Byrne (2002) to ascertain the level of knowledge on patients regarding the consent process where 100
subjects who underwent different operations ranging from cholecystectomy, gastrectomy, vagotomy and so on. Fifty-one percent of the subjects agreed that they knew the organ that had been operated on while 49% only knew that they had surgery performed on them. Sixty-seven percent of the subjects felt that they were not given sufficient time to ask questions and expressing their fears, and that most of the terminology was poorly understood. One’s level of education, medical state and age had an effect on the level of understanding. The illiterate and the elderly tended to avoid the gory details and just wanted to get over with the procedure as they expressed that too much detail would confuse them. Those who were in so much pain were too sick to listen and preferred to be spared the lengthy detail of the operation (Byrne, 2002).

Patients perception on adequacy of informed consent process

Another study in New Zealand was done by McKeague and Windsor (2003) on the patients perception of the adequacy of the informed consent process on patients who were undergoing elective general surgery. A pre-operative survey questionnaire was filled during the interview and forty-two (58%) of the patients also completed a postoperative postal questionnaire. Interviews were done after the patients had signed for consent but before any pre-operative medication was administered. Surgeries ranged from those of the head, neck, the breast, and the gastrointestinal tract. On disclosure of information, almost half (49%) received information about their operation verbally while 37 (48%) patients were given verbal and informed information. A further two (3%) patients were shown a video in addition to the verbal and informed information
Although the standard procedure at Mpilo requires the surgeon to obtain the consent from the patient according to New Zealand Standards the consent process requires that the person who provides the bulk of the information about surgery should be one who gets the patient to sign for the consent and overall the house officer obtained informed consent from (79%) of the patients, the registrar (6%) and the consultant (14%) (McKeague & Windsor, 2003).

Only 34 (44%) of the patients could name the person who was going to performs the operation and 33 (43%) knew their seniority and no nurse obtained the signature. The consultants and registrar were seen to provide most of the information which the patients required than from the House Surgeon. Thirty-nine (51%) patients were less than totally satisfied with the amount of information given before the operation. Only 36 (47%) patients considered that they had received enough information about the risks and complication of the proposed operation. Eighteen (23%) did not recall being told about the risks and dangers of the operation. Thirty-seven (48%) patients could not list a single risk of the operation although 68% could identify the consequences of not having the operation. Sixty-one (79%) patients stated that alternative approaches to treatment had not been discussed (McKeague & Windsor, 2003).

The post-operative survey found that 45% of patients were not satisfied with the information about the operation, 50% with the amount of time spent discovering the operation. The patients, however, listed specific information they would have liked to receive before their operation, that is complications and the risks of operation, recovery time after operation, how they would feel after the operation, alternative treatments to the
operation, likelihood of success of the operation, risks of the anaesthetics and the nature of disease (McKeague & Windsor, 2003).

On understanding the information, the language that was used was understood by all the patients as English was the preferred language. No research was done on the use of medical jargon.

On whether consent was given freely, the majority of patients (79%) felt free to ask questions and 94% had enough time to think about having the operation and to discuss it with friends and family. The post-operative survey found out that 86% of patients had enough time to read the consent process before signing it. Some degree of pressure to sign the consent process was experienced by 38% of patients. Thirty-three percent did not realize that they could change their mind after signing the consent (McKeague & Windsor, 2003).

The overall results show that there is need for more specific information, including the nature of the planned operation, the alternatives and complications to be given by the senior doctor undertaking the procedure and before the patient is admitted to hospital.

The Nurses role in informed consents process

The Nursing and Midwifery Council (NMC) code of professional conduct (2004) states that the nurse is accountable for her own practice, although it is her duty to in process the patient that a decision to withdraw from any operation will not compromise the quality of care they receive although the treatment may change. The International Council of Nurses (ICN) (2004) states that a professional nurse is accountable for her
practice and should always act in the best interests of her patients, to put their needs first. The nurse should have the necessary knowledge, expertise, capability and give sufficient information and be able to answer questions raised by a patient, be open and honest and ensure that the patient understands all they need to know about the operation.

According to the Boston Globe (2007), the nurse’s role includes, obtaining a signature from the patient, asking the patient to consent, explaining risks, the prognosis of the disease if the patient refuses surgery. This is in contradiction with Cadena (2007) who states that the physician is the one who is ultimately responsible for obtaining the signature, while the nurse witnesses the event.

The physician obtaining the permission from the patient and family gets a verbal consent, explains the risks, benefits and describes the procedure, Deciding whether or not to have the operation involves considering a number of factors, for example personal, and financial costs like travel expenses for reviews, childcare costs, remuneration for time off work, benefits of the operation and a better treatment outcome. Studies done in the United States and New Zealand have shown that most of the patients either deferred or cancelled their operation schedule about twice or more, as the above costs had a negative bearing on them coupled with the lack of psychological readiness for surgery. (Thompson, Melia & Boyd, 2000).

Requirements of a valid consent

According to Verschoor, Fick, Jansen and Viljoen, (1997), the requirements for a valid consent are; it must be voluntary and must be obtained freely without any physical force or any moral, social or economic pressure. Consent obtained from deceptive
misrepresentation is null and void. The consenting person must have the mental capacity to give legal consent. The individual must be accountable, must be able to process an intention. Mental illness, intoxication, the effects of drugs or even youth fullness, can diminish a consenting person’s capacity to understand the nature and consequences of his action and to express his decisions accordingly.

The consenting person must have the full knowledge of the extent of his treatment and its consequences especially when there is risk or harm. The definition of what constitutes full knowledge will depend on the patients’ ability to understand the complexities of the treatment and the procedures and to make rational decisions on these, the degree to which the patient wishes to be informed, the importance of the desired consequences and potential benefits of the medical treatment and procedure. He needs to know the possible health risks, other side effects, alternative treatment options and their consequences and the possible effects that the information might have on the patient, (Thompson, Melia & Boyd, 2000). It would seem however, that the full information concerning the diagnosis (that is the why question) does not need to be made known, unless if the patient insists on such information or consent required is for exploratory surgery needed for diagnosis, but information about the treatment, expected outcome and inevitable risks and prognosis must be provided, (Verschoor, Fick, Jansen & Viljoen, 1997). The consenting person must fully realize or appreciate the nature and event of impairment that may result. The consenting party must also realize and understand in what ways and to what extent he could be affected. He must consent subjectively, that is what was discussed with the doctor must be done by him and not anything else as he
might be charged with negligence. Consent must be lawful and not contrary to public policy or good morals, (Verschoor, Fick, Jansen & Viljoen, 1997).

The Consent Process and the Law

According to Stakes, (2006), if a patient consents to a course of treatment and subsequently suffers damage, he will have no claim in negligence provided that the consent he gave was an informed one. He must have the risks explained to him, and the person obtaining the consent must make sure that he has understood the possible consequences.

The patient should be given the time to think about it and should never be asked for his consent while under the influence of premeditation or drugs which might impair his ability to think clearly, (Stakes, 2006). Failure to get consent would result in a charge of negligence, assault and battery. However if a patient was to arrive in a casualty department unconscious and in desperate need of medical attention, it would be negligent in those circumstances not to treat him, (Stakes, 2006).

Thompson, Melia and Boyd (2000), explain that for a negligence claim to succeed, the plaintiff must show 3 elements, namely; that the defendant owed him a duty of care, that there was a breach of that duty of care. That as a result of that breach, the plaintiff suffered damage, and if there is no damage, then there can be no claim in negligence. The nurse is thus judged by the standards of a registered nurse as she is expected to have a special skill and is expected to exercise it, (Thompson, Melia & Boyd, 2000). Verschoor, Fick, Jansen and Viljoen (1997) agree with Stakes (2006) that if a person consents to having surgery done, for example appendicectomy and results in
damage, the person who caused the damage cannot be held responsible for those losses, because the aggrieved person consented to the risk of such harm.

It must be emphasized that courts judge the existence and the extent of consent very critically and have upheld consent as a defense only in a limited number of cases, partly because a high value is placed by the law on the individual’s physical integrity and institutes those safe guards to protect the individual against himself, (Crowe, 2003).

They further state that it is the doctor’s primary duty to obtain the informed consent from the patient, although the nurse must take note in case the patient revokes consent, checks on the validity of the consent received or respecting the patients refusal to treatment.

Thompson, Melia and Boyd (2000), further stress that nurses must know whether consent has been given and how it was gained and must be familiar with the requirements specified for consent to be legally valid as it reduces the fear of legal repercussions and allows the law to be used contractively for the nurses’ and patients’ protection.

The patient has the right to revoke his consent at any time before the operation or any other procedures are performed, (Thompson, Melia & Boyd, 2000).

Such revocation must be scrupulously respected and a need to be remindful of the patients “right to refuse” and report such wishes to those concerned. Should any medical treatment be carried out, despite the revocation of the consent, then those giving the treatment could undoubtedly be held responsible for wrongful action, (Thompson, Melia & Boyd, 2000).

Only a person capable of volition is entitled to consent to injury or harm. Therefore, the nurse must not just accept that consent was given but must actually check
that a person is deemed legally capable of volition when he possesses the mental capacity and lucidity to understand and accept the nature and consequences of the proposed operation or treatment, (Crowe, 2003).

The informed consent facilitates effective control and offers concrete protection to the doctor, hospital authority or nurse in case of dispute at a later stage, it facilitates proof. The mere fact that a patient consents to an operation does not mean that he has consented to any operation or treatment, which the hospital or doctors may decide (Thompson, Melia and Boyd, 2000).

The vulnerable people, that is those with limited ability to act autonomously, those with special needs, like writing and reading difficulty, visual and hearing impairment, language barrier, sensory deficits, no family members or a friend, would need the help of the Hospital protocol or policy with regards obtaining a consent where either a next of kin or the Chief Executive Officer gives consent. Also included are those together with the unresponsive patients due to injury or sedation, whose informed consent is obtained from a legal representative, (Thompson, Melia & Boyd, 2000).

There is available literature ascertaining the status in which patients come to hospital which determines whether they will understand their treatment. Some are anxious, some are under the influence of drugs and the level of emergency which might leave little time for sufficient information to be given to make an informed decision (Crowe, 2003)

Nurses should strive to provide the highest care possible so that the patient has a positive surgical experience and is more likely to relate to the procedure in a more positive manner.
Sometimes patients are subjected to unnecessary pain as the doctor blindly operates without having obtained the necessary diagnosis like waiting for Laboratory test results or scan results to come, exploratory operations are done only to discover that the condition could have been medically treated, (Jarrett & Payne, 2000).

There is need for the doctor to be knowledgeable so that he or she can explain the nature of the operation, its benefits, risks, and alternatives to treatment to appreciate human rights to autonomy, dignity and self-determination. Studies done in the United Kingdom by the Department of Medical Ethics (2007) showed that the doctor needed to have adequate knowledge of self so that they became aware of their own personal experiences and attitudes that influence the way they perceive a patient as some doctors and were found to be egocentric and stereotypes. This had a negative impact on how they viewed the patient. The study also revealed that long ingrained social and racial influences affected the doctors’ responses to the patient preoperatively as some of them held the belief that it was not socially acceptable for the patient to ask too many questions prior to surgery as they would become too learned and unpopular with the nurse, so most of the information was withheld from the patient to “cover” themselves lest something went wrong.

