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Informed consent as a continuous communicative process, not a documental event: a concept analysis grounded in a scoping review of elective aesthetic medicine consultations (2015-2024)

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Abstract

Background.

Informed consent in elective aesthetic medicine (EAM) is dominated by a documental model in which the patient signs a form listing procedures, risks and authorisation. That model satisfies the legal requirement under Spanish Law 41/2002 and equivalent regulations, but not the ethical requirement of an informed and autonomous decision. A recent scoping review of clinical communication in EAM (2015–2024) found consent to be the most represented thematic axis, with heterogeneous informational quality and measurable deficits in comprehension and autonomy.

Methods.

Concept analysis following the Walker and Avant method, grounded in a scoping review (4239 records identified; 377 mapping corpus; 40 prioritised subset; reported per PRISMA-ScR; pre-registered at OSF, DOI 10.17605/OSF.IO/739EQ). Four steps: identification of the canonical components of consent; characterisation of the structural features of the EAM consultation that condition them; mapping onto the six-block conversational structure of that consultation; derivation of operational implications.

Results.

The five canonical components (information, comprehension, voluntariness, capacity and explicit authorisation) are reconceptualised as properties verifiable across the temporal flow of the consultation, not events at the moment of signing. Four structural features of the EAM consultation condition them: patient-initiated trajectory, direct economic exchange, body-identity object of intervention, and asymmetric information with high emotional implication. Mapping onto the six blocks (A-F: opening, technical exposition, expected benefits, similar cases, price introduction, decision and closure) locates the construction of information in B, C and D, the verification of comprehension in D and F, the maximum risk to voluntariness in E and the E-F transition, and explicit authorisation at the close of F. Five operational implications follow for clinicians, quality assurance and regulators.

Conclusions.

Informed consent in EAM should be reconceptualised as a continuous communicative process whose ethical adequacy is verifiable across the temporal flow of the consultation, not reduced to a signature at the close. The documental model still satisfies the legal requirement but not, by itself, the ethical one. The model gives clinicians, quality assurance authorities and regulators an operational framework for preserving patient autonomy where the institutional architecture that usually protects deliberation is structurally absent.

Clinical trial number:

not applicable.

Background: why the documental model is insufficient in EAM

The legal and ethical articulation of informed consent in clinical practice has developed, over the second half of the twentieth century, around a documental model: the patient receives written information about the proposed procedure, signs a form acknowledging that the information has been received and consented to, and the procedure is carried out on the basis of that documented authorisation [1, 2]. The documental model is the operational expression of the legal requirement of informed consent and is codified in regulations such as Spanish Law 41/2002 on patient autonomy [3], the Mental Capacity Act 2005 in the UK and equivalent international instruments. The model has the merits of legal verifiability, traceability and standardisation.

The ethical articulation of informed consent in the bioethical literature, however, has long emphasised that the documental model is necessary but not sufficient for the ethical requirement of an informed and autonomous decision [4, 5]. The canonical components of informed consent —information, comprehension, voluntariness, capacity and explicit authorisation [4]— are not events that occur at the moment of signing; they are **properties of the decisional process** that must be verifiable across the temporal flow of the encounter that leads to the decision. The relational articulation of informed consent developed by Manson and O'Neill [5] further argues that consent is constituted by the communicative practices that surround the documental act, not by the act itself.

This distinction becomes structurally important in clinical contexts in which the deliberative window is short, the information density is high, the emotional load is elevated and the structural conditions of the encounter create specific risks for the components of consent. **Elective aesthetic medicine (EAM) is such a context.** Recent systematic-review evidence on clinical communication in EAM (2015–2024) [6] identifies informed consent as the most represented thematic axis of the literature, with substantial evidence that the informational quality of consent processes is heterogeneous and that the documental model alone produces measurable deficits in patient comprehension and autonomy. Multimodal formats (video, personalised audiovisual material, language-model-assisted supports) improve comprehension over the standard written format [7–9]; preoperative communicative adequacy is associated with subsequent satisfaction and decisional regret [10, 11]; communication breakdown ranks among the most frequent causes of medicolegal claims in aesthetic surgery [12].

