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Informed Consent in Bariatric Surgery: Information, Adequacy, and Consent

Termo de Consentimento informado em cirurgia bariátrica: informação, adequação e consentimento

Consentimiento Informado en Cirugía Bariátrica: Información, Adecuación y Consentimiento

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Abstract: Objective: Evaluate the process of obtaining informed consent among patients enrolled in a bariatric surgery program, considering its relationship with healthcare delivery, decision-making, and adherence to ethical guidelines. **Methods:** Retrospective and prospective study was conducted with patients enrolled in the bariatric surgery program at a teaching hospital in Pernambuco, Brazil. Study was carried out in two phases: medical record review and administration of three structured questionnaires. **Results:** Total of 85 patients were included, predominantly aged 30–39 years, with 45.9% having completed secondary education. Regarding the informed consent form (ICF), 60% of participants reported not reading it prior to signing, 47.1% indicated that it was presented by a medical resident, 98.8% reported receiving prior explanation, 92.9% reported understanding the information, including risks and technical terms, and 98.8% considered the language clear and accessible. However, 43.5% were unable to identify the purpose of the ICF. Higher educational levels were associated with better understanding of the document. **Conclusion:** ICF adequately addressed risks, benefits, therapeutic alternatives, and the surgical procedure. Despite high rates of explanation and self-reported understanding, a substantial proportion of patients did not fully understand the purpose of the document, highlighting gaps in the informed consent process. Educational level was a relevant factor associated with comprehension.

Keywords: Informed Consent; Bariatric Surgery; Ethics.

Resumo: Objetivo: Avaliar o processo do Termo de Consentimento Informado de pacientes cadastrados no programa de cirurgia bariátrica no contexto da assistência à saúde, tomada de decisão e se o termo foi capaz de alcançar as diretrizes éticas que o orientam. **Métodos:** Estudo retrospectivo e prospectivo, conduzido com pacientes cadastrados no programa de cirurgia bariátrica de um Hospital Escola de PE. Foi realizada em duas etapas, a primeira, um registro dos prontuários e na segunda, aplicado três questionários. **Resultados:** Dos 85 pacientes selecionados, com faixa etária entre 30 a 39 anos e escolaridade nível médio completo 45,9%. Sobre a leitura do TCI, 60% afirmou não ter lido antes de assinar, 47,1% passado pelo médico residente, 98,8% afirmaram ter uma explicação antes da assinatura, 92,9% compreendeu as informações contidas esclarecendo os termos e riscos, 98,8% afirma que a linguagem era clara e simples e 43,5% não sabiam informar para que serve. **Conclusão:** O TCI apresentou as informações adequadas quanto aos riscos, benefícios, alternativas e tipo de procedimento cirúrgico, houve uma leitura previa, explicação e compreensão entre os pacientes, porém a

maioria não sabia informar para que serve, foi visível que o nível de escolaridade maior proporcionou um maior entendimento.

Palavras-chave: Termo de Consentimento Informado, Bariatrica, Ética.

Resumen: Objetivo: Evaluar el proceso de obtención del consentimiento informado en pacientes inscritos en un programa de cirugía bariátrica. **Métodos:** Estudio retrospectivo y prospectivo realizado con pacientes inscritos en el programa de cirugía bariátrica de un hospital universitario de Pernambuco, Brasil. Se desarrolló en dos fases: historias clínicas y aplicación de tres cuestionarios. **Resultados:** 85 pacientes, con predominio de edad entre 30 y 39 años, y un 45,9% con educación secundaria completa. En relación con el consentimiento informado, el 60% de los participantes informó no haber realizado lectura previa antes de la firma, el 47,1% indicó que fue presentado por un médico residente, el 98,8% recibió explicación previa, el 92,9% refirió comprender la información, incluidos los riesgos y términos técnicos, y el 98,8% consideró que el lenguaje era claro y accesible. Sin embargo, el 43,5% no supo identificar la finalidad del documento. **Conclusión:** Consentimiento informado presentó información adecuada sobre riesgos, beneficios, alternativas terapéuticas y el procedimiento quirúrgico. A pesar de la alta tasa de explicación y comprensión autorreportada, una proporción significativa de los pacientes no comprendió plenamente la finalidad del documento, lo que evidencia brechas en el proceso de consentimiento informado. El nivel educativo se mostró como un factor relevante asociado a la comprensión.

