ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

GEOFFREY WILLIAM IRVINE MRCVS (1)

IGOR VASILEV MRCVS (2)

DECISION OF DISCIPLINARY COMMITTEE
ON DISGRACEFUL CONDUCT IN A PROFESSIONAL RESPECT

Summary of evidence

1. Dr Vasilev gave evidence about his failure to maintain clear, accurate and detailed records in relation to 11 July 1017 and 18 July 2017. He explained that he had done three Continuing Professional Development (CPD) webinars on complaint handling since he had been notified by the College about these concerns and had researched the websites of the British Small Animal Veterinary Association and the Veterinary Defence Society Guidance notes to inform himself further.

2. Dr Vasilev further stated that he now uses dental charts so he can record his assessments and the treatment he administers. He further explained that he now also regularly rechecks his notes to ensure that they consistently meet the standard necessary to meet the Code of Professional Conduct for Veterinary Surgeons (the Code). Dr Vasilev said that he had also sought out a model form which was recommended by the College in respect of informed consent.

3. Dr Vasilev said in relation to 11 July 2017 and 18 July 2017, that at the time he believed his notes met the standard of the Practice even though they did not meet the RCVS standard i.e. that to be expected of a reasonably competent veterinary surgeon. He said he appreciated that he should have recorded the details of an operation for his own information and that of other veterinary surgeons who practised at the practice, such as locums. He accepted that his notes on 11 July 2017 were deficient but he stated that Mr Irvine had been present throughout the dental surgery.

4. Mr Williams gave evidence as an expert witness for Dr Vasilev. He explained that he did not consider that the failures by Dr Vasilev in relation to the two instances of record keeping amounted to disgraceful conduct in a professional respect. Mr Williams considered that the notes fell below the standard required of a reasonably competent veterinary surgeon but not far below that standard.

5. Mr Williams explained his opinion on the basis of two veterinary surgeons working closely together where it is more likely that the clinical notes may not be detailed because of the informal discussions that they would be having between them. He said that in this practice there was also not a high turnover of other staff. Mr Williams agreed that in a busy practice the need to keep detailed clinical records is necessary to assist all the veterinary surgeons to remember the details of each animal's consultation. Mr Williams also said that if the dog was normal during a pre-operative check that could mitigate the lack of record keeping on 11 July 2017 as a veterinary surgeon might be less likely to note when all was well pre-operatively.

6. In relation to 18 July 2017, Mr Williams considered the shortcomings in the notes for that day were somewhat mitigated by the note on 12 July 2017 which provided information that 'blood tests were to take place if vomiting continued'.

7. Mr Williams accepted that because Rupert had suffered from CHF and because he had been vomiting it was particularly important to make detailed records. He also said that detail about an operation was necessary in case of post-operative complications and so that public confidence in the veterinary profession would not be undermined.

8. The Committee received a number of positive testimonials in relation to Dr Vasilev.

9. Mr Irvine called no further evidence at this stage of the proceedings.

10. Counsel for the College submitted that the conduct found proved in relation to Mr Irvine cumulatively amounted to disgraceful conduct in a professional respect.

11. Counsel for the College also submitted that the conduct found proved in relation to Dr Vasilev cumulatively amounted to disgraceful conduct in a professional respect.

12. Counsel for Mr Irvine and Counsel for Dr Vasilev submitted that the conduct of the veterinary surgeon whilst falling below the standard to be expected of a reasonably competent veterinary surgeon did not fall far below the standard and therefore did not amount to serious professional misconduct or disgraceful conduct in a professional respect.

The Committee's decision on disgraceful conduct in a professional respect

13. The Committee took all the evidence into account including the evidence of Mr Maltman.

14. In accordance with paragraph 16 of the Disciplinary Committee Procedure Guidance the Committee considered whether there were any aggravating or mitigating factors which were relevant to its decision on whether the facts proved amounted to disgraceful conduct in a professional respect.

Mr Irvine

15. The Committee considered the facts found proved cumulatively as Counsel for the College invited it to do.

16. In respect of expert evidence the Committee concluded that Mr Maltman had not expressed a view on whether inadequate discussions on 10 July 2017 would amount to disgraceful conduct in a professional respect. Mr Maltman said that a lack of informed consent would in his view fall far below the standard to be expected of a veterinary surgeon in ordinary practice; albeit that his view was premised on an absence of discussion between Mrs R and Mr Irvine. The Committee therefore did not find any assistance from Mr Maltman's evidence in exercising its judgement at this stage.

17. The Committee went on to consider whether there were any aggravating or mitigating factors relevant to its decision on disgraceful conduct in a professional respect.

18. The Committee did not find that there was actual harm caused to Rupert by Mr Irvine's actions in failing to obtain informed consent from Mrs R. Had the option of deferring dental surgery been offered to Mrs R and had she been informed about the risks of proceeding on 10 July 2017, the Committee considered that there could have been a reduced risk of harm to Rupert if dental surgery had been delayed. However the Committee was not persuaded that in the context of this case this was an aggravating factor. It did not find there to be any other aggravating factors in Mr Irvine's case.

19. The Committee found the following mitigating factor in that it was a single isolated incident.

20. The Committee considered whether the failure to obtain informed consent by inadequate discussions on 10 July 2017 was a breach of the Code and serious enough to undermine public confidence in the profession or serious enough to amount to disgraceful conduct in a professional respect.

