

SCIENTIFIC REPORT

What patients want to know before they have cataract surgery

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Aims: To investigate what patients want to know before undergoing cataract surgery.

Methods: A written questionnaire was answered by 190 patients prior to cataract surgery.

Results: The five pieces of preoperative information rated most important were: chance of visual improvement; when vision would improve; overall risk of losing vision from the operation; effect of not having the operation, and the types of serious complications. When asked “should you be warned of a serious complication if it has a risk of happening”, 93.5% said yes to a risk of 1 in 50 and 62.4% to 1 in 1000. Written information was requested by 85.7%. There were few differences between the sexes, and between those having their first or second operation.

Conclusions: Patients most wanted to know benefits and risks, even very small risks. Written information should be provided to ensure coverage and reinforce verbal information.

Informed consent has become an important part of medical practice,¹ and often a legal necessity for surgical procedures.² However it can be difficult to define how much and what kind of information is required before a patient can be said to have made an “informed decision”. The physician and the patient may have different opinions on what the patient needs or wants to know.³ Recent studies have examined what patients want to know before consenting to anaesthesia, general surgery, and otolaryngological surgery.^{3–12} However, there is no such data for ophthalmic surgery (PubMed and Medline searches). The aim of this study was to clarify what preoperative information patients wanted before they had cataract surgery.

METHOD

Approval was obtained from the Canterbury Ethics Committee. Two hundred and three consecutive patients booked to undergo elective routine cataract surgery were asked to complete a questionnaire before the start of their preoperative assessment visit in the Ophthalmology Department of Christchurch Public Hospital. This was before any formal information had been given by department staff, other than the verbal discussion leading to their booking some months previously. The questionnaire can be viewed online (www.bjophthalmol.com). For the questions on risk, the term “serious” was not defined for the patient.

RESULTS

Out of the 203 consecutive pre-admission patients requested to take part, 13 did not participate either because of a conscious decision not to, or because they were too physically or intellectually disabled. Therefore the study population was 190.

Of questionnaire responders, 59.7% were female, and the average age was 75.49 years. Two thirds of respondents were to undergo their first cataract operation. Data are presented in tables 1 and 2. The most important information wanted was the chances of the patient’s vision improving after surgery. Next were: when the vision would improve; the risk of losing vision; the consequences of not having the operation, and the types of serious complications. Awarded least importance was the technical detail of the cataract operation, although over 70% still awarded it a “3” or above.

We compared responses to questions 1–13 between males and females, using χ^2 . Where only a few “outliers” to each question were present (scale responses “1” to “3”), the small numbers were grouped. With $p < 0.05$, females placed higher importance on knowledge of the anaesthetic details, the overall risk of losing vision from the operation, and the types of serious complications (although all were still important to males as the majority awarded high scale grades). With $p < 0.05$, those about to have their second operation placed less importance on knowing the chance of their vision improving, the types of serious complications, and all of the possible complications.

The questions on defined levels of risk, legal requirement, and information delivery had large numbers of non-respondents (table 2). These were deemed too large for statistical comparisons between sex and first or second operation. We did find that as the level of risk decreased, the percentage wanting to be informed of it decreased, although 25% of all 190 patients still wanted to be informed of a serious complication if it had a risk of one in ten thousand.

DISCUSSION

The most important knowledge was the chances of visual improvement, when it would occur, and the overall risk of losing vision from the operation. These results are similar to an ENT study³ which found patients considered it most

Table 1 Responses to questions on Likert scale

| Questions | % of responses per grade | | | | | No* |
|-----------|--------------------------|------|------|------|------|-----|
| | 1 | 2 | 3 | 4 | 5 | |
| Q1 | 7.5 | 4.3 | 12.4 | 20.4 | 55.4 | 186 |
| Q2 | 8.6 | 5.9 | 12.3 | 24.6 | 48.6 | 187 |
| Q3 | 9.8 | 6.5 | 13.0 | 25.6 | 45.1 | 184 |
| Q4 | 4.3 | 1.6 | 4.3 | 16.7 | 73.1 | 186 |
| Q5 | 1.1 | 1.6 | 1.6 | 10.1 | 85.6 | 188 |
| Q6 | 1.1 | 3.2 | 3.7 | 11.2 | 80.8 | 187 |
| Q7 | 8.2 | 6.0 | 17.5 | 17.5 | 50.8 | 183 |
| Q8 | 15.8 | 12.5 | 20.1 | 17.9 | 33.7 | 184 |
| Q9 | 9.6 | 6.4 | 9.1 | 13.4 | 61.5 | 187 |
| Q10 | 10.8 | 6.5 | 13.4 | 13.4 | 55.9 | 186 |
| Q11 | 3.3 | 3.3 | 7.6 | 7.6 | 78.2 | 184 |
| Q12 | 4.4 | 5.5 | 7.2 | 12.6 | 70.3 | 182 |
| Q13 | 5.4 | 8.7 | 12.0 | 12.5 | 61.4 | 184 |

*The total study population was 190.