Palabras clave: Consentimiento informado; Cirugía bariátrica; Ética.

INTRODUCTION

For centuries, the physician-patient relationship was marked by a strongly paternalistic model in which the healthcare professional concentrated technical knowledge and occupied the central position in therapeutic decision-making, while the patient assumed a predominantly passive role in the course of treatment (VIDAL EIO, 2024; FERNANDEZ CF et al., 2007). In this context, the prevailing view was that the physician, by virtue of greater scientific knowledge, was the only person capable of deciding what was best for the patient. However, ethical, bioethical, and legal transformations in recent decades have significantly changed this paradigm, especially through the recognition of autonomy as a fundamental principle of healthcare practice.

With the consolidation of bioethics and the strengthening of the fundamental rights of the human person, informed consent began to progressively replace the old paternalistic logic of the “the doctor knows best” (ARAÚJO ATM; FERNANDES LS, 2021; ALBUQUERQUE ACTA, 2025; GODINHO AM et al., 2010). Thus, health decision-making is no longer understood as the exclusive attribution of the doctor and began to require the active participation

of the patient, through adequate access to the information necessary for the exercise of his autonomy.

The patient's autonomy became one of the main ethical pillars of the contemporary therapeutic relationship, requiring a horizontalized communication, dialogical and based on the sharing of understandable information (SILVA J, 2024). The new Code of Medical Ethics (CEM) monitors this transformation by strengthening the duty to inform, clarify and respect the decisions of the patient, in line with the constitutional principles of the dignity of the human person and individual freedom (ARAÚJO ATM; FERNANDES LS, 2021).

Although the normative wording has undergone updates over time, the ethical centrality of adequate information remains preserved as an essential requirement for the legitimacy of consent (PAZINATTO MM, 2019; ZILIO D, 2021).

Contemporary bioethical literature emphasizes that the mere signature of the Informed Consent Form (ICF) is not sufficient to ensure the ethical validity of consent. consent can only be considered truly free and informed when the patient effectively understands the information received, including the nature of the procedure, risks, benefits, therapeutic limitations, available alternatives and possible complications (BEAUCHAMP TL; CHILDRESS JF, 2019; GOLDIM JR et al., 2006). In this way, the real understanding of the content of the term is an indispensable element for the authenticity of the autonomous decision.

In the surgical context, this issue assumes even greater relevance, since invasive procedures involve significant risks, complex therapeutic expectations and potential physical, emotional and social repercussions. In bariatric surgeries specifically, several studies demonstrate that many patients sign ICF without full understanding of the information presented, especially regarding late risks, permanent lifestyle changes, possible metabolic complications and the need for continuous multiprofessional follow-up (MELENDO MP et al., 2016; SANTOS ROM, 2022). This situation shows that consent can become merely formal and bureaucratic, moving away from its true ethical purpose.

Authors of clinical bioethics highlight that the moral validity of consent depends not only on the transmission of information, but on the patient's ability to understand, process and use this information in their decision-making (CASTRO AF, 2020; ZILIO D, 2021). it is not enough to inform; it is necessary to ensure that there has been effective understanding. excessively technical language, low education, emotional vulnerability, fear of the disease and the asymmetry of knowledge between physician and patient can significantly compromise this understanding, reducing the practical autonomy of the individual (NUNES LNBT, 2007; SILVA J, 2024).

In addition, studies show that patients undergoing surgical procedures often have a partial or limited understanding of the content of ICF, especially in hospital contexts of high demand and short consultation time. In these situations, consent tends to be perceived only as an administrative or legal requirement, and not as a continuous and ethical communication process (GOLDIM JR et al., 2006; VIDAL EIO, 2024). This reality reinforces the need for more accessible pedagogical and communication strategies, capable of favoring substantial autonomy and not just formal autonomy.

