Privy Council Appeal No. 21 of 1989

Andrew John Charles Carmichael *Appellant*

v.

The General Dental Council *Respondent*

FROM

THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL DENTAL COUNCIL

JUDGMENT OF THE LORDS OF THE JUDICIAL COMMITTEE OF THE PRIVY COUNCIL, DELIVERED THE 2ND NOVEMBER 1989

Present at the hearing:-

LORD KEITH OF KINKEL
LORD TEMPLEMAN
LORD OLIVER OF AYLMERTON

*[Delivered by **Lord Templeman**]*

This is an appeal from a determination of the Professional Conduct Committee of the respondent council that the appellant, Mr. Carmichael, was guilty of serious professional misconduct and that his name be erased from the Dentists Register in accordance with section 27 of the Dentists Act 1984. The Committee found, and Mr. Carmichael disputes, that on four separate occasions Mr. Carmichael administered a general anaesthetic to a patient.

In May 1988 the General Dental Council issued a notice for the guidance of dentists entitled "Professional Conduct and Fitness to Practice". Under the heading "General Anaesthesia and Sedation" dentists were informed:-

> "12. Where a general anaesthetic is administered, the Council considers that it should be by a person, other than the operator, who should remain with the patient throughout the anaesthetic procedure and until the patient's protective reflexes have returned.
>
> 13. This second person should be a dental or medical practitioner appropriately trained and experienced in the use of anaesthetic drugs for dental purposes. ..."

Mr. Carmichael claimed that he did not administer a general anaesthetic on any of the four occasions in question and that therefore paragraphs 12 and 13 do not apply.

> "14. Where intravenous or inhalational sedation techniques are to be employed a suitably experienced practitioner may assume the responsibility of sedating the patient, as well as operating, provided that as a minimum requirement a second appropriate person is present throughout. ..."

A footnote defines simple sedation as:-

> "A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely."

Mr. Carmichael says that he employed an intravenous technique of sedation and complied with the requirements set forth in the footnote. He denies that any of the patients suffered any loss of consciousness.

> "16. A dentist who carried out treatment under general anaesthesia or sedation without fulfilling these conditions would almost certainly be considered to have acted in a manner which constitutes serious professional misconduct."

The Committee therefore had to decide whether on one or more of the four occasions in question a loss of consciousness was suffered. The patients themselves gave evidence that they were put to sleep and remained unconscious throughout the treatment carried out by Mr. Carmichael but the recollections of patients after sedation or unconsciousness are not to be relied upon.

On each occasion Mr. Carmichael administered two drugs by way of intravenous injections. He first injected midazolam. This is a drug which can be employed in small doses to produce sedation or in larger doses for the induction of anaesthesia. The manufacturer's recommended dose for sedation is 2.5 mg. to 7.5 mg or 0.07 mg/kg body-weight. Mr. Carmichael then injected a solution of methohexitone sodium sold under the brand name of brietal sodium. The manufacturers of brietal sodium describe it as "a rapid ultrashort acting barbiturate anaesthetic agent. It is used for induction of anaesthesia, as an intravenous anaesthetic for short surgical procedures and for supplementing other anaesthetic agents for more prolonged anaesthesia". The manufacturers recommend that it be administered intravenously in a one percent solution (10 mg. per ml). "As an initial guide a rate of

one ml of a one percent solution (10 mg.) in five seconds may be used ... The dose usually ranges between 5 and 12 ml (50 to 120 mg.) but it must be adjusted to the needs of the individual patient. The induction dose maintains unconsciousness for about 5 to 7 minutes." The manufacturers do not suggest that it may used for the purposes of sedation.

On two occasions Mr. Carmichael used 4 mgs. of midazolam followed by 30 mgs. of methohexitone in a two percent solution. On the other two occasions Mr. Carmichael administered 6 mg. of midazolam followed by 50 mgs. of methohexitone in a two percent solution.

Mr. Carmichael gave evidence that on each of the four occasions the patient was only sedated. He agreed that a dentist performing an operation on the mouth of a patient encountered difficulty in monitoring the patient's state of consciousness and that the patient cannot talk but he was satisfied that he detected enough responses from the patient to satisfy him that the patient was sedated but conscious.

