only discomfort and inconvenience are involved, and provided these do not last very long. On the other hand, patients will never, repeat never, willingly agree to risk their health or their lives for the sake of Science alone, except in *rare* instances, such as in a man seeking martyrdom or as in the case of a Walter Reed, whose lonely exploit is still celebrated 66 years later. In the ordinary case when *post hoc* it is evident that the health or life of several subjects have been jeopardized, it is plain that they did not all understand what they had agreed to.

Sixth. Coming late into a discussion of these matters gives me what might be considered an unfair advantage in the present debate. But I am certain that what these investigators are after is the truth, and so am I; therefore, whether comments are made late or early is irrelevant: if they are sound they will stand; if they are not they will not survive. In this connection Dr. Fink (ANESTHESIOLOGY 28: 1109, 1967) has said,

> . . . there is an obvious inconsistency between the claim to guarantee the patient's rights and the failure to honor the foremost of those rights, the right to exercise informed consent or dissent. A guarantee of this sort is nugatory. Further, the role itself implies infallibility, as if the investigator can always guess correctly whether the patient would consent to the procedure if she fully understood the nature of the experiment.

I am puzzled by Dr. Dripp's statement to Dr. Fink that "The *majority* [italics mine] acquiesced to the proposed study." Did some *not* acquiesce? Presumably, they were not included in the experiment; but this is not clear.

Seventh. It is clear from reading the context and from personal knowledge of these responsible investigators that their intent is an honest facing up to what they conclude is an impossible requirement; but they have adopted a defeatist attitude. They in fact promise something they cannot guarantee, and if the subject believes this "guarantee" he is deceived, certainly not an intentional result, but nevertheless the result of their policy.

Eighth. An adoption of the paternalistic view recommended really leaves decision-making to the investigator, and what should be a joint enterprise between subject and investigator becomes a monopoly of the investigator unhampered by personal discussion with the subject as to his wishes and interests. The sky could be the limit—not in the case of these responsible, careful investigators—but with less careful and less scrupulous investigators, if the policy stated here were to be generally adopted. I think it should not be adopted.

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To the Editor:—Dr. Beecher misunderstands our interpretation of the word "guarantor." We use it in one of the forms given in Webster's *New International Dictionary*, "to give security," to promise the best care of which we are capable. This does not seem revolutionary and I am sure that his concern stems from the perhaps unfortunate selection of the word itself.

We think of the term as applying to our responsibility to the unconscious patient who obviously cannot himself stop a given study.

I wish I could contribute to the problem of the use of man as a subject. But at least I do not want to be thought of as illegal or irresponsible. For the record, therefore, may it be stated that:

(1) we do no studies on a patient without obtaining the patient's signed and witnessed consent;

(2) we try to make this an *informed* consent, for we too know that many patients will give consent readily when they trust or like their physicians;

(3) we believe it difficult to inform the patient completely, but try to do our best;

(4) we promise nothing other than the best care of which we are capable;

(5) we regard clinical investigation as a major responsibility, demanding the utmost in integrity.

I do not wish to discuss in this letter the question of the safety of the protocol, except to state that if good evidence existed that ventricular fibrillation were a possibility we would not have done this work on humans at all.

I believe that clinical studies must continue. Society stands to lose much if they are banned. It is up to all of us to see that the rights of the individual are not compromised as one seeks new knowledge. If new knowledge cannot be obtained without disregarding these rights, then we must stop. I hope and believe for the good of the world that this will not be necessary.

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EDITOR'S NOTE

We feel obliged to reply only to the first point raised in the letter pertaining to the article by Long, *et al.*, wherein Dr. Beecher expresses incredulity that an editorial board could have agreed to the authors' statement on human consent.

The article was accepted for publication in July of 1966, first having been submitted in August of 1965, months before the February 1966 recommendation by the Surgeon-General concerning investigations on human subjects. Thus, the Pennsylvania group was not impelled to supply a statement on consent. Nevertheless, the article was returned for clarification and we were rewarded with the statement now under fire. Departing from usual practice, uanimous agreement was had from the Editorial Board before acceptance for publication.

It should be evident that a journal's policies are more often than not the distillation of experience, and at this stage of the controversy we, and many another reputable periodical, have not been able to adopt an all-or-none rule concerning the printing of papers wherein human studies are at issue. Consequently, we accepted a carefully worded statement on the problem prepared by a group of established senior investigators with a long and unblemished record of productive human experimentation. Their statement could not have elicited endorsement, suppression or condemnation, for any such action would have implied censorship. The Journal's attitude was the same when, in the November–December 1967 issue, the letters to the Editor of Drs. Fink and Dripps, which ordinarily might have terminated the matter for the good of all concerned, were printed. The discussion evoked has been in the best journalistic tradition and can only serve to define further the goals Dr. Beecher is striving for.

Surgery

TREATMENT OF HICCUPS Stimulation of the pharynx with a catheter introduced through the nose appears to be a valuable method for managing hiccups in conscious and anesthetized man. Immediate inhibition of hiccups occurred in 84 of 85 patients treated in this manner, of whom 65 were anesthetized. Hiccups recurred in some patients, but were managed successfully with the same maneuver. The area responding to stimulation is the middle of the pharynx, opposite the body of the second cervical vertebra, which is innervated by the pharyngeal plexus. The suggested mechanism of action is that impulses arising in response to pharyngeal stimulation may block or inhibit afferent impulses being transmitted through the vagi, thus interrupting the hiccup reflex. No undesirable effects have been encountered as a result of pharyngeal stimulation. (*Salem, M. R., and others: Treatment of Hiccups by Pharyngeal Stimulation in Anesthetized and Conscious Subjects, J.A.M.A. 202: 32 (Oct.) 1967.*)