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Article

The Impact of Video Consent on Patient Satisfaction When Undergoing Percutaneous Nephrolithotomy: A Randomized Control Trial

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Abstract: Introduction: Consent-taking for surgery evolved from a historical paternalistic approach to informed consent in the mid-20th century. Modern healthcare models prioritize patient-centric care, and the use of multimedia tools may overcome challenges such as language barriers and complex medical surgical steps. This study evaluates the impact of an educational video on patient satisfaction for those undergoing percutaneous nephrolithotomy (PCNL), a procedure where explaining complexities verbally can be challenging. **Materials and Methods:** A randomized control trial was conducted at a tertiary care center in India from July 2022 to April 2024. A total of 232 adult patients scheduled for PCNL were randomly assigned to a study group (Group A) or a control group (Group B). Group A viewed an educational video about PCNL, while Group B provided standard written consent. The video, presented in patients' native languages, covered procedural details, potential outcomes, and post-operative care. Patient satisfaction was assessed using a 10-question questionnaire at discharge, with scores ranging from one (poor) to five (best). Statistical analysis was performed using SPSS software to compare outcomes between the two groups. **Results:** The study found that Group A exhibited significantly higher satisfaction compared to Group B across all domains. Group A demonstrated a better understanding of the procedure, improved knowledge of post-operative care, reduced anxiety, and a greater awareness of potential complications. Specifically, the mean satisfaction scores for Group A were higher in understanding the procedure (13.15 vs. 10.00), post-operative care (8.46 vs. 6.84), and overall anxiety (8.65 vs. 6.96). The video also improved patients' comprehension regarding potential complications and the need for further procedures. Complication rates and hospital stay durations were similar between both groups. **Discussion:** The educational video significantly enhanced patient satisfaction and the understanding of PCNL. This multimedia approach provided a consistent, clear explanation of the procedure, which improved patient comprehension and reduced anxiety, irrespective of literacy levels. These findings support the integration of video-assisted consent in pre-operative education to enhance patient engagement and satisfaction. **Conclusions:** The use of an educational video for consent in PCNL improves patient understanding and satisfaction. This method effectively complements traditional consent processes, providing a valuable tool for patient education in complex procedures.

Keywords: percutaneous nephrolithotomy; PCNL; video consent

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1. Introduction

Before the mid-20th century, healthcare professionals made decisions for patients based on what they believed to be in the patient's best interest, often without involving the patient in the decision-making process. Healthcare professionals justified their authority over patient decision-making by possessing specialized knowledge and expertise [1].

The emergence of informed consent in the mid-20th century challenged these paternalistic practices. Legal precedents and ethical guidelines started to underscore the significance of upholding patient autonomy and providing sufficient information about their medical conditions and treatment alternatives. Modern healthcare models prioritize patient-centered care, which acknowledges the importance of incorporating patient preferences, values, and goals into decision-making processes. This approach contrasts with paternalism by empowering patients to actively participate in decisions about their own health. In recent times, legal cases and ethical guidelines have reinforced the rights of patients to make informed decisions about their healthcare. Healthcare providers are now required to disclose relevant information to patients, including risks, benefits, and alternatives to proposed treatments [2].

Still, there are challenges such as language barriers, patient comprehension, and the complexity of medical information, which have prompted innovations like multimedia tools, interpreters, and decision aids to facilitate effective communication. Technological integration in healthcare services may further enhance the consent process by providing interactive tools, virtual reality simulations, and personalized educational resources. The process of preparing and editing videos allows for the selection of unbiased and informative language. Videos have been effectively utilized in clinical trials, particularly in dermatology, to offer treatment alternatives for basal cell carcinoma, explain skin biopsies, and obtain consent for various medical procedures, including Mohs micrographic surgery [3].The aim of this study was to evaluate the impact of video-assisted informed consent on patient knowledge and understanding before undergoing percutaneous nephrolithotomy (PCNL). Specifically, we sought to compare the effectiveness of video-assisted consent to traditional consent methods in enhancing patient comprehension regarding the procedure, potential risks, and recovery expectations.