Another study done in the United States of America (2008) on different patients of different races on knowledge concerning the consent process prior to surgery showed that 95% of the Caucasian patients who were naturally linguistic, tended to receive more information and attention, whereas black patients would receive less attention and information (Crowe, 2003). Studies done by the University of Pennsylvania, (2006) on a group of patients revealed that a pleasant hospital nurse and doctor, the presence of a
husband or a friend and previous acquaintance enabled the patient to be able to cope effectively with surgery. A patient’s ability to cope in an unfamiliar territory controlled by people who will often be strangers may be enhanced if the patient is accompanied by a relative or a friend, (Crowe, 2003). Yet surveys conducted in Canada, (2000), United States of America (2003) and England (2006), showed that not all hospitals allow a relative or next of kin into theatre but is only allowed to stay prior, only in the department of obstetrics were they freely allowed to attend deliveries. At Mpilo Central Hospital the consent to operate process is obtained either 24 to 48 hours prior to surgery in cases of elective surgery even though the decision to operate might have been made days, weeks or months prior to the surgery before the patient is put on the waiting list for the operation. In between time the patient goes home and waits for their operation date and 24 hours prior to surgery a little if no recap of the nature of the operation is done. At times relatives and loved ones are allowed with the consent of the patient during the discussions. Only those who need physical or physiological stabilization like the diabetics or hypertensive patients or those going for major gastrointestinal or orthopaedic operations would need to be admitted earlier for special preparations of the gut or the skin. Rarely is literature provided to the patients or any visual aides. Journals, and pamphlets are used to equip the patient with the necessary knowledge (Crowe, 2003). If ever the literature exists, it is in English or in hospital jargon which would only require the patient to need the services of the nurse to explain to them. Beauchamp, Mark, Evers and Mattox, (2004) carried out a study on the importance of medical literature, journals, and visual aid use in patient education prior to surgery. Of the 250 candidates they had selected for different types of elective surgery, all (100) of the candidates, appreciated the
use of these education tools, and most of them still had them in their valuables and stated that the information they got helped them to face the operation with great anticipation for great relief and less anxiety as they knew what to expect.

The relationship between knowledge levels of the consent process and psychological readiness for surgery

Studies on the above variables are few as most studies have centered on one aspect either knowledge levels alone or psychological readiness for surgery.

According to Sharma (1996), 80% of surgeries in America are elective and are scheduled ahead of time meaning that there is plenty of time for psychological preparation if one’s will is put behind it. The psychological services are safe and can save hundreds of millions of dollars in medical costs.

Stress of an illness or injury requiring surgery can have a critical impact on the emotional state of a person together with that of post-operative care (Foreman, 2005). Patient education and preparation prior to surgery and psychological support pre and post-operatively can reduce the stress levels of patients and families, (Sharma, 1996).

Education and psychological preparation is necessary because most surgical consent form are highly technical and beyond the comprehension of most people.

Sixty percent (60%) of people in America don’t even bother to read them as they just sign on the dotted line and after signing they are scared even more (Sharma, 2006). Stress is so high at that time that even when surgical information is presented in simple words, patients only remember 30-50% of the information. Hospitalization before and
after surgery has become short and in frequent due to the changing managed care system, and thus surgeons and members of hospital staff do not get an opportunity to sit down with their patients, to listen to their inner most feelings and fears and reassure them or give them the guidance they need, (Sharma, 2006). Surveys done by the American Medical Association (2007), revealed that only 31% of patients felt that physicians spent enough time with them with a general average time spent with the patient of 7 minutes. Most patients were interrupted in their first 18 seconds of the description of their symptoms. Nurses were said to spend the most time trying to explain about surgery and giving reassurances to the patient with an average time of 15 to 30 minutes.

The survey done by the American medical Association (2007) revealed a need to train therapists or nurses who can guide patients at their own pace, level of understanding and readiness, so that there is less stress experienced. (Ronald 2007) Studies by the same association have also shown that patient worries about surgery were not addressed. The most common worries reported by 93% of patients facing surgery were on how much pain they would experience after surgery? What if the surgeon makes a mistake? Will I survive the surgery and the worries resulted in distress and the ensuing depression and anxiety negatively influenced recovery, (Ronald, 2007).

Psychological readiness before and after surgery is required as the psychological stress can weaken the healing process, (Sharma, 2006). Sharma (1996) carried out a study to determine the effects of lack of psychological readiness before surgery and the healing process of wounds post-operatively. Results showed that 78% of women’s wounds in that study with every day stress took 9 days later to heal than for those without. On going psychological support is necessary so that the patient and family can adjust to post
surgery life changes and helps the patients to manage their pain better which is not just physical but can be psychological too and can be anticipated negatively, (Sharma, 1996).

Sharma (1996) identified the following benefits of psychological preparation before and after surgery as being, reduced distress before and after surgery, reduced need for pain medication, less post-operative complications, faster recovery, higher levels of daily functioning, faster return to work and more satisfaction with the entire surgical process. Holmes-Rovner and Wills (2002), Berg, Appelbaum, Parker, and Lidz, (2004) and the University of Washington School of Medicine (2006), carried out researches as they had observed that most health care providers take into account pre-surgical physical factors for example amount of tissue damage and swelling when scheduling surgery and discovered that it might be worthwhile to also consider such aspects as the psychological readiness of patients for surgery.

Knowledge levels regarding the informed consent process and psychological readiness for surgery were found to improve adherence to treatment and recovery outcomes in 87% of cases and helped postponing surgery for those who did not appear ready and some reconsidered surgery and opted for other treatment modalities which had been offered to the patients especially the frail and the elderly who might not be able to withstand surgery, (Holmes-Rovner and Wills, 2002).

Knowledge and psychological readiness for surgery were seen to motivate and increase the patients’ participation in their operations in 67% of the cases and the effects of such preparedness were seen to be of a more positive effect, as the patient was more empowered to make a more informed decision, (Berg, Appelbaum, Parker, & Lidz, 2004).
Theoretical Framework

Peplau’s interpersonal process model

The four major related concepts of Peplau’s transpersonal processes which were focused on in this study were the interpersonal process, the nurse, the patient and anxiety. Peplau’s model is based on the assumptions that all individuals have the potential to change the self and move towards health. The individual is seen as a developing system composed of biochemical, physiological and interpersonal characteristics and needs. Anxiety is seen as an important determinant of growth since the self-system is an antianxiety system meaning that the individual has the capability to overcome the challenge in his life (Peplau, 1986). Anxiety is produced when communication with others threatens the biological or psychological security of the individual. A mild degree of anxiety heightens the person’s seriousness to the encouragement such that more information can be assimilated (Peplau, 1986). In this study the investigator assumed that if a patient presents with anxiety prior to surgery, and lack of knowledge regarding surgery and related issues, then it is the knowledge that is imparted to them together with the use of an inbuilt antianxiety system which would assist the patient to be psychologically ready for surgery and is health promoting in nature. It’s the nurse’s responsibility to assess the verbal and nonverbal communication of the patient and to influence their communicating in such a way that contributes to health modes of thought. Anxiety and human energy can be trans processed into either health promoting or debilitating behaviour (Peplau, 1986). Through interpersonal
interaction with the patient, the nurse facilitates the patient’s ability to transform symptom bound energy into problem solving energy.

Published research studies indicate that Peplau’s model has been widely used in psychiatric nursing and in areas where anxiety was found to be a problem for example prior to examinations or surgery. Locally published literature on interpersonal process is not widely disseminated. The model has otherwise been used in various situations for example in mental health to deal with situations about communication, learning, anxiety and human development, theoretical ideas on milieu and family therapy and psychotherapy in general.

Berg and Hallberg (2000) conducted a study on lived experiences of psychiatric nurses working with clients in a psychiatric ward. Peplau’s model was utilized. 68% nurses were interviewed and transcribed tests were analysed using content analysis. Results showed that nurses created a trusting relationship with clients and had no opportunity to provide education and networking. Peplau’s model has been found to be essential in enabling interpersonal relationships, which are critical in treating clients with mental illness as evidenced by the above study.

Forchuk and Brown , (1989) applied Peplau’s model in establishing a nurse patient relationship. The purpose of the study was to develop an instrument to measure the phases of the nurse patient relationship and to begin establishing validity and reliability. Nurses using the instrument found it to be clear, practical and easy to use. The study of Peplau’s theory was found to be a building block. Some of the studies highlighted that any person with any type of illness must rely heavily on the support of significant others.
Whitingham and McLaughing (2000) did a study in which they found that time constraints were found to be a hindrance to the nurse-client relationship. Forty-two (42%) of the nurses spent less than half a working day devoted to psychotherapeutic interaction. Nurses in the study accepted that communication with clients was an important part of their work. Gijbels (1995) stated that while most nurses including psychiatric nurses possess psycho-therapeutic skills, they do not use them.

O’Tootle and Welt (1989), as cited by Lindberg (1994) applied Peplau’s interpersonal model in general nursing practice. It was found to enhance nurse client relationship, which the nurses use to uncover the client’s unused capacities and help the client to realize and compliment them in their own recovery.

**Summary**

A review of literature on study variables was done in this chapter. The study variables were psychological readiness before surgery, knowledge on the informed consent process and the relationship between knowledge levels regarding the informed consent process psychological readiness for surgery. Literature has shown that knowledge of the consent process prior to any surgical procedure is a prerequisite as it has an effect on the psychological readiness pre and post-operatively as the patient tends to understand the reasons for pain, rest and adherence to the medical plan suggested by those who have the knowhow. The level of anxiety which the patient would be having about surgery also has a negative effect on the physical well being as the blood pressure and pulse goes up making it unsuitable for the procedure to be done. Regardless of the patient’s age, literacy level or education level, literature has shown that any procedure done on any patient without their consent can lead to the individual doctor or the
Institution being sued for battery, assault and so on. Hence the need for health workers to respect the patients. If knowledge of the consent process and psychological readiness prior to surgery have been proven significant, then these should be incorporated into medical-surgical nursing.
CHAPTER 3

METHODOLOGY

INTRODUCTION

This chapter explains the methodology for the study. The study design, sampling plan, sample size, sampling procedure, instruments used and Human Rights consideration.

Research Design

A descriptive correlational design was used for the study to examine the relationship between the knowledge levels of the patients regarding the consent and their psychological readiness for surgery. The purpose of this design was the examination of the relationship of the variables in the situation being investigated (Burns & Grove, 2005). The knowledge levels on the consent process was the independent variable and psychological readiness for surgery was the dependent variable. Polit and Hungler (1999) describe correlational research as investigations that explore the relationship among the variables of interest without any active intervention on the part of the investigator. The design describes the type of relationship which may be a perfect positive relationship (+), a perfect negative relationship (-) or there maybe no relationship (o) Dempsey and Dempsey, 2000).

