REFERENCES

2. Mifflin TE, Bruns DE, Wrotonski U, MacMillan RH, Stallings RG, Felder RA, Herold DA: University of Virginia case con-
ference. Macroamylase, macro creatine kinase, and other macro-

3. Shimomak H, Yamamoto M: Enzyme-linked immunoglobulins in
(Accepted for publication September 20, 1989.)

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.1 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 inter-
pretation 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 patient, 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 inter-
pretation. 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.

ROBERT M. KNAPP, D.O.
Assistant Professor of Clinical Anesthesia
Director, Obstetric Anesthesia
University of Cincinnati
Department of Anesthesia
Cincinnati, Ohio 45267–0531

REFERENCE

informed consent for anesthesia for labor and delivery (abstract).
ANESTHESIOLOGY 69:A664, 1988
(Accepted for publication September 20, 1989.)

Should Vecuronium Be Used for Rapid Sequence Induction?

To the Editor:—Recently, Ginsberg et al.1 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, there-
fore, 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 con-
ditions 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 μg/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