when other methods were difficult or impossible. Where very difficult intubation is anticipated, the patient should be awake, breathing spontaneously, and given topical anaesthesia. For the normal situation our patients have been anaesthetized and paralyzed. On at least three occasions intubation with the lighted stylet was successful when another consultant could not intubate the patient with a laryngoscope.

One of us (D.G.) has recorded his last 311 intubations. The Tube Stat[®] was used in 242 (78%) of these. Fifty-four were done by residents and 22 by medical students. The Tube Stat[®] was not used for rapid sequence inductions (38), for placement of RAE or endobronchial tubes (26), or for teaching reasons (5). The endotracheal tube was placed properly on the first attempt 90.9% of the time and on the second or third attempt in 7%. In five patients (2.1%) a Macintosh laryngoscope was required after failure with the stylet. Three of those were attempts by a resident and one was anticipated in an obese man with a very thick neck. Only one case in a tiny woman was unexplained or unexpected. One patient was intubated easily with the Tube Stat[®] after he could not be intubated by another anaesthetist because of a large epiglottic cyst. Two patients were easily intubated after giving a history of difficult intubation. The Tube Stat[®] was used with cricoid pressure on several occasions and in many patients with subluxation of the cervical spine.

We strongly recommend this method of intubation. We have no difficulty in teaching it to residents and medical students. In the majority of elective cases it is our method of choice. A new Tube Stat[®] treated with care will last from three to six months.

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*The Tube Stat[®] lighted oral intubation stylet is available from Concept Inc., Clearwater, Florida, U.S.A. The Canadian distributor is Lasswell Medical Ltd., 547 Main St., Milton, ON.

CMPA and Jehovah's Witness

To the Editor:

I read this year's CMAA annual report with particular interest in the report of the management of the Jehovah's Witness in Northern Ontario. The patient carried an undated, unwitnessed but signed "card" stating she did not want blood transfusions. The physician (unable to communicate with an unconscious patient) gave blood products and saved the patient's life. The physician was sued for negligence and assault and the verdict was that negligence did not occur but assault did and the physician was fined.

It is my opinion that the judgement in this case was incorrect and that this case should be pursued to the highest court with the objective of changing the law. I have expressed that opinion to the CMAA and would be interested in opinions from other anaesthetists who may have been faced with similar problems.

The problem in this case was that the patient held a card that was neither witnessed nor dated. Since management of the Jehovah's Witness in the case of an incompetent patient is entirely dependent on the information contained on a card to tell the physician what their current wishes are *the minimum responsibility of Jehovah's Witnesses should be to transmit their wishes on a "card" carried by them that is witnessed and dated within a reasonable period* (perhaps one year). To do otherwise is to place the physician in the impossible position of deciding (within moments) whether the card really is the current wish of an informed patient?

The implications of these "cards" will spread to "living wills." If the public want physicians to respect their wishes (and I do respect the individual's right to determine his own treatment) it must be the individual's responsibility to transmit the information in a way that can reasonably be interpreted as representing the current wishes of the patient. This must mean a signed, witnessed and recently dated statement carried by the patient. Whether the patient was correctly informed about the costs and benefits of treatment will remain a problem but at least we can be assured that the patient had recently considered the treatment they desired.

For these reasons the judgement in the Jehovah's Witness case was wrong.

In discussing similar types of cases with hospital lawyers their advice to me was "if you are going to be sued no matter which treatment course you embark on be sued for saving the patients' lives not for letting them die." I believe this is still sound advice and so believe the physician in Northern Ontario acted correctly.

I hope this case stimulates the formation of rational law. At the moment the physician is "hung out to dry" regardless of his or her best intentions.

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REFERENCE

CMPA annual report Pg. 17–26, 1990.

Erratum

The authors of the Letter to the Editor "Low-dose intrathecal-meperidine for lower limb orthopaedic surgery" Can J Anaesth 1990; 37: 947–8 should have read: S. Kavuri, J. Robalino, Y. Janardhan, K. Shevde from Maimonides Medical Center.