Sampling Plan

A sampling plan is a strategy the researcher uses to obtain a sample for a study (Burns & Grove, 2005). It attempts to increase representativeness and decrease systematic bias and sampling error (Burns & Grove, 2005). A good description of the sampling plan enables readers to critique and replicate the study. The sampling plan is
aimed at directing the investigator on the study, population sampling criteria and meaningful information (Polit & Hungler, 1999). In this study the investigator used systematic random sampling plan which involved the selection of every $K^{th}$ case from the group. In this study the target population was about 200 adult patients who are scheduled for surgery into Mpilo Hospital per month. The required sample was 80 and to get the number, the population was divided by the desired sample size that was $200/80 = 2.5$. Therefore every $3^{rd}$ case on the patient list was selected for the study. The inclusion and exclusion criteria help to control extraneous variables that could interfere with the measurement of study variables and should be controlled so that findings are credible (Polit & Hungler, 1999). The inclusion criteria included clients who have been admitted for elective general, orthopaedic, urological or gynaecological procedures, and were either male or female between the ages of 20 to 49 years of age and had signed the consent process before premedication. Subjects were fluent in either English, Ndebele or Shona. Exclusion criteria was those who were emergency surgical cases and those who had not signed the consent process, those who were below 18 years and above 60 years of age. The study sample were selected from Mpilo Central Hospital’s surgical wards where the study population was more accessible.

Sample Size

A sample is a subject of the population. A number of factors determine the size of the sample (Burns & Grove, 2005). The determining factors are power, effect size and significance level of the statistic in use. The sample size was calculated considering the amount of variance in the phenomenon on statistical test assumption and attrition rate. The power is the capacity of the study to detect differences or relationships that actually
exist in the population or to correctly reject a null hypothesis. The minimum acceptable power for a study is 0.80 (Burns & Grove, 2005). Power analysis verifies that the sample size is sufficient and the effect size is the extent of the presence of a phenomenon in the population (Cohen, 1988). The larger the sample size, the more representative it is of the population and the smaller the sampling error (Burns & Grove, 2005; Polit & Hungler, 1999). The sample size depends on the degree of variability of the phenomena, the number of variables, type of study and the sensitivity of the instruments to be used for measurement (Burns & Grove, 2005). Those who met the inclusion criteria stated in the sampling plan were recruited for the study. The sampling error also becomes smaller as the sample size grows (Uys & Basson, 2005). Polit and Sherman (2000) in their study found that a power of 0.80 was desirable in nursing, given the complexity and difficulty in measurements of phenomena. A power of 0.80 will be used in this study. In performs a power analysis to determine sample size, the investigator first determines the effect size (Burns & Grove, 2005). Effect size refers to the magnitude of the difference among variables. The other factors influencing sample size are the degree to which phenomena being studied is present in the population or the degree to which the null hypothesis is false (Cohen, 1988). The effect size has got a negative relationship on the sample size, (Burns & Grove, 2005; Polit & Hungler, 1999). As the effect size increases, the sample size decreases and vice versa. The effect size for this study was 0.50 for easy detection. The significance level is the probability of making a type 1 error when a null hypothesis was rejected when it is true (Burns & Grove, 2005). It determines the reliability of the study findings. In this study the sample size calculations were based on the Lipsey (1990) tables for estimating sample size. A significance level of alpha = 0.05 was used using a
power of 0.80, an effect size of 0.50 and a sample size of 65 with 15 subjects added to
cover for the attrition rate making a total of 80 subjects was sufficient to meet the
requirements of the study recruitment.

Sampling Procedure

Sampling procedure involves the process of selecting a portion of the population
to represent the entire population (Burns & Grove, 2005). The investigator screened, all
surgical patients from 0800 hours to get the target population. After screening, the
subjects were selected using the $K^{th}$ formula that is $K=\text{total population divided by sample}$
size, that is every 3$^{rd}$ surgical patient was be chosen for the study. From a register100
patients every 3$^{rd}$ patient from 3$^{rd}$, 6$^{th}$, 9$^{th}$, 12$^{th}$ and so on were chosen for the study.

Variables

These are qualities, study properties or characteristics of persons, things or
situations that change or vary and are manipulated or measured in research (Burns &
Grove, 2005). Three variables were measured in this study, that is demographic,
knowledge on the consent and psychological readiness for surgery. The independent
variable looked at the knowledge of the consent. The dependent variable looked at
psychological readiness for surgery.

Conceptual and Operational definitions

A conceptual definition provides a variable or concept with a theoretical meaning
and was derived from an authority, while an operational definition describes how
variables measured in a particular study (Burns & Grove, 2005). The operational definition
in this study included knowledge of the informed consent process and psychological
readiness for surgery.
Knowledge level regarding informed Process

In this study it referred to the description of what the consent process is legal implications, benefits, risks, complications and alternatives to surgery [Foreman, 2005]. It was operationalized through the knowledge of the consent process questionnaire whose concepts were obtained from Appelbaum (2009): (Gray & Santos, 2009).

Psychological readiness for surgery

It was conceptualised as the ability of the patient to recognize the presence of stressors that affect the pending surgical procedure and identify positive mood states that would enable one to be able to be psychologically ready for surgery. This was measured using the psychological readiness for surgery questionnaire whose concepts were from (Udry, Shelbourne, Gray and Williams, 2002). and some questions were designed by the researcher.

Demographic variable

These are characteristics, or attributes, of the subjects that describe the sample (Burns and Grove, 2005. These were operationalised using the demographic data of the questionnaire. The variable information about the patients back ground status; age, marital status, residence, education, occupation, economic status, and religion.

Instruments

An instrument is a device an investigator uses to collect data and answer the research questions (Polite & Hungler, 1999). The instrument in this study were Section A on the Demographic Data and Section B knowledge regarding consent process and
Section C on psychological readiness for surgery. These questionnaires were structured and administered using face to face interviews with subject.

Demographic Variables

The demographic questionnaire measured demographic variables of the subjects. It was structured and administered using face to face interviews. It sought data on age, gender sex, marital status, residence, education level, occupation, monthly income, religion and next of kin. It was the first of the three questionnaires and sought information on characteristics about the subject (Burns & Grove, 2005). This information was analysed to provide a picture of the sample characteristics.

Psychological readiness for surgery

The questionnaire attempted to find out the extent to which admitted surgical patients were psychologically prepared for surgery. Items in the questionnaire were developed for the study was psychological concepts from Udry, Shelbourne, Gray and Williams, (2002).

The instrument had five questions which sought information on the ability to recognize the presence of stressors, determination of mood state, decisional balance, self-efficacy and the presence of support system. The total score of this section was 17 and the minimum score was five. The maximum score was 17 and the mean score was 8.5. Any score above 8.5 represented psychological readiness for surgery and any score below 8.5 represented lack of psychological readiness for surgery.
The first question inquired if the patient was currently experiencing anxiety related to surgery. The score ranged from 1 to 3 points on an ordinal scale where 1 point was assigned to extremely, 2 points for slightly and 3 points for not at all.

The second question was a determination of mood state. The question asked if the patient was afraid of the operation. The score ranges from 1 to 3 points in an ordinal scale where 1 point was given for extremely, 2 points for slightly and 3 points for not at all.

The third question sought to determine decisional balance. The question was how important the operation was to the patient and the scores ranged from 1 to 4 points on an ordinal scale. More 1 point was given for least important, 2 points was given for not important, 3 points for important and 4 points for very important.

The fourth question was to determine self-efficacy, that is whether the patient could weigh the pros and cons for surgery. The question asked the patient to rate their confidence about going for operation and the scores ranged from 0 to 3 points on an ordinal scale. 0 point was given for not at all confident, 1 point for slightly confident, 2 points for confident and 3 points for very confident.

The fifth question sought to determine the presence of a support system. The question asked if the patient saw the presence of a current family support they have if it was sufficient to see them through surgery. The scores ranged from 0 to 3 on an ordinal scale where 0 point was awarded for strongly disagree, 1 point for disagree, 2 points for agree and 3 points for strongly agree.

A total of 2 – 17 indicated low levels of knowledge 17.5 to 25 indicated moderate levels of knowledge.
Knowledge on the consent Process

The instrument sought to find the information which the adult surgical patient had on the consent process. The items in the questionnaire were developed process concepts from Appelbaum (2009), Gray and Santos (2009).

Total number of questions in this section were (10). Total score for this section was 35 and the mean score was 17.5. Any score between 2 -17 represented low levels, between 17.5-25 points equals moderate levels and between 26-35 points equals high levels of knowledge.

The first question sought to find who gave the patient information about the operation. The scores ranged from 1 to 3 on an ordinal scale. 1 point was given for the nurse, 2 points for the anaesthetist, and 3 points for the doctor.

The second question sought information on whether the patient knew the category of their operation/procedure. The first five categories, namely general surgery, gynaecology, orthopaedics, urology, ear, nose and throat (ENT) had 1 point each and 0 points were given if the patient did not know the category of operation.

The third question sought information on when the patient signed the consent to operate process. The scores ranged from 1 to four points on an ordinal scale. 1 point for a few minutes before surgery, 2 points for hours before surgery, 3 points for a day before surgery and 4 points for days before surgery.

The fourth question was regarding what information they were told about regarding surgery. The scores ranged from 1 to 4 on an ordinal scale. 1 point for reasons for surgery, 2 points for reasons and benefits for surgery, 3 points for reasons, benefits
and risks for surgery and 4 points for reasons, benefits, risks, complications and alternatives to surgery.

The fifth question was to determine if the patient was aware of the body part which was to be operated on. The scores ranged from 0 to 1 point where 0 was for No and 1 for Yes.

The sixth question asked if it was a legal requisite to sign the consent process before the operation. The scores ranged from 0 to 3 points for strongly disagree, 1 for disagree, 2 for agree and 3 for strongly agree.

The seventh question asked if a patient could change his/her mind even after signing the consent process. The scores ranged from 0 to 3 points on an ordinal scale. 0 points for strongly disagree, 1 point for disagree, 2 points for agree and 3 points for strongly agree.

The eighth question asked if the next of kin could sign on the patient’s behalf if they were unable to do so in the case of an emergency. The score ranged from 0 to 3 points on an ordinal scale. 0 points for strongly disagree, 1 point for disagree, 2 points for agree and 3 points for strongly disagree.

The ninth question asked if the doctor could preprocess a different procedure from that specified on the consent process even if it was necessary. The score ranged from 0 to 3 points, 0 points for strongly disagree, 1 point for disagree, 2 points for agree and 3 points for strongly agree.

The tenth question sought information on whether the signing of the consent process is to protect the Hospital from litigation. The scores ranged from 0 to 3 on an
ordinal scale. 0 points for strongly agree, 1 point for disagree, 2 points for disagree, 3 points for strongly disagree.

The eleventh question sought to find out if the patient was given enough time to think about the operation before signing the consent process. Scores ranged from 0 to 3 points on an ordinal scale 0 points for strongly disagree, 1 point for disagree, 2 points for agree and 3 points if the patients strongly agreed.

Validity

Validity refers to the degree to which an instrument measures what it is supposed to measure (Polit and Hungler, 1999). In this study validity of the questionnaire was examined by a panel of experts from Mpilo Central Hospital and the department of nursing science, psychiatry and psychology personnel were included.