This article proposes a concept analysis of informed consent in EAM as a **continuous communicative process** rather than a documental event, and articulates the operational implications of this reframing for clinical practice, regulation and research.

Methods: concept analysis grounded in a scoping review

The analysis follows the Walker and Avant method for concept analysis in health services research [13]. The method articulates a sequence of steps: (i) identification of the concept and its uses in the literature; (ii) determination of the defining attributes of the concept; (iii) construction of model, borderline and contrary cases; (iv) identification of antecedents and consequences; (v) definition of empirical referents. The application of the method to informed consent in EAM is grounded in three converging inputs:

The choice of this method warrants a word of justification in a bioethics venue. Walker and Avant's procedure originates in nursing scholarship, but it is not a disciplinary claim: it is a procedure for conceptual clarification, and it is adopted here for three properties that matter to the present argument. It forces the defining attributes of a concept to be stated explicitly rather than assumed; it requires those attributes to be tested against model, borderline, related and contrary cases, which disciplines the boundary of the concept; and it demands empirical referents, which prevents the analysis from terminating in a definition that cannot be observed in practice. Where philosophical conceptual analysis interrogates the coherence of a concept, this procedure interrogates its operability. Since our question is whether informed consent, as currently practised in this setting, can be verified rather than presumed, the operational orientation is the appropriate one.

Input 1: Bioethical tradition. The canonical components of informed consent (information, comprehension, voluntariness, capacity, explicit authorisation) and the relational articulation developed by Faden and Beauchamp [4] and Manson and O'Neill [5] constitute the bioethical baseline of the analysis.

Input 2: Scoping-review evidence. The narrative synthesis and bibliometric mapping of a recent scoping review of clinical communication and SDM in EAM (2015-2024) [6] provide the empirical baseline on the state of informed consent practice in the field. The review was pre-registered in OSF (DOI 10.17605/OSF.IO/739EQ), is reported in accordance with PRISMA-ScR [14] and identified 4239 records; 377 met the eligibility criteria (mapping corpus); 40 were prioritised for narrative synthesis with a descriptive appraisal of methodological characteristics. Informed consent and risk communication emerged as the most represented thematic axis of the field.

Input 3: Structural features of the EAM consultation. The structural features of the EAM consultation that condition the components of informed consent —patient-initiated trajectory, direct economic exchange, body-identity object of intervention, asymmetric information with high emotional implication— have been articulated in parallel theoretical work [15,16] and observational research [17].

The concept analysis proceeds through four steps: (i) identification of the canonical components of informed consent; (ii) characterisation of how the structural features of EAM condition each component; (iii) mapping of the components onto the six-block conversational structure of the EAM consultation; (iv) derivation of operational implications.

Use of large language models. During the preparation of this work the authors used a large language model to assist with language editing and formatting. After using this tool the authors reviewed and

edited the content as needed and take full responsibility for the content of the publication. The concept analysis, its argument and its conclusions are the authors' own work.

Step 1. The canonical components of informed consent

The bioethical tradition has articulated informed consent as constituted by five components, which Faden and Beauchamp [4] consolidated as the canonical formulation: (i) **information** —the disclosure of relevant facts about the procedure, its alternatives, its risks and its expected outcomes; (ii) **comprehension** —the patient's understanding of the disclosed information; (iii) **voluntariness** —the patient's freedom from coercion, manipulation and undue influence; (iv) **capacity** —the patient's mental ability to understand, retain, weigh and communicate the decision; (v) **explicit authorisation** —the patient's verbal or written declaration of consent to the procedure.

The documental model addresses primarily components (i) and (v): the written form disclosed information and the signature evidences explicit authorisation. The remaining three components —comprehension, voluntariness and capacity— are conceptually present in the canonical formulation but are not operationally addressed by the documental act of signing. The ethical adequacy of informed consent depends on the integrity of all five components, not only on the documented presence of information and signature.

The relational articulation developed by Manson and O'Neill [5] reframes consent as a communicative practice: consent is constituted not by an act but by a sequence of communicative exchanges in which the components are constructed, verified and sustained. The continuous-process model proposed in this article is an extension of this relational articulation to the specific structural conditions of the EAM consultation.

