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A Qualitative Exploration of Informed Consent Practices for Emergency Surgery in Two Tertiary Hospitals in Uganda

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Abstract

Healthcare providers working in poorly equipped emergency departments within low-income countries frequently encounter difficulties when trying to secure informed consent from incapacitated individuals or their family members. These situations are usually marked by severe time pressure and occur in highly crowded conditions. For this reason, the current study set out to examine the actual informed consent procedures followed by medical professionals during emergency surgical interventions in two emergency surgical departments at two major teaching hospitals in Uganda. From October 2022 to February 2023, key informant interviews were performed in Uganda. Sixteen staff members were deliberately chosen from the surgical emergency teams at these two tertiary teaching hospitals. In addition, the research team directly observed how informed consent was being carried out in practice. All collected data were organized and examined inductively through NVivo version 12. Analysis of the key informant interviews revealed six central themes: staff knowledge and opinions concerning informed consent; the steps, routines, and real-world application of consent procedures; methods used to communicate during consent; ethical aspects involved; perceived advantages of obtaining consent in surgical emergencies; and the various obstacles faced when seeking emergency consent. Although the participating staff demonstrated reasonable understanding of informed consent principles, they reported facing numerous practical difficulties, largely due to the lack of formal institutional guidelines. In general, the consent process was unsatisfactory at both facilities. Basic elements such as greeting the patient, clearly outlining risks, and verifying comprehension were consistently performed inadequately. Discussions occurred in loud, disruptive surroundings at both locations, and the public hospital offered no private space whatsoever for these conversations. While emergency personnel at both institutions demonstrated solid theoretical knowledge of consent requirements, real-world application revealed major shortcomings, particularly in explaining risks and ensuring that patients or relatives fully understood the surgical procedure, including its potential risks and benefits. Staff emphasized the urgent need to develop standardized, procedure-specific consent documents that clearly record the information shared with the patient. They also called for official policies addressing consent in cases involving incapacitated patients who have no available surrogate decision-makers.

Keywords: Emergency surgery, Informed consent, Emergency staff, Uganda

Introduction

The surgical emergency department demands swift clinical decisions, which frequently complicates the emergency physician's ability to fully observe the four fundamental principles outlined in the Belmont Report — namely respect for persons (autonomy), non-maleficence, beneficence, and justice — principles rooted in the Hippocratic oath [1-3]. In low-income countries, hospital emergency units are commonly overcrowded and rarely provide sufficient privacy for informed consent. True informed consent entails clearly

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explaining the planned surgical intervention, its associated risks and benefits, as well as any available alternative treatments, confirming that the patient comprehends this information, and obtaining documented agreement from someone who possesses decision-making capacity. However, in many urgent surgical cases, the patient's capacity to consent is compromised, and occasionally no family member, caregiver, or legal surrogate is present to grant immediate permission for life-saving treatment. Under such circumstances, the responsible surgeon may need to proceed based on what they judge to be in the patient's best interest [4]. This is unavoidable when dealing with conditions that threaten life or cause permanent harm if not addressed promptly. In teaching hospital environments, surgical trainees are often the first clinicians to diagnose the emergency condition and subsequently perform the operation under consultant oversight. These trainees, along with other junior emergency team members, typically handle obtaining consent from patients, caregivers, or next of kin. Earlier investigations conducted in well-funded, high-income settings primarily examined informed consent practices among emergency staff in the context of general medical treatment rather than emergency surgery specifically [5]. Several qualitative studies have examined staff experiences with consent for both planned and urgent obstetric operations [6], while others have looked at consent for general surgery without focusing on emergencies [7]. As a result, there was a clear gap in understanding how emergency staff manage informed consent for emergency surgical patients in resource-limited, low-income country contexts, given that most existing literature has addressed consent processes for elective procedures, obstetric surgery, or routine medical care in better-resourced environments. Accordingly, this study aimed to investigate the informed consent practices for emergency surgical care among healthcare professionals working in two emergency surgical units at two tertiary teaching hospitals in Uganda. The findings are intended to support improvements in emergency consent procedures within low-resource healthcare systems. The research specifically sought to compare how these practices differ between a public hospital and a private hospital, where patients also face direct financial responsibilities.

Materials and Methods

Study design

From October 2022 to February 2023, a cross-sectional qualitative study was conducted. It combined key informant interviews with direct observation of healthcare workers in the emergency setting, specifically nurses, intern doctors, surgery residents, and surgeons. A phenomenological framework was applied to capture and portray the real-life experiences and consent-related behaviors of staff providing emergency surgical care. The primary goal was to explore how emergency personnel subjectively perceive and navigate the consent process in their daily practice.

Study setting

The research was undertaken in the Accident and Emergency Departments of one public National Referral Hospital and one private hospital. Both facilities serve as university teaching hospitals and are located in Kampala, the capital of Uganda, a low-income country. Most emergency operations take place inside these Accident and Emergency units. Surgery residents, supervised by attending surgeons and supported by interns, nurses, and anesthetists, perform the majority of these procedures. At both hospitals, the frontline emergency team is composed mainly of surgical residents, most of whom are male. Female surgical residents make up only about 20% of trainees across all surgical fields in these institutions. Nursing staff, by comparison, are overwhelmingly female, with men representing fewer than 10% of nurses at each site. These units are also active training environments for both undergraduate and postgraduate students, so the practices seen here tend to shape the standards that future practitioners will carry into health facilities throughout the country.

Sampling methods

Sixteen participants were deliberately chosen for the study. They included nurses, medical officers, and surgical residents who routinely worked in emergency departments and participated in obtaining informed consent from patients requiring emergency surgery. Surgeons themselves were neither interviewed nor observed, since their involvement in the emergency unit is limited to oversight; the residents are the ones who actually perform the operations and manage the consent discussions. Face-to-face key informant interviews were conducted with six staff members from the private hospital and ten from the public hospital. Emergency

personnel were also observed while obtaining consent for emergency surgical cases. At the private hospital, the head of the emergency unit supplied contact details for all full-time nurses and doctors working in the Accident and Emergency department. These individuals were reached by telephone, and those who agreed to join the study were asked to sign written consent forms. In the public hospital, selection ensured that at least one doctor was included from each of the following surgical specialties: Orthopaedics, Neurosurgery, Gastrointestinal surgery, ENT, Cardiothoracic surgery, and Urology, plus three full-time nurses based in the Accident and Emergency Unit. All potential participants were contacted by phone, and written informed consent was obtained from all volunteers. None of the contacted individuals declined to participate or left the study.