Reliability

Reliability refers to the degree of consistency with which an instrument measures the attribute it should measure (Polit and Hungler, 1999). It is considered as a measure of the amount of random error in the measurement technique and is concerned with such characteristics as dependability, consistency, accuracy and compatibility (Burns and Grove, 2005). Reliability testing was done on each instruments prior to conducting the study, through a pilot study. The investigator modified parts of the research instrument found necessary.
Data Collection Plan

Data Collection Procedure

A data collection procedure details how the study will be conducted (Burns and Grove, 2005). The process is timed for example, how much time will be needed for identification of potential subjects explaining the study, obtaining consent and actually collecting data (Burns and Grove, 2005). Pretesting was undertaken at Mpilo Central Hospital to help refine the instrument and ascertain the possibility of carrying out the interviews in the proposed time limit. Permission was sought and granted by the Medical Research Council of Zimbabwe, an ethical review board for protection of human subjects in the study. The Chief Executive Officer of Mpilo Central Hospital also granted the investigator the permission to carry out the study at the institution. Staff from the various wards where the research was conducted were informed in order to gain support and cooperation. Clients who met the inclusion criteria were sampled and selected for interview. Interview times were agreed upon by the investigator and the subjects. Six (6) patients were interviewed every week day over a period of four weeks between 0800 hours to 1300 hours. The length of interview for each subject ranged from 25 to 30 minutes.

Ethical Considerations

Human rights are claims and demands that have been justified in the eyes of an individual, and having these rights is necessary for the self-respect, dignity, and health of an individual (Burns & Grove, 2005). A detailed but simplified explanation of the purpose of the ethical conditions of participation time commitment, risks and benefits was given to all the subjects. The investigator obtained verbal and informed consent before each
Interview was started. Anonymity was maintained by coding information on data collection tools instead of using the participants’ names and/or identifying information such as the institution or regions. The information given was not at any time used against the subjects and the data collected was reported in aggregated process to ensure anonymity and data was treated as grouped data for the same reasons. Information from the records was not shared with the staff until it was aggregated and analysed. The principle of respect for humanity and human dignity was observed for the clients irrespective of their status. Unwilling subjects had their decisions respected with no subsequent prejudice in their care and they were assured that they would not be victimized if they did not agree to participate. The purpose of the study and request were explained to the prospective subjects in the languages that they best understood (Shona, Ndebele, English). Filled in questionnaires were locked up in a cupboard to ensure confidentiality.

Data Analysis

Data analysis is the systematic organisation and synthesis of research data and testing of research hypothesis using those data (Polit & Hungler, 1999). Questionnaires with collected data were checked for completeness. Data was coded by the investigator. A code book was created to enter all the coded data. Then data was entered from the code book into the computer for analysis using the statistical packages for social sciences (SPSS). Descriptive and inferential correlation statistics were used to analyse data. Pearson’s correlation co efficient (r) was used to determine the nature and strength of association between levels of knowledge regarding the informed consent process and
psychological readiness for surgery. Statistical significance was set at the 50% level or at alpha < 0.05.

Demographics

Nine demographic variables were analysed namely: age, gender, marital status, residence, educational level, occupation, income status, religion and next of kin. Descriptive statistics such as frequencies, tables, and means were used to describe and analyse these demographic variables under study.

Psychological Readiness for surgery

Research question 1: “What is the extent of psychological readiness for surgery for these patients? The total psychological responses score of 5 questions were computed and presented on frequency tables. This was the dependent variable.

Knowledge Levels Regarding The Consent Process

Research question 2: What are the knowledge levels of patients regarding the consent process? Descriptive statistics such as frequency, tables, and means were used to describe and analyse this variable. This was the independent variable.

Relationship between knowledge levels regarding the consent process and psychological readiness for surgery

Research question 3: “What is the relationship between the knowledge levels of patients regarding the consent process and their psychological readiness for surgery? It was analysed using the Pearson Correlation Coefficient. Simple linear regression analysis
was used to test the direction of the relationship between the independent variable, knowledge levels on the consent process and the dependent variable, psychological readiness for surgery.
CHAPTER 4

Results

This chapter presents results of the study and highlights of major findings. Data were analysed using descriptive and inferential statistics. The data were presented in

Summary

The purpose of the study was to examine the relationship between knowledge levels regarding the consent process and psychological readiness for surgery among patients aged 20 to 49 years of age at Mpilo Central Hospital. The clients were those who were undergoing elective surgery and had signed the informed consent process. The study attempted to answer the following questions:-

1) What is the extent of psychological readiness of the patients aged 20 to 49 years prior to surgery?

2) What are the knowledge levels of patients aged 20 to 49 years regarding the consent process?

3) What is the relationship between the knowledge levels of patients regarding the consent process and psychological readiness for surgery among patients aged 20 to 49 years?

Data were collected during the month of March 2010. The response of the clients was one hundred percent. Analysis was done using descriptive statistics which involved frequencies, percentages and mean. Descriptive statistics were used to describe demographic information, levels of knowledge regarding the consent process and psychological readiness for surgery among patients aged between 20 to 49 years. International statistics were used to test the relationship between knowledge levels
regarding the consent process and psychological readiness for surgery among patients aged between 20 to 49 years at Mpilo Central Hospital. Simple linear regression was used to examine the strength of the relationship between knowledge levels regarding the consent process and psychological readiness for surgery.

Sample Demographics

Table 1 shows demographic characteristics of respondents which are age gender, material status. The age range was between eighteen to sixty years. The mean age was 36.25 years. Sixteen respondents (20%) were aged between 20 to 29 years. thirty respondents (37.5%) were aged between 30 to 39 years. Thirty four respondents (42.5%) were aged between 40 – 49 years.

Seventeen respondents (21.3%) were single, forty nine respondents (61.3%) were married, one respondent (1.3%) separated, four respondents (5%) were divorced, and nine respondents (11.3%) were widowed.

Table 2 shows residence level, of education and occupation.

Sixty five respondents (81.3%) stayed in the high density suburbs, seven respondents (8.8%) stayed in the low density suburbs and 8 respondents (18%) stayed in the rural areas.

Nine respondents (11.3%) had never been to school, while twenty four (30%) were educated up to primary school. Forty five (56%) had attained Secondary education and two (2.5%) had gone up to tertiary level. Fifteen (18.8%) were employed, twenty six (32.5%) were self-employed and thirty nine (48.8%) unemployed.

Table 3 shows sample demographics namely, income status, religion and next of kin. Forty (50%) had an income less than fifty dollars per month, nineteen (23.8%)
earned between fifty one and a hundred dollars per month, twenty (25%) earned between one hundred and one dollars and two hundred dollars and 1 (1.3%) earned above two hundred dollars.

Seventy one (88.8%) were Christians, three (3.8%) were Moslems and six (7.6%) were traditionalist. Twenty six (32.5%) had their mother as next of kin. Fifteen (18.8%) had their father as their next of kin. Seventeen (21.3%) had their spouse as next of kin. Eleven (13.8%) had their daughter as next of kin and three (3.8%) had their uncle as their next of kin while two (2.5%) had their aunt as their next of kin.

Table 4 shows sample demographics on category of operation. On the category of surgery within which the patients’ operation fell into, nineteen (23.5%) were of general surgery. Twenty two (27.5%) were of gynaecology, sixteen (20.0%) were of orthopaedics, twelve (15.0%) were urology, eleven (13.8%) were of ear, nose and throat (ENT).

Psychological readiness for surgery

Table 5 indicates psychological readiness for surgery which included information on anxiety questions on whether the patient was afraid of the operation, the importance of surgery, how the patient rated his/her confidence regarding the operation and if family support was seen as an important measure in psychological readiness. On the ability to recognize the presence of stressors, seventy one (88.8%) respondents expressed that they extremely felt anxious about the operation, nine (11.3%) had slight anxiety and none of the respondents had no anxiety at all.
On determination of mood state, sixty six (82.5%) were extremely afraid of the operation fourteen (17.5%) were slightly afraid, and none of the respondents were not at all afraid of the operation.

On determination of decisional balance, none of the respondent affirmed that the operation was least important to them, two (2.5%) felt it was not important. Thirty five (43.8%) said it was important and forty three (53.8%) expressed that it was very important.

On determination of self-efficacy, fifty seven (71.3%) were not at all confident about surgery, ten (12.5%) felt slightly confident, seven (8.8%) were confident and six (7.5%) were very confident.

On determination of the presence of a support system, none of the respondents strongly disagree that the family support was efficient to see them through surgery, none of the respondents disagreed, twenty one (26.3%) agreed and fifty nine (73.8%) strongly agreed that the current family support that they had was sufficient to see them through surgery.

Table 6 shows total scores on psychological readiness for surgery. Eight (10%) scored 8 points, twenty one (26.3%) scored 9 points, twenty five (31.3%) scored 10, fourteen (17.5%) scored 11 points. Eight (10%) scored 12 points and four (5%) scored 13 points.
Table 1

Sample demographic (1)

N = 80

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<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
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<td>Age in years</td>
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<td></td>
</tr>
<tr>
<td>20 – 29</td>
<td>16</td>
<td>20.0</td>
</tr>
<tr>
<td>30 -39</td>
<td>30</td>
<td>37.5</td>
</tr>
<tr>
<td>40 – 49</td>
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<td>Variable</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
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<td>-------------------</td>
<td>-----------</td>
<td>------------</td>
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<td><strong>Residence</strong></td>
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<td>Tertiary</td>
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Table 3
Sample Demographic (3)

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<td>$101 - $200</td>
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<td>Tradition</td>
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<td>7.6</td>
</tr>
<tr>
<td><strong>Next of kin</strong></td>
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<td>Mother</td>
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<td>32.5</td>
</tr>
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<td>Father</td>
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<td>Spouse</td>
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<td>Daughter</td>
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Table 4
Sample demographics (4)

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<td><strong>Category of operation/procedure</strong></td>
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<td>Gynaecology</td>
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<tr>
<td>Orthopaedics</td>
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<td>Urology</td>
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<tr>
<td>Ear, nose and throat (ENT)</td>
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<td>13.8</td>
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Table 5

Psychological readiness for surgery

N = 80

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<td>Anxiety</td>
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<tr>
<td>Extremely</td>
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<tr>
<td>Slightly</td>
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<td>11.3</td>
</tr>
<tr>
<td>Not at all</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Fear</td>
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<tr>
<td>Extremely</td>
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</tr>
<tr>
<td>Slightly</td>
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<td>17.5</td>
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<tr>
<td>Not at all</td>
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<td>0.0</td>
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<tr>
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<tr>
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<tr>
<td>Not important</td>
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<td>2.5</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Not at all confident</td>
<td>57</td>
<td>71.3</td>
</tr>
<tr>
<td>Slightly</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Confident</td>
<td>7</td>
<td>8.8</td>
</tr>
<tr>
<td>Very confident</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>Family support during the operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agree</td>
<td>21</td>
<td>26.3</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>59</td>
<td>73.8</td>
</tr>
</tbody>
</table>
Table 6

Total scores on psychological readiness for surgery

N = 80

<table>
<thead>
<tr>
<th>Value (scores)</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>9</td>
<td>21</td>
<td>26.3</td>
</tr>
<tr>
<td>10</td>
<td>25</td>
<td>31.3</td>
</tr>
<tr>
<td>11</td>
<td>14</td>
<td>17.5</td>
</tr>
<tr>
<td>12</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>13</td>
<td>4</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Knowledge levels regarding the consent process

Table 7 shows knowledge levels regarding the consent process, time frame for signing the consent process, information about the procedure and awareness of body part to be operated on. Four (5.0%) were informed by the nurse. Three (3.8%) were informed by the anaesthetist and seventy (91.2%) were informed by the doctor results on the knowledge regarding the informed consent process. Regarding the time when the informed consent process was signed prior to surgery, six (7.5%) signed a few minutes before surgery, fifty two (65.0%) signed at hours before, fourteen (17.5%) a day before and eight (10.0%) signed at days before surgery.