2. Material and Methods

Study design: This randomized controlled trial was conducted from July 2022 to April 2024 at a tertiary care center in India. Randomization occurred one day before surgery. In addition to surgical consent, all participants provided written informed consent to join the study, which included details about the study's objectives, procedures, risks, and confidentiality. Routine informed consent was obtained from both groups (A and B), with Group A additionally shown an educational animated video on PCNL surgery. The operating surgeon was blinded to the video assignment. The study protocol was approved by the institutional ethics committee prior to its commencement.This trial was registered at ClinicalTrials.gov with the registration number CTRI/2023/05/053084. The trial was conducted following all applicable guidelines and ethical approvals.The questionnaire was designed to assess patient knowledge of the informed consent process for percutaneous nephrolithotomy (PCNL), based on the existing literature and validated instruments. It was first created in English and then translated into Hindi, with back-translation to ensure accuracy. Although not formally validated for this population, it was pre-tested for clarity. For patients unable to read, trained research assistants read the questions aloud and recorded their responses.

Patients: In the above-mentioned duration, all adult patients (age >18 years) admitted for PCNL were included;the exclusion criteria were not being willing to participate in

the study and a patient less than 18 years of age. A total 232 renal stone disease patients fulfilling the inclusion criteria were enrolled (Figure 1).