From an ethical perspective, informed consent simultaneously represents a patient's right and a professional duty of the physician. Its main purpose is to ensure that the individual can consciously deliberate, free from coercions, manipulations or vices of will, about interventions that will affect his own body and his quality of life (BEAUCHAMP TL; CHILDRESS JF, 2019). , free and informed consent materializes the right to information and realizes the dignity of the human person in the field of health care (CASTRO AF, 2020).

From the legal point of view, although the Brazilian system does not expressly use the expression "informed consent" in all legal provisions, there is broad recognition of the patient's freedom to accept or refuse medical treatments, according to constitutional principles, ethical norms and consolidated jurisprudential understanding (ABREU MMDE et al., 2006; BRAZIL, 2021; VIDAL EIO, 2024). Consent also stems from the principle of objective good faith, which requires transparency, loyalty and information duty in the relationships between health professionals and patients.

In this context, the ICF should not be understood only as an instrument of professional legal protection, but above all as an ethical mechanism for promoting autonomy, conscious participation and shared decision-making. Its effectiveness depends on the quality of the communication established, the adequacy of the language used and the real understanding of the patient about the proposed procedure.

Thus, considering the ethical complexity involved in bariatric surgery and the need to ensure truly free and informed consent, the present study highlights the importance of evaluating the process of ICF application in a bariatric surgery program of a Hospital-School in Pernambuco. Thus, the study aimed to evaluate the process of the Informed Consent Form among patients registered in the bariatric surgery program, analyzing aspects related to understanding, autonomy, adequacy of the information provided and ethical validity of the consent obtained.

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METHODS

The present retrospective and prospective study was conducted with patients treated at the general surgery outpatient clinic of a Hospital Escola de Recife/PE, from 2015 to 2019. In accordance with Resolution No. 466 of December 12, 2012, of the National Health Council (CNS), the draft was approved under Opinion No. 4,182,727 and CAAE No. 33493120.7.0000.8807.

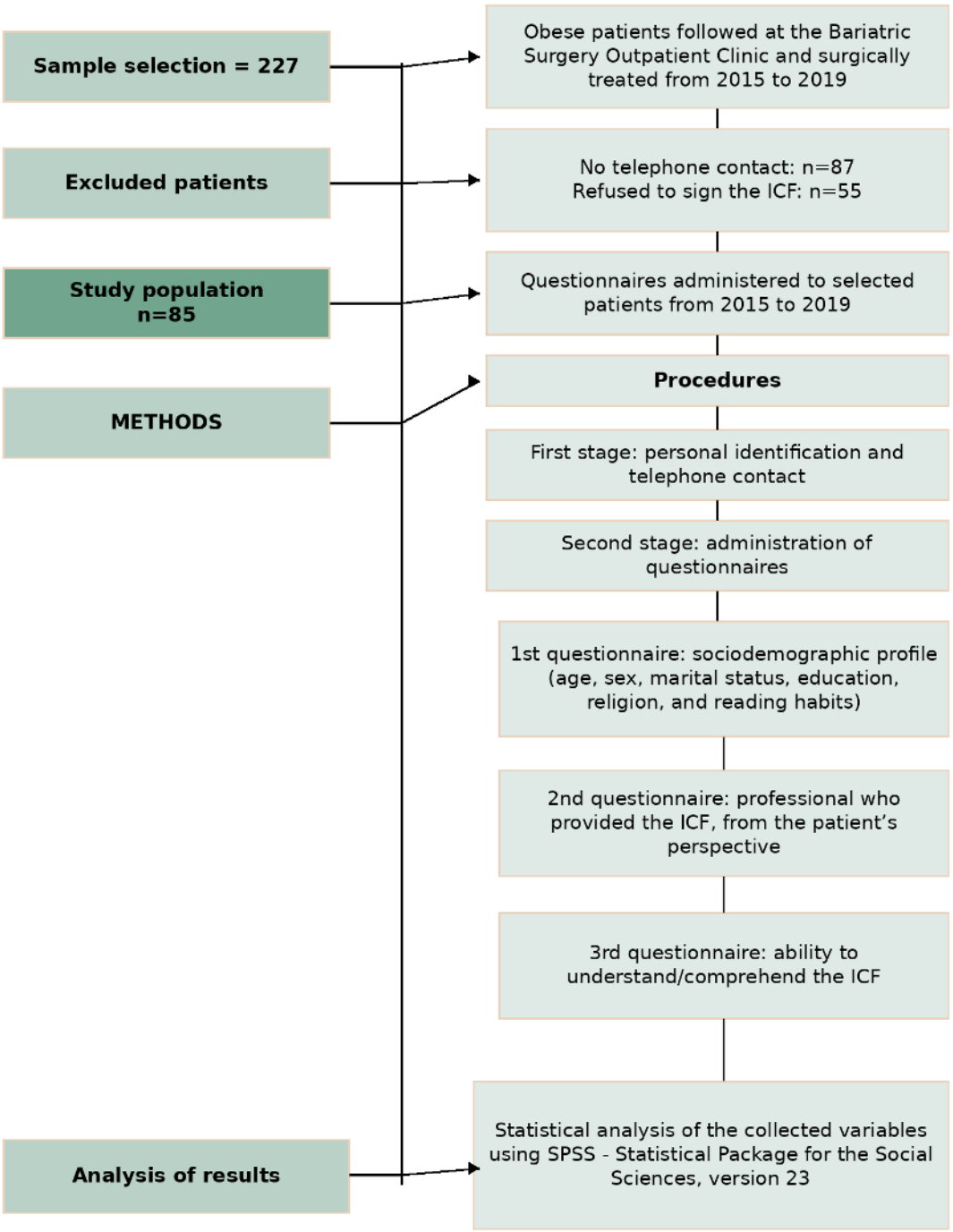
All patients included were interviewed and informed about the objectives and procedures to which they would be submitted, as well as the ethical implications and benefits of the research. only those who previously consented to their inclusion and signed the Informed Consent Form (ICF) participated in the study. After signing the term, data collection began.