Data collection

Key informant interviews with emergency department personnel at each tertiary teaching hospital were conducted in a quiet staff room within the Accident and Emergency Unit of the private hospital and in the surgery department office of the public hospital. The interviewer and participant were the only people present. An interview guide featuring open-ended questions and adaptable follow-up prompts was used to examine staff views and firsthand accounts. Topics included their understanding of the main components of informed consent, the way consent is actually handled in practice, their encounters with consent for incapacitated patients facing surgical emergencies, and their overall opinions on the process — what they regarded as sufficient, what elements ought to be covered, and which parts they found positive or problematic. The interviews were led by the principal researcher, a female surgeon and PhD Bioethics fellow. She also serves as a lecturer and oversees research projects carried out by surgical residents in the emergency unit of the public hospital. Her academic focus is improving emergency surgical service delivery, and she has repeatedly witnessed difficulties with consent in urgent situations. During the consent process for this study, participants were informed about the interviewer's background as both a practicing surgeon and a PhD Bioethics fellow, as well as her specific interest in learning how emergency consent is obtained. The interviewer recorded field notes throughout each session. Direct observations were performed by two trained research assistants, one at each hospital. The assistant at the private hospital was a male third-year surgery resident who had finished his emergency rotation and was pursuing independent research in a different surgical area. At the public hospital, the assistant was a female fifth-year medical student enrolled in the Bachelor of Medicine and Surgery program; she had been trained by the principal researcher and had assisted with supervised research projects for two years. All three individuals — the principal researcher and both assistants — possessed current certification in Responsible Conduct of Research and Good Clinical Practice. Written informed consent was obtained from participants for both interviews and audio recordings. All sessions took place in English in a private room, and confidentiality was maintained by not recording names or specific surgical specialties. Each interview ran for approximately 20–30 minutes. Data saturation was confirmed because new interviews, after joint analysis by the principal researcher and an independent reviewer following every four sessions, produced no additional themes. With participants' permission, interviews were audio-recorded and later transcribed word-for-word in English. Data collection occurred between October 2022 and February 2023, while analysis began during collection and continued until June 2023.

Direct observation of emergency staff securing informed consent from patients was conducted covertly, without the staff's awareness or consent. A waiver of consent for these observations was granted to prevent any alteration in normal behavior that might result from knowing they were being watched. Nonetheless, official administrative permission was received from the hospitals and the unit leaders before any observation began. Observations were spread across four weekdays and four times of day at each of the two teaching hospitals to identify possible differences linked to day or time of day. If any serious concerns arose during observation, the unit supervisor was immediately notified so corrective measures could be applied. A structured observation checklist was utilized to document staff actions during the consent encounter, covering aspects such as communication style, the person responsible for consent, the setting and timing, and related details. This checklist was built upon core elements of informed consent and adapted from the Process and Quality of Informed Consent Instrument (P-QIC). The original P-QIC used a four-point Likert scale (well done, done, done poorly, not done) across 20 items, yielding a total score of 40-100 (Cohn, Jia, Smith, Erwin, & Larson, 2011). For the present study, the tool was revised to assess 16 specific observations grouped under

four domains: Communication skills, Disclosure, Voluntariness, and Understanding. A five-point Likert scale (Well done, fairly done, done, poorly done, not done) replaced the original four-point version. New items were also added to evaluate privacy and confidentiality, the availability and completion of consent forms, the length of the consent discussion, and the identity of the person administering consent — features absent from the original instrument.

Data analysis

Inductive thematic analysis was performed on material gathered from key informant interviews across multiple respondent groups, including nurses, medical officers, surgical residents, and surgeons. The approach focused on interpreting meanings, detecting emerging themes, and identifying recurring patterns in the spoken accounts. Two coders worked independently: each read every transcript and extracted central ideas to form a preliminary coding structure. This structure began with a careful manual examination and coding of three transcripts, followed by repeated comparisons and adjustments among the coders until full agreement was achieved, thereby enhancing overall consistency. Once finalized, all transcripts were loaded into NVivo version 12 to facilitate open coding and the organized handling of the qualitative material. A detailed codebook was prepared, after which the updated codes were clustered into larger categories that ultimately defined the key themes. For each theme that surfaced, vivid example quotes were picked out to enrich the reporting of results. The transcripts were not returned to the participants for review, comments, or suggested changes.

Every single observation was scored on a five-point Likert scale, with values running from 1 (poorly done) to 5 (well done). Modes and medians were used as statistical measures to analyze each Likert-scale item. An overall average was computed for each observed item across the four time periods. Any average of 2.5 or higher was considered good performance, while anything below 2.5 was considered poor performance. Extra standalone observations were recorded for privacy and confidentiality, the existence and completion of consent documentation, the length of the consent conversation, and the individual who carried out the consent. These aspects were examined separately by tallying the frequency of each rating recorded for each specific area.

Results and Discussion

The majority of participants in the study were men, and the largest group was surgery residents. This distribution applied to both the key informant interviews and the direct observations. Although surgeons remained accessible for advice during urgent cases, none were included in the observations or interviews conducted in the emergency units. A summary of these details appears in **Table 1.**

Table 1. Participant characteristics.

		Direct Observation		Key Informant Interviews	
		Public	Private	Public	Private
Gender	Male	8	4	6	4
	Female	2	2	4	2
Total (Gender)		10	6	10	6
Professional cadre	Nurse	2	3	2	3
	Intern doctor	2	1	1	1
	Surgery resident	6	2	7	2
Total (Cadre)		10	6	10	6

From: Informed consent practices among emergency staff for patients undergoing emergency surgery in the emergency surgical units of two tertiary teaching hospitals in Uganda: a qualitative study.

The following sections describe the principal outcomes of the key informant interviews and the findings from direct observation of consent activities in emergency departments.

Direct observation of emergency staff

Observations of emergency staff took place across four distinct weekdays at each research location and during four varied time slots. The particular aspects examined in these sessions are presented in **Table 2**.

Table 2. Domains observed during informed consent for emergency surgery.

Domain	Item code	Paraphrased description
A. Communication skills	A1	Welcomes the patient and/or their next of kin and demonstrates engagement and attentiveness
	A2	Communicates using simple, non-technical language and avoids medical terminology
	A3	Identifies themselves to the patient or next of kin
B. Disclosure	B1	Explains the patient's clinical diagnosis
	B2	Describes available treatment options
	B3	Explains the recommended treatment plan
	B4	Outlines the benefits of the proposed treatment
	B5	Communicates potential risks associated with the surgical procedure
	B6	Clarifies the intended goal of treatment
	B7	Explains possible complications
	B8	Provides information regarding the cost of the surgical procedure
C. Voluntariness	C1	Offers the patient or next of kin the choice to accept or refuse the proposed treatment
	C2	Allows sufficient time for the patient or next of kin to make a decision
	C3	Ensures the decision is made freely without coercion or undue influence
D. Understanding	D1	Asks whether the patient or next of kin has any questions about the procedure
	D2	Requests the patient or next of kin to repeat the procedure details, including risks and benefits, to confirm understanding

From: Informed consent practices among emergency staff for patients undergoing emergency surgery in the emergency surgical units of two tertiary teaching hospitals in Uganda: a qualitative study.

