

Press release, European Association of Urology

## [Study shows patients prefer iPads to doctors when discussing surgery](#)

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Often patients undergo procedures without real informed consent being achieved due to technical language, jargon and time pressure, with up to half of patients finding it difficult to understand what their doctor tells them [1, 2]. Now a group of Australian doctors has prepared patients for surgery using iPads, and found that patients' understanding was much better than after a face-to-face consultation.

It is vitally important that patients understand what medical procedures they face, both so that they can cope better with the procedure, and so that they can give fully informed consent to the treatment. However, many patients come out of critical face-to-face interviews with doctors not really understanding what to expect or what they might have agreed to.

*“Patients often find it difficult to understand the medical language used by doctors during face-to-face standard verbal communication, and they often feel intimidated by the interaction”, said lead researcher, Matthew Winter (Royal North Shore Hospital, Sydney, Australia). “Often doctors work within busy practises and clinical environments with time limiting the quality of a consult and or verbal consent for a procedure. Patients often find it difficult to comprehend their planned procedure. We have found patient’s knowledge is greatly improved through the use of portable video media and is their overall preferred method of information delivery compared with standard verbal communication”.*

The researchers designed a randomised controlled trial (RCT) to check the understanding of 88 patients facing surgery for acute renal colic (the abdominal pain often caused by kidney stones). 45 of the patients discussed the forthcoming surgery with their doctor as normal, whereas 43 patients were given a video presentation with cartoon animation narrated by a doctor which could be viewed on tablets such as an iPad. The patients were then questioned on their understanding of the medical procedure and their satisfaction regarding the information delivery technique. After this they were switched, with those who had received face-to-face counselling receiving the video, and vice versa, followed by the same questionnaire. Patients were then asked to give their overall preference of information delivery.

They found that that use of the video increased understanding by 15.5%, in comparison to the direct consultation. In addition, 71 patients (80.7%) preferred the video as against 17 (19.3%) who preferred the face-to-face meeting.

Commenting, Dr Winter said:

*“Informed consent for patients undergoing procedures is both an ethical and legal responsibility and crucially important for optimising treatment. Patients should be intimately involved in deciding upon their treatment, and understanding their treatment is often vital to a good recovery. Although medicine has advanced by leaps and bounds, there has been little change to the informed consent procedure and how a doctor explains the treatment to the patient. Through the use of portable video*

*media, a doctor can present his/her own practise and procedural technique in an innovative, dynamic and engaging manner.*

*We are not saying that using portable video media should replace consent. Our work shows that there are alternatives to interviews, which can help significantly, improve patient understanding and satisfaction. Most patients prefer being able to use the portable media devices to a face-to-face consultation which benefits both clinician and patient through improved quality of care. Portable video media is a useful addition to the informed consent process and I predict will form a crucial component of this process in years to come”.*

Commenting, Professor Fiona Burkhard, chairman of the EAU Guidelines panel for Urinary Incontinence said:

*“This innovative approach to patient information, using a cartoon animation narrated by a doctor, allows each individual patient as much time as needed to understand the proposed procedure. It should not replace a face to face discussion with the physician, but will allow patients to meet the physician already informed and prepared, thus benefiting both the physician and the patient”.*

Note: This paper will be presented in Munich by Dr Sunny Nalavenkata.

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**ENDS**

### **Notes for Editors**

**PLEASE MENTION THE EUROPEAN ASSOCIATION OF UROLOGY CONGRESS IN ANY STORY  
RESULTING FROM THIS PRESS RELEASE**

**An edited version of the patient video is available from the press office**

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The 31<sup>st</sup> Annual EAU Congress takes place in Munich from 11<sup>th</sup> to 15<sup>th</sup> March. This is the largest and most important urology congress in Europe, with up to 13,000 expected to attend: [eau16.org](http://eau16.org).

1. Rowlands, G., *Health literacy*. Hum Vaccin Immunother, 2014. **10**(7): p. 2130-5.
2. Kinnersley, P., et al., *Interventions to promote informed consent for patients undergoing surgical and other invasive healthcare procedures*. Cochrane Database Syst Rev, 2013. **7**: p. CD009445.

**Abstract Nr: 947** (NOTE: some statistics in the press release have been updated from those in the published abstract)

**Title: The use of portable video media versus standard verbal communication in the urological consent process: A randomised controlled clinical trial**

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**Introduction & Objectives** With increasing demand on our health care system, technology can be used to facilitate efficiency and improve patient care, especially regarding the process of informed consent. The aim of our study is to determine patient satisfaction and knowledge acquired during the consent process for cystoscopy and insertion of a ureteric stent comparing the use of Standard Verbal Communication (SVC) to Portable Video Media (PVM).

**Material & Methods** A randomised controlled cross-over trial design was implemented. Patients presenting with acute renal colic to the emergency department of two major public hospitals requiring a ureteric stent, were randomised to receive SVC or PVM prior to the procedure. A validated questionnaire (CSQ-8, maximum score of 32) assessing patient satisfaction and a true/false 28-point questionnaire assessing understanding of the critical components of a cystoscopy and ureteric stent was then completed. The groups were then crossed over and the questionnaire re-tested. Patients were asked to give their overall preference at the conclusion of both delivery methods. SVC involved the typical verbal interaction of a urology registrar consenting a patient for a procedure. The PVM consisted of an audio-visual presentation with cartoon animation presented on an iPad.

**Results** Eighty patients were randomly assigned and completed the trial. 36 patients received PVM as the first intervention and 44 patients received SVC as the first intervention and then crossover was performed according to protocol. Recruitment was completed over two sites over a 15-month period (7/7/2014 – 8/10/2015). The mean age of participants was 54 years old. 21 (26%) patients were female and 59 (74%) male. The mean SVC time was 4.34 min. The patient satisfaction as measured by CSQ-8 was the same between groups (mean PVM 30.30 v SVC 29.1,  $p=0.119$ ). A statistically significant 15.2% increase in understanding, as assessed by the 28-point questionnaire, was demonstrable favouring the use of PVM (mean PVM 23.06 v SVC 20.02,  $p=0.001$ ). Upon group crossover analysis a statistically significant 18.5% increase in MCQ score was seen when the SVC group were crossed over to the PVM arm ( $p<0.001$ ). No increase in MCQ score was seen when crossover from PVM to SVC was performed ( $p=0.893$ ). A total of 81% ( $n=65$ ) patients preferred PVM and 19% ( $n=15$ ) preferred SVC.

**Conclusions** This study demonstrates patients' preference towards PVM in the urological consent process of cystoscopy and ureteric stent insertion. PVM leads to increased patient understanding and information retention compared with SVC. PVM appears to be a more effective means of content delivery to patients in the acute hospital setting in terms of overall preference and knowledge gained.