pointed that this article was authored exclusively by American physicians and relied almost entirely on American case law and literature and, as such, did not address some of the important legal principles of informed consent that are unique to Canada.

The CMPA is a leader in Canada in the area of medicolegal risk management and has extensive experience with topics such as informed consent. The CMPA would have welcomed the opportunity to submit an article to *CMAJ* on this important medicolegal concept. Indeed, the CMPA has published numerous articles on the subject of informed consent, including a comprehensive booklet for its members entitled, *Consent: A Guide for Canadian Physicians*.[2]

The CMPA appreciates that the authors of this article acknowledge that "it is important for clinicians to determine the precise standard used in their jurisdiction and to adapt their practice accordingly. The Canadian Medical Protective Association provides detailed information on Canadian standards (www.cmpa-acpm.ca)."[1] However, the article should have more clearly emphasized at the outset that the information is based on American legal principles and does not specifically address well-established Canadian legal principles, most notably "material risk."

Given the significance of this Canadian legal concept, *CMAJ* may wish to consider clarifying that Canadian physicians should discuss "material risks" when obtaining informed consent from their patients. The determination of what constitutes a "material risk" requires consideration of what a reasonable person in the circumstances of the particular patient would want to know.

John E. Gray MD
Executive Director/CEO, Canadian Medical Protective Association, Ottawa, Ont.

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With regard to the *CMAJ* article by Hall and colleagues,[1] informed consent is a redundancy, because being properly informed is a precondition of consent. Without being properly informed, a patient or client cannot give any legitimate, binding consent. Therefore, that all professionals withhold any request for agreement or signatures until after all information and questions have been fully addressed is imperative.

Hugh Mann MD
Eagle Rock, Mo.

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The authors respond

We thank Dr. Gray for his comments regarding the Canadian legal tradition of informed consent and the concept of "material risk."[1] Our article notes the need for "clinicians to determine the precise standard used in their jurisdiction and to adapt their practice accordingly."[2] Because we were recruited to write for an international audience, further discussion of these points seemed beyond the scope of our review. Indeed, given our charge, we deliberately avoided detailed comparisons of distinctly national legal traditions. Instead, we sought to emphasize how the ethics of informed consent have come to guide medical practice internationally, in a way that goes above and beyond the requirements of unique local laws.

Although the specific legal precedent and lineage of "material risk" is important in Canada, we fail to appreciate how it is substantively different from the "reasonable patient standard," which we mentioned in our article and which is used in the United States and throughout the world. The difference between the two terms is likely more relevant to lawyers trying to defend cases rather than to clinicians trying to avoid trouble. Whether in the US, Canada or elsewhere, physicians should always explicitly discuss risks that patients would likely want to know about.

That our review reflects a bias toward US law merely reflects that we chose to write about the context we know best. It also reflects that the legal and ethical concepts of informed consent emerged out of the US. Indeed, the still-emerging discipline of bioethics has been increasingly criticized for its latent, often unrecognized, chauvinism that reflects distinctly American philosophical assumptions.[3] If our review is perceived to contribute to such cultural bias, we sincerely apologize. That said, we believe that our review provides a balanced summary of the broadest consensus regarding informed consent — one that can guide the practice of physicians in a wide range of legal contexts.

We also agree with Dr. Mann's comment[4] that any robust understanding of consent demands that the patient has been informed about the decision at hand. Yet there is a legal and philosophical distinction between "simple" consent, by which a patient explicitly authorizes an intervention, and the higher bar of "informed" consent. As our review outlines, unfortunately a multitude of forces limit the capacity of clinicians and patients to achieve "ideal" informed consent. These limitations in no way abrogate the need to continually strive for excellent clinical communication. Rather, we contend that excellent informed consent requires clinicians to recognize these limitations so they can develop pragmatic approaches to mitigate their effects.

Daniel E. Hall MD MDiv, Allan V. Prochazka MD MSc, Aaron S. Fink MD
The Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System and the Department of Surgery (Hall), University of Pittsburgh, Pittsburgh, Pa.; Ambulatory Care, Denver Veterans Affairs Medical Center, Denver, Colo. and the Department of Medicine (Prochazka), University of Colorado School of Medicine, Aurora, Colo.; and Surgical Service, Veterans Affairs Medical Center Atlanta, Decatur, Ga.; and the Department of Surgery (Fink), Emory University School of Medicine, Atlanta, Ga.

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