21. The Committee decided the conduct of Mr Irvine was in breach of the Code because he failed to inform Mrs R of all the treatment options and risks on 10 July 2017. It found his conduct fell below the standard to be expected but not far below the standard to be expected because some discussion had taken place albeit an inadequate discussion given Rupert's changing clinical picture.

22. The Committee had found that Mr Irvine had not explained to Mrs R about the increased risk of mortality due to the CHF or the option to delay dental surgery. The Committee considered that such a discussion was extremely important because ongoing communication with clients as circumstances changed would ensure that there was appropriate informed consent.

23. The Committee was not persuaded that the failure to obtain informed consent from Mrs R and discuss matters further with her on 10 July 2017 in the circumstances of this case would amount to serious professional misconduct which would bring the profession into disrepute. In the Committee's judgment, the breach of standards whilst amounting to professional misconduct was not serious professional misconduct in the context of other discussions which had taken place. It therefore did not find that the

failure to obtain informed consent amounted to disgraceful conduct in a professional respect.

24. The Committee further decided that a finding of serious professional misconduct in this case would be disproportionate having taken into consideration the discussions that Mr Irvine had with Mrs R prior to the 10 July 2017 and the fact that he was dealing with a complex and changing case.

25. The Committee therefore found that Mr Irvine was not guilty of disgraceful conduct in a professional respect.

Dr Vasilev

26. For Dr Vasilev the Committee considered the recent decision of RCVS v Maillo and Rafiq (7 May 2019) where the Disciplinary Committee determined that a veterinary surgeon's failure to maintain clinical records was not found to amount to disgraceful conduct. However the Committee considered that each case was fact specific and different and that it was necessary to apply its judgment to the facts and context in this case which was distinct from that previous decision.

27. The Committee considered the facts found proved cumulatively as Counsel for the College invited it to do.

28. The Committee noted that Dr Vasilev admitted breaching the code in relation to clinical records. The sections from the code are set out below:

13. Clinical and client records

13.1 Clinical and client records should include details of examination, treatment administered, procedures undertaken, medication prescribed and/or supplied, the results of any diagnostic or laboratory tests (including, for example, radiograph, ultrasound or electrocardiogram images or scans), provisional or confirmed diagnoses, and advice given to the client (whether over the telephone or in person). They should also include outline plans for future treatment or investigations, details of proposed follow-up care or advice, notes of telephone conversations, fee estimates or quotations, consents given or withheld, contact details and any recommendations or discussion about referral or re-direction.

13.2 The utmost care is essential in writing records or recording a client's personal details to ensure that they are clear, accurate and appropriately detailed. Clinical and client records should be objective and factual, and veterinary surgeons and veterinary nurses should avoid making personal observations or assumptions about a client's motivation, financial circumstances or other matters."

29. In Dr Vasilev's case there was expert evidence from Mr Maltman who said that the two failures, on 11 July 2017 and on 18 July 2017, to maintain clear, accurate and detailed clinical records amounted to serious professional misconduct. There was a different expert opinion from Mr Williams who maintained that such failures did not amount to serious professional misconduct.

30. The Committee noted that both experts determined that the failure to maintain detailed records on those two dates amounted to professional misconduct. The difference of opinion between them was whether it amounted to serious professional misconduct. The Committee accepted their evidence that the failures in the notes amounted to professional misconduct. Both experts agreed that in a small practice the risk to animals was reduced by the failure to maintain detailed records. However in the Committee's judgment the context of Dr Vasilev's failures was important and significant.

31. The Committee found no aggravating factors in Dr Vasilev's case. There was no actual harm caused to Rupert because Mr Maltman said his death could not be linked to the general anaesthetic given for the dental surgery. The Committee found the risk of harm by Dr Vasilev's failure to maintain notes on 11 July 2017 and 18 July 2017 was reduced because this was a small animal practice where both vets were present during Rupert's operation and available to locums thereafter.

32. The Committee accepted the evidence that Rupert had improved by 10 July 2017. The Committee considered that public confidence in the profession would be undermined by Dr Vasilev's failure to record in the notes the detail of the pre-operative clinical examination on Rupert because there was no note reflecting Rupert's improvement.

33. The Committee found the following mitigating factors:

    - The failure to maintain adequate notes related to two entries in relation to one dog in circumstances where Dr Vasilev had followed the standard of notetaking in the practice as set out by the principal veterinary surgeon at the Practice, Mr Irvine.

- The Committee took into account the fact that Dr Vasilev had only worked with Mr Irvine in the United Kingdom and therefore Dr Vasilev's experience of record keeping was limited to his work within that one practice.
- Dr Vasilev had admitted his failures in relation to the clinical notes at an early stage of the proceedings.
- Dr Vasilev had made efforts to avoid repetition in the future by undertaking CPD webinars and research.
- Dr Vasilev had insight into the need to ensure full communication and detailed note taking.

34. In relation to Dr Vasilev, the Committee was satisfied that Dr Vasilev's standard of record keeping was in breach of the Code of Professional Conduct for Veterinary Surgeons and that the breach of the Code amounted to professional misconduct.

35. The Committee concluded that the breaches overall when considering the context and number of mitigating factors were in the Committee's view insufficient to amount to serious professional misconduct.

36. The Committee therefore found that its findings on charge 1(iv)(a) and charge 1(iv)(b) although falling below the standard to be expected of a reasonably competent veterinary surgeon did not fall far below the standard to be expected. Accordingly it found Dr Vasilev not guilty of disgraceful conduct in a professional respect.

DISCIPLINARY COMMITTEE
22 OCTOBER 2019