A 5-point Likert scale was used to rate each observation within the listed domains. Such scales are especially appropriate for examining attitudes, conduct, and personal characteristics [8], and they helped evaluate how emergency staff behaved during the informed consent procedure. Mean Likert-scale scores were calculated for each domain across the four observation windows and are illustrated in the figure below, enabling a side-by-side comparison between the public and private hospitals **(Figure 1).**

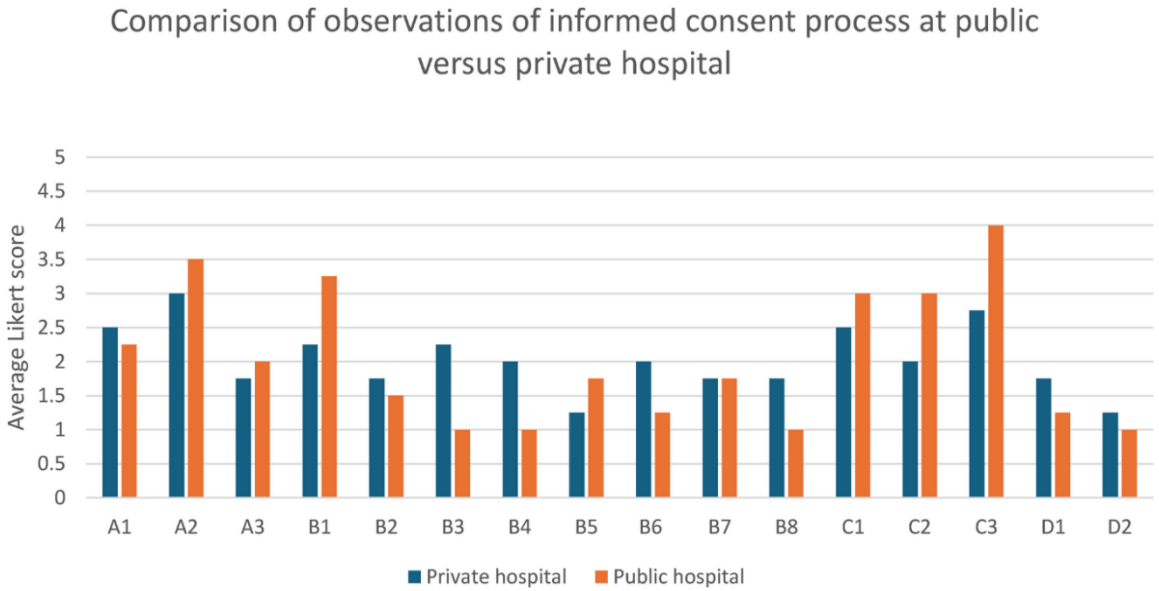

Figure 1. Comparison of average Likert scales of observations of the informed consent process at public versus private hospitals. From: Informed consent practices among emergency staff for patients undergoing emergency surgery in the emergency surgical units of two tertiary teaching hospitals in Uganda: a qualitative study

Taken together, the area showing the lowest performance at both facilities was disclosure. All eight observations connected to disclosure produced average scores below 2.5 in each institution. These observations included explaining the patient's clinical diagnosis, presenting available treatment options, describing the proposed intervention, outlining risks, highlighting benefits, stating the aims of treatment, noting possible complications, and discussing the cost of the operation. When the four domains were analyzed more closely, it became clear that speaking in straightforward language within the communication skills and voluntariness categories stood out as the most competently handled parts of the consent procedure **(Figure 1).** On the other hand, greeting patients, sharing necessary information, and checking whether patients had understood were all handled inadequately. Staff seldom introduced themselves to patients at either hospital, doing so only once at each location. The weakest elements observed at both sites concerned explaining risks and testing comprehension by asking patients to restate the planned operation, including its associated risks and benefits **(Figure 1).**

Both hospitals had noisy surroundings. The public hospital setting remained consistently crowded and lacked any privacy, whereas the private hospital experienced less crowding and offered somewhat better privacy. Nurses usually obtained consent at the private hospital, while at the public hospital, the task fell mainly to intern doctors and surgical residents. Across all instances at both institutions, the full consent discussion took under 30 minutes.

Key informant interviews

Six main themes emerged from the key informant interviews. These included: knowledge and perspectives on informed consent; practices, processes, and procedures related to informed consent; communication strategies for informed consent; ethical considerations; benefits of informed consent during surgery; and challenges to the informed consent process in emergency surgery **(Table 3).** No differences were observed in the themes between the public and private hospitals.

Table 3. Summary of themes and codes for key informant interviews of emergency staff

Theme	Codes
Knowledge and perceptions of informed consent	• Meaning and definition of informed consent • Essential elements included in surgical consent documentation
Procedures, processes, and practices of obtaining informed consent	• Individuals responsible for obtaining consent and their respective roles • Time required to obtain consent from emergency patients • Decision-making processes
Information disclosure in informed consent	• Factors that facilitate effective communication during the consent process • Types of information communicated during consent discussions
Ethical considerations in informed consent	• Voluntary decision-making • Patient capacity to provide consent • Recording and documentation of consent • Management of patients without accompanying caregivers or relatives • Principle of beneficence • Right of patients to receive information
Perceived benefits of informed consent in surgical care	• Upholding patient autonomy • Enhancing confidence and legal/ethical protection for healthcare workers and institutions
Challenges in emergency informed consent processes	• Insufficient disclosure of information • Communication barriers • Poor documentation practices • Unfavorable working environments • Medicolegal concerns • Financial limitations and time constraints

From: Informed consent practices among emergency staff for patients undergoing emergency surgery in the emergency surgical units of two tertiary teaching hospitals in Uganda: a qualitative study

Theme 1: Knowledge and perspectives on informed consent

Definition of informed consent

All participants demonstrated good knowledge of the definition of informed consent and its associated elements. They generally described it as a way to provide understanding and obtain permission for surgical procedures or hospital admission. Consent for surgery could be either written or verbal. Participants emphasized that informed consent involves explaining the patient's specific health condition, the planned procedures, and their benefits, while ensuring the patient's voluntary agreement to proceed with a surgical or medical intervention.

"Informed consent is essentially a process that we routinely apply when patients require an intervention, whether surgical or medical. We preferably provide written information covering what the intervention involves, its benefits, and potential risks. In some cases, we also describe how the condition developed, what caused it, and how it can be treated" [KII 12, doctor, Private hospital].

Key components of consent documents for surgery

Participants highlighted the essential elements that should appear in an informed consent document for emergency surgery. The most frequently mentioned component was basic patient information such as name, age, date and time, address, and contact details. Additional elements included the patient's signature, the name of the surgeon, a witness, the indication for surgery, and provisions for cases where the patient cannot provide written consent themselves (for instance, due to disability or when the patient is a child).

"I would expect to see the time and date, the section where the patient or their attendant signs, and the area for the witness signature or the person who guided the patient through the consent process. There should be clear documentation of what was explained to the patient. The forms currently used in the Casualty unit are inadequate as they only record the patient's name, the doctor, and the witness" [KII 5, doctor, public hospital].

All participants agreed that consent documents must outline the potential risks, complications, and expected outcomes of the surgery. One participant suggested that the document should also include a specific clause allowing the patient to consent to the use of any photographs or images captured during the procedure.

"They would record the diagnosis, benefits of the procedure, associated complications, 5. The name of the surgeon operating… Photography during the procedure" [KII 4, doctor, public hospital].

One participant recommended including detailed information on the surgical procedures and steps involved, as well as the materials and medications (drugs) that would be used during the operation.

