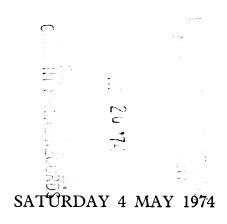
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Who is the Dental Anaesthetist of the Future?

SIR,—It would appear to be generally recognized that opportunities for training in general anaesthesia for dentistry are unsatisfactory and may indeed worsen. In view of the potential seriousness of the situation, and in order to encourage young doctors and dentists to enter this field and to obtain the appropriate training, we feel that there is an urgent need to initiate a list of approved dental anaesthetists (both doctors and dentists) similar to the list of general medical practitioners approved for obstetrics.

Admission to this list would follow individual clinical attachment to an established dental anaesthetist of, say, a half-day a week, combined with formal lectures on core subjects such as basic anaesthetic pharmacology, resuscitation, and drug interactions together with such hospital-based experience as is agreed to be relevant. The duration of the training would depend on the judgement of the teachers, who perhaps would be recognized by the Faculties of Anaesthesia and Dentistry. Follow-up, with refresher courses at set intervals, would help to maintain contact with specialists in the field and provide opportunity for discussion and feed-back.

Finally, to encourage recruitment to the list of approved dental anaesthetists a fee differential should be made between approved dental anaesthetists and others. A precedent for this has been established with the creation of the obstetric list for general

medical practitioners. This has undoubtedly made a contribution to the reduction of maternal and perinatal morbidity and mortality.

It is realized that limited finances are available and that there will be problems of "no detriment" to existing practitioners. However, we believe that the above proposals present a viable system which will help to combat the present and future deficiencies in the supply and training of dental anaesthetists.—We are, etc.,

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Innocent Praecordial Murmurs in Children

SIR,—Your leading article (23 March, p. 529) on this subject prompts me to make several points which I think are important. These, which I dealt with at greater length elsewhere are as follows:

(1) An innocent systolic murmur is frequently due to a relatively shallow chest. These come in different shapes but the explanation is not only satisfying to the doctor,

but very reassuring to the patient and the parents, who then realize that there is no mystery about the murmur. There is nothing more damaging to morale than for the patient to be left thinking: "I have a murmur, but the doctors don't really know what it is due to—they say it doesn't matter."

(2) It is wrong to suggest that the murmur will disappear with growth. It should be clearly stated at the initial interview that it does not matter, and it therefore does not matter whether or not it goes. Only too frequently it is again heard in pregnancy or fever and there is nothing worse than the anxious question, "Has it gone yet, doctor?" The question should never have arisen if the matter had been properly handled in the first place.

(3) Your article makes no mention of prophylaxis against bacterial endocarditis. The lesion, such as a small ventricular septal defect, may be haemodynamically insignificant, but advice about the risks of infective endocarditis should be given.

For all these reasons I have long suggested that children with murmurs should freely and without delay be referred to a cardiologist so that an authoritative view can be given about innocent conditions and yet important but clinically unimpressive diagnosis like atrial septal defect not overlooked.—I am, etc.,

HUGH A. FLEMING

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1 Fleming, H. A., Update, 1972, 4, 561.