The canonical formulation summarised above is embedded in the wider bioethical architecture articulated by Beauchamp and Childress [1], whose four-principle framework -respect for autonomy, beneficence, non-maleficence and justice- structures contemporary clinical ethics. Among these four principles, respect for autonomy carries a distinctive weight in elective decisions: when the intervention is neither imposed by pathology nor justified by clinical necessity, the ethical warrant for proceeding rests almost entirely on the substantive quality of the patient's authorisation. In the EAM consultation, where the demand originates in the patient and no clinical necessity mediates the decision, respect for autonomy is not one principle among four but the operative principle governing whether the encounter is ethically legitimate at all.

Faden and Beauchamp [4] further articulate a distinction between two senses of informed consent that is decisive for the argument developed here. In their first sense -consent as autonomous authorization- the term names the substantive act by which a patient with capacity, adequately informed and free from controlling influences, authorises the intervention as an expression of her own values and deliberation. In their second sense -consent as legally or institutionally effective consent- the term names the

institutional and legal fulfilment of consent procedures: the document exists, the signature is present, the professional and the centre are protected against a claim of unauthorised intervention. The documental model widely operative in EAM satisfies the second sense reliably and the first sense contingently. The gap between the two senses is the ethical space that a continuous-process model of consent is designed to occupy.

O'Neill's account of autonomy and trust in bioethics [28], together with the communicative reformulation of Manson and O'Neill [5], locates the ethical adequacy of consent in the trustworthiness of the communicative exchange rather than in the isolated moment of decision. The continuous-process model proposed here stands in explicit filiation with this tradition: the five components enumerated above are reformulated as the empirical operationalisation of Faden and Beauchamp's autonomous authorization [4], distributed for the first time explicitly across the temporal architecture of the hybrid clinical-commercial encounter. Where the canonical formulation situates the five components at the moment of the decision, the model developed in Steps 2-3 situates their verification across the six blocks of the EAM consultation (Figure 1), making the substantive fulfilment of autonomous authorization empirically verifiable rather than presumptively documented.

Step 2. How the structural features of EAM condition each component

The EAM consultation has four structural features that condition each component of informed consent in a manner that the canonical documental model does not address [15,16]:

Feature 1: Patient-initiated trajectory. The patient arrives at the consultation without referral, without diagnosed pathology, with a self-formulated demand and frequently with a pre-decisional state that the consultation negotiates rather than introduces. The conventional sequence of disclosure (clinician informs about a clinically necessary procedure → patient deliberates → patient consents) is inverted: the patient arrives having already pre-decided, and the consultation operates as a confirmation or contestation of the pre-decision rather than as the introduction of an option.

Implication for the components: the disclosure of **information** must address the patient's pre-existing understanding and correct, when necessary, what has been pre-decided on the basis of incomplete or distorted information. The verification of **comprehension** must address whether the patient's pre-decision is consistent with an informed deliberation rather than with social-media-mediated expectations.

Feature 2: Direct economic exchange. The patient pays the professional or the centre directly for the procedure, typically at or shortly after the moment of the decision. The professional has a direct economic interest in the patient's acceptance of the procedure. This structural feature, absent from publicly-funded therapeutic medicine, creates a permanent risk for the **voluntariness** component: the conditions under which the patient deliberates are not neutral with respect to the professional's

economic interest. The patient may experience the consultation as a sales situation rather than as a clinical deliberation, and the **voluntariness** of the consent may be compromised by perceived pressure to decide in the same visit.

Feature 3: Body-identity object of intervention. The procedure modifies the patient's body or face in ways that implicate self-image, social identity and intimate self-perception [18-20]. The body-identity object distinguishes the EAM consultation from interventions on functions or organs: the decision is not only about a medical procedure but about a transformation of the self. This feature has specific implications for the **capacity** component: when the patient's motivation is conformed by self-perception alterations (body dysmorphic disorder, idealised aesthetic imagery exposure, photo-editing application use [21-25]), the standard presumption of capacity may not be sustained and **should be re-examined** in the consultation.

Feature 4: Asymmetric information with high emotional implication. The patient typically arrives with elevated prior interest, limited technical knowledge and emotional anticipation that includes both expectation and apprehension. The clinician possesses technical experience that the patient cannot easily verify, in a context in which the patient's emotional state may compromise reflective deliberation precisely in the moments when the most consequential decisions are being made. This feature compounds the previous three and creates the conditions under which **the components of consent may be present in their documental expression but absent in their substantive realisation**.