The collected data were entered in electronic spreadsheets (Microsoft Excel®), and the numbers of the medical records were encoded in a numerical and random way to preserve the identity of the participants. The file containing this information was only available to researchers.

Patients of both sexes, aged between 19 and 60 years, all diagnosed with obesity and undergoing bariatric surgery, were included. those without possibility of contact were excluded, with incomplete medical records or who did not participate in all the necessary steps to perform the surgery.

Data collection was performed in two stages: the first consisted of the consultation of electronic medical records, and the second, in the application of three questionnaires. Throughout the process, the confidentiality of the participants was ensured, guaranteeing their anonymity and respecting their autonomy to refuse participation or withdraw their consent at any time. Figure 1.

Figure 1 : Data collection flowchart



Source: Carvalho MM, et al.; 2026.

Data collection was performed in two stages. In the first, the identification of patients and the verification of complementary documentation was carried out in the medical records of all obese individuals registered in the bariatric surgery program in the period from 2015 to 2019, which had signed the Free and Informed Consent Form for the surgical procedure. After

this identification, the patients were selected according to the inclusion and exclusion criteria, enabling the characterization of the sample.

In the second stage, a list of patients undergoing bariatric surgery was drawn up, totaling 85 participants. Then, telephone contact was made for the application of three questionnaires: the first for the characterization of the sociodemographic profile (age group, gender, marital status, education, religion and reading habit); the second, related to the professional responsible for providing the Informed Consent Form (ICF), in the perception of the patient; and the third, referring to the capacity of understanding and understanding of ICF.

In the first telephone contact, patients were informed about the project objectives. those who agreed to participate were communicated that they would receive a new call to answer the questionnaires. In the second connection, any doubts were clarified and the application of the data collection instruments began.

Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) software, version 23.0 (Chicago, USA). Descriptive analyses were presented by means of absolute and relative frequencies of categorical variables. to evaluate the association between the level of education of the participants and the responses related to ICF, the Pearson's chi-square test was used or, when necessary, Fisher's exact test. associations with p values below 0.05 were considered statistically significant.

RESULTS

The selection of the sample was performed from the database of the Bariatric Surgery program of a Hospital Escola de Recife/PE, covering patients operated from 2015 to 2019, totaling 227 patients. Of this total, 87 were excluded for lack of telephone contact and 55 for refusing to sign the Free and Informed Consent Form (ICF), with 85 patients left to participate in the study.