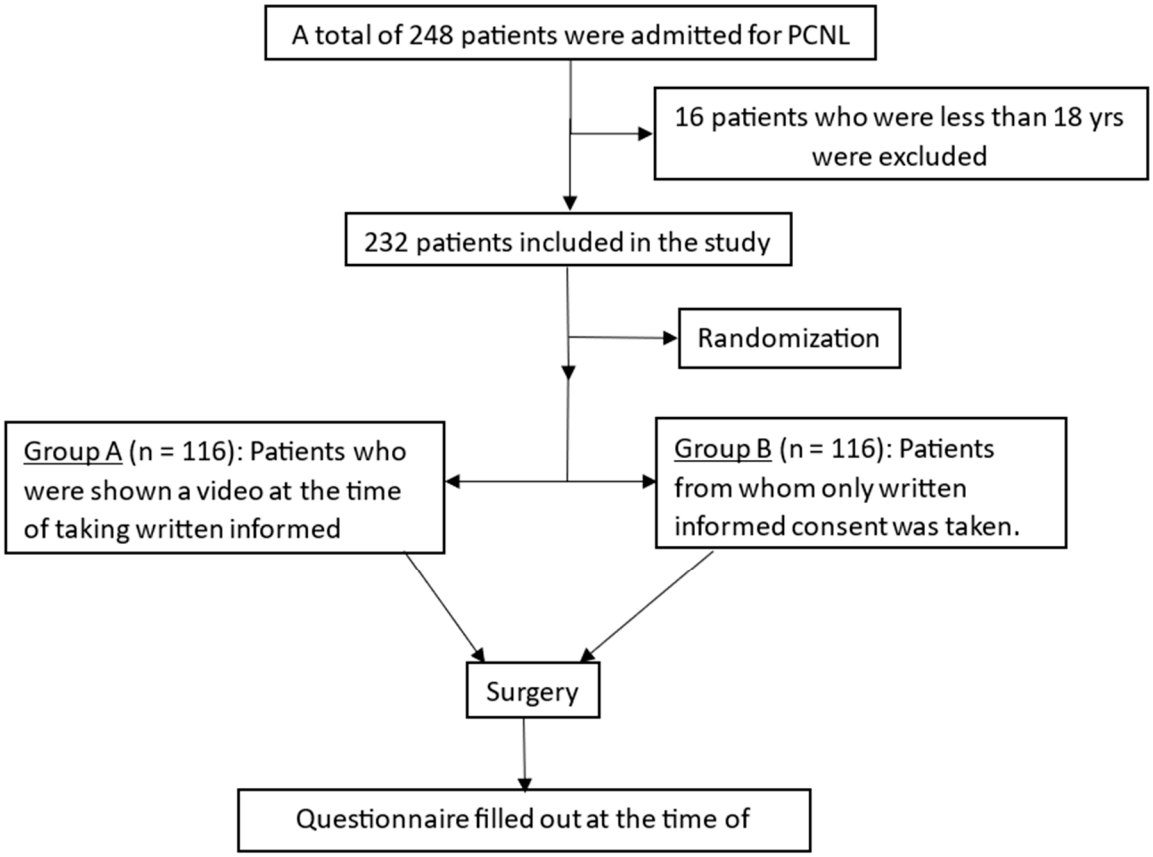


Figure 1. Showing study design.

Procedure: A thorough history and clinical examination was carried out. The case record proforma contained the following information: the age, gender, educational status, and pertinent clinical history and investigative details were recorded. All patients who were included in the study were divided into two groups randomly as study Group A (n = 116) and a control Group B (n = 116). Patients in Group A were shown an educational video (Supplementary Materials: video S1) in a separate preparation room in the presence of an attendant. The video was explained to the patients in their native language and the help of a member of paramedical staff was provided if required. A self-constructed animated short video of 1 min consisted of the position, steps of the procedure, instrument to be used, probable duration of surgery, possible outcomes of surgery (with a special mention of residual fragments and/or theneed for aredo procedure), and post-operative patients' status (the number of sutures, drain dressings, etc.). Patients and attendants were allowed to ask questions during and after the video. The investigator was one of the senior residents in the department of urology. Surgeries were performed by five faculty members of the department. All patients underwent standard prone PCNL and the type and number of punctures and the dilatation of the tract (24 fr to 30 fr) weredetermined according to the size and location of the stone and the surgeon's preference. Peri-operative events including complications and residual stones were documented and patients were discharged. The final feedback for the assessment of the impact of the video demonstration was taken in the ward at the time of discharge through a self-constructed questionnaire consisting of a total of 10 questions with five responses each from a score of 1 (strongly disagree) to a score of 5 (strongly agree).

3. Statistical Analysis

Statistical analysis was performed using SPSS software, version 20. Data were expressed as the mean ± SD and the frequency with percentages *n* (%). A paired *T* test and χ^2 test were used to evaluate data statistically. Statistical significance was assumed if the *p* value found was less than 0.05.

4. Results

The demographic data including the age, sex, educational status, size of the stone, number of punctures made during surgery, and the size of the dilated tract were noted (Table 1). At the time of discharge, all patients were asked to fill out a self-constructed questionnaire comprising a total of 10 questions to determine their understanding of and satisfaction with the surgery, with response ranges from one (poor) to five (best). The total score was 50. A score of less than three was seen as negative, and a score of more than three as positive. The questionnaire was further divided into four domains as follows.

Table 1. Demographic parameters.

Sr No	Demographic Parameters	Group A 116 (50%)	Group B 116 (50%)	Total 232 (100%)
	Age (Years)			
	a. ≤20	6 (2%)	4 (2%)	10 (4%)
1	b. 21 to 40	56 (25%)	58 (25%)	114 (50%)
	c. 41 to 60	44 (19%)	40 (17%)	84 (36%)
	d. >60	10 (4%)	14 (6%)	24 (10%)
	Gender			
2	a. Male	70 (30%)	68 (29%)	138 (59%)
	b. Female	46 (20%)	48 (21%)	94 (41%)
	Educational Status			
3	a. Illiterate	48 (21%)	40 (18%)	88 (39%)
	b. Literate	68 (29%%)	76 (32%)	144 (61%)
4	Stone Size			
(a)	Less than 3 cm	68 (60.7%)	73 (62.9%)	141 (60.7%)
(b)	Partial stag horn calculus	26 (22.4%)	17 (14.6%)	43 (18.5%)
(c)	Complete stag horn calculus	22 (18.9%)	26 (22.4)	48 (20.06%)
5	Number of Punctures			
(a)	Single	73 (62.93%)	75 (64.46%)	148 (63.7%)
(b)	Multiple	43 (37.06%)	41 (35.34%)	84 (36%)
6	Size of Dilated Tract			
(a)	Up to 24 fr	48 (41.37%)	54 (46.55%)	102 (44%)
(b)	More than 24 fr	68 (58.62%)	62 (53.44%)	130 (56%)

