All doctors are equal

As a visitor to any BMA committee will see, women doctors and overseas doctors are underrepresented. There are over 16 000 women doctors in the NHS and nearly 20 000 doctors from overseas,¹ figures that, even given the overlap, form an appreciable proportion of the profession. The committees, however, do not reflect this proportion, and the reasons for this were discussed at two informal debates held recently at BMA House (p 79). Despite their colleagues' relatively small voice in the BMA's counsels most of the doctors at both meetings rejected the idea of special electoral arrangements, preferring that women and overseas doctors should use the normal channels to achieve election to committees.

Neither meeting was intended to be representative in any formal sense—the BMA council had discussed the problem and decided to invite doctors from the two groups on a regional basis to air their views.² Two questions were debated: should there be separate representation, and should there be reserved seats or special electoral mechanisms on existing committees? The outcome—no to both questions—probably reflects the views of both groups in the country, though the chairman's "straw polls" showed that the overseas doctors were much less decisive in their rejection than were the women. The preference for normal channels is welcome—particularly in an age when minorities and pressure groups customarily clamour for special treatment—for this is the most effective route to fair and equal treatment in an organisation with the BMA's democratic traditions. Both groups have at various times had special seats reserved on craft committees but without any conspicuous advancement of their causes. That said, it is in both groups' interests, as well as those of the BMA and the profession, to ensure that all sections of the profession are fairly represented on local and national medicopolitical committees.

Women and overseas doctors have their own organisations—the Medical Women's Federation and the Overseas Doctors Association, both of which have championed their members' interests with vigour—but the BMA is the doctors' recognised negotiating body (and not just inside the NHS), and the Association has a responsibility to ensure that it fairly represents all quarters of the profession—including, for example, such groups as clinical assistants, of whom women form an appreciable number. Its constitution is already admirably fashioned to do this. Indeed, the BMA is probably unique in the lengths to which it goes to give everyone a voice, including, on the craft committees, non-members. What is needed is the political will on all sides to make sure that the machinery is properly used.

Women doctors have been in the BMA for over a century: Elizabeth Garrett Anderson joined the Metropolitan Counties Branch in 1873, though it was another 20 years before the Association's constitution was formally adjusted to include women, and the BMA subsequently championed their treatment as equals, resolving in 1914 that they should receive the same pay as men. Given this early recognition of women's rights, it may seem odd that in 1982 a conference on women's representation was necessary, especially as the proportion of BMA members among women doctors in the NHS (68%) is slightly higher than it is among their male colleagues. One explanation for the paucity of women on many committees is that the work there tends to be done by older doctors, among whom women form a much smaller proportion than is the case among doctors now qualifying.

The fact that about 30% of the Hospital Junior Staff Committee comprises women members supports this explanation and is indeed a good augury for their future representation.

Overseas doctors have made a prominent contribution to British medicine for 25 years or more but their membership of the BMA has been disappointingly low, possibly because many of them see themselves as postgraduate birds of passage. Some, however, have made notable contributions to the local and central activities of the BMA. This should encourage others, who may be deterred by cultural and language differences from playing an active part in medicopolitics, to try their hand. There may well be something in the suggestion made at the conference that BMA divisions should consider coopting overseas doctors on to their committees to prime the pump to improve their representation.

Women doctors and their overseas colleagues are not alone in their reluctance to board the medicopolitical bandwagon. Other professional commitments, domestic responsibilities, hobbies, leisure activities, and antipathy to medicopolitics keep many doctors out of committee rooms. Paradoxically, the low attendance at local BMA business meetings offers the interested woman or overseas doctor an ideal opportunity to enter medicopolitics. By devoting some time and dedication to this work they may then find themselves elected on their merit to represent not just their particular group but all their colleagues. In the BMA's constitution all doctors are equal: it is up to all members to ensure that in practice this is so.

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¹ Review Body on Doctors' and Dentists' Remuneration. *Twelfth report 1982*. Cmnd 8550. London: HMSO, 1982.

² Anonymous. From the Council: representation of overseas and women doctors. *Br Med J* 1982;284:1501-2.

Deaths and dental anaesthetics

This summer saw the publication of *Mortality Associated with Anaesthesia*,¹ and now an important paper on deaths associated with dentistry has just been published in the *British Dental Journal*.²

Coplands and Curson have surveyed the data for the 10 years 1970-9 of deaths related to dentistry and found, not surprisingly, that most of these deaths were related to general anaesthesia. A total of 120 deaths occurred, of which 100 were in patients having general anaesthesia—including the intermediate techniques according to Dinsdale and Dixon³—that is, intermediate between conventional general anaesthesia and sedation and analgesia. The important feature of this intermediate state is that it may entail loss of consciousness at some time during the procedure.

