practitioners. No one could advocate such a program today as increasing patient safety.

Anesthesiology can continue to advance only by keeping patient safety as a paramount consideration. General anesthesia in a dental office often means that one person, the dentist, is administering general anesthesia and doing operative procedures at the same time. Continuous monitoring of the progress of and patient responses to the anesthetic by the dentist is impossible. The occasional patient may unsuspectedly have a full stomach or a profound adverse response to anesthetic drugs, necessitating endotracheal intubation or cardiopulmonary resuscitation. These unexpected, untoward events cannot be properly managed by a lone party in a dental office. I sincerely doubt that the program outlined by Klein *et al.* "would go far toward increasing the quality of a significant number of the general anesthetic administrations in this country." It could equally well have the disastrous effect of conferring the implied approval of prestigious dental school faculty on the practice of general anesthesia in the dental office. By increasing the numbers of patients anesthetized in dental offices, it could well exacerbate the problem that exists today.

To become involved, however vicariously, in promoting this activity is not in the best interests of patient safety or anesthesiology. We in anesthesiology should strongly support the total discontinuance of general anesthesia in the dental office. Using the authors' own figures, it appears that 90 to 96 per cent of dentists practice effectively with local anesthesia, thus making a very strong case for the position that general anesthesia in the dental office is totally unnecessary. The extremely small number of dental patients who need general anesthesia can be cared for safely in hospitals or outpatient surgery centers. The dentists have shown that they are the most accomplished health care professionals in the use of local anesthesia. Let us continue to encourage them to use this expertise for all their patients.

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REFERENCE

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In reply:—We thank Dr. McLaughlin for his comments on our paper. Both he and we are interested in the same results—the highest possible quality of care and the greatest safety for the patient in the dental office. Dr. McLaughlin believes that if principles of general anesthesia are taught in dental schools, we may create a large number of barely trained individuals who feel that they have the stamp of approval to administer general anesthesia in a dental office. We would consider that result highly undesirable, but we do not believe that would be the result if the principles of general anesthesia and sedation were taught in dental schools. It is our own experience from the teaching of anesthesia to medical students, interns, and residents in other specialties that the result of such instruction is a healthy respect for possible complications and a greater tendency to call on the services of a qualified and fully trained individual more frequently.

Whether or not it is desirable that dental practice in offices be limited to local anesthesia, a significant number of general anesthetics and intravenous sedation techniques continue to be performed in dental offices. No amount of discouragement of this practice has successfully decreased it. We therefore believe that training in anesthesia is a more logical approach, not because we would like to see the individual who has had a few weeks of anesthesia training in dental school administer anesthesia, but because we believe that individual will have a better concept of what he should and should not do as a solo practitioner in the office.

We do not believe there is any objection to the fully trained practitioner administering anesthesia, and we believe that if adequate numbers of dental faculty are fully trained they can provide others with as much as two years of clinical anesthesia training. These trainees could then safely administer anesthesia to dental patients.

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