"1. The procedure to be performed should be clearly and boldly written and properly explained to the patient. 2. Medicines such as analgesics, antibiotics, and sedatives should be discussed in the consent. 3. Any materials to be used in the operation should be specified, for example, artificial valves, prostheses, or grafts" [KII 1, doctor, public hospital].

One participant pointed out that for certain minor procedures, there should be a clear option to document that verbal consent has been obtained.

"Patients can give verbal consent for minor procedures such as taking vital signs or inserting a cannula; they do not require written consent. We do not need written consent for these, and verbal consent is sufficient. This applies to minor procedures like STS and catheterization" [KII 11, nurse, Private hospital].

Theme 2: Processes, procedures, and practices of informed consent

Person expected to administer consent and their roles

Participants from both hospitals indicated that surgeons should be responsible for obtaining consent due to their experience and ability to provide accurate, detailed information about the surgery. However, in practice, nurses sometimes obtained consent in both settings.

"If possible, and if the specialist who will operate is available or nearby, we prefer to involve them so that the patient or caretaker can meet the actual surgeon and receive more detailed information. But sometimes they are busy, so we handle it. In such cases, doctors in the department, rather than nurses, should obtain consent, because simply asking the patient to sign here and there is not enough" [KII 12, nurse, Private hospital].

"In my view, the surgeon who will actually carry out the procedure should be the one to obtain consent from the patient. They have the best understanding of what will be done, the associated risks, and the available alternative plans if the initial plan fails during surgery. A nurse may not fully grasp these details. The surgeon who knows when the procedure should be performed is the most appropriate person to take the consent" [KII 3, doctor, public hospital].

For unconscious patients who had no caretakers available to provide consent, participants from both hospitals stated that the heads of the accident and emergency department, consultant surgeons, or surgical residents managing the case should give consent on the patient's behalf.

"There are situations in which the patient is unable to consent for themselves. In such urgent cases, a senior medical professional, such as the head of the hospital, can provide consent on the patient's behalf" [KII 11, nurse, Private hospital].

Duration of consent for emergency patients

Participants explained that the length of the consent process is influenced by the urgency of the surgery and the unit's current workload. They observed that consent is usually obtained more rapidly for true emergency operations and during periods of heavy patient influx.

"In life-threatening situations where a patient requires an immediate procedure, we complete the consent quickly according to the level of urgency. This often means we cannot allocate sufficient time for the patient to carefully weigh the options, ask questions, or consider what they might prefer in a less critical setting. We generally speak briefly with the patient and their family, outlining the diagnosis and the necessary intervention" [KII 1, doctor, public hospital].

"The surgical cases we handle are not numerous and are mostly head injuries. On average, we admit roughly 5–10 theatre cases per week. The consenting step itself is very brief. For relatively straightforward conditions like obstructed hernia, which carry fewer complexities or risks, the discussion usually lasts about 5–10 minutes. Once patients grasp that it is an emergency operation, most are eager to proceed without delay, so we rarely exceed 10 minutes" [KII 12, doctor, Private hospital].

Decision making

Participants noted that although patients are expected to make their own decisions, relatives and other representatives often become involved in the decision-making process.

"Ultimately, the patient must sign on their own behalf. However, if the patient prefers not to share details of their condition with family, we respect that. When caretakers are present, we still brief them so they feel reassured, particularly if the patient will be in theatre for an extended period" [KII 11, nurse, Private hospital].

"It is helpful to involve someone else besides the patient—usually a relative or close friend. Even adults above 18 years benefit from having another person present who can serve as a witness" [KII 1, doctor, public hospital].

"We provide a full explanation to the patient and typically include one or two family members or caretakers to prevent overcrowding in the emergency area. Family members often assist the patient in deciding because they are usually the ones covering the costs. In genuine emergencies, the entire process moves very quickly. Sometimes, while preoccupied with worry about the patient's condition, families struggle to absorb all the details we share" [KII 12, doctor, Private hospital].

Participants added that absent family members or caretakers who are financially responsible for the bills often contribute remotely by helping the patient decide based on what they can afford.

"At times, patients or attendants contact relatives by phone to secure financial backing for the operation. Although financial matters are not always discussed during emergency consent, they remain relevant, and there may be an option to perform the urgent procedure at a more affordable facility" [KII 9, doctor, Private hospital].

Participants recognized that conflicting views among emergency team members about the best treatment plan can sometimes confuse patients and complicate the consent process.

"We occasionally see patients who received consent earlier while still stable. We usually build on that earlier consent, but repeat the explanation. This area requires better coordination. Even within the same orthopedic team, different doctors on call may propose different plans. One doctor might assess the patient and recommend waiting until the next day, while another insists the case must be addressed immediately. Such discrepancies leave the patient uncertain" [KII 6, doctor, public hospital].

Theme 3: Disclosure of informed consent

Factors enabling effective communication during informed consent

Emergency staff identified face-to-face verbal discussion as the main channel for informed consent. In this interaction, the healthcare provider introduces themselves and builds a connection with the patient or their caretakers.

"I greet the patient, perform triage and record vital signs, then escort them to the examination area. I introduce myself and describe what I intend to do. After they accept that surgery is required, I present the consent form and ask for their assistance in filling it out so we can proceed to theatre" [KII 10, nurse, Private hospital].

"The first step is to establish a good rapport with the patient or attendant. This starts with clearly identifying yourself and confirming you are speaking with the right person. Next, you explore how much they already understand about the situation before providing the

specific information they need regarding the planned intervention" [KII 5, doctor, public hospital].

Healthcare workers emphasized giving thorough, understandable explanations about the surgical procedure, possible complications, alternative treatments, and the consequences of each choice.

"The provider carefully describes the patient's condition, the confirmed diagnosis, the proposed intervention, and any associated risks. Only after the patient or their representative has received and understood this information do they make a voluntary decision about whether to accept the treatment, free from pressure" [KII 4, doctor, public hospital].

Staff reported that consent is sometimes obtained by telephone with the next of kin who cannot be present. In private hospitals, these calls may also confirm the family's willingness to cover costs.

"We make every effort to obtain consent from the attendants. When they are not on site, we often call them using the contact numbers provided" [KII 8, doctor, Private hospital].

"Occasionally, they make phone calls to those who can support them financially to take care of the financial implications of the operation. We do not always need to discuss finances during the emergency consent process. Still, it is an important thing, and there is an option of having this emergency procedure done at a place where they can afford" [KII 9, doctor, Private hospital].

A few participants mentioned using drawings and simple diagrams to clarify the illness and the planned operation.

"We usually explain verbally and support the explanation with diagrams. After describing the problem, we ask the attendant to sign. In most cases, we complete the patient details and the surgeon's name ourselves. This means many shortcomings actually originate from our own practice" [KII 7, doctor, public hospital].

The majority of participants stressed that information must be delivered in clear, everyday language. When patients do not understand English, the consent form is translated into a suitable local language, such as Luganda.

"We allow patients time to read the admission consent form before signing. If they cannot read, we read it aloud to them. If English is not understood, we go through the content so they know exactly what they are agreeing to, rather than simply instructing them to sign. Our surgical consent document includes both English and Luganda sections, which helps patients who are more comfortable with Luganda" [KII 11, nurse, Private hospital].

