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## Signature Informed Consent Workflows: “Gurney Consent”

The National Center for Ethics in Health Care (NCEHC) has received a number of questions regarding the “gurney consent” provision in [VHA Handbook 1004.01, \*Informed Consent for Clinical Treatments and Procedures\*](#) (August, 2009).

Paragraph 13.b.(3) states, “Patients must not, as part of the routine practice of obtaining informed consent, be asked to sign consent forms ‘on the gurney’ or after they have been sedated in preparation for a procedure.”

The “gurney consent” prohibition was included in VHA Handbook 1004.01 to help ensure that completion of signature informed consent does not occur so late in the process (including when the patient is on a gurney) that the patient feels pressured or forced to consent or is deprived of a meaningful choice because he or she is in a compromised position, for example, sedated or without reading glasses. VA practitioners have an ethical and a legal obligation to support the ethical underpinning of this provision, i.e., that patients have the right to make informed, voluntary choices about recommended treatments and procedures.

In recent years, health care systems, including VA, have taken steps to improve efficiency and increase the number of patients successfully examined, screened and treated. These steps include a more team-based approach to providing care, and incorporate a variety of communication methods into practices that are convenient for patients and

providers, including telehealth, telephone, mail, fax and face-to-face discussions. In some new processes, the patient does not see the practitioner who will perform the procedure until the day of the procedure. These improvements in workflow have created challenges in obtaining appropriate informed consent.

When Handbook 1004.01 is next revised for re-issue, NCEHC will propose replacing the phrase “on the gurney” with language that clearly explains the workflows appropriate for ensuring a valid signature informed consent process. Until that time, appropriate workflows include the following elements:

1. **The informed consent discussion.** The informed consent discussion is the basis for ensuring that patients are aware of the risks, benefits and alternatives of a recommended treatment or procedure before they decide whether to have it. The discussion can occur in person, by telephone or via videoconference, and can be conducted by the practitioner or delegated to trained team members. The discussion can be *supplemented* by written education materials provided to the patient in person, by mail, fax, email or other methods. However, written materials cannot be provided to the patient (or surrogate) *in lieu of* the informed consent discussion. The informed consent discussion may be initiated by trained staff and completed by the practitioner who answers the patient’s questions and confirms the patient’s consent prior to completing the informed consent process with signatures. At a minimum, every patient must be provided with relevant information and offered the opportunity to speak with the practitioner if they have any questions or concerns.

2. **Completing the informed consent process with signatures.** The placement of the signature by the *patient* (or surrogate) on the consent form documents the patient's voluntary consent to the treatment or procedure based on the information provided about its risks, benefits and alternatives. The placement of the signature by the *practitioner* documents the practitioner's attestation that the patient has been provided with appropriate information about the risks, benefits and alternatives of the treatment or procedure, has had the opportunity to have their questions answered, and voluntarily consents. As described in [Handbook 1004.05, iMedConsent™](#), except under specified conditions, the signatures are documented using iMedConsent™. The signatures may be obtained using a variety of workflows, including:

a. ***Asynchronously in iMedConsent™.***

iMedConsent™ allows for the signatures of the practitioner and the patient (or surrogate) to be obtained and saved at different times and/or locations. For example, a patient may receive education from trained staff at a CBOC, speak via telephone or videoconference with their practitioner at the medical center to answer any additional questions and complete the informed consent discussion. Then, with assistance, the patient can sign the consent form in iMedConsent™ while at the CBOC. The practitioner would then open the saved form and add his or her signature. (See [FAQ: iMedConsent™ Asynchronous Signature](#) for additional information.)

b. ***In person, with signatures applied to the consent form by both patient (or surrogate) and practitioner in iMedConsent™.*** For procedure workflows where the patient and practitioner do not meet until the day of the procedure, but the preparation for the procedure would be ordered and started prior to the procedure (e.g., colonoscopy), the patient's signature can be obtained in the procedure room on the day of the procedure as long as these conditions have been met: The informed consent discussion, including information about the preparation, had been initiated by trained staff in advance of the procedure preparation, and the practitioner completes the informed consent discussion before sedation by answering any remaining questions that the patient may have, and confirming the patient's consent.

While efficient workflows are required to promote access to care, efficiency should not be achieved at the expense of respecting and honoring the patients' right to be informed about — and given a meaningful opportunity to make decisions about — their medical care.

For additional information on informed consent, please visit the National Center for Ethics in Health Care's website at

<http://vaww.ethics.va.gov/activities/policy.asp>