85 obese patients underwent bariatric surgery and followed up at the Hospital das Clínicas da UFPE were evaluated, predominating the age group of 30 to 39 years (31.8%). of the total, 83.5% were women and most were married (91.8%). Regarding schooling, the highest percentage had a complete secondary level (45.9%), followed by literacy and complete elementary education, both with 20.0%, and a complete higher level with 14.1%. the majority (55.3%) declared themselves Catholic, 28.2% evangelical, 2.4% Spiritist and 14.1% did not declare themselves. About the reading habit, the highest percentages were: rarely (50.6%) and

daily (31.8%); the percentages of never reading, reading on Sundays and reading more than once a week were, respectively, 9.4%, 3.5% and 4.7%, according to Table 1.

Table 1 – Demographic profile of the bariatric patient sample

Variable	**n (85)**	**%**
Age group		
19 a 29	11	12,9
30 a 39	27	31,8
40 a 49	22	25,9
50 a 59	20	23,5
≥ 60 years	5	5,9
Sex		
Male	14	16,5
Female	71	83,5
Marital status		
Single	0	0,0
Married	76	91,8
Separated	7	8,2
Education		
Literacy	17	20
Complete primary education	17	20
Complete secondary education	39	45,9
Complete higher education	12	14,1
Religion		
Catholic	47	55,3
Spiritist	2	2,4
Evangelical	24	28,2
None of the alternatives	12	14,1
Reading habit		
I never read	8	9,4
I rarely read	43	50,6
I read on Sundays	3	3,5
I read more than once a week	4	4,7
I read daily	27	31,8

Of the term-related questions, highlighted in Table 2, 47.1% answered that ICF was informed by the resident physician; more than half (60.0%) stated that they had not read the

term before signing. Regarding the explanation of the term, 98.8% reported that there was clarification before the signature. In addition, 92.2% understood all the information contained in the document.

The majority confirmed that they had been clarified about the terms and risks (98.8%); considered the language clear and simple (88.2%); 64.7% declared to have no doubts; approximately 83.5% said they had had time for dialogue; 58.8% said they had had security when signing; and 81.2% reported satisfaction.

The items embarrassment, fear of the professional, and receipt of a copy of the form were reported by 9.4%, 3.5%, and 49.4% of participants, respectively.

When asked about the purpose of the form, 43.5% were unable to answer. The remaining alternatives received the following percentages: A - “So that the patient has prior knowledge of the surgical procedure and the risks and benefits involved, while respecting the patient’s wishes, choices, and decisions”: 10.6%; B - “To protect the physician if the patient suffers physical or moral harm”: 24.7%; C - “So that the patient has prior knowledge of the surgical procedure, with respect for the patient’s wishes, choices, and decisions, and to protect the physician if the patient suffers physical or moral harm”: 21.2%.

Table 2 – Evaluation of variables related to the informed consent form

Variable	**n (85)**	**%**
Professional who provided the ICF		
Social worker	8	9,4
Surgeon	3	3,5
Nurse	5	5,9
Medical resident	40	47,1
Others	29	34,1
Read the form before signing		
Yes	34	40,0
No	51	60,0
The form was explained		
Yes	84	98,8
No	1	1,2
Signed without an explanation		
Yes	1	1,2
No	84	98,8
Understanding of the information		

Variable	**n (85)**	**%**
Yes	79	92,9
No	6	7,1
Clear and simple language		
Yes	75	88,2
No	10	11,8
The form and risks were explained...		
Yes	84	98,8
No	1	1,2
Questions		
Yes	30	35,3
No	55	64,7
Dialogue to clarify questions		
Yes	71	83,5
No	14	16,5
Confidence when signing		
Yes	50	58,8
No	35	41,2
Satisfaction		
Yes	69	81,2
No	16	18,8
Embarrassment		
Yes	8	9,4
No	77	90,6
Fear of the professional		
Yes	3	3,5
No	82	96,5
Copy of the form		
Yes	42	49,4
No	43	50,6
Purpose of the form		
So that the patient has prior knowledge of the surgical procedure and its risks and benefits, while respecting the patient's wishes, choices, and decisions	9	10,6
To protect the physician if the patient suffers physical or moral harm.	21	24,7
So that the patient has prior knowledge of the surgical procedure, with respect for the patient's wishes, choices, and decisions, and to protect the physician if	18	21,2