Step 3. Mapping the components onto the six-block conversational structure

Observational research in EAM consultations [17] has identified a six-block conversational structure that segments the encounter into operationally distinct conversational moments: **A** (opening and empathic framing), **B** (technical exposition), **C** (expected benefits), **D** (similar cases), **E** (price introduction), **F** (decision and closure). The five components of informed consent can be mapped onto this six-block structure, identifying where each component is constructed, verified or at risk. This mapping is offered as an analytical proposal, not as a normative derivation: that consultations in fact unfold in these blocks does not by itself establish that they ought to, and the ethical weight of the model rests on the argument, developed above, that the substantive components of autonomous authorization must be verifiable across the encounter, not on the empirical regularity of the blocks themselves.

[FIGURE 1 HERE]

Figure 1. Verification of the five components of informed consent across the six consultation blocks.

The matrix maps the five canonical components (information, comprehension, voluntariness, capacity, authorisation) onto blocks A to F of the elective aesthetic medicine consultation: opening, technical exposition, expected benefits, similar cases, price introduction, and decision and closure. Standard

verification, critical verification by verbal-corporal check, maximum vulnerability to voluntariness at the price-introduction block, and presumed or non-primary cells are distinguished by the colour key incorporated in the graphic. The matrix operationalises the argument of Steps 1 to 3 as a single visual object.

Table 1. Mapping of the five components of informed consent onto the six-block consultation structure.

Component	Where constructed	Where verifiable	Where at risk
Information	Blocks B, C, D	Block D (recap), Block F (final summary)	Block E (price overload may displace technical content)
Comprehension	Across all blocks	Block D (patient articulates), Block F (closing question)	When sequence is collapsed; when D is omitted
Voluntariness	Throughout	Verbal expressions; corporal cues	Block E and E-F transition (price moment, time pressure)
Capacity	Presumed	When body-image cues suggest non-standard presumption	When motivation is conformed by self-perception alterations
Explicit authorisation	Block F (closing)	Block F (verbal or written)	Only interpretable in light of integrity of components 1-4

The status of this mapping should be stated without ambiguity. The six-block structure derives from the authors' own observational work, which is unpublished and therefore not independently verifiable at the time of writing; the mapping of the five components onto it is accordingly advanced as a proposal open to empirical contestation, not as an established finding. Its warrant is analytical rather than evidential: it claims that if the encounter unfolds in these blocks, then each component of consent has an identifiable locus of construction, verification and risk. Whether the blocks are the right segmentation, and whether the loci hold across settings and practitioners, are empirical questions that this article does not settle and that the research agenda in the final section is designed to open.

The mapping yields five concrete observations:

1. The construction of **information** occurs in blocks B, C and D, not in the act of signing in block F. If the consultation collapses these blocks (omits the social-proof block D, shortens the technical block B, anticipates the price block E), the information component is structurally compromised.

2. The verification of **comprehension** is verifiable through the patient's articulation in block D (when the patient asks about cases) and in block F (when the patient summarises or asks final questions). A consultation that does not include these verification moments leaves comprehension presumed rather than evidenced.

3. The **voluntariness** component is at maximum risk in block E and in the E-F transition. The introduction of the price compromises the conditions of free deliberation if it is accompanied by time pressure, financing incentives conditioned on immediate decision, or commercial framing that minimises the saliency of the price.

4. **Capacity** is presumed unless body-image cues suggest that the standard presumption may not sustain. The clinician's observation of self-perception alterations [21-25] is the trigger for re-examination.

5. **Explicit authorisation** in the closing of block F is only ethically interpretable in light of the integrity of the previous four components. A signature in the absence of constructed information, verified comprehension, preserved voluntariness and confirmed capacity satisfies the legal requirement but not the ethical requirement.

Step 4. Operational implications

The continuous-process model produces five concrete operational implications.

For clinicians

Implication 1. Map the consultation practice against the six-block structure to identify systematic shortcuts. Are blocks B, C and D consistently included or are some routinely shortened or omitted? Where is the construction of information actually occurring? Is the verification of comprehension elicited or presumed?

