Correspondence

Consent in anesthesia research: the pre-admission phone call

To the Editor:

Authors of clinical research papers must state that patients gave informed consent, but not when, where, how or by whom consent was obtained. In the 1980s, the University of Calgary Research Ethics Board (REB) refused to approve anesthesia studies unless patients were approached before hospital admission. This was upheld by the National Council of Bioethics in Human Research,¹ but anesthesiologists in Calgary believed this would breach confidentiality because investigators and research assistants are "strangers"² to patients before admission.

Since 1993, the Calgary REB has considered staff anesthesiologists, residents, and research assistants as a single unit, whereas in Seattle the research assistant takes the role of OR booking clerk. This permits a pre-admission telephone call outlining the protocol to patients, who can decline at once or receive full details on admission. Those who are interested look forward to meeting the research assistant to review the protocol. They then have time to read the consent form in privacy, ask questions, and make a final decision. Their positive attitude is comparable to the Hawthorne effect, in which workers' attitudes and performance improved when their help and advice were sought by the company.³

Our concern that patients might resent being approached over the telephone by a "stranger" were unfounded. An informal survey of 84 American and Canadian centres revealed that only 16 use the pre-admission telephone call.* We have now used this process in several hundred patients and can commend it to other investigators and REBs.

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- 2 Maltby JR, Eagle CJ. Informed consent for clinical anesthesia research. Can J Anaesth 1993; 40: 891-6.

- 3 The New England Britannica, 15th ed. 1998; Chicago 29: 925.

* Details of telephone survey available from the authors

Use of the laryngeal mask after tracheal extubation

To the Editor:

Dob and colleagues recently studied respiratory complications associated with the use of the laryngeal mask or Guedel airway after tracheal extubation and found that complications were much fewer for the laryngeal mask than for the Guedel airway.¹ However, this point had already been shown² well before the acceptance date of Dob and colleagues' article. They omitted to cite this previous randomized study, which compared the incidence of respiratory complications under the following three circumstances: tracheal extubation while the patient was still deeply anesthetized followed by the use of either the laryngeal mask or Guedel airway during emergence from anesthesia, and tracheal extubation after the patient had regained consciousness.²

Several authors, including Dob's colleagues, have suggested extubating the trachea while the patient is still anesthetized and then inserting the laryngeal mask.³⁻⁵ However, there is a risk of losing a patent airway if insertion of the laryngeal mask is impossible after tracheal extubation. I reported a simple method which can avoid this risk - insertion of the laryngeal mask *before* tracheal extubation (with an explanatory photograph).^{2,6} Dob and colleagues omitted to mention my idea despite their use of the latter method (and a very similar photograph to mine) in their study.

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References

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