Patients and caregivers are always allowed to ask questions about the surgery and confirm their agreement with the proposed plan.

"Before any examination, test, procedure, or treatment, the patient receives relevant information. We confirm they understand what has been said, encourage them to raise any questions, and make clear that they have the right to decline the planned intervention" [KII 9, nurse, Private hospital].

Participants underlined that informed consent in the emergency department benefits from a team-based approach. Surgeons, nurses, anesthetists, and other professionals all contribute to helping patients understand the process, as reflected in these statements:

"Ultimately, the consent involves both the surgeon and the nursing team working together. I see it as a multidisciplinary process: the first clinician obtains consent for examination and investigations, while the operating surgeon reinforces the explanation when reviewing the patient before theatre" [KII 9, doctor, Private hospital].

"We speak with the patient and attendants to explain the diagnosis and planned actions. However, consent should ideally be multidisciplinary. A gap often exists because doctors provide information, yet the anesthetist is frequently absent, and other important elements are overlooked" [KII 1, doctor, public hospital].

Type of Information shared during informed consent

Participants highlighted benefits, risks, consequences of declining consent, and expected surgical results as the primary categories of information discussed. They maintained that openly discussing surgical risks helps patients make a truly informed decision about proceeding with the operation.

"Along with this, you outline the difficulties, advantages, and possible complications of the intervention. This allows patients to decide whether to move forward with the surgery. I believe it starts with building trust, learning from both the patient and their attendants, then clearly describing the procedure, its risks and benefits, any available alternatives, and potential complications. You follow up by asking if they agree to go ahead. They need this knowledge because the entire point of informed consent is acceptance with full awareness of the risks. No operation is completely risk-free, so you have to disclose those risks" [KII 5, doctor, public hospital].

Participants explained that they describe the advantages of the recommended surgical approach and provide

reassurance about the likelihood of a positive outcome. They also create space for patients to raise questions so they can confirm their understanding.

"The details we share depend on the nature of the surgery. We walk them through the procedure, highlight its benefits, and disclose any risks. We also comfort them by saying the operation is likely to proceed smoothly and achieve good results, so there is no need for excessive worry" [KII 10, nurse, Private hospital].

"You then invite their thoughts and ask whether, after hearing everything, they are comfortable with the procedure or if they have doubts they want to express or points that need further explanation" [KII 5, doctor, public hospital].

Participants indicated that they also cover other possible treatment pathways, justify the recommended option, and describe what could occur if surgery is not accepted.

"Following that, you let patients know about alternative routes you could have pursued, explain why those were set aside, and clarify the reasons for selecting this particular approach" [KII 9, doctor, Private hospital].

"We outline for the family the choices we consider most suitable, given their circumstances. Once explained, we present the potential upsides and downsides of surgery. Simultaneously, we describe the possible outcomes if they choose not to proceed with the operation" [KII 6, doctor, public hospital].

Participants added that discussions also include the expenses linked to the surgery and hospital admission.

"Because this is a private facility, we begin by detailing the monetary requirements. This directly influences who can move forward. For families who can manage the cost, it is fine. During consent discussions, we must disclose the expected expenses, guide them to the billing office, and occasionally bring in the social worker to assist with payment arrangements" [KII 8, nurse, Private hospital].

Theme 4: Ethical considerations

Voluntariness

Participants emphasized that patients should make their own decisions freely, without pressure or outside influence.

"Informed consent involves securing uncoerced agreement from the patient for any planned procedure. You supply all relevant details without forcing them. The patient retains full freedom to accept or reject the surgery. They receive complete information and are permitted to choose whether to accept or turn down the medical intervention" [KII 6, doctor, public hospital].

Capacity to consent

Emergency staff noted that a patient must have the mental capacity to understand the information provided and to give consent. Individuals aged 18 or older were considered capable of consenting on their own behalf, sometimes with assistance from close family.

"The patient needs adequate capacity to consent, must be 18 years or older, should receive clear details about the procedure, demonstrate comprehension, be offered the chance to ask questions, and be told they can refuse consent if they wish" [KII 9, doctor, Private hospital].

They recognized that some patients lack this capacity during emergencies — for instance, when unconscious, experiencing mental impairment, or under 18 years old. In those situations, staff advised confirming the legal standing of whoever is acting as the substitute decision-maker.

"When another person consents for the patient, they should clearly indicate their relationship to the patient" [KII 9, doctor, Private hospital].

"How familiar are they with the patient's situation? Are they immediate family? Just acquaintances? Or unrelated helpers? Decisions can differ greatly depending on the connection. What a mother or spouse would approve is often quite different from what a casual helper might agree to" [KII 5, doctor, public hospital].

"An essential element is that consent should come directly from the patient whenever possible. If the patient cannot provide it, the person signing must note the specific reason the patient was unable to do so. This might apply when the patient is unconscious, has a disability, or is a minor" [KII 12, doctor, Private hospital].

Emergency staff further noted that family members or attendants are frequently asked to sign even when the patient can consent.

"In reality, once the team decides on surgery and the patient is being prepared and moved toward theatre, consent is typically obtained during that transition period. Most often, it is not the patient who signs, even when they are mentally capable; instead, attendants usually provide the consent on their behalf" [KII 7, doctor, public hospital].

Documentation of consent

The private hospital maintains two separate consent documents: one for general or admission purposes and another specifically for emergencies. Emergency team members explained that the attending doctor must sign the form to confirm that a full explanation was given to the patient, followed by a nurse signing as a witness. One respondent stressed the importance of recording the actual content of the doctor's discussion with the patient to ensure clear evidence of what was covered. When patients are physically unable to sign their name, a thumbprint is accepted as a substitute.

"So, we have high-risk consent forms, both medical and surgical, then we have the general consent forms. What we do first is to get the right condition for the right patient. If we think the patient needs surgery, we categorize it as: does this patient need emergency surgery, is it urgent surgery, or can this patient be worked up? We wait, then plan for the surgery (electives). That's what we do. If it's an emergency, we have emergency consent forms" [KII 12, doctor, Private hospital].

"… they will not be able to hold a pen to sign, but they will allow you to get a thumbprint. So, you get a pen and shade the thumb, and then they put it there." [KII 2, doctor, public hospital].

"Unfortunately, all that I say is not written down. If there is a way in which I, the provider, can be helped to write it down. Let's say they leave a space where you say "Dr…". This is what you have explained to the patient in 3 or 4 lines. I have explained that this will happen, that this will be good. I think that would be beneficial for that informed process." [KII 2, doctor, public hospital].

In certain low-risk or minor interventions, emergency personnel sometimes relied solely on verbal agreement from the patient, with no written record kept.

"The patient can consent verbally for minor procedures, e.g., doing vitals and putting a canula, but they do not give a written consent. We do not need a written consent, and they give verbal consent." [KII 11, nurse, Private hospital].

"As for us nurses, the doctor explains to the patient, and then I also reinforce and re-explain to the patient. Then I make the patient sign…… The doctor may have to sign because they are the ones who explain to the patient what will be done. I go through again with the patient, and then I sign as a witness" [KII 11, nurse, Private hospital].

