Informed Consent for Medical Procedures*

Local and National Practices

Constantine A. Manthous, MD, FCCP; Angela DeGirolamo, MD; Christopher Haddad, BA, JD; and Yaw Amoateng-Adjepong, MD, PhD

Background: No studies have assessed whether clinicians obtain informed consent for invasive medical procedures, and there are no explicit national standards to guide the process. **Hypothesis:** Informed consent practices are inconsistent for commonly performed invasive medical procedures.

Methods: A simple questionnaire was electronically mailed and/or faxed to training program directors of critical care medicine and internal medicine departments, and to ICU directors in the state of Connecticut. The questionnaire listed common invasive medical procedures and asked the respondents to check those for which practitioners routinely obtain informed consent in their hospital.

Results: The three samples, national intensivists (88 respondents), Connecticut intensivists (29 respondents), and national internists (56 respondents) demonstrated heterogeneity of consenting practices. The rate of obtaining consent for common vascular access procedures ranged from 20 to 90%. The rates of obtaining consent for Foley catheterization and nasogastric intubation were uniformly < 10%, and those for endoscopic procedures were > 90%. Separate consent (beyond the general consent to treat) was not uniformly obtained for the transfusion of blood products (range, 74 to 93%) and common diagnostic medical procedures (eg, thoracentesis, paracentesis, or lumbar puncture; range, 77 to 96%). Surgical intensivists reported that the obtaining of consent for invasive procedures was less routine compared to medical intensivists. Lower rates of consent were noted by those respondents who used a “blanket” consent form, which was signed at the time of hospital admission, to cover subsequent procedures.

Conclusions: In this relatively small sample, there was no uniform practice of informed consent for commonly performed invasive medical procedures. Consent was routinely obtained for GI endoscopy, bronchoscopy, and medical research, and was not obtained for Foley catheterization and nasogastric intubation. The obtaining of consent for vascular cannulation and diagnostic procedures was not routine in the ICUs of a substantial number of respondents. Explicit standards that delineate specifically which procedures require consent may be required to assure more uniform practices.


Key words: critical care; informed consent; intensive care; procedures

Abbreviation: JCAHO = Joint Commission on Accreditation of Health Organizations

There are no published studies examining the medical procedures for which physicians routinely obtain informed consent. Although informed consent is mandated for all surgical procedures, there are no explicitly stated national standards of practice regarding patient/surrogate consent for in-
vasive medical procedures. In this study, we hypothesized that the lack of explicit guidelines engenders considerable heterogeneity in the practice patterns of informed consent, both nationally and locally. We tested this hypothesis with a simple questionnaire, which was sent to critical care fellowship program directors, to critical care unit directors in the state of Connecticut, and to internal medicine program directors.

**Materials and Methods**

Our investigational review board waived a formal review of this study. In March 2002, a questionnaire was e-mailed and faxed to program directors of internal medicine-based and surgery-based critical care fellowships (see Appendix 1). The mailing to critical care program directors was limited to those directors who listed their e-mail addresses in the Graduate Medical Education Directory (of the American Medical Association). In addition, the critical care questionnaire was transmitted by fax to ICU directors of the 31 hospitals in the State of Connecticut. Connecticut intensivists who did not answer by fax were contacted by telephone to respond to the questionnaire.

Internal medicine residency program directors were also e-mailed the questionnaire through the Majordomo list-server (at the University of Pittsburgh) for the Association of Program Directors of Internal Medicine, which is distributed to roughly 840 internal medicine program directors and other graduate medical educators. If a respondent was uncertain as to whether consent was obtained for a given procedure, this response was not counted in frequency calculations.

**Results**

**Critical Care**

**National Questionnaire:** Sixty of 208 ICU program directors (29%) who were e-mailed and 28 of 116 program directors (24%) who were faxed responded to the questionnaire. Twenty-two respondents indicated that they attended mainly in a surgical ICU, 54 in a medical ICU, and 12 in mixed medical-surgical ICUs. Blanket consent was used to cover procedures performed in 64% of surgical ICUs and 22% of medical ICUs. In surgical ICUs, the rate of separate consent ranged from 0 for Foley catheterization to 100% for medical research. The rates of separate consent ranged from 7% for Foley catheterization to 100% for medical research. The rates of obtaining separate consent for medical procedures were uniformly greater among medical units than surgical units (Table 1). The rates of separate consent were consistently lower among units using some form of blanket consent than for those not using blanket consent (Table 2).

