Introduction
Documentation of informed consent in the patient’s chart is important from a number of perspectives: health care ethics, malpractices risk management, and effective patient management. The most important goal of informed consent is that the patient has an opportunity to be an informed participant in health care decision making. It is generally accepted that complete informed consent should be obtained from patients before carrying out any diagnostic or therapeutic procedure and includes a discussion of the following elements:

- The nature of the treatment plan, procedure or diagnostic testing
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative, including the risk of refusing care
- Assessment of patient understanding
- The acceptance of the intervention by the patient

Ethics
Informed consent is the process by which fully informed patients can participate in choices about their health care. It originates from the legal and ethical right each patient has to direct what happens to their body and from the ethical duty of the physician to involve the patient in his or her health care. Fully informed patients have adequate foreknowledge or understanding of the recommended treatment and/or diagnostic testing, the anticipated outcomes and alternatives to it. It is the process of effectively communicating with patients in terms they understand, and then allowing them the opportunity to ask questions.

Malpractice Risk Management
Despite our best efforts as careful clinicians to do what is right, bad outcomes do happen. In an informed consent process, the potential risks of an adverse outcome are dealt with up front with each patient in a straight-forward and non-threatening manner. Having this conversation with patients first helps a great deal in those unlikely cases with a less-than-optimum outcome. What is more, patients who have access to open information exchanges are less likely to sue for malpractice.

To protect yourself in malpractice litigation, in addition to carrying adequate liability insurance, it is important that communication about the informed consent process itself be documented in the clinical file. Good documentation can serve as evidence in a court of the law that the process indeed took place. A timely and thorough documentation in the patient’s chart by the provider of the treatment can be a strong piece of evidence that the provider engaged the patient in an appropriate discussion.
Of the complaints that we receive at CHP, the most common is “the practitioner hurt me.” Often the patient goes on to describe an uncomfortable procedure (adjusting, massage, acupuncture needles) followed by post-treatment soreness, stiffness or other symptoms. The perception of an uninformed patient in this scenario boils down to “That practitioner hurt me.” and CHP gets a complaint. A complete “informed consent” discussion with that patient acknowledging the risk of discomfort with the procedure and the potential of post-treatment soreness may well have prevented this perception and prevented a complaint.

**Patient Management**

Informed patients make better health care decisions. Open discussion with patients about treatment plans, common alternative treatments that may be available, the risks that may be associated with them, including refusing care, and invitation to patients to ask questions and receive clarification are primary activities for all health care providers. Often dubbed the “PARQ” conference (an acronym for “procedures, alternatives, risks, and questions”), this open communication empowers each patient to obtain all necessary information, ask questions and to collaborate with the clinician in making decisions about care.

Patients who are able to make informed decisions are more likely to follow through on your treatment recommendations. They have demonstrably better clinical outcomes, are more satisfied with you and your care and they are more likely to refer their family and friends.

**Documenting Informed Consent: “PARQ”**

Informed consent is a process involving verbal discussion as well as proper documentation. CHP recommends as a “best practice” that informed consent be fully documented and included in the clinical file.

One common option for documenting informed consent is noting the acronym “PARQ” which can be written in the patient’s chart indicating that the provider has explained the procedures (P), viable alternatives (A), material risks (R), if any, and has asked if the patient has any questions (Q). “PARQ” should be noted prior to the implementation of any treatment. If the patient requests further information or has specific questions, the provider can underline the PARQ chart notation to reflect the patient’s request. The provider should note the particular question and note the more detailed information provided. While this is an appropriate method of documenting that this process has occurred, there is no substitute for the patient’s written confirmation of those facts.

It is also recommended that the patient execute some document acknowledging that they have been part of an informed consent process, the material risks have been disclosed including a description of those risks and that the patient has agreed (“consented”) to the procedures understanding any risks inherent to that procedure. This could be accomplished using a prepared written consent form that must be signed by the patient and should be signed by the doctor. Again, it is important to note that practitioners should not rely exclusively on those forms and must communicate directly with the patients.
As new conditions occur that may require different evaluation procedures or different treatment procedures, additional informed consent should be obtained from the patient. In addition, consent given to one physician is not consent for any other physician unless the patient agrees to the substitute. This assent to the substitute physician should be noted in the clinical record.

**THE MINOR PATIENT** *(In the United States, minor is legally defined as a person under the age of 18)*

As with all patients, informed consent is required for minor patients. There are different considerations required based on the type of provider delivering the service, e.g. DC, MD, as well as the services that are being provided, e.g. chiropractic adjustments, reproductive healthcare. For the purposes of Best Practices, it is recommended that the provider review the specific statutes or rules regarding obtaining informed consent from a parent/legal guardian or the minor patient, whichever is appropriate, that applies to the services rendered in the state in which they practice.