Table 2 Responses to categorical questions

| Description | No | % | No response* |
|-----------------------|-----|------|--------------|
| Sex | | | |
| Female | 117 | 59.7 | 7 |
| Male | 79 | 40.3 | |
| Second operation? | | | |
| No | 127 | 66.5 | 11 |
| Yes | 64 | 33.5 | |
| Warn if 1 in 50 risk? | | | |
| No | 10 | 6.5 | 47 |
| Yes | 145 | 93.5 | |
| 1 in 100 | | | |
| No | 18 | 15.9 | 89 |
| Yes | 95 | 84.1 | |
| 1 in 1000 | | | |
| No | 38 | 37.6 | 101 |
| Yes | 63 | 62.4 | |
| 1 in 10000 | | | |
| No | 51 | 50.0 | 100 |
| Yes | 51 | 50.0 | |
| Legally required? | | | |
| No | 15 | 8.5 | 25 |
| Yes | 162 | 91.5 | |
| Verbal | | | |
| No | 1 | 0.7 | 56 |
| Yes | 145 | 99.3 | |
| Written | | | |
| No | 15 | 14.3 | 97 |
| Yes | 90 | 85.7 | |
| Video | | | |
| No | 37 | 77.1 | 154 |
| Yes | 11 | 22.9 | |
| Internet | | | |
| No | 41 | 91.1 | 157 |
| Yes | 4 | 8.9 | |

*No response to that particular question; the subject may have answered some of, or all of, the rest of the questionnaire.

important to meet the surgeon (which we did not ask because they knew they were about to do so), know the advantages and disadvantages of possible treatments (which grouped several questions asked in this study), the common risks and complications, the operative technique, and discussion of the rare risks of the operation. Responses in other studies^{3 4 6 7} are not comparable because of the specialty specific questions and methodological differences.

When considering the absolute responses to each question rather than their ranking, the majority of responses for all questions were from "3" to "5", with a response rate of over 90% for each question. This suggests that all of this information in Q1–13 should be given to patients.

Comprehensive preoperative information causes little or no increase in overall patient anxiety.^{3 4 6–8} The question of how large a risk must be before it should reasonably be regularly disclosed is more difficult to answer. We found that 62.4% of patients felt they should be warned of a serious complication

if it has a risk of happening of 1 in 1000. In a study on general surgery,³ 67% of patients thought that all "serious risks" should be explained when the chance of their occurrence was greater than or equal to 1 in 1000. Unfortunately conclusions from our data on risk must be made with caution owing to the number of non-respondents. Many respondents circled a response to only one of the levels of risk, suggesting they may have misunderstood the intent of the question. This was not the case for questions 1–13.

Poor patient recall of verbal preoperative information is well documented^{1 4 6 10} and most respondents wanted written preoperative information. A standard written information sheet may also be the best medium in which to mention rare complications, leaving time for the surgeon to verbally discuss the particular risks and postoperative expectations pertaining to that particular patient.



The questionnaire can be viewed on the *BJO* website (www.bjophthalmol.com)

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REFERENCES

- 1 Nisselle P. Informed Consent. *N Z Med J* 1993;**106**:331–2.
- 2 Health and Disability Commissioner's Regulations (1996) of NZ. Wellington, New Zealand: Government Printer, 1996.
- 3 Newton-Hawes PAG, Bedford ND, Dobbs BR, et al. Informed consent: what do patients want to know? *N Z Med J* 1998;**111**:340–2.
- 4 Dawes P, Davison P. Informed consent: what do patients want to know? *J Royal Soc Med* 1994;**87**:149–52.
- 5 Courtney MJ. Information about surgery: what does the public want to know? *Aust N Z J Surg* 2001;**71**:24–6.
- 6 Garden AL, Merry AF, Holland RL, et al. Anaesthesia information—what patients want to know about anaesthesia. *Anaesth Intensive Care* 1996;**24**:594–8.
- 7 Kain ZN, et al. Parental desire for peri-operative information and informed consent: a two-phase study. *Anesth Analg* 1997;**84**:299–306.
- 8 Lonsdale N, Hutchison GL. Patients' desire for information about anaesthesia. *Anaesthesia* 1991;**46**:410–12.
- 9 Bryme DJ, Napier A, Cuschieri A. How informed is signed consent? *BMJ* 1988;**296**:839–40.
- 10 Morgan LW, Schwab IR. Informed consent in senile cataract extraction. *Arch Ophthalmol* 1986;**104**:42–5.
- 11 Taylor D. "Don't worry my good man—you won't understand our medical talk": consent to treatment today. *Br J Ophthalmol* 2001;**85**:894–6.
- 12 Nijkatip MD, et al. Determinants of patient satisfaction after cataract surgery in 3 settings. *J Cataract Refract Surg* 2000;**26**:1379–88.