**Connecticut Questionnaire:** Twenty-nine ICU directors responded from 25 of 31 acute care hospitals in Connecticut. There are six pulmonary and/or critical care training programs in Connecticut that may have been included in the programs survey described (national survey responses were not site-identified). Of the 25 responses from Connecticut ICU directors, 6 were from medical ICUs, 5 were from surgical ICUs, and the remainder included mixed medical-surgical ICUs. Some form of blanket consent was used in only three ICUs (10%). In surgical ICUs, the rate of separate consent ranged from 0 for Foley catheterization to 100% for clinical research. In medical ICUs, the rates of separate consent ranged from 17% for Foley catheterization to 100% for medical research. The rates of obtaining separate consent were greater among medical units than surgical units for all medical procedures (Table 3).

Four hospitals were included for which data were available for both medical and surgical ICUs. The ICUs of all four hospitals demonstrated different consent practices between medical and surgical ICUs. Consent practices were inconsistent for between three and five procedures listed in the questionnaire. Consenting practices within the same hospital differed by a mean of 29% (nearly one in three) of the listed procedures.

**Internal Medicine**

**National Questionnaire:** The pooled responses of 56 internal medicine program directors were pre-

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**Table 1—Critical Care Unit Data on Consent for Various Procedures From Program Directors**

<table>
<thead>
<tr>
<th>ICU</th>
<th>Blanket</th>
<th>AC</th>
<th>CVC</th>
<th>PAC</th>
<th>FEVC</th>
<th>Thorac</th>
<th>Parac</th>
<th>LP</th>
<th>BT</th>
<th>IVC</th>
<th>EI</th>
<th>FB</th>
<th>GIE</th>
<th>NI</th>
<th>FC</th>
<th>MR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (n = 54)</td>
<td>0.22</td>
<td>0.67</td>
<td>0.81</td>
<td>0.87</td>
<td>0.70</td>
<td>0.93</td>
<td>0.93</td>
<td>0.91</td>
<td>0.87</td>
<td>0.48</td>
<td>0.49</td>
<td>0.96</td>
<td>0.94</td>
<td>0.11</td>
<td>0.07</td>
<td>1.0</td>
</tr>
<tr>
<td>Surgical (n = 22)</td>
<td>0.64</td>
<td>0.14</td>
<td>0.23</td>
<td>0.23</td>
<td>0.09</td>
<td>0.50</td>
<td>0.45</td>
<td>0.41</td>
<td>0.36</td>
<td>0.18</td>
<td>0.14</td>
<td>0.35</td>
<td>0.32</td>
<td>0.05</td>
<td>0</td>
<td>0.91</td>
</tr>
<tr>
<td>Mixed (n = 12)</td>
<td>0.33</td>
<td>0.50</td>
<td>0.67</td>
<td>0.67</td>
<td>0.67</td>
<td>0.53</td>
<td>0.53</td>
<td>0.83</td>
<td>0.83</td>
<td>0.50</td>
<td>0.17</td>
<td>0.92</td>
<td>1.0</td>
<td>0</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>Total cohort (n = 88)</td>
<td>0.34</td>
<td>0.51</td>
<td>0.65</td>
<td>0.69</td>
<td>0.55</td>
<td>0.81</td>
<td>0.80</td>
<td>0.77</td>
<td>0.74</td>
<td>0.40</td>
<td>0.35</td>
<td>0.85</td>
<td>0.92</td>
<td>0.08</td>
<td>0.05</td>
<td>0.98</td>
</tr>
</tbody>
</table>

*Values given as frequency of consent. AC = arterial catheterization; CVC = central vein catheterization; PAC = pulmonary artery catheterization; FEVC = femoral vein catheterization; Thorac = thoracentesis; Parac = paracentesis; LP = lumbar puncture; BT = blood transfusion; IVC = IV contrast; EI = endotracheal intubation; FB = fiberoptic bronchoscopy; GIE = GI endoscopy; NI = nasogastric intubation; FC = Foley catheterization; MR = medical research.
sented in Table 4. Some form of blanket consent was used in 26 medicine programs (46%). Informed consent was obtained at a high frequency for pulmonary artery catheterization (84%), fiberoptic bronchoscopy (88%), and GI endoscopy (88%). Consent for Foley catheterization and nasogastric intubation was infrequent (9% and 11%, respectively). Nine respondents who reported the use of blanket consent indicated they did not obtain consent for nearly all medical procedures. We recontacted them to assure that they were not listing procedures for which they used separate consent forms. None retracted their initial answers.