Implication 2. Defer the introduction of the price (block E) until after the technical exposition (B), the expected benefits (C) and the similar cases (D) have been completed. The premature introduction of the price collapses the deliberative window. Late introduction creates the temporal architecture for sequential integration of technical and economic information by the patient.

Implication 3. Monitor the verbal-corporal dissociation in the patient as a signal of potential undue influence. When the patient verbally accepts but corporal cues indicate hesitation, anxiety or discomfort, the consultation should verbally acknowledge the dissociation and offer the patient the option to defer the decision. The clinician's explicit verbal acknowledgement of the patient's right to defer without commercial cost is a concrete operational expression of the voluntariness component.

For quality assurance and regulators

Implication 4. Operationalise the six-block structure and the continuous-process model as quality indicators of the EAM consultation. The current quality-assurance frameworks in private elective health services typically rely on retrospective outcome measures (satisfaction surveys, complication rates) and

on documental compliance (signed consent forms). The continuous-process model provides a complementary indicator set focused on the integrity of the decisional process itself.

Implication 5. For regulators (Ministry of Health, professional colleges, sectoral organisations), consider the continuous-process model as a candidate framework for sectoral guidance on informed consent in private elective health services, conditional on prior empirical validation of its operational implications. The Spanish regulatory framework, anchored in Law 41/2002 [3] and Royal Decree 1277/2003 [26], establishes the documental requirement; any articulation of the continuous-process model as an operational framework for the ethical adequacy of consent in elective contexts would require both empirical validation and sectoral guidance from the Sociedad Española de Medicina Estética and equivalent organisations. International precedents (Australian Health Practitioner Regulation Agency, 2023 [27]) provide comparable guidance frameworks.

Step 5. Cases: model, borderline, related and contrary

Following the Walker and Avant sequence, the analysis identifies four cases that operationalise the defining attributes of the concept *informed consent as a continuous communicative process* in the EAM context. The four cases are synthesised in Table 2 and elaborated below.

Table 2. Model, borderline, related and contrary cases for informed consent as continuous process.

Cases are constructed for the concept informed consent as a continuous communicative process in elective aesthetic medicine, following the Walker and Avant method.

Attribute of the concept	Model case (all attributes present)	Borderline case (some attributes present)	Related case (adjacent concept)	Contrary case (attributes absent)
Temporal continuity across the encounter	Blocks A-F identifiable and adequately paced	Blocks A-D present, E-F compressed	Health education encounter (different concept)	Consent form signed at door, discussion absent
Verbal-corporal verification of comprehension	Explicit re-explanation on hesitation cues	Explicit verbal check, corporal cues ignored	Structured interview (different purpose)	No verification; presumption of comprehension
Sequential integration of technical, expectation and economic information	B → C → D → E in the sequence	E introduced before D	Sales encounter (different concept)	E introduced before B
Recognition of the right to defer without cost	Explicitly stated verbally by clinician	Not stated but assumed	Educational session (no decision)	Deferring framed as commercially costly
Documentation of the decisional process, not only of the outcome	Log of the six-block segmentation	Log of A and F only	Clinical audit (different focus)	Only signed consent form archived

Model case. A 42-year-old woman attending a first-visit consultation for a demand type 1 procedure. Block A (12 min): the practitioner opens with a personal greeting, acknowledges her reasons and elicits prior expectations. Block B (10 min): technical exposition of the procedure, alternatives and limits, with two anatomical diagrams. Block C (7 min): expected outcomes with realistic margins and explicit reference to what the procedure will not achieve. Block D (5 min): five before-after comparable cases showing the range of outcomes. Block E (6 min): total cost, package composition and payment options, presented after the technical and expectation blocks. Block F (5 min): recap, invitation to final questions, explicit statement that she may defer the decision without cost. The patient chooses to defer. The clinician offers a follow-up appointment and provides a written summary. All five defining attributes of the concept are present.