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Variable	n (85)	%
the patient suffers physical or moral harm.		
Unable to answer	37	43,5

Of the results presented in Table 3, related to the level of education, the items “Read the term before signing” and “What is the use of the term” stand out. Regarding the reading of the term, it was found that patients with literacy (18.8%) did not read ICF, while those who claimed to have read had complete high school education (22.4%) and higher complete (9.4%). In the item “What is the use of the term”, the largest percentage differences occurred in the categories of complete high school (15.3%), complete higher (1.2%), literacy (2.4%) and complete fundamental (5.9%). The option “Not knowing how to inform” presented higher values among those who had literacy (15.3%) and full elementary education (12.9%); among those who had complete higher education and complete high school, this percentage ranged from 3.5% to 11.8%.

Table 3 – Correlation between educational level and the presentation protocol for the Informed Consent Form (ICF).

Variable	Education n (%)	Education n (%)	Education n (%)	Education n (%)	p
Variable	**Literacy**	**Complete primary education**	**Complete secondary education**	**Superior Completo**	**p**
Professional who delivered the ICF					0,096b
Social worker	3 (3,5)	2 (2,4)	3 (3,5)	0 (0,0)	
Surgeon	2 (2,4)	1 (1,2)	0 (0,0)	0 (0,0)	
Nurse	2 (2,4)	2 (2,4)	0 (0,0)	1 (1,2)	
Resident	4 (4,7)	7 (8,2)	22 (25,9)	7 (8,2)	
Others	6 (7,1)	5 (5,9)	14 (16,5)	4 (4,7)	
Read the form before signing					0,003a*
Yes	1 (1,2)	6 (7,1)	19 (22,4)	8 (9,4)	
No	16 (18,8)	11 (12,9)	20 (23,5)	4 (4,7)	
The form was explained					1,000b
Yes	17 (20,0)	17 (20,0)	38 (44,7)	12 (14,1)	
No	0 (0,0)	0 (0,0)	1 (1,2)	0 (0,0)	
Signed without an explanation					1,000b
Yes	0 (0,0)	0 (0,0)	1 (1,2)	0 (0,0)	

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Variable	**Education n (%)**	**Education n (%)**	**Education n (%)**	**Education n (%)**	**p**
Variable	**Literacy**	**Complete primary education**	**Complete secondary education**	**Superior Completo**	**p**
No	17 (20,0)	17 (20,0)	38 (44,7)	12 (14,1)	
Understanding of the information					0,376b
Yes	16 (18,8)	17 (20,0)	34 (40,0)	12 (14,1)	
No	1 (1,2)	0 (0,0)	5 (5,9)	0 (0,0)	
Clear and simple language					0,457b
Yes	16 (18,8)	14 (16,5)	33 (38,8)	12 (14,1)	
No	1 (1,2)	3 (3,5)	6 (7,1)	0 (0,0)	
The form and risks were explained...					1,000b
Yes	17 (20,0)	17 (20,0)	38 (44,7)	12 (14,1)	
No	0 (0,0)	0 (0,0)	1 (1,2)	0 (0,0)	
Questions					0,167[a]
Yes	5 (5,9)	10 (11,8)	12 (14,1)	3 (3,5)	
No	12 (14,1)	7 (8,2)	27 (31,8)	9 (10,6)	
Dialogue to clarify questions					0,146b
Yes	13 (15,3)	12 (14,1)	34 (40,0)	12 (14,1)	
No	4 (4,7)	5 (5,9)	5 (5,9)	0 (0,0)	
Confidence when signing					0,143[a]
Yes	9 (10,6)	7 (8,2)	24 (28,2)	10 (11,8)	
No	8 (9,4)	10 (11,8)	15 (17,6)	2 (2,4)	
Satisfaction					0,164b
Yes	15 (17,6)	12 (14,1)	30 (35,3)	12 (14,1)	
No	2 (2,4)	5 (5,9)	9 (10,6)	0 (0,0)	
Embarrassment					0,062b
Yes	2 (2,4)	4 (4,7)	1 (1,2)	1 (1,2)	
No	15 (17,6)	13 (15,3)	38 (44,7)	11 (12,9)	
Fear of the professional					0,287b
Yes	0 (0,0)	2 (2,4)	1 (1,2)	0 (0,0)	
No	17 (20,0)	15 (17,6)	38 (44,7)	12 (14,1)	
Copy of the form					0,255[a]
Yes	8 (9,4)	5 (5,9)	23 (27,1)	6 (7,1)	

