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## Legal View of Informed Consent for Anesthesia during Labor

*To the Editor:*—The authors of a recent study in ANESTHESIOLOGY concluded that the woman in labor is at least as competent to give informed consent for an anesthetic as is someone about to undergo cardiac surgery.<sup>1</sup> Many anesthesiologists, however, feel that consent given during labor is invalidated by stress and pain. Many also feel that the legal view focuses on the patients present recollection and interpretation of her consent. Both concerns, it turns out, are groundless. The courts have been relatively unconcerned with the subjective claims of the patient, and far more favorable to anesthesiologists than many of them would suspect.

In the Lexis database there are three cases that address the issue of adequacy of anesthetic consent given during labor.\*†‡ Each court decided the issue in favor of the defending anesthesiologist. Not one even speculated that a consent obtained during the stress of labor might be inadequate for that reason. Each court cited three common factors that supported its finding of informed consent: the information given to the patients, the lack of objection by the patients, and the cooperation given by the patients during performance of the procedures.

Two points here are important to the anesthesiologist. First, there are three factors, rather than just one, that support a finding of adequate consent during labor. This works in favor of the anesthesiologist, since it is unlikely an anesthetic will be given over the objection of the patient or without her cooperation. Second, of the three common factors only one, the information given to the patient, is open to subjective interpretation. Here, again, the courts have favored the anesthesiologist. They have not looked exclusively at the opinion of the patient, nor

have they sought a specific kind of documentation. Instead, they have looked for evidence that reasonable information was given. For the two courts that discussed this issue explicitly, reasonable information would be a brief description of the anesthetic and its effects, a general acknowledgement of serious risks with an approximate probability of occurrence, and an opportunity for the patient to ask questions.†‡

Acquiring anesthetic consent during labor should not be viewed as an impossible or even an academic task. Consent is recognized by the courts as both appropriate and necessary. However, its components are not particularly demanding. It is found as much in the patient's actions as in what is claimed the physician did or did not say. Only for that part of consent based on the information given by the physician does a court need some tangible indication that reasonable information was given. For this, we can best assist the court toward a favorable conclusion by noting on the chart that reasonable information was given by the physician and considered by the patient.

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\* *Hall v. United States*, 136 F. Supp. 187 (1955).  
† *Dunlap v. Marine*, 51 Cal. Rptr. 158 (1966).  
‡ *Patterson v. Van Weil*, 570 P.2d 931 (1977).

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## Should Vecuronium Be Used for Rapid Sequence Induction?

*To the Editor:*—Recently, Ginsberg *et al.*<sup>1</sup> provided us with useful information on the dose-response relationships of vecuronium during induction of general anesthesia. However, I believe that the conclusions and experimental protocol deserve comment.

Ginsberg *et al.* concluded: "High doses of vecuronium may, therefore, be a useful alternative to succinylcholine when a rapid onset of neuromuscular blockade is required." The conclusion has significant clinical implications because the time from loss of consciousness (or apnea) until the time required to obtain high-quality intubation conditions could be critical (*e.g.*, patient with a full stomach). Unfortunately,

the design of the study does not permit us to rule out bias introduced by factors that could effect the quality of intubation conditions. For example, prior to tracheal intubation the dosages of diazepam, fentanyl, and thiopental varied greatly among patients: 5-10 mg diazepam, 1-3 ug/kg fentanyl, and 4-7 mg/kg thiopental.

Succinylcholine is the standard for rapid, predictable onset of neuromuscular blockade. Vecuronium could have been directly compared in a randomized, blinded trial with succinylcholine in the context of a rapid sequence induction. Until this comparison is done, caution should be exercised in using the results from this study as a basis for choosing

vecuronium over succinylcholine when rapid sequence endotracheal intubation is required.

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*In Reply:*—Our study was not intended to compare vecuronium with succinylcholine for rapid sequence induction of anesthesia. Our objective was to assess the speed of onset of high-dose vecuronium and the duration of these larger doses in a controlled situation. We demonstrated that the speed of onset of vecuronium was reduced from  $208 \pm 41$  s with 100  $\mu\text{g}/\text{kg}$  to  $106 \pm 35$  s with 400  $\mu\text{g}/\text{kg}$ . The times given in this article are until  $T_1$  reached 0% of control as measured by an electromyogram. This provides the information required for a clinician to make an informed decision on what dose of vecuronium is optimal to use for each particular situation. A study using the same technique (performed by one of the authors of the vecuronium study) demonstrated that following 1.5 mg/kg of succinylcholine, the time until  $T_1 = 1.6\%$  of control was 100 s.<sup>1</sup> Thus we feel that the statement made in our article, "vecuronium may be used as an alternative to succinylcholine for rapid sequence of general anesthesia," is valid. However, to establish the advantages of high-dose vecuronium to succinylcholine will require a controlled, double-blind study.

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## Postoperative Care following Intrathecal or Epidural Opioids. I.

*To the Editor:*—The use of intrathecal morphine for the treatment of postoperative pain is an excellent modality to use for pain control. It joins a variety of medicinal combinations used, both epidurally and intrathecally, that are rapidly approaching a level of acceptance in the surgical community as the standard of excellence. Unfortunately, they may not be the standard of care because of the cost generated in monitoring these patients in intensive care settings.

As the current Chief of Staff, member of the Hospital Board of Directors, and chairman of our hospital committee responsible for resource use and cost control, I am involved daily in defense of these procedures and costs. As we all know, cost is a valid and real concern in the current setting of medical practice today. Until these methods can be used with less intense, *i.e.*, cheaper monitoring requirements, the real medical expense as well as the medical legal exposure presents a real barrier to their widespread use in large numbers of patients. Research is needed in this area.

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Since the advent of aggressive governmental control of costs in medicine, hundreds of hospitals have closed and many more are in similar jeopardy. In order for these pain-control modalities to be widely accepted and widely used, less intensive monitoring and care must accompany them rather than mandatory ICU stays.

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