Borderline case. A 38-year-old woman attending a first-visit consultation for a demand type 2 procedure. Blocks A-B-C are executed as in the model case. Block D is compressed to a single before-after case shown in less than one minute. Block E is introduced immediately after D and occupies eight minutes with detailed payment options and financing terms. Block F is compressed to under two minutes with the direct question "Shall we schedule you?". The patient verbally accepts. The temporal continuity attribute is partially present; the sequential integration attribute is partially compromised (D

compressed); the recognition of the right to defer attribute is absent (Block F does not offer the option to defer without cost). Some attributes are present, others compromised: borderline.

Related case. A pre-procedure health-education session in which the same clinician explains the anatomy, the technique and the realistic outcomes over a 30-minute meeting. The session has no decisional endpoint and no economic disclosure. This is a **related but different concept**: health education, not informed consent. It shares two attributes (temporal continuity, sequential integration) but lacks the decisional endpoint and the economic disclosure. It is a valid clinical activity but not what the concept of informed consent as a continuous process is intended to capture.

Contrary case. A patient attending a first-visit consultation for a demand type 3 procedure. Immediately upon arrival, the receptionist hands the patient the consent form and asks for a signature "as a formality before you see the doctor". The consultation proper is 12 minutes: technique, expected outcomes and price in a single continuous exposition. The patient asks a clarifying question about downtime, which the practitioner answers briefly. The clinician then says: "So, when would you like to book?" The patient books the procedure. All five defining attributes of the concept are **absent**: no temporal continuity, no verbal-corporal verification, no sequential integration (all information collapsed into a single exposition), no recognition of the right to defer, no documentation beyond the signed form. This case exhibits the pattern that the documental model of informed consent fails to detect: a signed form archived as evidence of consent that does not correspond to a substantive process.

The four cases together operationalise the concept as a bounded, verifiable construct: the presence of the five defining attributes distinguishes the concept from adjacent concepts (health education) and from its inversion (the documental-only fulfilment of the legal requirement).

Antecedents and consequences

The antecedents of informed consent as a continuous communicative process include the clinician's training in structured clinical communication, the organisational allocation of adequate consultation time, and the regulatory framework's recognition of the process (not only the document) as the object of ethical adequacy. The consequences include the patient's decisional autonomy exercised over an adequate deliberative window, the ethical adequacy of the encounter beyond the documental compliance, and the alignment of the encounter with the sectoral quality standards on private elective health services.

Empirical referents

The empirical referents of the concept are (i) the identifiable presence of the six blocks A-F in the encounter, (ii) the recorded temporal duration of each block within pre-established ranges, (iii) the verbal check of comprehension explicitly enacted by the clinician, (iv) the verbal statement of the right to defer, and (v) the documentation of the six-block segmentation as part of the clinical record. These referents

constitute the operational specification of the concept and are the potential basis for its incorporation into quality-assurance protocols and, following empirical validation, regulatory frameworks.

Table 3. Proposed empirical referents of the five components of informed consent.

Attribute (component)	Verifiable empirical indicator	Proposed operational threshold
Information	Identifiable presence of Blocks B, C and D in the encounter	Block B of sufficient duration to construct the technical information
Comprehension	Verbal check of comprehension enacted by the clinician	At least one verbal check across Blocks B, C and D
Voluntariness	Explicit offer to defer the decision, stated in Block F	Verbal statement present (coded yes / no)
Capacity	Baseline elicitation of the motivation in Block A	No evidence of compromised deliberation
Explicit authorisation	Signature at Block F after the final recap	Signature follows the final recap rather than preceding the encounter

Each referent is given with the proposed operational threshold for its verification. The referents are derived from the continuous-process model articulated in Steps 1 to 3 and are put forward for prospective empirical validation; they are not counts drawn from the reviewed literature.

Discussion

What the continuous-process model adds to the literature

The continuous-process model articulates four contributions to the literature on informed consent in EAM. **First**, it reframes consent from a documental event to a temporally extended communicative process, in line with the relational tradition of Faden and Beauchamp [4] and Manson and O'Neill [5] but operationally specified for the EAM context. **Second**, it maps the canonical components of consent onto the six-block conversational structure of the EAM consultation [17], providing clinicians with a concrete diagnostic for where each component is constructed, verified or at risk. **Third**, it identifies block E and the E-F transition as the locus of maximum risk for voluntariness, an identification not made explicit in prior literature. **Fourth**, it derives operational implications for clinical practice, quality assurance and regulation, translating the conceptual analysis into actionable recommendations.