Regarding information about surgery, sixty seven (83.8%) were told only reasons for surgery, seven (8.8%) were told reasons and benefits, four (5.0%) knew the reasons, benefits and risks and two (2.5%) were told about the reasons, benefits, risks, complications and alternative to surgery.

On identification of the body part to be operated on, nine (11.3%) were not aware of the part and seventy one (88.8%) were aware of the body part to be operated on.
### Table 7

**Knowledge levels regarding the consent process(1)**

N = 80

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source of information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Doctor</td>
<td>70</td>
<td>91.2</td>
</tr>
<tr>
<td><strong>Time frame for signing the consent process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A few minutes before surgery</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>Hours before surgery</td>
<td>52</td>
<td>65.0</td>
</tr>
<tr>
<td>A day before surgery</td>
<td>14</td>
<td>17.5</td>
</tr>
<tr>
<td>Days before surgery</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td><strong>Information about the operation/procedure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons for surgery</td>
<td>67</td>
<td>83.8</td>
</tr>
<tr>
<td>Reasons and benefits for surgery</td>
<td>7</td>
<td>8.8</td>
</tr>
<tr>
<td>Reason, benefits and risks for surgery</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>Reasons, benefits, risks, complications of surgery</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Awareness of body part to be operated on</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>11.3</td>
</tr>
<tr>
<td>Yes</td>
<td>71</td>
<td>88.8</td>
</tr>
</tbody>
</table>
Table 8 shows the knowledge levels regarding the consent process on whether it is a legal requisite to sign the consent process before surgery. Five (6.3%) strongly disagree, forty nine (61.3%) disagreed, fifteen (22.5%) agreed and eight (10.0%) strongly agreed.

On whether the patient can change his/her mind even after signing the consent process, six (7.5%) strongly disagreed, fifty four (67.5%) disagreed, nine (11.3%) agreed and eleven (13.8%) strongly agreed.

Regarding if the next of kin can sign on the patient’s behalf if they are unable to do so on their own in an emergency, twenty five (31.3%) strongly disagree, twenty nine (36.3%) disagreed, twelve (15.0%) agreed, fourteen (17.5%) strongly agreed.

Table 9 shows knowledge regarding the informed consent process.

On whether the doctor can preprocess a different procedure from that specified on the process, if it is necessary, twenty two (27.5%) strongly disagreed, forty five (56.3%) disagreed, four (5.0%) agreed, nine (11.3%) strongly agree.

Regarding the importance of signing the consent process, to protect the hospital from litigation, forty six (57.5%) disagreed, eight (10.0%) agreed and six (7.5%) strongly agreed that signing of the consent process was to protect the hospital from litigation.

Regarding the ability to give free consent, fifteen (18.8%) strongly disagreed that they were given enough time to think about the operation before signing the consent process thirty eight (47.5%) disagreed, ten (12.5%) agreed, seventeen (21.3%) strongly agree.
Table 8
Knowledge level regarding the consent process(2)

N = 80

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal requisite for consent process signing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Disagree</td>
<td>49</td>
<td>61.3</td>
</tr>
<tr>
<td>Agree</td>
<td>18</td>
<td>22.5</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>8</td>
<td>10.8</td>
</tr>
<tr>
<td><strong>Changing of mind after consent signing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>54</td>
<td>67.5</td>
</tr>
<tr>
<td>Agree</td>
<td>9</td>
<td>11.3</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>11</td>
<td>13.8</td>
</tr>
<tr>
<td><strong>Next of kin signing in emergency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>25</td>
<td>31.3</td>
</tr>
<tr>
<td>Disagree</td>
<td>29</td>
<td>36.3</td>
</tr>
<tr>
<td>Agree</td>
<td>12</td>
<td>15.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>14</td>
<td>17.5</td>
</tr>
</tbody>
</table>
Table 9

Knowledge levels regarding the consent process(3)

N = 80

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor performing different procedure than that specified on process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>22</td>
<td>27.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>45</td>
<td>56.3</td>
</tr>
<tr>
<td>Agree</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>9</td>
<td>11.3</td>
</tr>
<tr>
<td>Importance of signing consent to protect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The hospital from litigation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>20</td>
<td>25.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>46</td>
<td>57.5</td>
</tr>
<tr>
<td>Agree</td>
<td>8</td>
<td>10.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>Enough time given to think about the operation before signing the consent process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>15</td>
<td>18.8</td>
</tr>
<tr>
<td>Disagree</td>
<td>38</td>
<td>47.5</td>
</tr>
<tr>
<td>Agree</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>17</td>
<td>21.3</td>
</tr>
</tbody>
</table>
Table 10 shows the total scores on the levels of knowledge on the consent process. Respondents’ scores ranged from 12 to 25. The mean score was 16.5.

Twenty six respondents (23.9%) scored above the mean. Two (2.5%) scored 12, six (7.5%) scored 13, thirteen (16.3%) scored 14. Thirteen (16.3%) scored 15, eleven (13.8%) scored 16, and nine (11.3%) scored 17, seven (8.8%) scored 17, ten (12.5%) scored 19, while four (5.0%) scored 20. Three (3.8%) scored 22, one (1.3%) scored 23, and one (1.3%) respectively.

Table 11 shows categorised level of knowledge on the consent process which showed that forty five (56.4%) had low levels of knowledge. Thirty five (44.6%) had moderate levels of knowledge and none of the respondents had high levels of knowledge regarding the consent process. Twenty six (23.9%) scored above the mean.
Table 10

Total scores for level of knowledge on the consent process

N = 80

<table>
<thead>
<tr>
<th>Scores</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>7.5</td>
</tr>
<tr>
<td>14</td>
<td>13</td>
<td>16.3</td>
</tr>
<tr>
<td>15</td>
<td>13</td>
<td>16.3</td>
</tr>
<tr>
<td>16</td>
<td>11</td>
<td>13.8</td>
</tr>
<tr>
<td>17</td>
<td>9</td>
<td>11.3</td>
</tr>
<tr>
<td>18</td>
<td>7</td>
<td>8.8</td>
</tr>
<tr>
<td>19</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>20</td>
<td>4</td>
<td>5.0</td>
</tr>
<tr>
<td>22</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Table 1

Categorised levels of knowledge on the consent process

N = 80

<table>
<thead>
<tr>
<th>Categorised</th>
<th>Level of knowledge</th>
<th>Range</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>2 – 16</td>
<td>45</td>
<td></td>
<td>56.4</td>
</tr>
<tr>
<td>Moderate</td>
<td>17 - 25</td>
<td>35</td>
<td></td>
<td>44.6</td>
</tr>
<tr>
<td>High</td>
<td>26 – 35</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Relationship between knowledge levels regarding the consent process and psychological readiness for surgery.

Pearson correlation analysis was used to examine the relationship between knowledge levels regarding the consent process and psychological readiness for surgery. The correlation coefficient is an index that measures the strength or magnitude and direction of a linear, relationship (Brink, 1988). After computing the Pearson’s correlation coefficient it was found to be .375. The positive sign on the correlation coefficient (r) indicates that there is a positive linear relationship.

It means that as the independent variable increases, the dependent variable increases. The results support that as the level of knowledge increases, there is psychological readiness for surgery.

This shows that the level of knowledge on the consent process was positively correlated with psychological readiness for surgery (r = .375, p>.01).

Regression analysis was used to examine the strength of the relationship between level of knowledge regarding the consent process and psychological readiness for surgery. Results of the regression analysis of the level of knowledge regarding the consent process are shown on table 12. According to Brink (1988) regression analysis is an estimation of the linear relationship between the independent variable and the dependent variable. This effect of the level of knowledge on the consent process (Independent variable) as indicated by R- squared =(.01,p<.001).The effect of the independent variable (level of knowledge regarding the consent process) accounts for 1% of the variance in the dependent variable (psychological readiness for surgery, unstandardised Beta ( 0.04916 ) represents a change in psychological readiness for
surgery for every unit change in the knowledge levels regarding the informed consent process.
Table 12

Pearson correlation matrix of knowledge levels regarding the consent process

N = 80

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>Y</td>
<td>.375**</td>
<td></td>
</tr>
</tbody>
</table>

*P>.05  **P<.01  ***P<.001

Y  Psychological readiness for surgery

X knowledge level regarding the consent process.
The significant Beta indicates the relative importance of the independent variable (knowledge levels) regarding the informed consent process. The bigger the value of the significant beta, the more important in terms of its contribution to the dependent variable (psychological readiness for surgery). The importance of the knowledge levels in this study, therefore was 1% in terms of its contribution to psychological readiness for surgery. The knowledge level regarding the consent process has a positive but weak influence on psychological readiness for surgery.
Table 13
Regression analysis of psychological readiness for surgery
N = 80

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>S E B</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>0.05515</td>
<td>0.0492</td>
<td>0.04916</td>
</tr>
<tr>
<td>(constant)</td>
<td>9.2526</td>
<td>0.9203</td>
<td></td>
</tr>
</tbody>
</table>

R-squared = .01

F=0.79

*P<0.5  **p<.01  ***p<.001

X (knowledge levels regarding the consent process)
CHAPTER 5

DISCUSSIONS, IMPLICATIONS AND RECOMMENDATIONS

This chapter discusses the findings, draws conclusions and implications of the study. It finally gives recommendations that are based on the research findings. Relevant literature was used as a frame of reference during discussion finding.

Summary

The purpose of this study was to describe and examine the relationship between knowledge levels regarding the consent process and psychological readiness for surgery in adults aged between eighteen to 60 years who were admitted at Mpilo Central Hospital. Peplau’s Interpersonal Process Model was used to guide this study. A descriptive correlational design using a systematic random sampling plan was used to select the clients who met the inclusion and exclusion criteria. Data were collected from a sample of eighty subjects using a structured interview. The instrument was made of namely demographic, psychological readiness for surgery and knowledge levels about surgery sections.

The study findings showed that respondents lacked psychological readiness for surgery. Seventy one (88.8%) of the respondents expressed extreme anxiety, and nine (11.3%) were slightly anxious. Sixty six (82.5%) were extremely afraid of the operation, and fourteen (17.5%) were slightly afraid of the operation.