(1) Questions evaluating the understanding of the procedure (question 1, 2, and 3).
(2) Questions evaluating knowledge of the post-operative tubing, suture, and dressing the patient would have (question 4 and 5).
(3) Questions evaluating whether the video/consent helped in decreasing the anxiety of the patient (question 6 and 7).
(4) Questions evaluating knowledge about the complications and need for a redo procedure (question 8, 9, and 10).

In all assessed domains, the study group demonstrated statistically significant improvements compared to the control group. The study group showed a better understanding of the procedure (mean score of 13.15 ± 2.17 vs. 10.00 ± 2.25), greater knowledge and acceptance of the post-operative tubing, suture, and dressing (8.46 ± 1.50 vs. 6.84 ± 1.23), lower surgery-related anxiety (8.65 ± 1.33 vs. 6.96 ± 1.27), and improved knowledge and

acceptance of surgery-related complications and the need for possible redo or ancillary procedures (13.18 ± 2.00 vs. 10.29 ± 2.31).

In Group A, complications included fever in twenty-one patients (18%), a blood transfusion in one patient (1%), and residual fragments in an X-ray KUB in seven patients (6%). In Group B, fever occurred in twenty-three patients (20%), blood transfusion was needed for two patients (2%), and six patients (5%) had residual fragments in an X-ray KUB. Hospital stays of two days or less were observed in 90 patients (77%) in Group A and 87 patients (75%) in Group B. Stays exceeding two days were noted in 26 patients (23%) from Group A and 29 patients (25%) from Group B, a difference that was statistically insignificant.

When the scores of all questions were summed, 79% of patients in the study group scored more than 30 out of 50, compared to 47% in the control group, a difference that was statistically significant (Table 2). When questionnaire scores were further evaluated on the basis of gender, literacy, and the complications of the surgery, the results were as follows: In Group A, 80% of males and 96% of females scored over 30, compared to 70% and 63%, respectively, in Group B, though this difference was not statistically significant. Among literate patients, 82% in Group A scored over 30 (56/68 cases), compared to 47% in Group B (36/76 cases). Among illiterate patients, 92% in Group A scored over 30 (44/48 cases), compared to 45% in Group B (18/40 cases).A statistically significant correlation was found between the two groups.

Table 2. Questionnaire response.

Sr No	Question	Score Range	Group A (116, 100%)	Group B (116, 100%)	Total (232, 100%)	Chi-Square	*p* Value
1	I understand what procedure is going to happen and why I need to undergo the procedure.	≤Scoreof 3	12 (10%)	58 (50%)	70 (30%)		
		>Scoreof 3	104 (90%)	58 (50%)	162 (70%)	21.64	<0.00001(S)
2	I understand what all instruments are used in surgery to clear renal stones.	≤Scoreof 3	20 (17%)	70 (60%)	90 (39%)		
		>Scoreof 3	96 (83%)	46 (40%)	142 (61%)	21.64	<0.00001 (S)
3	I understand from where the nephroscope will be inserted and how the stone will be fragmented.	≤Scoreof 3	18 (16%)	72 (42%)	90 (39%)		
		>Scoreof 3	98 (84%)	44 (58%)	142 (61%)	21.64	<0.00001 (S)
4	I understand what a double-J stent is and why I may require a temporary double-J stent after the PCNL.	≤Scoreof 3	22 (19%)	76 (66%)	98 (42%)		
		>Scoreof 3	94 (81%)	40 (34%)	134 (58%)	21.64	<0.00001 (S)
5	I understand that I have to carry a temporary per urethral catheter after the PCNL.	≤Scoreof 3	20 (17%)	72 (42%)	92 (40%)		
		>Scoreof 3	96 (83%)	44 (58%)	140 (60%)	21.64	<0.00001 (S)
6	I was confident about the PCNL after the explanation by the doctor regarding the procedure, which also helped me prepare for the procedure.	≤Score of 3	18 (16%)	70 (60%)	88 (38%)		
		>Score of 3	98 (84%)	46 (40%)	144 (62%)	21.64	<0.00001 (S)