Several emergency staff members observed that when a patient required more than one surgical intervention, the procedure often proceeded using only the consent form signed by the first surgical team.

"Most times when we are called in, those patients have already undergone certain procedures. When the first team on board calls us, we go forward to explain to the patient. But we tell them what we are going to do, although our assumption is the first team got consent and this is an emergency" [KII 2, doctor, public hospital].

Handling patients without caretakers

At the public hospital, one interviewee described how consent can be bypassed by the medical team when an unconscious patient arrives without any accompanying caretaker. In these circumstances, the head of the emergency department, the surgical resident on call, the consultant on duty, and the unit administrator all provide counter-signatures for patients lacking a representative.

"We have several unknowns who come to the ward, and sometimes they need surgery, but there is no one to consent for them. So, in those instances, especially for the unknowns, we usually have a countersignature from the head of the Accident and Emergency unit, with the unit's Administrator if they are available. But at night, it is a bit of a challenge. And so, most of the time at night, it's the SHO or any available surgeon who takes the consent form from this patient if they need emergency surgery. For the minors, there is no clear policy, so it will depend on the will of the parents who bring these patients here. I think the good observation, I also need to create a policy about that" [KII 3, doctor, public hospital].

A respondent from the private hospital reported that healthcare providers there typically decline to operate on patients without a caretaker present. Instead, such individuals are redirected to the public hospital to shift any potential legal responsibility away from the private facility.

"We sometimes refer patients who cannot consent or refuse to consent, and therefore, the liability and repercussions of refusing surgery go to someone else. We refer them to the national referral hospital so that we do not take up this liability" [KII 9, doctor, Private hospital].

Beneficence

Before obtaining informed consent, emergency staff carefully evaluate whether the proposed surgery will actually benefit the patient. The goal is to prevent situations where the intervention might cause greater harm than benefit.

"That means we have to explain to the patient or the attendant their diagnosis, and after the diagnosis, then we can talk about getting informed consent, because

sometimes there might be no need for some procedures to be done if the patient is too sick or won't benefit. So that's an important thing. Then we look at the procedure itself. Is it doing better than harm? Those are important facts that need to be balanced. In the conversation." [KII 1, doctor, public hospital].

Right to information

Patients are legally entitled to receive clear information throughout the consent process.

"…you do not just go and work on a patient on something which they haven't understood. You see people here coming and saying they have removed my kidney when they did something else. If you have informed the patient what you are going to do and explained that if you are going to remove an organ, you will tell them so they do not complain later because it has legal issues. It is even the patient's right to know what is going on in their lives and what one is going to do" [KII 11, nurse, Private hospital].

Theme 5: Benefits of informed consent

Respect for patient autonomy

Most participants agreed that informed consent offers benefits to both emergency healthcare providers and, especially, patients. They commonly described informed consent in surgical settings as a patient-focused practice that demonstrates genuine respect. Additionally, it empowers patients by enabling them to choose their treatment options actively.

"In this day and age, consent is very paramount because. It gives a patient the liberty to choose. The health care system the drive is now more patient-centered than physician-centered" [KII 1, doctor, public hospital].

Building confidence and safeguarding emergency personnel and healthcare facilities

Emergency staff felt that obtaining informed consent provided them with a strong sense of security and reassurance, mainly because of the clear transparency it created regarding patient care. They further explained that this process helped protect the healthcare institution against possible legal claims from patients or their families. In addition, emergency staff observed that informed consent played a key role in fostering good relationships and mutual trust, as patients and caretakers frequently showed appreciation when physicians took time to discuss the illness, diagnosis, planned intervention, and potential risks.

"I consider it vital because it can easily turn into a medicolegal problem. I have come across situations where lawsuits were filed following complications after a procedure, with family members taking the case to court. A key protective factor is having the patient or their attendant sign the form after understanding both the procedure and the possible complications… Informed consent matters because signing confirms that everyone involved has grasped the details. It ensures clarity on exactly what will happen. In my view, it shields both the medical team and the patient" [KII 8, doctor, Private hospital].

Theme 6: Obstacles in obtaining informed consent for emergency operations

Insufficient information sharing

Emergency staff identified inadequate explanation of details to patients as one of the greatest difficulties. This stemmed from gaps in the providers' own knowledge and the severe time pressure surgeons faced when trying to cover every aspect of the surgery. Staff at the public hospital openly admitted that the information shared was often incomplete because the person taking consent lacked a deep understanding of the surgical procedure. On many occasions, surgeons handed over responsibility to nurses or less experienced doctors who lacked sufficient background information.

"Occasionally, even we as healthcare professionals cannot anticipate every possible outcome. Should an unforeseen issue arise that was not mentioned, the surgeons themselves should explain it, since as a medical officer I may not be familiar with all potential dangers" [KII 8, doctor, Private hospital].

"In most cases, the task of getting consent falls almost entirely on the nursing staff, who themselves may not possess enough detailed knowledge to clarify things properly for the patient. This creates a major shortfall in patient comprehension. Yet given that many of our patients are in vulnerable positions, they usually have no real alternative except to sign whatever document is placed in front of them" [KII 3, doctor, public hospital].

Several participants from the private hospital pointed out that some healthcare providers had only a weak understanding of fundamental informed consent principles, particularly the importance of respecting patient autonomy.

"It is clear that we frequently carry out the consent process without reflecting on its core foundations. As professionals, we should make a conscious effort to study informed consent in greater depth, including principles such as honoring human dignity and bodily integrity, while remembering that overlooking these can expose us to serious legal risks. Updating and refreshing our knowledge in this area is essential" [KII 9, doctor, Private hospital].

Difficulties in communication

Participants highlighted several communication-related barriers, such as reluctance to discuss risks openly, language differences, and insufficient time to explain matters properly. Emergency staff noted that some medical professionals hesitated to discuss surgical risks with patients.

"When asking for consent, there is often anxiety that spelling out the risks might make patients refuse the procedure. As a result, we frequently either skip some risks entirely, mention only selected ones, or present them in a less serious light" [KII 7, doctor, public hospital].

Language barriers were exacerbated by the frequent use of technical medical terms that proved difficult to simplify or translate into everyday language that patients could understand.

"Even after we explain things and believe the patient has understood, we still struggle to convert terms like 'herniorrhaphy' into the patient's native language in a way that retains the full meaning" [KII 12, doctor, Private hospital].

"One aspect I particularly dislike is how hurried the whole process feels. We rarely manage to communicate clearly with patients. Explaining the medical issue itself can also be surprisingly difficult. Overall, I don't think we do this nearly as well as we should—it always feels rushed" [KII 2, doctor, public hospital].

One doctor from the public hospital admitted feeling uneasy about seeking consent for procedures that carried a high chance of serious complications, long-term disability, or even death.

"On a personal level, I find it uncomfortable to obtain consent for a procedure that offers limited benefit or could cause permanent harm. In those situations, I usually ask a colleague to take over the discussion" [KII 6, doctor, public hospital].