**Discussion**

This study demonstrates clinically significant heterogeneity, both locally and nationally, of consent practices for invasive medical procedures. This lack of consensus applies not only to national and local practices but, as our data illustrate, may even differ within institutions. Consent for arterial and femoral vein catheterization were not obtained in roughly half of the institutions that responded, and one third to one quarter of respondents did not routinely obtain consent for central vein or pulmonary artery catheterization. Consent was more common for medical diagnostic procedures (75% for lumbar puncture, paracentesis, and thoracentesis; nearly 100% for bronchoscopy and GI endoscopy).

Our study appears to illuminate a difference in consenting cultures between internists and surgeons. The surgeons queried in this study were intensivists. A sizeable number of their patients, if not the majority, are admitted to the ICU following surgical procedures. One argument for not obtaining numerous separate consents for medical procedures is that when a patient consents to surgery, a number of invasive procedures (eg, placement of lines or diagnostic procedures) associated with the operative and postoperative period are part of the “package,” even if not separately described or enumerated. Surgeons may obtain written or verbal preoperative consent for transfusions and the placement of lines, and simply may extend that permission into the postoperative period. However, these explanations for our results remain speculative as our study does not address how/why local practices arose. It is equally likely that consent practices are passed down from generation to generation without a significant interrogation of rationale. Nonetheless, it is interesting to note the consistent differences in the obtaining of consent for medical procedures between medicine and surgery, differences that were even noted between units in the same hospital.

We were surprised by the responses concerning informed consent for medical research. Although the rates of consent for medical research were very high (ie, > 95%) in all three cohorts, it was not 100%. This observation is difficult to explain. It is possible that some respondents do not conduct medical research and therefore did not check medical research in the questionnaire. However, it may suggest a relatively small group of respondents who did not understand the questionnaire (vide infra).

A substantial number of physicians answered that they depended on “blanket consent,” typically obtained at the time of hospital admission, to cover subsequent medical procedures. Previous studies on blanket consent have suggested that patients have little understanding of such documents. Moreover, some have argued that blanket consent obtained in emergency and/or critical care settings is especially subversive of patients’ rights. Severe illness may

| Table 2—Critical Care Unit Data on Consent Form Use From Program Directors* |
|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------- |
| Consent          | AC     | CVC    | PAC    | FEVC   | Thorac | Parac  | LP     | BT     | IVC    | EI     | FB     | GIE    | NI     | FC     | MR     |
| Blanket (n = 30) | 0.23   | 0.30   | 0.37   | 0.23   | 0.50   | 0.50   | 0.47   | 0.53   | 0.30   | 0.07   | 0.63   | 0.87   | 0      | 0      | 0.97   |
| Nonblanket (n = 58) | 0.66   | 0.83   | 0.86   | 0.47   | 0.97   | 0.95   | 0.93   | 0.84   | 0.46   | 0.50   | 0.97   | 0.95   | 0.12   | 0.07   | 0.98   |

*See Table 1 for abbreviations not used in the text.

Table 3—Critical Care Unit Data on Frequencies of Separate Consent for Various Procedures From Connecticut ICU Directors* |

<table>
<thead>
<tr>
<th>ICU</th>
<th>Blanket</th>
<th>AC</th>
<th>CVC</th>
<th>PAC</th>
<th>FVC</th>
<th>Thorac</th>
<th>Parac</th>
<th>LP</th>
<th>BT</th>
<th>IVC</th>
<th>EI</th>
<th>FB</th>
<th>GIE</th>
<th>NI</th>
<th>FC</th>
<th>MR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (n = 6)</td>
<td>0.17</td>
<td>0.50</td>
<td>0.67</td>
<td>0.67</td>
<td>0.67</td>
<td>1.0</td>
<td>1.0</td>
<td>0.53</td>
<td>0.33</td>
<td>0.67</td>
<td>0.17</td>
<td>1.0</td>
<td>1.0</td>
<td>0.17</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Surgical (n = 5)</td>
<td>0</td>
<td>0.20</td>
<td>0.40</td>
<td>0.40</td>
<td>0.40</td>
<td>0.75</td>
<td>0.75</td>
<td>0.75</td>
<td>0.80</td>
<td>0.80</td>
<td>0.20</td>
<td>0.80</td>
<td>1.0</td>
<td>0</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>Mixed (n = 18)</td>
<td>0.11</td>
<td>0.50</td>
<td>0.53</td>
<td>0.59</td>
<td>0.61</td>
<td>1.0</td>
<td>0.94</td>
<td>0.94</td>
<td>0.94</td>
<td>0.65</td>
<td>0.06</td>
<td>1.0</td>
<td>1.0</td>
<td>0.06</td>
<td>0</td>
<td>1.0</td>
</tr>
<tr>
<td>Total cohort (n = 29)</td>
<td>0.10</td>
<td>0.45</td>
<td>0.72</td>
<td>0.76</td>
<td>0.59</td>
<td>0.96</td>
<td>0.93</td>
<td>0.89</td>
<td>0.79</td>
<td>0.71</td>
<td>0.10</td>
<td>0.97</td>
<td>1.0</td>
<td>0.07</td>
<td>0.03</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*See Table 1 for abbreviations not used in the text.
engender a potentially coercive atmosphere (eg, “you or your loved one need this procedure or they may suffer worsening condition” or “we wouldn’t offer it if we didn’t think it was necessary”) in which requesting carte blanche permission for medical procedures is particularly inappropriate. Moreover, even in nonemergent circumstances, patient understanding of the consent process may be poor.2–4