Previous studies have had to rely on information provided by the Dental Estimates Board and the Registrar General (whose office is now that of Population Censuses and Surveys). Additional information on all deaths in which dentistry was mentioned was obtained by identifying the coroners concerned. In the past the place of death was always given but never the place of accident or collapse. Because of modern resuscitation

measures and a good ambulance service nearly 70% of patients reached hospital before dying—and it was (wrongly) assumed that hospital was a dangerous place for dental outpatients.

The Dental Estimates Board authorised for payment a total of general anaesthetic administrations between 1970 and 1979 of 10 167 000; so that some 10 deaths occurred for every million anaesthetics given. On subdividing these further, in only five of these 10 deaths was the general anaesthetic directly responsible for and the sole factor in the death of a healthy patient; in a further three cases it made a contribution to the outcome. Plainly the problem is numerically small. Nevertheless, any unnecessary death presents us with a challenge, and those of us engaged in dental anaesthetics need to study this paper to see what we can learn from it.

One factor which emerges quite clearly is that prolonged anaesthesia and complex techniques carry considerable additional risks. Many of the findings may surprise previous commentators. Thus in the 10 year period over two million sedative and analgesic techniques were used, of which one and a half million were performed by operating dentists. Only one recorded death was attributed to a sedative technique, and that to a patient given 16 mg of unsupplemented diazepam intravenously at midday who was at 6 pm killed in a road traffic accident while driving a motor cycle. When, however, an operating dentist used general anaesthesia, the mortality rate was substantially higher. Some 13 deaths were wholly due to anaesthesia of this kind, a rate of 1:143 000, compared with only six where a second dentist gave the anaesthetic, a rate of 1:598 000, and 28 where a doctor gave the anaesthetic, with a rate of 1:367 000, each of these deaths being where the general anaesthetic was the sole factor in the death. Of the 13 deaths associated with the operating dentist, the anaesthesia was prolonged in at least 10 and eight of the operations included conservative dentistry. The figures show quite clearly that the operating dentist should stick to local anaesthesia, with or without the assistance of sedation, rather than general anaesthesia.

The investigation undoubtedly supports the attitude of the Medical Defence Union outlined in its annual report for 1982, in which it condemns the practice of a dentist acting as operator and general anaesthetist.⁴ As long ago as 1975 Sir Rodney Swiss, when president of the General Dental Council, said "A dental practitioner who does not take sensible precautions may be found to have been negligent in law and his actions or omissions could constitute infamous or disgraceful conduct in a professional respect. A practitioner who

regularly administers general anaesthetics single handed for conservation work is, in my view, acting inexcusably." Yet, despite this, the Dental Estimates Board's annual report for 1981 records that payment was made for general anaesthetics given by operating dentists in 52 960 cases, of which 24 360 were for dental treatment other than extractions.⁵ I cannot believe that, even if the Department of Health and Social Security cannot ban the practice, it should not at least review the question of paying for it.

The investigation also provides evidence for the apparent safety of unsupplemented nitrous oxide with oxygen in an era when more complex alternatives were readily available. This traditional technique was probably reserved for very short, uncomplicated tooth extractions, and the technique was likely to have been used by administrators with considerable experience, since it has not been part of orthodox anaesthetic teaching since the early 1960s. The choice between supine and non-supine posture appeared to play no great part in safety. Though sudden cardiovascular collapse was more frequent during recovery than earlier in the anaesthetic, the frequency was reversed when collapse was associated with respiratory or other problems.

What conclusions emerge for the patient? Clearly, if possible, he should avoid general anaesthesia for conservative dentistry, avoid the operator-general anaesthetist altogether, and ensure that in whoever's hands he places himself he is experienced and properly trained.

We can only hope that the combined efforts of Professor Donald Campbell, as dean of the Faculty of Anaesthetists, and Professor Paul Bramley, for the Faculty of Dental Surgery, will lead to the early implementation of the Seward Report⁶ on training for dental anaesthesia.

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¹ Lunn JN, Mushin WW. *Mortality associated with anaesthesia*. London: Nuffield Provincial Hospitals Trust, 1982.

² Coplans MP, Curson I. Deaths associated with dentistry. *Br Dent J* 1982;**153**:357-62.

³ Dinsdale RCW, Dixon RA. Anaesthetic services to dental patients: England and Wales, 1976. *Br Dent J* 1978;**144**:271-9.

⁴ Medical Defence Union. *Annual report 1982*. London: Medical Defence Union, 1982.

⁵ Dental Estimates Board. *Annual report 1981*. Eastbourne: Dental Estimates Board, 1981.

⁶ Inter-Faculty Working Party formed to consider the implementation of the Wylie Report. The Seward Report. *Br Dent J* 1981;**151**:389-91.