Knowledge on the consent process is essential in that it helps the patient understand the nature of the operation, its benefits, risks and complications so that the patient makes an informed decision whether or not to undergo the operation.
The level of knowledge regarding the consent process scores ranged from 12 to 25 from a possible 35. Twenty six respondents (23.9%) scored above the mean. The study findings showed a generally low level of knowledge regarding the consent process and psychological readiness for surgery. Fifty four (76.1%) of the respondents scored below the mean. Calculation of the Pearson Product moment correlation test showed that there was a positive correlation (r.375). The results of the study show that levels of knowledge on the consent process have a positive effect on psychological readiness for surgery. R-squared indicated that levels of knowledge regarding the consent process accounts for 1% of variance in psychological readiness for surgery. In this study, the findings supported the premise that as the levels of knowledge increases, psychological readiness also increases.

Discussion and Implications

Sample Demographics

The sample studied was composed of eighty respondents who were all admitted at Mpilo Central Hospital’s surgical wards. The age range was between 20 to 60 years. Phipps et al (2003), stated that as one grows older, disease frequency increases and the need for surgical intervention for various illnesses. The findings of this study indicated a mean age of 36.25 years. Forty six respondents (57.5%) were females as compared to thirty four (42.5%) who were males. This could have been due to the fact that there were more females in the category of gynaecology who were 27.5% . Forty nine respondents (61.3%) were married ,which according to Sowle (2010) is essential for psychological preparedness prior to surgery. One’s spouse is seen as a valuable support system during the difficult time which the patient would be going through.
Seventeen (21.3%) were single and 68% were males, and 61.3% most of the married were females, and all the widowed were females.

More than half (81.3%) of the respondents came from the high density areas. The study was done at a hospital which caters for the poor. The educational level of most (56.3%) of the respondents was secondary. One’s education status is important in that, according to Byrne (2002), the patient understands the information that is imparted to them. The less educated one is, the less likely they are to search for more knowledge regarding their operation. Literacy levels are a good determinant of the tool which the health worker can use to provide information to the patient, for example pamphlets, videos, audio visuals and so on,(Byrne 2002). Almost half of the respondents (48.8%) were unemployed. Cadena (2007) states that one’s security in the work place lessens the worries which the patient has about payment of hospital bills which arise due to the surgical intervention that would have been done on them. Forty (50%) of the respondents had a monthly income status of below $50.00. This is a negative situation in the recovery of the patient as they would need to pay for their hospital bills which might affect their psychological readiness for surgery. According to Crowe, (2003), most patients who fail to adjust to hospital life had either a failed marriage, or relationship or are not doing well at their work places or unemployed. Such patients were discovered to stay in hospital longer by 40% as compared to those who would be having a stable marriage, education and income status (Sharna 2006).The majority of respondents, 71 (88.8%) were Christians. The American College of Surgeons (1998) stresses on the need for health care providers to consider the spiritual aspect of the patient during surgical treatment as
it has either an negative or a positive effect to their treatment outcome. The human being is seen as a bio-psycho-socio-spiritual being, whose religious beliefs must be honored.

Twenty six (32.5%) of the respondents stated that their mother was their next of kin, fifteen (18.8%) had their father as their next of kin, while seventeen (21.3%) had their spouses as next of kin. Sowle (2010) in a study carried out on patients undergoing bariatric surgery reiterated the importance of the family support in the preparation of the surgical patient, as these helped the patient to make a decision which they could all live with whether it was negative or positive. Twenty two respondents (27.5%) were from the gynaecology category while nineteen respondents (23.8%) were in the general surgical category. Sixteen respondents (20%) were in the orthopaedics section and twelve respondents (15%) were in the urology category. While eleven (13.8%) were in the ear, nose and throat (ENT) category.

Psychological Readiness for Surgery

Psychological preparation of a patient undergoing surgery is an important part in the management of that surgical patient as not just physical healing is required but the spiritual and psychological wellbeing are important determinants of one’s health status (American College of Surgeons, 1998).

Psychological readiness for surgery was categorised on the following aspects, ability to measure the presence of stressors, determination of mood state, determination of decisional balance, determination of self-efficacy and determination of the presence of a support system. Almost all, seventy one respondents (88%) had extreme anxiety, and nine respondents (11.3%) were slightly anxious. The American Medical Association(2007) in their study revealed that 78% of those patients who had various
process of stress in their lives, had a weakened healing process as their wounds took 9 days later to heal than in those patients who did not have everyday stresses. Sharma (2006) states that any admission by the patient to anxiety is a sign of lack of psychological readiness for the procedure and that distressing before surgery would be essential for a positive outcome. Kerrigan (1993) in his study of males undergoing inguinal hernia repair showed that 88% of the patients did not experience any anxiety. This is in contrast with results of the above study. Sixty six respondents (82.5%) had extreme fear of the operation. This is in agreement with the study by the National Athletic Trainers Association (2009) which showed that 98% of the patients undergoing anterior cruciate ligament repair expressed fear of the pending surgery.

This is the same result in a study done by the American Medical Association (2007) which showed that (93%) of patient were also afraid of the pain they would experience after surgery, that the surgeon might make a mistake and were afraid that they might not survive the operation. Forty three respondents (53.8%) expressed that surgery was very important to them. This is in contrast with results of the study done by the National Trainers Association(2002) on 44% of athletes undergoing anterior cruciate ligament repair surgery who viewed surgery as not being important to them.

Fifty seven (71.3%) of the respondents in this study were not at all confident about surgery. This concurs with results of the study by the National Trainers Association (2002) which showed that 74% of the patients lacked confidence in surgery. This lack of confidence in surgery might have been necessitated by the fact that most respondents had anxiety and fear of surgery.
More than half, (73.8%) of the respondents strongly agreed that the current family support that they had was sufficient to see them through surgery. Results of a study done by Sharma (2006) revealed that family support helped on 97% of patients to manage their pain better. This is also in agreement with the study done by Sowle (2010) which revealed that family support in 64% of the patients was seen to play a major role in how well they recovered. A study done by the University of Pennsylvania (2006) revealed that in 93% of the patients the presence of a friend and previous acquaintance enabled the patient to cope effectively with surgery. Reviewed literature also showed that a patient’s ability cope in an unfamiliar environment controlled by strangers was often enhanced if the patient was accompanied by a relative or a friend (Crowe, 2003).

Knowledge levels regarding the consent process

Knowledge of the consent process is essential in enhancement of psychological readiness for surgery. The levels of knowledge regarding the consent process for the respondents ranged from 12 to 25 from a possible of 35. The mean score was 16.5. Twenty six respondents (23.9%) scored above the mean. Study findings revealed a generally low level of knowledge on the consent process. On the level of knowledge regarding the consent process categorization, none of the respondents scored between 75 – 100%, thirty five (44.6%) of the respondents scored between 50 to 66.7% and forty five (56.4%) of the respondents scored between 3.8 – 41.7%. These results show that knowledge level scores were below average. This contradicts with the fact that most of the respondents attained secondary education as one would expect their level of understanding to be high unless if medical personnel used too much medical jargon or
that the amount of information that was given was inadequate which might have contributed to low levels of knowledge.

This is in contradiction with a study by Sowle (2010) which showed that 68% of the patients who had a good level of education were able to ask, regurgitate the information and were able to ask questions both from the doctor, nurses and counselors. Byrne’s (2002) study revealed that one’s level of education, medical state and age had an effect on the level of understanding. The illiterate and the elderly tended to avoid the gory details of the operation as they expressed that too much information would confuse them. Those who were too sick or in pain preferred to be spared the lengthy detail of the operation (Byrne, 2002). Scores of below 50% are a cause for concern because it shows that these respondents’ level of knowledge is not adequate. These can improve if the surgical patients are taught on their procedures also with the full utilization of the department of Health Education which is responsible for the dissemination of health information.

Seventy three (91.3%) of the respondents were given information by the doctor, which was appropriate because according to Cadena (2007), the surgeon or physician is the one who is ultimately responsible for obtaining the signature while the nurse witnesses the event. ICN (2004) and the Boston Globe (2007) are in contradiction with the above as they say that the nurse is the one who also obtains the signature, asks the patient to consent, explains the risks and the problem of the disease if the patient refuses surgery. McKeague & Windsor (2003) in their study revealed that 79% of the patients were informed by the registrar while only 14% were informed by the consultant.
Fifty two (65%) of the respondents signed the informed consent process hours before surgery. According to Foreman (2005), the patients need time to assimilate the information they would have received prior to surgery, to even consult relatives, friends, although the assumption might be that since it was elective surgery, the doctor might have taken, days or weeks preparing the patient in the Outpatient Department or surgical clinic.

Sixty seven (83.8%) of the respondents in this study were only told about the reasons for surgery. This is in contradiction with results in Kerrigan’s study (1993) which found out that of those men who were told the reasons, benefits, risks, complications and alternatives to surgery, 88% of the patients remained stable. Merriam-Webster (2007) in her study showed that 86% of the patients who received detailed information, did not have anxiety compared to those who did not receive much information and exhibited some level of anxiety.

Almost all (88.8%) of the respondents were aware of the body part to be operated on. This is in contradiction with the study that was carried out by Byrne, Napier and Cuschieri (2000), which showed that 68% of the patients expressed that they could only remember that they were operated on but could not recall the organ operated on. The wound was the only guide on where the operation was done.

Forty nine (61.3%) of the respondents disagreed that it is a legal requisite to sign the informed consent process before surgery. This concurs with a study done by Akad et al (2004) where 78% of the patients did not see the signing of the consent process as functioning in their own interests, however in a study done by the University of
Pennsylvania (2005) 88% believed that it was a legal requisite to sign a consent process before surgery.

Fifty four (67.5%) of the respondents disagreed that a patient can change his/her mind even after signing the informed consent process. In a study done by the University of Pennsylvania (2005), 33% of the respondents were not aware that they could change their minds after signing the consent process. Twenty nine (36.3%) of the respondents disagreed and twenty five (31.3%) of the respondent strongly disagreed that their next of kin could sign on their behalf if they were unable to do so in an emergency.

This is an agreement with the study done by University of Pennsylvania (2005) where 71% of patients were not aware that their next of kin could sign on their behalf if they were unable to do so. This shows that most patients are not aware of their legal rights regarding the informed consent process.

Forty five (56.3%) of the respondents disagreed that the doctor could perform a different procedure from that specified on the process even if it is necessary.

A study done by RCN (2004) showed that signing of the consent process was seen as a bureaucratic hurdle which satisfied administrative and legal requirements without satisfying patients’ needs. Seventy eight percent of patients in that study also refused to give the doctor full rights to do as they wished.

Forty six (57.7%) of the respondents disagreed that the signing of the consent process was to protect the hospital from litigation. Forty six percent of the respondents in the study done by the University of Pennsylvania (2005) believed that signing of the consent process helped to protect the hospital from litigation while 71% thought that it gave the doctor control over what happened.
Thirty eight (47.5%) of the respondents disagreed that they were given enough time to think about operation before signing the informed consent process. In a study done by Byrne (2002), 67% of the subjects felt that they were not given sufficient time to ask questions. In another study done by McKeague and Windsor (2003), 94% were satisfied with the amount of time given prior to the operation. Some degree of pressure to sign the consent process was experienced by 38% of the patients. Enough time to think about the operation helps in that those patients who are not ready for surgery either defer or cancel their operation schedule and it helps avoid taking those patients who are not psychologically ready for surgery.

Relationship between knowledge levels regarding the consent process and psychological readiness for surgery.

