routine "crash inductions" for elective surgery is quite questionable. The entire technique is irrational.

Most clinical anesthesiologists believe that spinal analgesia for elective cesarean sections is still the most satisfactory and safest method for both mother and child. When a general anesthetic is required, the classical cyclopropane technique combined with an obstetrician willing to deliver the baby in eight minutes produces the highest Apgar scores. The only rationale for an intravenous induction is the avoidance of a face mask for an awake patient.

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To the Editor:—I have read with considerable misgivings the article by Kosaka, Takahashi, and Mark. Some of their patients were subjected to procedures I would not want carried out on my family, even with consent (cf. Group IV). No evidence is presented that consent was sought or obtained. Some of the stresses and risks imposed are, in my view, unacceptable.

The authors say that to "obstetrics and other causes of fetal distress" one should not add "the further burden of neonatal depression from anesthetic drugs." They do not seem to have had any compunction about so doing in this study.

It is a tribute to the present-day high editorial standards of ANESTHESIOLOGY that the inclusion of this study in that fine journal comes as a surprise.

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To the Editor:—These studies were carried out in Japan, where informed consent is a new concept, just now being introduced. Instead, the investigating physician with whom I worked were all acutely aware of their responsibilities to their patients. When, in the course of establishing reasonable and safe limits of dosage in the technique being developed, the balance between "good" and "fair" began to shift unfavorably in Group IV, this series was abandoned. Some authors have lumped these two categories together as "satisfactory," which would have given us a 94 per cent incidence with this rating. Our criteria were more rigorous. We were dissatisfied with our clinical impression of Group IV, although the numbers were insufficient for statistical analysis to validate the impression. Consequently, as responsible physician–investigators, we reverted to the other, more clinically-satisfactory groups, with no desire to augment the numbers in Group IV for the statistician. I might also add that each mother awoke to find a healthy baby; this still was not enough to suit us.

As for our admonition not to add "the further burden of neonatal depression from anesthetic drugs," the very next sentence emphasizes that we were referring to the inhalation anesthetics; the whole point is to use only oxygen and succinylcholine, neither of which is depressant, and thiobarbiturate, which, properly used, is also not depressant to the fetus (and may even protect the fetal brain against hypoxia, according to Stan James, Ole Secher and others). The evidence is there, and I believe we accomplished our purpose. The technique described is a safe one, which has remained standard and uniformly successful in Hiroshima, where the work was done. I am proud to have been a participant in such a worthy effort.

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