Table 2. *Cont.*

Sr No	Question	Score Range	Group A (116, 100%)	Group B (116, 100%)	Total (232, 100%)	Chi-Square	*p* Value
7	Explanation by the doctor regarding the procedure has improved my knowledge about the procedure.	≤Scoreof 3	18 (16%)	74 (64%)	92 (40%)		
		>Scoreof 3	98 (84%)	42 (36%)	140 (60%)	21.64	<0.00001 (S)
8	After explanation by the doctor regarding the procedure, I could understand the risk and complications that may happen even after performing the procedure in well-known safe steps.	≤Scoreof 3	16 (14%)	66 (57%)	82 (35%)		
		>Scoreof 3	100 (86%)	50 (43%)	150 (65%)	21.64	<0.00001 (S)
9	After explanation by the doctor regarding the procedure, I could understand the complexity of the procedure and risk of residual fragments.	≤Scoreof 3	16 (14%)	68 (59%)	84 (36%)		
		>Scoreof 3	100 (86%)	48 (41%)	148 (64%)	21.64	<0.00001 (S)
10	After explanation by the doctor regarding the procedure, I could understand the complexity of the procedure and the need to redo the procedure.	≤Scoreof 3	16 (14%)	62 (53%)	78 (34%)		
		>Scoreof 3	100 (86%)	54 (47%)	154 (66%)	21.64	<0.00001 (S)
	Total score	≤Scoreof 30	24 (21%)	62 (53%)	86 (37%)		
		>Scoreof 30	92 (79%)	54 (47%)	146 (63%)	21.64	<0.00001 (S)

S = significant.

5. Discussion

Informed consent traditionally involves a signed document following verbal discussion, but patient understanding can vary. Video demonstrations may offer more consistent information, especially for complex procedures like percutaneous nephrolithotomy (PCNL). Our study aimed to assess how video-assisted consent affects patient satisfaction and understanding following PCNL, a procedure with many steps and potential complications that are challenging to explain verbally. Our study found that video-assisted consent significantly enhanced patient satisfaction and comprehension, in line with prior research. J mann et al. (2021) [4] demonstrated that educational videos improved understanding in patients undergoing Mohs surgery. One more study conducted by Fenn et al. (2022) [5] found that multimedia education increased patient satisfaction in those hospitalized for acute renal colic, underscoring the value of interactive tools in healthcare settings. Rossi et al. (2005) [6] found that video-assisted consent improved the understanding of knee arthroscopy, and Tipotsch-Maca et al. (2016) [7] showed that multimedia tools reduced anxiety and enhanced satisfaction among cataract surgery patients. Similarly, Mednick et al. (2016) and Bowers et al. (2017) [8,9] reported that multimedia presentations improved comprehension and satisfaction in ophthalmologic and vascular procedures, respectively.

Our study showed that video-assisted consent enhanced understanding and reduced anxiety for both literate and illiterate patients undergoing PCNL. This aligns with findings from Miao et al. (2020) and Fenn SA et al. (2022) [5], who found that videos improved patient comprehension and satisfaction. However, Delcambre et al. (2019) [10] reported no significant difference in comprehension between video-assisted and traditional consent for

Mohs surgery, likely due to differences in the video content, delivery methods, or patient demographics. Sahai et al. (2006) [11] noted that video-assisted consent not only improved comprehension but also increased patient engagement, as reflected by more follow-up questions. We observed this particularly among illiterate patients, indicating that videos bridge educational gaps effectively.

