The health of the Maltese people—the crux of the long and bitter dispute in Malta—can be left to imported doctors, who, I hear, are surpassing themselves at the job.

I would like to mention how the Government of Malta has helped the students so far: (a) it has denied completion of their courses and qualification of the required standard; (b) it has threatened both the BMA and Whitehall when help was offered and given to the students; and (c) in Parliament it has cheered the news of the unfortunate failures in the recent Conjoint examinations. But then students are not “the people.” The students in Malta have done what they could—they held demonstrations and were beaten up by thugs in the full view and with the co-operation of scores of police.

Yes, we *do* have the BMA to be thankful for—after all, the George Cross is not a settlement for some wartime business deal.

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Dental anaesthetic fees

SIR,—I am delighted that at long last some action is being recommended with regard to dental anaesthesia. This anomalous situation has existed since the NHS began, so nobody can accuse the BMA of precipitate action. Indeed, one might ask why it has taken 30 years in coming.

I am also pleased to note that the proposals (24-31 December, p 1680) are on the same lines as those I made in 1970,¹ but there will also have to be some system whereby the dentist is adequately reimbursed for the provision of anaesthetic equipment.

Another incidental anomaly of the present system, which arises from the fact that dental anaesthesia is treated as part of the dental service, is that the dental surgeon gets the superannuation benefits of the service provided by his anaesthetist. As one who practised dental anaesthesia throughout his career and who has now retired, I find this an anomaly which is hard to bear.

E O EVANS

Dulverton, Somerset

¹ Evans, E O, *Journal of the Royal College of General Practitioners*, 1970, 20, 72.

Ban on dental anaesthetics

SIR,—Members of the BMA and of the Association of Anaesthetists of Great Britain and Northern Ireland have been advised that they should impose a ban on the administration of dental anaesthetics for the NHS (24 December, p 1680). It would appear to apply only to those anaesthetics given at the surgeries of general dental practitioners (as opposed to hospitals, clinics, etc) and to exclude “priority” classes. It is understood that the British Dental Association has been asked to co-operate in this action. I believe that many (in fact most) anaesthetists doing dental work disagree with this.

What has become known as “discriminatory industrial action” is foreign to the principles of the profession and should remain so. If a patient is accepted by a dental practitioner for treatment under the Health Service, including the extraction of teeth under general anaesthesia, it is morally and, I think, legally wrong

that a medical practitioner co-operating in this treatment should demand private remuneration.

I agree that the present scale of fees (normally £2-4.60 per anaesthetic, depending upon the number of teeth extracted) is not commensurate with the skill required and the responsibility taken by the anaesthetist. However, most of the anaesthetists visiting dental surgeries do so in a capacity over and above their main employment, and if they find it unprofitable they can withdraw altogether from dental anaesthetics.

The “single emergency” is a rare event. There is, however, a wide variation in the number of patients treated in anaesthetic sessions at the surgeries of different dentists. If the anaesthetist does not wish to take the rough with the smooth he should not anaesthetise for those dentists who have only a few cases at a time. At the same time it should be remembered that the “gas session” often runs at a loss to the dentist who undertakes it as a necessary part of his practice. The ban would damage the relationship between the medical and dental professions and would drive the dentists to find anaesthetists with less skill, thus reversing the efforts which have been made to improve the quality of dental anaesthetics and the training of the practitioners concerned.

The two remedies which might be applied are: (1) the wider application of the special fee, which could distinguish between the services of a visiting anaesthetist with special skill and accredited training and those of a relatively untrained dental practitioner who gives anaesthetics for a colleague in the adjacent surgery; (2) that we encourage the dental practitioners to take on patients only on an independent basis, rather than on the NHS, that we have a recommended scale of fees payable by the patient for the services of the anaesthetist, and that some guidance should be given as to the manner in which the anaesthetist should contribute towards the expenses attached to an anaesthetic session.

C S WARD

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*The Secretary writes: “As stated in the letter, signed on behalf of the Council, the CCHMS, the GMSC, and the Association of Anaesthetists, reasonable argument has failed to persuade the Department of Health of the need for any action to increase these derisory fees.”—Ed, *BMJ*.

Bringing deputising services into the fold

SIR,—It is a personal opinion that the time has come for the BMA to be sincere and logical over our attitude to deputising services as constituted now and as planned for the future.

It is extraordinary for any vital public service—water, fire, transport, or health—to be organised and monitored by one “authority” during so-called “normal working hours” and by others after 7 pm, at weekends, and on bank holidays—in other words, for the majority of the time. Critics of such an opinion may say that a general practitioner should be entitled to employ any “agency” on his or her behalf so long as the ultimate responsibility is understood. In support of such a view it is said that many GPs on local family practitioner committee lists are employed by deputising services in their area and thus they accept the

total responsibility while acting for their colleagues in other practices by night and their own by day. This brings into question individual doctor lists and free choice of doctor (and patient).

To negotiate separate codes of conduct and standards of service for the hours when deputising services are employed—that is, 14 hours out of 24 hours a day and about eight days out of 30 days in a month—seems to me irrational but obviously necessary if a dual service is the objective. Surely LMCs would wish to advise, indeed control, a unified service.

I fully realise the chilly reception my views on a voluntary salaried service on a sessional basis for those GPs who so desired received in 1965, but now years on one sees GPs staunch in support of themselves employing other doctors, often GPs, on such a basis and to their financial gain. I do not criticise this, for in pursuance of giving the coverage we had agreed to hitherto we now realise that we cannot personally fulfil a total commitment. No one can blame a senior GP, especially those aging, for opting out of night and weekend duty; but why not tell the State we now realise our limitations and need help and co-operation to make our best efforts, and continuation of the same, possible during the watches of the night and over weekends and bank holidays, or ask for a 9-to-6, 5-day-a-week contract?

At present deputising services flourish where doctors and casualty departments are most plentiful and are absent where work load is higher and hospitals fewer and more scattered—that is, where their need is greatest. Deputising services will be anathema to some dedicated doctors and often the envy of many “have-nots” but always a target for criticism. Why not bring them all into the fold, set them up where they are most needed, and let the highest possible standards night and day be vouchsafed?

General practice is a life to be lived and not merely a job to be done, but let us be honest and admit we have our limitations and that our total personal commitment availability cannot be guaranteed. Perhaps the stand-in is having a little too much of the footlights these days. Does this mean “curtains” for the genuine independent contractor?

G MURRAY JONES

Caerphilly, Mid Glamorgan

SIR,—I feel the Review Body should approach the forthcoming pay negotiations in the light of a modification of the contract that now exists for general practitioners.

Our terms of reference must be to provide accurate diagnosis and proper treatment for our patients. Our present contract is such that we are forced to work and be on call many hours at a stretch both during the day and at night. GPs cannot be off sick without embarrassing their partners with even longer hours of work and on-call commitments. A doctor who is fatigued, ill, or both is a menace to his patient.

I suggest the following modification of the contract. (1) The general practitioner service retains its independent status from 9 am to 6 pm Monday-Friday. (2) The family practitioner committee would be responsible for employing a new type of Clinical Assistant for out-of-contract commitment. Whether a practice wished to allow a member to be a clinical assistant with the family practitioner committee