What the continuous-process model does not solve

The continuous-process model does not eliminate the structural conflict of interest between professional and patient in EAM, nor does it resolve the fundamental ethical tension between clinical care and commercial logic. What it makes possible is the **explicit identification of where the conflict is most acute** (block E, E-F transition) and the **deliberate adoption of communicative practices that**

preserve patient autonomy despite the structural conditions of the encounter. The model is a framework for ethical practice within a commercially structured context, not a solution to the structural conflict itself. A further objection must be met on its own terms. The relational tradition on which this article draws is itself wary of multiplying verifiable consent requirements, warning against a consent ritual that substitutes procedure for genuine understanding. The continuous-process model could, if implemented mechanically, reproduce that very failure: it could replace the fetish of the signature with a fetish of the six documented blocks. We therefore stress that the model specifies where the components of consent are at risk and must be verified, not a checklist to be performed. Its object is the substantive quality of the communicative exchange, and a consultation that completes all six blocks while leaving comprehension unverified or voluntariness compromised does not satisfy it. The six-block structure is a diagnostic heuristic for locating risk, not the normative content of consent. Two features of the model answer the ritualization objection in substance rather than in label. First, what the model asks clinicians to verify is not additional procedure but uptake: the comprehension checks and the explicit acknowledgement of the right to defer are communicative acts whose object is the patient's actual understanding and actual freedom to decide, which is precisely what Manson and O'Neill identify as the normative work of consent; a verification of uptake cannot be ritualized without ceasing to be a verification of uptake. Second, the audit indicators derived from the model are process-tracing proxies for quality assurance, not the criterion of ethical adequacy itself; the model explicitly separates the auditable trace from the normative standard, so that documented completion of the six blocks is treated as necessary evidence of, never as sufficient grounds for, the substantive adequacy of the consent.

Limitations of the analysis

The concept analysis has explicit limitations. **First**, the scoping review on which the empirical baseline is grounded [6] has single-reviewer screening (Cohen's $\kappa = 0.44$ over 39 records), restriction to four databases and to English and Spanish, and restriction to the 2015–2024 window. **Second**, the six-block conversational structure [17] is empirically derived from a single-centre observational study (N = 60) that has limitations of single observer, single clinical team and confounding between professional style and demand line. **Third**, the application of the continuous-process model to other elective health-service contexts (refractive surgery, aesthetic dentistry, assisted fertility) requires specific adaptation of the six-block structure to the conversational architecture of each context. **Fourth**, the regulatory implications are articulated for the Spanish regulatory framework; transfer to other jurisdictions requires consideration of the corresponding legal and professional regulation.

Implications for future ethics and empirical research

The continuous-process model opens three lines for future research. **First**, empirical validation of the operational implications: do consultations that include all six blocks, defer price introduction, monitor verbal-corporal dissociation and explicitly acknowledge the right to defer produce measurably different decisional outcomes (less regret, higher satisfaction, more reflective consent)? **Second**, instrument development for the operationalisation of the continuous-process model as a quality indicator measurable in routine clinical practice. **Third**, regulatory analysis of the implications of the continuous-

process model for the sectoral guidance frameworks of professional colleges and sectoral organisations in different jurisdictions.

Conclusions

Informed consent in elective aesthetic medicine should be reconceptualised as a continuous communicative process whose ethical adequacy is verifiable across the temporal flow of the consultation, not reduced to the signing of a documental form at the close. The documental model continues to satisfy the legal requirement under Law 41/2002 and equivalent regulations but does not by itself satisfy the ethical requirement of an informed and autonomous decision under the specific structural features of the EAM consultation —patient-initiated trajectory, direct economic exchange, body-identity object of intervention, asymmetric information with high emotional implication. The five canonical components of consent —information, comprehension, voluntariness, capacity and explicit authorisation— map onto the six-block conversational structure of the consultation, with block E and the E-F transition as the locus of maximum risk for voluntariness. The model produces operational implications for clinicians (map practice; defer price; monitor verbal-corporal dissociation), for quality assurance (operationalise as quality indicator) and for regulators (a candidate framework for sectoral guidance, conditional on empirical validation). The continuous-process model provides a framework for the ethical preservation of patient autonomy in a clinical context in which the institutional architecture habitually protective of the deliberative process is structurally absent.

