

is under the supervision and instruction of medical and dental anesthesiologists. The instruction in the operating room is directed towards both inpatient and outpatient care of the anesthetized patient. The dental residents are then taught office-type anesthesia in the outpatient clinic of the department of dentistry. The dentist-anesthesiologists are taught when they do go into private practice to operate as a team of two dentists or two oral surgeons. Monitoring of the patient's vital signs is routine during the pre-, intra- and postoperative periods. Facilities for excellent recovery room care are mandatory, and well established. Those of us in anesthesiology for dentistry are equally concerned that optimum care be given a dental patient who needs general anesthesia.

Anesthesiology
49:374, 1978

To the Editor:—Having read Dr. McLaughlin's letter in the May 1978 issue of ANESTHESIOLOGY,¹ we feel that the reply by Drs. Klein, Wollman, and Cohen² is inadequate.

A three-month training program in general anesthesia is not considered adequate, nor is it acceptable for a dentist to administer general anesthesia and render dental treatment simultaneously, any more than it is acceptable for a physician-anesthesiologist to administer anesthesia to several patients in different operating rooms at the same time. In addition, it is unconscionable to state that patients who need dental treatment should be denied the full range of pain control methods that are available for other health services.

The American Dental Society of Anesthesiology requires a minimum of one year of full-term hospital training in general anesthesia for eligibility for its Fellowship program. The American Dental Association and a number of state boards have accepted this criterion.

The economic impact on the patient would be overwhelming if every general anesthetic were to be administered in a hospital, the cost easily being three

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Rational Use of a Scavenging Mask

To the Editor:—One of the commonest faults in the conduct of dental anesthesia is to neglect the critical balance between fresh gas flow and suctioning at the mask. Considered superficially, the very idea of the scavenging mask seems so self-defeating as to be ludicrous, for if the velocity of suctioning equals or exceeds

STANLEY R. SPIRO, D.D.S., F.A.C.D.
*Clinical Associate Professor of Dentistry
(Anesthesiology)
Albert Einstein College of Medicine
of Yeshiva University
1165 Morris Park Avenue
Bronx, New York 10461*

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to four times what it is in the dental suite. In addition, there is serious question as to the ability of institutions and personnel to handle the multitudes who need these services daily if that were to become a requirement.

Dentistry's role in general anesthesia and other methods of pain control requires no apology. From Wells to Heidbrink to Monheim, we have contributed to discovery and progress in the field of anesthesiology. This progress will not be sidetracked. Training programs that we need and want must continue to be developed.

JUSTIN H. STONE, D.D.S.
ROBERT G. KROLL, D.D.S.
*123 South Munn Avenue
East Orange, New Jersey 07018*

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the peak velocity of fresh gas flow plus peak expiratory flow rate, not one molecule of nitrous oxide will become available to the patient. On the other hand, if the velocity of inspiratory flow exceeds the velocity of fresh gas flow, rather more resistance than was intended in the Brown Exhalation Valve (McKesson)