# BRIEFS FROM THE LITERATURE

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Briefs were submitted by Drs. John Adriani, Gerald Allen, C. M. Ballinger, Lee S. Binder, M. T. Clarke, Martin Helrich, J. R. Householder, J. J. Jacoby, S. J. Martin, R. E. Ponath, William Rabenn, Alan D. Randall, R. W. Ridley, and H. S. Rottenstein. Briefs appearing elsewhere in this issue are a part of this column.

**ANESTHESIOLOGY INTERNISTS** Few of us can develop new anesthetics, most of us are not sufficiently experienced to design better equipment, the wider use of monitoring devices requires considerable knowledge of electronics, and not many of us are in a position to train more anesthetists. However, progress as important as any yet accomplished can be made in anesthesia if all of us in the field move even further in the direction of becoming internists or medical consultants to surgical patients. A broad background in medicine and therapeutics will be required. (*Dripps, R. D.: Editorial. Internists in Operating Room, Surv. Anesthesiol. 4: 127 (April) 1960.*)

**HUMAN EXPERIMENTATION** Experimentation admits of two possible purposes: benefit to the individual patient who submits to experimental treatment and/or the advance of medical science and consequent benefit to the common good of future patients. The doctor must prefer the certain to the uncertain remedy unless the patient's legitimate choice to the contrary is explicitly expressed. No individual patient can legitimately be considered an expendable member to be exploited for the common good. Man does not have unlimited power to dispose of his bodily members and functions, and his right of self-disposition is limited. The circumstances of individual cases must determine whether there exists sufficient reason for whatever degree of risk or harm may be entailed in the contemplated procedure. (*Lynch, J. J. (Prof. of Moral Theology): Part III. Human Experimentation in Medicine–Moral Aspects, Clin. Pharmacol. & Therap. 1: 396 (May–June) 1960.*)

**STATISTICS** Although the use of statistics has become more common-place in medical research in recent years, better planning and control of the clinical trial and the early participation of experimental statisticians would improve clinical research. Emphasized are: (1) careful choice of investigators, (2) adequate time for planning, (3) realism in planning including patient-doctor relationships, place of auxiliary personnel, careful assessment of the work load, (4) careful carrying out of the plan including reading of instructions and avoiding chipping bits from the protocol, (5) consider including a practice period, (6) retain permanence of investigators, (7) consider sample sizes and case loads carefully, (8) secure a good policeman or chairman of the co-ordinating committee. (*Mainland, D.: Clinical Trial–Some Difficulties and Suggestions, J. Chron. Dis. 11: 44 (May) 1960.*)

**LIABILITY** The surgeon is responsible for the acts of the nurse-anesthetist. Neither she nor any other hospital employee in the operating room may accept or carry out any orders contradicting those of the surgeon. However, a medical anesthesiologist owes his legal duty solely to the patient; he is under no contractual duty or obligation to the surgeon. Each serves with the other by mutual consent, and each is entitled to make such division of authority as the circumstances may require. The surgeon is not liable for the negligent acts of the anesthesiologist. Neither is the anesthesiologist responsible for the negligent acts of the surgeon–except that each is answerable for all the wrongful and negligent acts of the other that he observes, or that in the exercise of reasonable care he should have observed, and that