Informed consent

“Informed consent” is the name given to the idea that a patient has a legal and ethical right to direct what happens to his/her body. Even though the term specifically appears in a limited number of AAAHC Standards* it is the philosophical basis for positioning patient rights first among the requirements for accreditation.

The goal of informed consent is that a patient has the opportunity to be an active participant in his/her health care decisions. This means that the provider has a responsibility to disclose the nature of the proposed treatment or procedure, the relevant associated risks, and any options—along with the attendant risks of those alternatives.

These disclosures represent only the first (and perhaps the simplest) step in a process. There is often an inherent power imbalance in the provider-patient relationship that can easily become coercive. Patients may be vulnerable and reluctant to, or incapable of, asking clarifying questions about the information that has been provided. They don’t know what...
they don't know.

For this reason, the provider must confirm patient understanding, (or that of his or her representative) prior to seeking consent to ensure that the consent is voluntary and intentional. It may help to frame the issue as a decision-making partnership. The provider will certainly share a recommendation, but the patient must have ample opportunity to participate in the decision to proceed. Including a consent form among a stack of papers to sign could reduce an individual's agency and unfairly shifts responsibility to the patient to ask rather than on the provider to explain.

With regard to the expectations of an accreditable organization, here are some questions that have arisen with regard to issues of consent.

Combining consents

Q: An organization with an integrated medical and behavioral health service uses a single "consent to treat" for the whole health center. Is this acceptable?

A: A single consent may be used, but the consent must cover all services provided in sufficient detail that the patient/client is able to make an informed decision. To address behavioral health services, it may be appropriate for the consent to include items such as treatment expectations and parameters, and potential risks and protections related to treatment. The organization might also wish to consider ensuring that instances of limited confidentiality are clearly articulated, reviewed with the client, and acknowledged by signature. It may also be desirable to obtain consent for the coordination of care with family members and/or significant others who play a role in the plan of care or treatment of the client.

Q: For a surgical procedure, can a single consent form cover both the anesthesia and the procedure?

A: Again, the heart of the issue is voluntary, informed patient consent. If the provider(s) have fully communicated the options, risks, recommended course of action, and assessed the patient’s understanding and willingness to proceed, it is acceptable to use a single consent document. In cases where the anesthesia provider and the surgeon are individually discussing their roles with the patient, it is more usual to see separate forms. In settings where a surgeon is supervising anesthesia provided by a CRNA, a single consent form is more common.

Consent for a procedural service

Q: Can documentation that the proposed procedure was discussed with the patient or the patient’s parents/guardian, and that they consented to the procedure be included in the
medical notes rather than being documented on a separate form?

A: Some states require a written consent; many do not. However, beginning in 2016, AAAHC Standard 10.H is quite specific on this:

Informed consent for the proposed procedure is obtained.

1. There is documentation that the necessity of the proposed procedure or surgery, as well as alternative treatment techniques, have been discussed with the patient.

2. The organization obtains written informed consent from the patient or the patient’s representative before the procedure or surgery is performed.

Written informed consent has always been required in Medicare-certified ASCs, and the Standard now requires it in other surgical/procedural settings as well. To apply 10.H.2 in primary care settings, surveyors will ask for the organization’s policies or guidelines regarding when written vs. verbal consents are required, assess the rationale of those guidelines, and then confirm compliance through the review of clinical records. The intent is that in primary care settings, some procedures such as cryotherapy of warts, removal of skin tags, etc. are sufficiently benign that they will not require separate written, signed consents. In this case, a note in the clinical record is sufficient.


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