Application of the Pearson product moment correlation was done to examine the relationship between the knowledge level regarding the consent process and psychological readiness for surgery. It showed a positive correlation (r = .375) implying that as knowledge on the informed consent process increases, psychological readiness for surgery also increases. Linear regression showed that the level of knowledge on the consent process had a positive effect on the psychological readiness for surgery although in theoretical terms the effect seemed insignificant-squared indicated that levels of knowledge on the consent process accounts for 1%. Variance in psychological readiness for surgery. The study findings supported the premise that as knowledge levels increase, psychological readiness for surgery also increases although in theoretical terms the strength was weak and insignificant.
Theoretical Framework

Hildegard Peplau’s interpersonal process model was used to guide this study. The focus of the assumption of the model is that all individuals have the potential to change the self and move towards health. Anxiety is seen as an important determinant of growth since the self-system is an anti-anxiety system which the individual uses to overcome the challenges in his life, in this case surgery. The concepts chosen were the interpersonal process, the nurse, the patient and anxiety.

According to Peplau (1986), there is a direct relationship between anxiety and illness. In illness, the energy from anxiety for growth is instead bound in non-healthy symptoms like headache, raised blood pressure and a high pulse rate which make it difficult for the surgical patient to be fully prepared for surgery.

A major goal of the nurse would be to assess the degree of anxiety existing in the patient’s life. The way it’s communicated by the patient and its effect upon the patient’s ability to learn and maintain healthy behavior patterns by showing an understanding of their illness and the need for surgery and implementation of strategies that effectively reduce debilitating levels of anxiety. Through interpersonal interaction with the patient, the nurse facilitates the patient’s ability to process symptom bound energy into problem solving energy, and that only the individual can change himself as he deals with his fears.

Knowledge on the informed consent process was considered as a goal of nursing in which it was assumed that if patients have such knowledge, this will ensure psychological preparedness for surgery. The framework was useful in this study in the sense that it focused on anxiety which is seen as a normal response to the presence of a stressor or any threatening situation, but the way the patient deals with it will depend on whether its
effects are beneficial, that is towards positive decisions towards surgery. With the nurse using her six roles of being the resource person, the teacher, counselor, surrogate and advocate the patient is psychologically prepared for surgery. The nurse patient relationship should seek to free energy in anxiety and illness to being a productive person. This the interpersonal process leads to intended consequences of the model – higher degree of health.

Implications to Medical and Surgical Nursing Practice

The following are the implications to medical-surgical nursing practice. More effort must be made by the nursing fraternity to teach patients on the informed consent process. Psychological preparation of a patient should be reinforced to reduce the number of patients who withdraw from surgery or who complain about lack of readiness in surgery. There is need for the patient to make an informed decision as knowledge of the informed consent process will lessen unnecessary delays in surgery. Various process of disseminating information like pamphlets, journals and videos should also be used in patient teaching.

Research

Medical and surgical nursing should be influenced by research and be evidence based. There is need to focus on future research which should be on the development of psychometric scales to be used for assessing psychological readiness for surgery, and formulation of different consent process for each faculty of medicine as each has got different aspects peculiar to it. For example for gynaecology in a female undergoing
hysterectomy, there would be a need to include the spouse’s consent as there is permanent loss of the ability to bear children which most spouses do not agree with.

Administration

The findings of the study indicate that lack of knowledge regarding one’s operation, its benefits, risks and complications and lack of psychological readiness for surgery are situations which if not properly handled could end up with the hospital being sued for battery. There is need to emphasise on its importance to both doctors and nurses.

Education

There is need to incorporate psychometric measurements in preparing a patient for surgery in the medical surgical nursing curricula as anxiety is bound to occur in almost every surgical patient and that there would be need to find ways to psychologically prepare the patient. Pre and post-operative preparation and care of a patient should become an examinable area so that there’s improved care of the surgical patient and so that the students appreciate its importance.

Recommendations

1. Medical - surgical nursing should enhance the client’s ability to identify stressors in their life and be able to deal with them, for example the presence of anxiety, and to find support systems for dealing with challenges which include both the patient’s own next of kin and nurses who would assist the individual to cope effectively.
2. There is need to reopen the department of health education and include periodic ongoing teaching of health care providers on how to psychologically prepare patients for surgery.

3. There is need to make use of trained nursing personnel in psychology to be able to provide the necessary counseling of patients and to identify and delay the surgery of those patients who are not psychologically ready for surgery.

4. Further research could be done to find out more information about other variables that have an effect on lack of psychological readiness for surgery and knowledge on the informed consent process. The study could focus on doctors and nurses as they are the ones who provide the education.

5. Peplau’s interpersonal process model could be used to understand the relationship between the use of psychometric evaluation tools in the preparation of a patient undergoing surgery.

6. Further revision needs to be made on the current consent process that is used in the hospitals as most of the information on it is outdated and shallow and would need to have a consent process created for each category of surgery.

Limitations

Limitations are restrictions in a study that may decrease the general ability of the study findings (Burns & Grove, 2005). The following were limitations of this study

1. The investigator developed own instrument under the guidance of the psychological readiness for surgery concepts in the study and knowledge on the consent process in the study. However, efforts to ensure content validity and
reliability of the instrument was realized by consulting senior experts staff working in the surgical and psychology department.

2. The investigator used face to face interviews which is disadvantageous in that subjects could have given socially accepted responses.

3. The study targeted only those undergoing elective surgery and excluded those with emergency procedures, therefore the results cannot be generalized.

Summary

Lack of psychological readiness for surgery has a critical impact on the emotional state and post-operative state of that patient. The number of patients postponing or complaining about surgery is increasing rapidly (Mpilo Public Relations Officer’s report, 2009). The purpose of this study was to examine the relationship between knowledge levels regarding the consent process and psychological readiness for surgery. The study utilised Hildegard Peplau’s interpersonal process model. A descriptive correlational design was used and a probability sampling method was used. The study had three instruments namely demographic questionnaire, psychological readiness for surgery questionnaire and knowledge levels regarding the consent process and face to face structured interviews were used to collect data from 80 subjects. Calculation of the Pearson Product Moment correlation test showed that there was a positive but weak correlation (r=.375) between knowledge levels on the informed consent process and psychological readiness for surgery. Results supported that knowledge of the consent process increases psychological readiness for surgery.
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Sharma, V. (1996). C:\documents and settings\admin\desktop\health\stress of surgery can be reduced (part 1).mht.www.uri.edu


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APPENDIX A
Informed Consent

My name is Charity Gamuchirai Nyandoro. I am a student at the University of Zimbabwe doing a Masters of Science Degree in Nursing Science. I am carrying out a research project to examine the relationship between knowledge levels on the informed consent process and psychological readiness for surgery. The research will provide information that will enable nurses to improve on the nursing care of surgical patients. Although the study might not benefit you directly, it will provide information that will benefit others in future. In making your decision to participate be assured that all information will be treated confidentially. You are requested to answer the following questions honestly. No names will be used as data will be coded. None of the collected data will be shared with anyone without your permission and will be stored in a secure place. The interviews will take about 30 – 45 minutes of your time. You are free to ask questions about the study or about being a subject for queries and further clarification; my study address is MpiloCentralHospital, P O Box 2096, Bulawayo. Phone Number: (09) 208050, Cell number 0772401758, email address; charitynyandoro@yahoo.com. You are also free to contact the Medical Research Council for any clarification on telephone number 04-791792 or email address mrcz@mrczimahred.co.zw

Participation declaration: The study described above has been fully explained to me and I voluntarily consent to participate in the study.

Signature………………………………………. Date…………………

I have explained the study to the subject and have sought her understanding for Informed Consent.
Thank you.
APPENDIX B

DEMOGRAPHIC DATA QUESTIONNAIRE

SECTION A

INSTRUCTION

I am going to ask questions about yourself, would you respond to the best of your ability?

Section A

1. How old are you?
   - Below 20
   - 20-29
   - 30 – 39
   - 40 – 49
   - 50 – 59
   - 60 years

2. What is your gender?
   - Male
   - Female

3. What is your marital status?
   - Single
   - Married
   - Separated
   - Divorced
   - Widowed

4. Where do you stay?
   - High Density area
   - Low Density area
   - Rural area
5. What is your academic level of education?
   - Never attended school
   - Primary level
   - Secondary level
   - Tertiary level

6. What is your employment status?
   - Employed
   - Self Employed
   - Not employed

7. What is your income status?
   - Below $50
   - $51-$100
   - $101 - $200
   - Above $200

8. What is your religion?
   - Christianity
   - Moslem
   - Traditionalist
   - Other - Specify

9. Who is your next of kin?
   - Mother
   - Father
   - Spouse
   - Son
   - Daughter
   - Other – specify

10. Did you know the operation you were going for?
    - Yes
    - No
SECTION B

KNOWLEDGE LEVEL ON THE INFORMED CONSENT PROCESS QUESTIONNAIRE

11. Who gave you the information about your operation?
   1. Nurse
   2. Anaesthetist
   3. Doctor

12. When did you sign the consent to operate process?
   1. A few minutes before surgery
   2. Hours before surgery
   3. A Day before surgery
   4. Days before surgery

13. Regarding the information about surgery, what were you told about?
   1. Reasons for surgery
   2. Reasons and benefits for surgery
   3. Reasons, benefits and risks of surgery
   4. Reasons, benefits, risks, complications and alternatives to surgery

14. Are you aware of which body part is to be operated on?
   No
   Yes

Ability to recognize the legal status of the consent process.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. It is a legal requisite to sign the consent process before the operation</td>
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<tr>
<td>16. A patient can change his/her mind even after signing the consent process.</td>
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<tr>
<td>17. Your next of kin can sign on your behalf if you are unable to sign for</td>
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<td>yourself in an emergency.</td>
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<tr>
<td>18. The doctor can perform a different procedure from that specified on the process if it is necessary.</td>
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<tr>
<td>19. The importance of signing the consent process is to protect the hospital from litigation.</td>
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</table>

**The ability to give free consent**

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<tbody>
<tr>
<td>20. Enough time was given to me to think about the operation before signing the consent process?</td>
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</table>
SECTION C

Psychological readiness for surgery questionnaire

Ability to recognize presence of stressors

21. Are you currently experiencing anxiety related to surgery?  
   1. Extremely  
   2. Slightly  
   3. Not at all

Determination of mood state

22. Are you afraid of the operation?  
   1. Extremely  
   2. Slightly  
   3. Not at all

Determination of decisional balance

23. How important is this operation to you?  
   1. Least important  
   2. Not important  
   3. Important  
   4. Very important

Determination of self efficacy

24. How would you rate your confidence about going for the operation?  
   0. Not at all confident  
   1. Slightly confident  
   2. Confident  
   3. Very confident

Determination of presence of a support system

25. The current family support I have is sufficient to see me through the operation  
   0. Strongly Disagree
1. Disagree
2. Agree
3. Strongly agree
Appendix C

Incwadi Yesivumelwano


Ikheli lami lokuhlolisisa yileli elilandelayo MpiloCentralHospital, P. O. Box 2096, Bulawayo. Phone Number (09)208050.