The present study demonstrates that video consent significantly improves patient satisfaction, particularly among individuals with lower educational levels and those who are illiterate, compared to traditional consent methods. This study also suggests that alternative consent approaches, such as simplified written information, visual aids, and computer-based presentations, can enhance participant understanding and the willingness to take part in research (Ditai et al., 2018) (Raich, 2012). Informed consent is a critical aspect of research, as it ensures that participants fully understand the potential benefits, risks, and details of a study before agreeing to participate [12,13]. There is ample evidence that participants often have poor comprehension of the information provided in consent forms. Patients in Group A (video consent) with an educational level of $\leq$12th standard and illiterate patients had notably higher satisfactory scores (>30), with statistically significant results. In contrast, graduates and postgraduates showed no significant differences in satisfaction between the two groups, indicating that the benefits of video consent are most pronounced in populations with limited educational backgrounds (Table 3).

Table 3. Association of demographic factors with satisfactory scores (>30) across Groups A and B.

Sr. No.	Category	Group A Score > 30 *n*/Total (%)	Group B Score > 30 *n*/Total (%)	Odds Ratio/Chi-Square	*p* Value
Educational Status					
1	$\leq$12th Standard	23/27 (85%)	13/29 (45%)	Odds Ratio = 2.27	0.047 (S)
2	Graduate	3/5 (60%)	4/8 (50%)	Odds Ratio = 0.73	0.697 (NS)
3	Postgraduate	2/2 (100%)	1/1 (100%)	Odds Ratio = 2.03	0.566 (NS)
4	Illiterate	22/24 (92%)	9/20 (45%)	Odds Ratio = 3.32	0.007 (S)
Gender					
1	Male	28/35 (80%)	12/34 (35%)	Chi-Square = 0.93	0.332 (NS)
2	Female	22/23 (96%)	15/24 (63%)		

S = significant and NS = non-significant.

6. Reducing Anxiety and Improving Engagement

Video-assisted consent also reduced anxiety, particularly among lesseducated patients, in line with Duygu Soydaş Yeşilyurt et al. (2019) and Mettarikanonet al. (2023), who found that multimedia interventions alleviate pre-operative stress and enhance confidence. Our study demonstrated that video consent enhanced comprehension and satisfaction, especially among illiterate and lesseducated patients [14,15].

The strength of our study lies in its randomized controlled design, minimizing bias. The inclusion of both literate and illiterate participants highlights the universal applicability of video-assisted consent. The video content was tailored to cover all the critical aspects of PCNL, ensuring consistent and standardized information delivery. The single-center nature of the study limits the generalizability of our findings. The one-minute video duration may have also restricted the depth of information conveyed. While the video effectively reduced anxiety and improved comprehension, the long-term effects on patient retention and clinical outcomes remain unclear.

Unexpectedly, illiterate patients asked more follow-up questions after viewing the video, possibly indicating greater trust in the healthcare team. This warrants further

exploration. Future studies could examine the long-term impact of video-assisted consent on patient satisfaction and adherence to post-operative care. Investigating varying video lengths, interactive features, and incorporating patient feedback mechanisms could further enhance comprehension. Multicenter studies are needed to validate the scalability and generalizability of this approach.

7. Conclusions

This study underscores the value of video-assisted consent in improving patient comprehension, reducing anxiety, and ensuring equitable education, particularly for illiterate and lesseducated patients. By demonstrating that video tools are effective for complex procedures like PCNL, our findings advocate for a shift toward more patient-centered communication. Multimedia tools can bridge literacy and educational gaps, leading to better patient outcomes and greater healthcare equity.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/siuj6010003/s1, Video S1: Educational video for PCNL.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data is unavailable due to privacy or ethical restrictions.

Conflicts of Interest: The authors declare no conflict of interest.

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