Emergency staff also noted that poor patient understanding—often linked to low literacy levels and difficulty grasping complicated medical concepts—further complicated the consent process.

"I suspect many of our patients do not truly understand what the procedure involves. This appears to be connected to factors such as their educational background; even when we provide explanations, they may still fail to fully grasp what will be done. This makes the situation quite difficult" [KII 1, doctor, public hospital].

In some cases, family members signed the consent form hastily without genuinely comprehending the details. Emergency staff observed that, in urgent situations, both patients and relatives sometimes agreed under heavy emotional pressure created by the crisis.

"…when we ask them to sign, they often do so immediately without reading anything. For literate individuals, we encourage them to read first, but as soon as surgery is mentioned, they shift focus to questions like the cost and quickly ask where to sign. It seems our explanations are barely registering because they are overwhelmed with fear for their loved one" [KII 12, doctor, Private hospital].

"In the emergency department, patients and their attendants are usually in a state of panic and desperation, so they tend to accept whatever is suggested. ……They feel their right to proper informed consent has been removed… their extreme anxiety leads them to believe they are simply receiving help and have no say in decisions" [KII 5, doctor, public hospital]."

Poor working environment

Participants from the public hospital observed that the clinical setting offered little privacy and was often overcrowded, making it difficult for doctors to hold proper discussions and obtain informed consent for surgery. They also noted that the large number of patients arriving at once worsened overcrowding and further complicated the consent process.

"It [the emergency area] currently feels like a busy marketplace. It is not a suitable place to obtain consent. Privacy is completely absent. The whole atmosphere is neither patient-friendly nor supportive for doctors" [KII 6, doctor, public hospital].

It was also noted that the lack of clear protocols to guide consent in complex emergencies created additional difficulties for the emergency team.

"Perhaps there should be a written guideline stating that if the patient is unable to consent, I can do it on their behalf. It should include details on when this is allowed

and the specific conditions under which it applies" [KII 10, nurse, Private hospital].

Several participants, particularly those working in the public hospital, mentioned that the shortage of specialists and social workers made supporting the consent process more challenging.

"At times, certain support services are missing, which creates real difficulties for us. You assess the patient and realize a social worker is needed, but none is available" [KII 1, doctor, public hospital].

Inadequate documentation of consent

Some participants at the public hospital said the existing consent document was too basic and failed to capture the actual discussion during the consent process. They added that blanket consent was sometimes used instead of a detailed one. Emergency staff at the public hospital also reported problems, including the absence of procedure-specific consent forms and missing information on the forms.

"It is a general blanket consent form where nothing is documented about what was actually explained to the patient" [KII 2, doctor, public hospital].

"The form does not include all the essential details a patient needs to make an informed choice. The consent documents we currently use do not leave enough room or space to write down those important points" [KII 5, doctor, public hospital].

Medicolegal challenges

Emergency staff at the private hospital expressed concerns about the risk of being sued by patients or their families if proper consent was not obtained.

"Respecting a patient's dignity and bodily integrity is extremely important; performing a procedure without consent can lead to lawsuits and carry serious legal consequences. Failing to secure informed consent creates clear legal liability" [KII 9, doctor, Private hospital].

The team also struggled when patients refused consent, often because the planned procedure carried high risks, the family could not afford the cost of surgery, or they disagreed with the recommended treatment.

"In such cases, we usually bring in as many team members as possible to explain the risks and benefits clearly. If the patient still refuses after that, we refer them elsewhere. Another common reason for refusal is financial difficulty. These issues create significant problems for us" [KII 11, nurse, Private hospital].

Emergency staff further noted the difficulty of obtaining valid informed consent when patients were incapacitated and had no available caretaker, or when the next of kin was younger than 18 years old and therefore not legally permitted to consent.

"The problem arises when the next of kin is under 18. At that point, the whole process comes to a halt. The patient themselves may not understand what you are saying, and they have arrived with a son or daughter who is only 15 or 16 years old" [KII 2, doctor, public hospital].

Patient financial constraints

According to emergency staff from both hospitals, the inability to pay for surgical services, medications, and necessary equipment significantly influenced decision-making during the consent process.

"The main difficulties we face stem from being a private facility and the costs involved. In emergencies, we sometimes find ourselves stuck because the family has no money, yet the patient's life is at stake. It becomes meaningless when treatment cannot proceed despite the family having understood and signed the consent forms. Our hands are tied in such cases" [KII 12, doctor, Private hospital].

"You may need to act very quickly in an emergency to save the patient ……but the hospital lacks certain essential supplies. This is one of the biggest obstacles—trying to obtain consent while knowing the family has no means to purchase the required items" [KII 6, doctor, public hospital].

Time constraints

Emergency staff at the public hospital observed that the limited time available to obtain consent in urgent situations negatively affected patients' understanding of the information provided.

"I think the biggest challenge is we rush the process." -- KII 7, doctor, public hospital.

Limitations

Although informed consent places the patient at the center, this study did not capture patients' own voices, as the focus remained on emergency staff's views. Earlier research conducted by the same authors in the same environment explored the perspectives of patients and their next of kin [9]. In analyzing the direct observation part of this study, 2.5 was set as the cut-off point to

distinguish poorly performed from well-performed consent, based on 50% of the maximum score on the 5-point Likert scale. A more precise cut-off could be established through expert consensus, comparison with similar validated studies, testing across various cases, and fine-tuning to better reflect the reality of the consent process. Observations at each institution were carried out by a single research assistant, which may have introduced personal biases and assumptions.

Informed consent during emergencies is shaped by severe time pressure and the urgent need for treatment that can be life-saving yet carries uncertain results. These difficulties become even greater when a patient lacks the capacity to give consent [4]. In surgical emergencies, obtaining informed consent is not always feasible, as the process itself could delay critical, life-saving interventions. Securing consent may also prove impossible when patients are unable to comprehend the information or when their right to consent has been set aside [10-12]. Emergency staff should make every effort to obtain informed consent while clearly disclosing risks and alternative treatment options. This study captured the experiences of emergency staff as they sought consent for patients scheduled for emergency surgery. Their knowledge, attitudes, and actual practices revealed the specific difficulties associated with informed consent for surgical emergencies in a resource-limited environment.

Knowledge and attitudes

Emergency staff demonstrated a good understanding of informed consent, as evidenced by their accurate identification of its main elements. They viewed the process as valuable and recognized that it offers them protection against potential lawsuits. They also openly acknowledged barriers such as insufficient time, incomplete knowledge about the planned surgery, and hesitation to discuss risks fully. Consistent with other research, emergency staff recognized the importance of informed consent and generally supported its use. This positive stance was evident in the fact that all emergency staff guided patients or their surrogates through the consent process, even though some gaps in information sharing remained. The disconnect between strong knowledge and actual practice in fast-paced emergency settings—where time is short, and there is no agreement on how much detail to provide—has been documented in previous studies [13-15].