Is this observed heterogeneity of obtaining consent important? This question can be answered by considering the ethical, regulatory, and medical-legal underpinnings, and the implications of our findings. Following World War II and the Nuremberg trials, which revealed involuntary human experimentation, medical ethicists and policy makers devised more formal and legally binding standards for informed consent for human research.5,6 The three basic ethical principles, outlined in the landmark Belmont report,7 are as follows: (1) respect for persons (ie, right to self-determination); (2) beneficence (ie, do no harm and maximize benefits/minimize harm); and (3) justice (ie, fairness of distribution). Although created to address human experimentation, these tenets have been extrapolated to patients’ rights in general. Informed consent is the process whereby health-care providers provide the patient with the information necessary to make an informed decision. It necessarily includes explaining the risks, benefits, and alternatives of procedures and treatments. If there is sufficient opportunity, without compromising the well-being of the patient, it is generally accepted that informed consent is required for all surgical procedures. The act of cutting and the risks inherent in anesthesia apparently entail sufficient risk (in both magnitude and frequency) to warrant universal consent for surgical procedures. However, no such standard exists for invasive medical procedures described in this study.

Our data demonstrate that medical procedures may represent an ethically “gray area” for practitioners. Most medical procedures are not as invasive/risky as a hysterectomy, for example, but are more so than a peripheral IV catheter. Several of the procedures examined in our study may cause life-threatening complications, the rates of which vary from “operator” to operator. The number of types of complications that should be explained is also not clear. Should the information provided to patients/surrogates include only frequent complications, those that are very severe, or both? Moreover, complications may eventuate in differing outcomes based on the severity of underlying diseases of the patient. Thus, a complication (eg, pneumothorax following central vein catheterization) may not be life-threatening in a patient who has been admitted to the hospital floor with a soft-tissue abscess but carries significantly more risk in a patient receiving mechanical ventilation with severe ARDS. Properly administered informed consent allows the patient or the surrogate decision maker to perform a calculus that takes into consideration the frequency and severity of complications, and the effects that a complication might have in the context of each patient’s pathophysiology. Even when attempts are made to obtain consent in emergency settings, a minority of patients understand what they have “agreed to.” Consent in the ICU is complicated further because surrogate decision makers (who most often provide consent) may not necessarily reflect the wishes of the patient. Finally, the clinical circumstances in which consent is obtained for medical procedures range from mildly coercive (eg, an elective, outpatient screening endoscopy) to highly coercive (eg, procedures required for major decompensations during critical illness). Thus, in light of these many limitations, one could challenge the legitimacy of even well-performed consent, especially in life-threatening scenarios. The complexity of these many factors may render “proper consent,” in which the patient or surrogate decision maker comes to understand the risks and benefits and then makes an “informed choice,” extremely difficult or impossible in some cases. In an ideal world, the goal would be to “fully consent” to the procedures examined in our study. However, in reality it may be nearly impossible to create uniform standards to guide practitioners of differing procedural proficiencies to adequately inform patients/surrogates of differing educational backgrounds in a variety of clinical circumstances.3,9