Variable	Education n (%)	Education n (%)	Education n (%)	Education n (%)	p
Variable	**Literacy**	**Complete primary education**	**Complete secondary education**	**Superior Completo**	**p**
No	9 (10,6)	12 (14,1)	16 (18,8)	6 (7,1)	
Purpose of the form					0,002b*
So that the patient has prior knowledge of the surgical procedure and its risks and benefits, while respecting the patient's wishes, choices, and decisions	1 (1,2)	0 (0,0)	5 (5,9)	3 (3,5)	
To protect the physician if the patient suffers physical or moral harm.	2 (2,4)	5 (5,9)	13 (15,3)	1 (1,2)	
So that the patient has prior knowledge of the surgical procedure, with respect for the patient's wishes, choices, and decisions, and to protect the physician if the patient suffers physical or moral harm.	1 (1,2)	1 (1,2)	11 (12,9)	5 (5,9)	
Unable to answer	13 (15,3)	11 (12,9)	10 (11,8)	3 (3,5)	

a = Pearson's chi-square test; b = Fisher's exact test; * = Significant difference.

DISCUSSION

The moral and legal validity of Informed Consent (CI) depends directly on the individual's ability to understand the information received and use it in a manner consistent with their own personal values, interests, objectives and beliefs (SILVA J, 2024). The autonomy of the patient is not restricted to the formal freedom to accept or refuse a procedure, but presupposes in the real capacity of understanding and conscious deliberation about the consequences of the decision taken (GOLDIM JR, 2021; SILVA CA, 2003). , informed consent represents the patient's right to actively participate in decisions related to treatments and surgical interventions that may affect their physical, psychological and moral integrity (VAZ RJ, 2021).

One of the greatest ethical challenges of informed consent lies precisely in the difficulty of ensuring that patients without technical training can adequately understand complex information related to diagnosis, surgical risks, prognosis, benefits and therapeutic alternatives (SILVA JJ, 2023; ROCHA IEGM et al., 2023). Thus, the ethical purpose of informed consent goes beyond the simple documentary signature, consisting in the construction of a communicational process capable of ensuring that the patient effectively understands what has

been explained to him and can exercise his autonomy in a free and enlightened manner (VIDAL EIO et al., 2024).

The findings of the present study reinforce this problem by demonstrating that, although most patients reported having received previous explanations and considered the language of the Informed Consent Form (ICF) clear and accessible, 43.5% did not know what the document is for. This data reveals a fundamental difference between three dimensions often confused in the consent process: receiving information, understanding the content, and understanding the ethical purpose of ICF.

Receiving explanation does not necessarily mean understanding. , partially understanding the risks or benefits of the procedure does not imply full understanding of the ethical and legal function of informed consent. many patients demonstrated to recognize that the term contained information about surgery, risks and care, but failed to identify that ICF exists to ensure its decision-making autonomy, ensure the right to information and legitimize their conscious participation in the therapeutic process (SILVA JJ, 2024).

This distinction has profound bioethical relevance. Contemporary literature differentiates perceived understanding from functional understanding. Perceived understanding occurs when the patient believes they have understood the information presented; functional understanding involves concrete ability to interpret, explain and use this information for autonomous decision-making (SILVA JJ, 2024; VIDAL EIO et al., 2022). In this context, the results of the study suggest that a significant part of the patients presented only superficial or operational understanding of the document, without complete assimilation of its ethical purpose.