Abbreviations

EAM: elective aesthetic medicine. OSF: Open Science Framework. PRISMA-ScR: Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews. SDM: shared decision-making.

Declarations

Ethics approval and consent to participate. Not applicable (concept analysis grounded in a scoping review of published literature).

Consent for publication. Not applicable: the manuscript contains no individual person’s data in any form.

Availability of data and materials. The parent scoping review is openly deposited in the Open Science Framework repository, https://doi.org/10.17605/OSF.IO/739EQ.

Competing interests. The authors declare the following non-financial interest: the six-block conversational structure (A-F) discussed in this article was identified in the authors' own observational research, and the continuous-process model builds on that work. The authors have no financial interest

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Figures

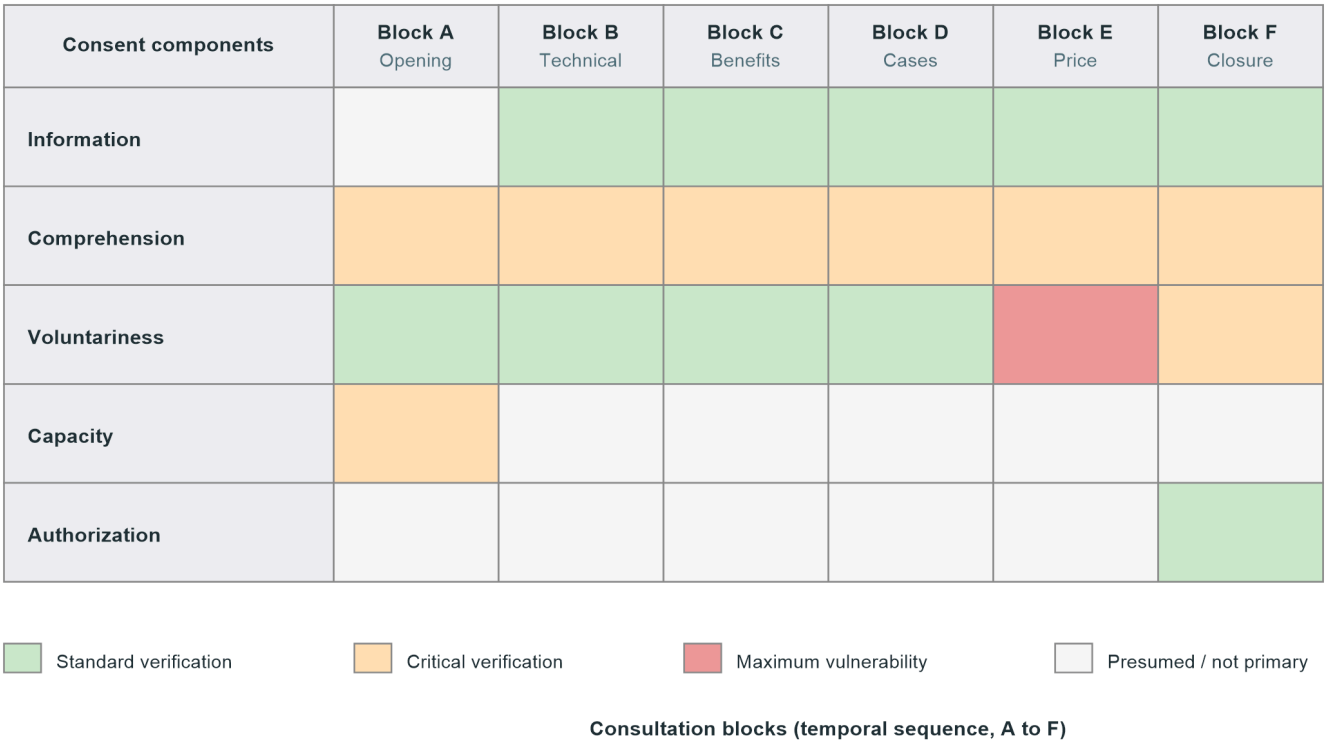


Figure 1

Verification of the five components of informed consent across the six consultation blocks.