Regulatory and accrediting agencies do not stipulate explicitly whether consent is necessary for the procedures listed in our study. Item 2 of the 1992 Patients’ Bill of Rights,10 states: “The patient has the
right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis. Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits. The Joint Commission on Accreditation of Health Organizations (JCAHO) does not list what procedures require informed consent, but its standard TX.5.211 states: “Before obtaining informed consent, the risks, benefits, and potential complications of procedures are discussed with the patient and family, and alternative options are considered.” The JCAHO mandates “discussions with the patient and family about the need for, risk of, and alternatives to blood transfusion when blood or blood components may be needed.” JCAHO further states that “plans of care (should be) developed and documented in the patient’s medical record before the operative or other procedure is performed.” The goal of these standards is that “Patients receive adequate information to participate in care decisions and provide informed consent. If the patient’s condition does not allow for such interaction, appropriate documentation is provided in the medical record.”

Each state also has regulations that govern patient care. In Connecticut, the Health Care Code requires consent for medical procedures but does not specify which procedures. Except for blood transfusions and medical research (for which informed consent is mandated nationally), no regulatory body addresses the criteria for determining which procedures (other than surgical procedures) require consent. If no specific procedure is listed, does that mean all medical procedures are included? Or is it left to local authorities to create standards? In a chapter entitled “Informed Consent: Answers to Common Questions,” JCAHO asks the following: “What procedures or treatments require informed consent?” It answers, “This question is best addressed by your organization’s leadership, including medical staff, risk management staff, and legal counsel.” In the absence of external standards, clinicians and hospitals have been left to create local standards based on common sense and clinical judgment, which accounts for the relative heterogeneity of practice patterns demonstrated in our study.

Three legal standards of consent for medical care exist. The first posits that informed consent must be obtained for any procedure/treatment in which a “reasonable physician” would obtain consent. The second is that informed consent is required when a “reasonable patient” would expect to be advised of the risks, benefits, and alternatives of a given procedure or treatment. The third model is a hybrid in which both the expectations of physicians and patients are considered in determining whether consent is necessary. The current legal standard in the state of Connecticut (and in many other states) arose from the case of Canterbury v. Spence, in which a patient became quadriplegic after undergoing cervical laminectomy but had not been told of this potential complication before the procedure. The plaintiff won the case on the grounds that “a reasonable person” would have expected to know of such complications before the procedure in order to make an informed decision about whether to undergo the laminectomy.

Few court cases have examined the legal consequences of not obtaining informed consent for a procedure that goes awry. Some cases are settled with plaintiffs before they make it to court. Other suits are not brought because the recovery of monetary damages on cases that hinge purely on informed consent is insufficient to warrant filing suit. However, we could find no specific precedent test cases regarding the list of procedures in our study. Even though major complications and death are rare complications of these medical procedures, such results are possible, especially in critically ill patients. If patients are not informed and a major complication of a procedure ensues, the violation of regulatory standards (vide supra) and the invocation of the reasonable person standard could, theoretically, leave practitioners open to punitive judgments.

Interestingly, many physicians who responded to our questionnaires appear to use the hospital admission blanket consent form to cover invasive medical procedures performed during the hospital stay. We suspect that permission to give transfusions in the perioperative period is part of some surgical consent forms and may account for the rate (36%) of separate consent obtained for transfusions reported by surgical intensivists. Insofar as a patient’s condition varies and is an important determinant of the risk of each procedure, blanket consent (to general treatments) at hospital admission may not adequately inform the patient about risks. We invited those using such a strategy to send us their blanket consent form, but no respondent sent a form. We suspect that the general (nonsurgical) hospital admission consent-to-treat form for most institutions is similar to ours. That form does not list specific procedures, risks, benefits, and alternatives that might be undertaken during hospitalization/critical illness. Such general blanket consent (used to cover invasive procedures) may not satisfy the criteria of informed consent as outlined in the Belmont report.
This study has at least three important limitations. First, the method of national sampling (ie, of program directors in critical care and internal medicine programs) is unlikely to represent a broad cross-section of clinical practices. The study did not examine the practices of hospitals without teaching programs. Second, the response rates of the two national questionnaires, fair (27%) for critical care directors and poor (5%) for medicine directors, could contribute to significant reporting bias. Nonetheless, data from the state of Connecticut (where almost all ICUs were surveyed) included many institutions that were not university-affiliated, and consent practices were not dissimilar to the national sample. Finally, response patterns suggest that some (as many as nine) internists may have interpreted the questionnaire to ask how many unique consent forms they use (rather than for which procedures they go through the process of obtaining consent). Aside from these nine respondents, the patterns of other respondents suggest that they understood the intent of the question, but the frequencies listed in the internist’s questionnaire may underestimate (by roughly 15%) the true frequencies at which internists obtain consent for various procedures. These shortcomings notwithstanding, this study demonstrates a relative lack of consensus regarding whether the obtaining of separate informed consent is required for many common medical procedures.

