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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Deaths and dental anaesthetics

SIR,—May I congratulate Dr Brian Lewis on his wise, fair, and clear headed leading article (1 January, p 3)? Dr Lewis distinguishes clearly, as many unfortunately still do not, between the safe intravenous and inhalational sedative and analgesic techniques short of loss of consciousness, which are now available to operating dental surgeons, and full general anaesthesia with the loss of protective pharyngeal reflexes. He also rightly includes the so called intermediate techniques (usually intermittent methohexitone administrations) in the category of full general anaesthetics, at which a second trained medical or dental practitioner solely responsible for the anaesthetic should be present. I hope that it is unnecessary to add that neither sedative nor general anaesthetic techniques should be administered except in the presence of nurses and attendants trained to assist with such techniques.

If we could get the leaders of the medical and dental professions and the Department of Health and Social Security to accept these definitions and their implications we could go a long way towards solving the problems and increasing the safety of outpatient anaesthesia. We could go still further if (as Dr Lewis suggests) we could induce the department to stop paying for full general anaesthesia administered by the operator and, instead, to devote the money thus saved to paying an adequate fee both for the administration of full general anaesthesia by a second trained medical or dental practitioner and to a trained operating dental practitioner for administering sedative techniques.

The implementation of the Seward report, for which both Dr Lewis and myself fervently hope, would also imply that medical or dental practitioners who seek to undertake to administer general anaesthesia or sedation should have received adequate postgraduate training in the use of these techniques.

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SIR,—Dr E B Lewis's explanation for the low mortality rate of the technique of nitrous oxide associated with hypoxia could be read as an apologia. Surely we should be asking those who use this technique to prove that there is no risk of cerebral damage, and in the absence of such proof we should condemn the technique to the dustbin of anaesthetic history. Likewise we should be critical of the use of benzodiazepines in ambulant patients. Allowing anyone to drive within six hours of administration of 15 mg of intravenous diazepam shows ignorance of both the pharmacokinetics and the behavioural effects of this drug.[1 2] Patients should be warned of the amnesic effects, not allowed home unaccompanied, and told not to drive or use potentially harmful machinery for at least 24 hours.

Interestingly the latest confidential inquiry into maternal deaths shows the extreme safety of modern anaesthesia when dealing with a healthy population. Thus in the triennium 1976-8 only two anaesthetic deaths occurred in patients undergoing suction termination of pregnancy. Yet one of those deaths occurred when after premedication with papaveretun and hyoscine hydrobromide (Omnopon-Scopolamine) 20 ml of epidural bupivacaine (Marcain) was administered followed by 10 mg of intravenous diazepam. The obstetrician-anaesthetist then undertook the termination, during which the patient aspirated stomach contents and subsequently died. It should be clear that a person performing an operation cannot also perform the essential functions of an anaesthetist—namely, to maintain respiration and circulation.

The dental operator-anaesthetist is now as anachronistic as the surgeon-anaesthetist, and Dr Lewis's contention that the Dental Estimates Board should not be paying wages for these people's sins deserves our ardent support.

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[1] Baird ES, Hailey DN. Plasma levels of diazepam and its major metabolites following intramuscular administration. *Br J Anaesth* 1973;**45**:546.
[2] Cundy JM. Medical aspects of fitness to drive. *Anaesthesia* 1979;**34**:1056-9.