Professor Robinson, who has been a consultant anaesthetist for 27 years, had used methohexitone for anaesthetic purposes but never for sedation because "if midazolam is given with methohexitone then I cannot see how the patient can be prevented from entering into a general anaesthetic state". He said that midazolam would potentiate the sedative effect on the brain of methohexitone and would not only potentiate the length of time that the patient was asleep but also potentiate the dose of drug so that less methohexitone was needed to put the patient to sleep. He said that a patient administered with 4 mg. of midazolam and 30 mg. of methohexitone would go to sleep if the methohexitone were administered at the normal injection rate. If however the methohexitone were given extremely slowly it would never reach the concentration to put the patient to sleep because it would be redistributed before it reached the brain. By slow injection he meant over a period of 4 to 5 minutes. The evidence was that Mr. Carmichael gave an initial dose of 20 mg. taking some 45 seconds followed if necessary by a further dose also taking about that sort of period of time giving a total of time of about $1\frac{1}{2}$ minutes. Professor Robinson said that a patient of Mr. Carmichael who was injected with 4 mg. of midazolam and 30 mg. of methohexitone would go to sleep and stay asleep for 4 or 5 minutes and that the higher dosages administered by Mr. Carmichael on two occasions would induce general anaesthesia lasting some 9 or 10 minutes.

Professor Robinson gave evidence that the use of midazolam and methohexitone in combination for the purpose of sedation was not taught and received no support from medical or dental literature.

Dr. Buxton who has been a consultant anaesthetist for 40 years gave evidence for Mr. Carmichael. Dr. Buxton did not indicate that any literature or teaching supported the use of midazolam and methohexitone in combination and said that he had never taught this technique and would not currently advise dentists to use it, because "I think if you are using two drugs you want to have considerable experience in both those drugs before you combine them". He said that "certain doses of the two drugs in a healthy patient of, say, 70 kg, are unlikely to produce anaesthesia" and then in answer to a confusing question agreed that "administration of 70 mg." of methohexitone might produce anaesthesia and "if it is given rapidly, it certainly can do so". He disagreed with the manufacturers' instructions of an initial dose of between 50 and 120 mg. to produce an anaesthetic state. A dose of 50 mg. would be unlikely to produce unconsciousness if given slowly. After questioning, Dr. Buxton was unable to describe Mr. Carmichael's method of injection as "slow" and agreed that a solution of 2% instead of the recommended 1% would double the speed of injection. Dr. Buxton agreed that midazolam would potentiate the methohexitone but could only hazard a guess that the potentiating effect would be 50%. Nevertheless Dr. Buxton expressed the opinion that the methods used by Mr. Carmichael would be "most unlikely" to cause anaesthesia "provided the administration was slow".

The task of the Committee was to determine whether in fact the drugs administered by Mr. Carmichael resulted in loss of consciousness by his patients. It was for the Committee to evaluate the evidence of Mr. Carmichael, Professor Robinson and Dr. Buxton, taking into account the manufacturers' instructions with regard to the drugs administered and in the light of the knowledge of dental practice of members of the Committee. Seven of the eight members of the Committee had practical experience. The Board can only interfere with a finding of fact by the Committee if the determination was not supported by credible evidence or if the weight of the evidence was overwhelmingly against the view taken by the Committee. The Committee was fully entitled to conclude that, having regard to the techniques for administration of the drugs described by Mr. Carmichael and in the light of the views expressed by Professor Robinson and Dr. Buxton respectively, Mr. Carmichael's patients had suffered a loss of consciousness. Mr. Carmichael denied that he intended to produce a state of anaesthesia but in adopting a combination of drugs Mr. Carmichael, knowingly or unknowingly, took the risk that the effect would not be confined to sedation.

Mr. Carmichael alleged that there had been breaches of the rules governing the furnishing of documents in the course of the proceedings. He also criticised some

of the members of the Committee and attacked some of the witnesses. Mr. Carmichael is understandably bitter at the result of the proceedings but having carefully considered Mr. Carmichael's complaints, the Board are satisfied that there is nothing in any of the complaints which would justify the Board in intervening.

Finally Mr. Carmichael submitted that the penalty of erasure from the Register was too severe and that if it stands the Council will not treat fairly any application he makes for reinstatement.

The rules which forbid an operator from administering a general anaesthetic as opposed to a sedative reflect the unexpected problems and difficulties which may arise as a result of the administration of a general anaesthetic. If and when these problems and difficulties arise they require prompt identification and treatment otherwise they may cause serious injury or death. The Council clearly consider that the safety of patients requires that a general anaesthetic should only be administered by a qualified practitioner who can give his or her undivided attention to the reactions of the patient to the anaesthetic procedure. The Council also clearly consider that a sole operator should take great care to ensure that he is only administering a sedative. In these circumstances the Board could only interfere with the sentence pronounced by the Committee if the Board were satisfied that the sentence was wrong in principle or wholly disproportionate to the offence. The Committee which was composed almost entirely of members of the dental profession was the best and proper body to decide sentence. Their Lordships will accordingly humbly advise Her Majesty that the appeal ought to be dismissed. The appellant must pay the respondent's costs before this Board.