Disclosure of consent in communication

Emergency staff described difficulty in discussing surgical risks with patients, largely because they worried that full disclosure might lead patients to refuse the operation. Effectively communicating risk demands solid knowledge of the procedure and strong communication skills to ensure the patient comprehends the details. Consent forms frequently omit information about risks, leaving emergency staff to struggle with how best to convey them [16]. In elective surgery, verbal explanations are often supported by visual tools such as diagrams, videos, or brochures, but these approaches are rarely feasible in emergencies due to severe time limitations [17]. Nevertheless, some emergency staff mentioned using diagrams to explain procedures, which helped patients understand, although this practice was not observed during the study.

Disclosure during informed consent covers the benefits, risks, and potential complications of the procedure. The difficulties emergency staff faced in communicating risks—both as described in interviews and observed—align with findings from other research [6, 18]. Information should be delivered in clear, simple language that patients can easily follow. In this study, emergency staff highlighted barriers to adequate disclosure, including language differences, patients' literacy levels, time pressure, and uncertainty about how much information to share—issues also reported in similar studies [18]. Inadequate disclosure can additionally stem from the person obtaining consent lacking sufficient knowledge of the surgery. This was confirmed by nurses, who admitted feeling under-equipped regarding the procedure, treatment choices, and possible complications, which led to incomplete explanations. Nurses often preferred that doctors or surgeons handle consent because they possess deeper knowledge of the surgical details. In emergencies, the amount of information shared should focus on the main risks and complications that are essential for patients to understand and that can support meaningful discussion [19]. Therefore, emergency staff must determine the critical, procedure-specific details that need to be disclosed to the patient within the short time available during an emergency.

Understanding

Emergency staff observed that in surgical emergencies, patients or their surrogates sometimes fail to absorb the provided information because they are focused on the

immediate need for care and have little time to process details. This perception likely explains why staff rarely paused to check whether the patient or next of kin had truly understood what was said. This pattern aligns with reports from other researchers who have identified problems confirming comprehension during urgent situations. Some studies have examined the teach-back method used by physicians to assess and improve patient understanding and health literacy. However, this approach has not yet been widely tested in emergency settings [20]. Participants recommended using visual aids to enhance patient comprehension, and existing research supports the use of tools such as videos, brochures, and diagrams to effectively improve understanding during the consent process [17, 21].

Decision making

Emergency staff described how decision-making regarding informed consent in urgent cases frequently followed a group-oriented, or communitarian, style. Family members, close friends, and those expected to cover the treatment expenses were routinely brought into the discussion. This pattern aligns with the communitarian decision-making framework documented in other research, in which the patient, along with relatives and other interested parties, collaborates with medical providers and shares responsibility for the final choices [22]. Additional studies indicate that when surrogates or next of kin must decide for patients whose preferences are unknown, collective group decisions tend to produce better outcomes than decisions made by a single person [23, 24]. Emergency staff further observed that family involvement in high-stakes emergencies often took a hierarchical form. A senior or influential family member would guide the decision even if they were not physically there to sign the consent document, a dynamic reported in earlier literature [25]. In such urgent situations, the family's collective autonomy could override the individual patient's autonomy, especially when the patient's own wishes had not been expressed beforehand. By comparison, the standard Western model of informed consent is strongly individualistic. It centers on the patient's personal autonomy and comprehension developed through one-on-one conversation with the physician, sometimes called an autonomy-enhancing model [26].

In contrast, certain African cultural contexts approach informed consent more collectively, shaped by social traditions. Here, consent may require approval from a community elder, a clan leader, or a senior family member [25, 27]. Emergency staff working in this African environment acknowledged the clear conflict between personal autonomy and community-based decision-making. Drawing on Baron's analysis of ethical decision-making, autonomy should not be viewed as unlimited; instead, a utilitarian lens may help balance competing principles when choices must be made [28].

Administration and Documentation of Informed Consent

Results from this study show that consent administration involves multiple roles, including nurses, junior doctors, and surgeons. Nurses and junior doctors in particular struggled to provide complete information about the planned operations because they lacked detailed knowledge of the procedures. They generally preferred that surgeons lead the consent discussion. At the same time, they recognized that surgeons often had too little time to handle consent properly in a busy emergency department with heavy patient turnover. Staff at both the public and private institutions agreed that the current consent forms were unsatisfactory. The forms did not include dedicated sections for recording the information actually shared with the patient or family. Comparable research on surgical consent practices has repeatedly found that surgeons rarely document the specific complications they discuss with patients [14, 29, 30]. In the present study, emergency staff believed that having signed documentation offered them important legal protection, a view supported by several previous studies [13, 31]. Timfote and colleagues recommend applying three core principles—equality, utility, and justice—when handling informed consent in emergency surgery [32]. Equality treats every life as equally valuable and deserving of care; utility focuses on directing scarce resources toward the greatest overall benefit; and justice prioritizes based on the severity of the emergency. When a patient faces immediate life-threatening danger and consent cannot be obtained, the circumstances must still be carefully recorded [32].

Challenges

Emergency staff in this research encountered several key obstacles: difficulty explaining surgical risks, concerns about potential lawsuits, insufficient familiarity with specific procedures, severe time pressure during consent, and the complete absence of tailored guidelines for

emergencies. These same difficulties appear consistently in studies covering both planned and urgent surgical consent [5, 6, 33]. Surgeons themselves often find it hard to reach swift yet ethically sound decisions in acute emergency operations, particularly when working without support, and this pressure can weaken the ethical reasoning required for proper consent [34]. Direct observations revealed a noticeable lack of privacy in the public hospital's emergency area, which seriously impaired effective communication. Unlike the calmer private hospital unit, the public facility suffered from chronic overcrowding that directly reduced available privacy for both staff and patients during consent discussions. High patient numbers in emergency departments generally make it difficult to maintain confidentiality and a calm environment, both of which are needed for meaningful consent conversations.

Conclusion

While emergency staff possessed solid knowledge of consent procedures, actual information disclosure was frequently incomplete. This stemmed mainly from tight time limits and nurses' limited understanding of the surgery, its risks, and potential benefits. Patient comprehension suffered due to widespread low literacy, heavy use of technical medical language, and language differences between staff and patients. Staff at both hospitals consistently reported problems explaining surgical risks clearly. There were no formal institutional policies to guide consent for incapacitated patients who arrived without any surrogate or next of kin, which left staff anxious about legal repercussions. The public hospital environment, marked by very high patient loads, offered poor conditions for consent discussions and provided almost no privacy. When surgical care involved direct costs, emergency staff routinely raised financial considerations during the consent conversation.

Recommendations

Surgeons should take the lead in obtaining consent and explain procedures in plain language, supported by visual tools such as diagrams whenever time permits. Consent forms need to be redesigned to be more specific to each procedure and should include sufficient space to document exactly what was discussed with the patient. Hospitals must create and distribute clear policy guidelines for emergency staff to follow when dealing with patients unable to consent who have no available surrogate decision-maker or next of kin. A dedicated, quiet, and private area should be set aside within Accident and Emergency departments specifically for consent discussions. The likely financial costs, along with requirements for medications and other supplies, should be openly addressed during consent to prevent later delays due to missing resources. Finally, emergency staff should consider incorporating a communitarian style of discussion during consent to facilitate smoother and more culturally appropriate decision-making.

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