The fact that 98.8% of the participants claim to have received a prior explanation and, simultaneously, 43.5% do not know how to explain what the ICF is for, evidences that the consent process may be occurring predominantly formally and bureaucratically. this suggests that, in many cases, the focus of communication focuses on the transmission of technical information about the procedure, without ensuring that the patient understands his active role in the decision-making process. Thus, consent risks becoming a mere administrative formality or instrument of institutional legal protection, moving away from its main ethical purpose: to promote substantial autonomy.

From this perspective, patient autonomy depends not only on the provision of information, but on the ability to process it critically, integrating them to one’s own expectations, values and life projects (GOLDIM JR, 2021; SILVA CA, 2003). consent can only

be considered truly valid when the patient understands not only “what will be done” but also “why he is consenting” and what his rights are within that process.

In the context of bariatric surgery, this issue becomes even more relevant due to the complexity of the procedure and the profound physical, psychological and social changes involved in the postoperative period. Bariatric surgery requires continuous adherence to treatment, permanent behavioral changes, and adequate understanding of therapeutic risks and limitations. Thus, the lack of understanding about the purpose of ICF can compromise the ethical legitimacy of the surgical decision.

The results also indicated a statistically significant association between education and understanding of the purpose of the term, demonstrating that patients with a higher educational level had a better understanding of the role of informed consent. This finding reinforces the influence of health literacy on the practical autonomy of patients and evidences that the current model of ICF may favor individuals with higher educational capital, expanding vulnerabilities among those with lower education (CAWICH SOC et al., 2013; GOTA V et al., 2018).

In addition, although many patients have reported satisfaction with the explanations received and a sense of security when signing the document, the literature demonstrates that subjective satisfaction does not necessarily equate to effective understanding (FALAGAS M et al., 2009; CASTRO AF et al., 2020). Patients may feel satisfied that they trust the medical team, even without fully understanding the information provided. Similarly, the absence of doubts does not always mean adequate understanding, and may reflect embarrassment, insecurity or inability to identify informational gaps.

In this context, informed consent must be understood as an ongoing communication process and not merely as an isolated documentary act. Active strategies for verifying understanding, such as the teach-back method, in which patients explain in their own words what they understood, have been recommended in the international literature as effective tools for strengthening autonomy and reducing failures in consent (ALSAFFAR H et al., 2016; SUTHERLAND et al., 2002).

The findings related to the origin of the explanations, made mainly by resident physicians and other team professionals also reinforce the need for specific training in health communication. The ethical quality of consent depends directly on the professional’s ability to adapt language to the sociocultural level of the patient, identify difficulties of understanding and promote accessible and participatory dialogue.

Thus, the results of the present study suggest that the ethical effectiveness of ICF should not be evaluated only by the delivery of the document, prior reading or subjective perception

of clarity, but mainly by the patient's ability to understand its purpose, exercise conscious autonomy and actively participate in therapeutic decision. The high percentage of patients unable to explain what ICF is for evidences the need to review the communication strategies used in the surgical context, especially in populations with different levels of education and literacy in health.

Thus, our results corroborate the findings of VIDAL EIO et al. (2024) and SILVA JJ (2024), who recommend patient-centered communication practices, simplified language and multimodal resources, routine use of comprehension-verification strategies such as the teach-back method, specific training for multidisciplinary teams and resident physicians in ethical communication, and reformulation of the ICF to make it more accessible and understandable. These measures may reduce the discrepancy between apparent and actual understanding, strengthening patients' effective autonomy and the ethical validity of the consent obtained.

Finally, the present study has some limitations, including the reduced sample size and the collection in a preoperative context during the pandemic, factors that may have influenced the participants' ability to understand. Thus, future studies, with larger samples and more in-depth qualitative approaches, are necessary to investigate in a more detailed way the factors associated with the misunderstanding of the ethical purpose of ICF in the surgical context.

CONCLUSION

The Informed Consent Form (ICF) used in the Bariatric Surgery program of the Hospital Escola de Recife/PE, presented adequate information regarding the risks, benefits, alternatives and type of surgical procedure. Emphasizing that the contents contained in this were informed by the resident physician and the patients confirmed that there was a proper explanation and understanding of all the information, but it was identified the need for a patient-centered communication relationship through a simplified language transmitted by the entire multidisciplinary team.

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