Ukuvuma kohlanganelayo : Isifundo esichaziweyo phezulu sichasisiwe kimi ngokujulileyo njalo ngiyavuma ukuhllanganela kulesisisifundo

Ibizo ------------------------------ usuku-----------------------------

Sengichazile isifundo lenhlosa njalo ngadingisisa ukuzwisisa

Umfakazi ------------------------------ Usuku-----------------------------

111
APPENDIX D

DEMOGRAPHIC DATA QUESTIONNAIRE (NDEBELE)

Isigaba sokuqala

Isixwayiso

Ngizakubuza imibuzo ngawe kumele uphendule ngokwanelisa kwakho.

1. Uleminyaka emingaki?

Iminyaka engaphansi kwe20

20-29

30-39

40-49

50-59

60

2. Ungumhlobo wuphi?

Owesilisa

Owesifazana

3. Uthethe na?

Hatshi

Yebo ngithethe

Seselukana

Sengasula umtshado

Ngafelwa

4. Uhlala ngaphi?
Emalokitshini
Emasabhabha
Emakhaya

5. Wafunda wafika kusiphi isibanga?
Angizange ngiye esikolo
Ngafika kugrade 7
Ngafika esekhondari
Ngafika ekolitshini

6. Uyasebenza na?
Ngiyasebenza
Ngiyazisebenza
Angisebenzi

7. Iholo lakho limi njani?
Phansi kwe $50
Phakathi kwe $51-$100
Phakathi kwe $101-$200
Phezu kwe $200

8. Iyiphi inkolo yakho?
NgingumKristu
Ngingumoslem
Ngeyesintu
Okunye chasisa
9. Ngubani isihlobo sakho seduzane?

Umama

Ubaba

Umkakho

Indodana yakho

Indodakazi yakho

Omunye/ chasisa
ISIGABA SESIBILI

Ulwazi ololutshiweyo kuleliphepha lobufakazi

10. Ngubani owakunika ulwazi ngokuhlinzwa?

Ngumongikazi
Ofundele ukulalisa
Udokotela

11. Ukuhlinzwa kwakho ngokwayiphi ingxenye?
eyenyama yaphezulu
Ngeyesinye
Nyeyamathambo
Nyeyokomthambiso
ngokwamakhala lompimbo

12. Wacindezela nini isifungo sokuhlinzwa?

Imizuzu emilutshwana ngingakahlinzwa
Amahola athize ngingakahlinzwa
Ilanga elilodwa ngingakahlinzwa
Amalanga athize ngingakahlinzwa

Ukwenelisa ukukhumbula ngezehlakalo zoku hlinzwa

13. Mayelana lokuhlinzwa yikuphi owakutshelwayo

Izizatho zokuhlinzwa
Izizatho lobuhle bokuhlinzwa
Izizatho lobuhle lobunzima bokuhlinzwa

Izizatho, ubuhle, ubunzima lokungenzima ngaphandle kokuhlinzwa

14. Uyazi naisitho somzimba esizahlinzwa?
Hatshi

Yebo

Amandla okunanzelela isimo somthetho kulolugwalo lokufunga

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<tr>
<th></th>
<th>Ngiyaphikisa</th>
<th>Angivumi</th>
<th>Ngiyavuma</th>
<th>ngiyavuma ngeqiniso</th>
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<tbody>
<tr>
<td>15. Kuyinto esemthethweni ukufaka uphawu ngingakahlinzwa</td>
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<tr>
<td>16. Ngingatshintsha ingqondo loba sengifake uphawu</td>
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<tr>
<td>17. Isihlobo esiseduze singafaka uphawu lwaso nxa ngingenelisi</td>
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<tr>
<td>18. Udokotela angahlinza lapho esingavumelananga khona</td>
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<tr>
<td>19. Uphawu lwami encwadini yesivumelwano lwenza ukuthi isibhedlela singabotshwa</td>
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Ukwenelisa ukuvuma ngenhliziyo emhlopho

|                               |              |          |           |                     |
| 20. Ngaphiwa isikhathi eseneleyo ngokuhlinzwa ngingakafaki uphawu |          |          |           |                     |
ISIGABA SESITHATHU

Ukulungiselela ingqondo mayelana lemibuzo yokuhlinzwa

Amadla okunanzelela okukhathaza ingqondo

21. Ulokungahlaliseki engqondweni okumayelana lokuhlinzwa khoakho na?
   awuhlalisekanga engqondweni?

Khakhulu
Kancane
Ngitsho

22 Uyesaba ukuyahlinzwa

Kakhulu
Kancane
Ngitsho

Ukwenelisa ukuthatha isinqumo esiqakathekileyo

23. Kuqakatheke kangakanani ukuhlinzwa kwakho

Akuqakathekanga ngitsho
Akuqakathekanga
Kuqakatheke
Kuqakatheke kakhulu

Ukuhloxisa kokuphathisa kokuzinikela

24. Uzihlola kanjani ngesibindi sokwanelisa ukuzinikela?

Angilasibindi ngitsho
Ngilesibindi esincane
Ngilesibindi

Ngilesibindi kakhulu

**Ukuvuma kokubakhona kokuphathisa**

25. Ukuqiniswa yimuli kwanele okungenza ngama ekuhlinzweni

Ngiyaphikisa ngokuphakemeyo

Ngiyaphikisa

Ngiyavuma

Ngiyavumangokuqinisekileyo
APPENDIX E

Chinyorwa chechibvumirano


Kubvuma kuva nhengo yekuzeya:Kuzeya kwatawurwa pamsoro ndakutsananguirwa wuye ndinobvuma kuva nhengo yekuzeya uku.

Zita remuzeyewa ..................................................

Ruoko .............................................................

Zuva .............................................................
Ndatsanangurira uyoarinhengo yekuzeywa uye kuti anzwisisa zvandamutsanangurira akagutsikana nazvo.

Zita remuzeyewa ............................................................

Ruoko .................................................................

Zuva .................................................................

Zita repakazi ............................................................

Ruoko .................................................................
**APPENDIX F**

**Chinamatidzwa A**

Ndichabvunza mibvunzo pamusoro pako, ungada kupindura sekuda kwako

**Chikamu chekutanga**

1. Munemakore mangani?

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<td>50-59</td>
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2. Muri muhnui?

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<td>Mukadzi</td>
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3. Makamira seyi panyaya dzekuroora kana kuroorwa?

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4. Munogara kupi?

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<tr>
<td>Kumarukesheni</td>
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</table>
Kumasabhabha

Kumaruwa

5. Makasvika padanho ripi panyaya dzezvedzidzo?

Handina kumboenda kuchikoro

Ndakagumira kupuraimari

Ndakagumira kusekondari

Ndakasvika kukoreji/kuyunivhesiti

6. Munoita basa reyi?

Ndinoshanda

Ndinozvishandira

Andishandi

7. Munotambira mari yakawanda zvakadii pamwedzi?

Pasi pe$50

$51-$100

$101-$200

Pamusoro pe$200

8. Munopinda chitendero chipi?

NdirimuKristu

NdirimuMoslem

Ndiri wechivanhu
Zvimwe (jekea)………………….

9. Ndiyani hama yako yepedyo

Amai
Baba
Murume /mukadzi
Mwanakomana
Mwanasikana

Zvimwe (jekea)………………………………………………..
CHIKAMU CHECHIPIRI

Ruzivo nokuda kwe bepa rekubvumirana

10. Ndiyani akakupa ruzivo nekuvhiiyiwa kwako?

Mukoti
Anondirarisa
Chiremba

11. Urikuziva here chikamu chokuvhiiyiwa kwako?

Ndechenyama dzekunze
Ndechechibereko
Ndezvekokuenda kunze
Ndezvemhino nzeve pahuro
Andizivi

12. Makasaina bepa rokutenderana kuvhiiyiwa rini?

Maminiti mashoma ndisati ndavhiiyiwa
Maawa ndisati ndavhiiyiwa
Zuva rimwechete ndisati ndavhiiyiwa

Kugona kurangarira nezvekuvhiiyiwa

Tichitarisa nekuvhiiyiwa kwako ndezvipi zvawakawudziwa ?

Chikonzero chokuvhiiyiwa
Chikonzero nezvinondibatsira pakuvhiiyiwa
Chikonzero, zvinondibatsira nenjodzi pakuvhiiyiwa

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13. Munoziva here nhengo yemuviri wenyu ichavhiyisa

Kwete

Hongu

**Kugona kucherechedza zviripamutemo nebebpa rechibvumirano**

<table>
<thead>
<tr>
<th></th>
<th>Kana zvachose</th>
<th>Andibvumiranenazvo</th>
<th>Ndinobvuma</th>
<th>Ndinobvuma zvachose</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Zviripamutemo here kusaina bepa rechitenderano musati mavhiyiwa?</td>
<td></td>
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<tr>
<td>15. Murwere anokwanisa kushandura pfungwa dzake nyangwe atosaina</td>
<td></td>
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<tr>
<td>16. Hama yako inotenderwa kusaina yakakumirira kanausingakwanisi</td>
<td></td>
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</tr>
<tr>
<td>17. Chiremba anotenderwa kuvhiya imwe nhengo yemiri wako musina kutenderana</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>18. Kusaina bepa rekutenderana kunobatsira kutichipatara chisazopomerwa</td>
<td></td>
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</tr>
</tbody>
</table>

**Kugona kusaina bepa rechibvumirano wakasununguka**

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<tr>
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<th>Ndinobvuma zvachose</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Ndakapiwa nguva yakakwana ndichifungu nekuvhiyiwa ndisati ndasaina</td>
<td></td>
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</tr>
</tbody>
</table>
CHIKAMU CHECHITATU

Mibvunzo yokugadzikana kwepfungwa munhu asati avhiyiwa

Kugona kucherechedza zvinotambudza pfungwa

20. Murikumbudzika here nekuvhiyiwa kwenyu?

Zvikuru
Zvishoma
Kwete

21. Munonzwa muchitya here kuvhiyiwa?

Zvikuru
Zvishoma
Kwete

Kugona kupa sarudzo yakakosha

22. Kuvhiyiwa kwakakosha zvakadii kwamuri?

Kwakakosha zvishoma
Hakuna kukosha
Kwakakosha
Kwakakosha zvikuru

Kugona kumira wega usina kumanikidzwa
23. Unowona sei kuzigadzirira kwako uchienda kunovhiyiwa?

Andina kugadzirira
Ndakagadzirira zvishoma
Ndakazvigadzirira
Ndakazvigadzirira chaizvo

**Kugona kucherechedza vanomira neni**

24. Hama dzangu dzakamira neni ndichivhiyiwa

Andibvumi zvachose
Andibvumi
Ndinobvuma
Ndinobvuma zvachose
22 February 2010

The Chief Executive Officer
Mpilo Central Hospital
P.O Box 2096
Bulawayo

RE: REQUEST TO CARRY OUT A STUDY AT MPilo CENTRAL HOSPITAL
BETWEEN THE PERIOD OF APRIL TO MAY.

Dear Madam

I am seeking permission to carry out a study in your institution.

My name is Charity Gamuchirai Nyandoro and am requesting to carry out research in partial fulfillment of the Master of Science in Nursing Science degree programme, at the University of Zimbabwe.

Your consideration will be greatly appreciated.

Yours sincerely

Charity Gamuchirai Nyandoro