Insofar as there has been a paucity of case law or regulatory scrutiny of informed consent practices, an argument can be made that these findings do not warrant further consideration, and that uniform policies are not required because “the system is not broken.” An insightful essay written in 1979 suggested some of the inherent difficulties of informed consent for medical procedures, and a review entitled “Why the Goals of Informed Consent Are not Realized” posited that physicians must play an integral role in formulating informed consent policies. So long as medical professionals fail to address this issue, policies could be dictated instead by regulatory agencies or through case law. This may be a juncture at which clinicians can inject a reasonable, clinically sound standard before the solution is imposed from without.

In conclusion, to our knowledge, this is the first study to examine informed consent practices for invasive medical procedures of physicians around the United States. This descriptive information engenders important ethical and legal questions for practitioners and hospital policy makers. Despite the everyday nature of this topic, issues regarding consent remain poorly studied. In the absence of data and explicitly stated standards, practitioners have been left (at the suggestion of JCAHO and others) to devise local solutions that may reflect inherited practices rather than reasoned policies based on the ethical and legal foundations of American medicine.

ACKNOWLEDGMENT: The authors are grateful to the clinicians who contributed their time to filling out the questionnaires for this study.

APPENDIX 1: QUESTIONNAIRE SENT TO CRITICAL CARE FELLOWSHIP PROGRAM DIRECTORS AND INTENSIVE CARE UNIT DIRECTORS IN THE STATE OF CONNECTICUT

Informed Consent for Procedures Performed in the Critical Care Unit

CA Manthous, MD; Yale University School of Medicine

Thank you for taking the time to fill out this brief questionnaire, the results of which we hope to publish to help ICU physicians understand the consenting practices of fellow practitioners. We are not asking your policies regarding consent but rather how your intensivists actually practice. In any published report, no individual, program or institution will be mentioned by name — pooled data will be presented. You can either enter your answers in the body of the e-mail or in the attached Word document.

Please highlight (embolden or underline) one:

I attend, mainly, in a:

[ ] Medicine ICU
[ ] Surgery ICU
[ ] Mixed ICU

Please make an X or embolden those that apply:

[ ] We use a “blanket” or “global” consent to cover the below procedures except for those that I have specifically highlighted for which we obtain separate consent.

Except in immediately life-threatening situations, physicians in my ICU routinely obtain SEPARATE informed consent from a patient or proxy for:

[ ] Arterial catheterization
[ ] Central vein catheterization
[ ] Swan-Ganz catheterization
[ ] Femoral vein catheterization
[ ] Thoracentesis
[ ] Paracentesis
[ ] Lumbar puncture
[ ] Blood product transfusions
[ ] Administration of intravenous contrast agents
[ ] Endotracheal intubation
[ ] Bronchoscopy
[ ] Gastrointestinal endoscopy
[ ] Nasogastric intubation
[ ] Foley catheterization
[ ] Medical research

APPENDIX 2: QUESTIONNAIRE SENT TO INTERNAL MEDICINE RESIDENCY PROGRAM DIRECTORS

Informed Consent for Procedures Performed by Internists

CA Manthous MD, Yale University School of Medicine

Thank you for taking the time to fill out this brief questionnaire, the results of which we hope to publish to help physicians
understand the consenting practices of fellow practitioners. We are not asking your policies regarding consent but rather how internists at your institution actually practice. In any published report, no individual, program or institution will be mentioned by name — pooled data will be presented. You can either enter your answers in the body of the email or in the attached Word document.

Please make an X or embolden those that apply:

We use a “blanket” or “global” consent to cover the below procedures except for those that I have specifically highlighted for which we obtain separate consent.

Except in immediately life-threatening situations, internists (including trainees) at my hospital routinely obtain SEPARATE informed consent from a patient or proxy for:

- Arterial catheterization
- Central vein catheterization
- Swan Ganz catheterization
- Femoral vein catheterization
- Thoracentesis
- Paracentesis
- Lumbar puncture
- Blood product transfusions
- Administration of intravenous contrast agents
- Endotracheal intubation
- Bronchoscopy
- Gastrointestinal endoscopy
- Nasogastric intubation
- Foley catheterization
- Medical research

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