ROYAL COLLEGE OF VETERINARY SURGEONS

INQUIRY RE:

DR KATHARINE SARAH POWER MRCVS (Respondent)

DECISIONS AND REASONS ON DISGRACEFUL CONDUCT IN A PROFESSIONAL RESPECT

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1. Having heard all of the evidence and submissions on the facts, the Committee retired to consider its findings on the facts on 25 November 2022. As there was insufficient time available within the remaining scheduled hearing time to write up and hand down its decisions on the facts, the Committee adjourned and announced its decisions on the facts on 20 February 2023. On 20 March 2023, the Committee resumed the case to consider stage 2, namely whether the facts found proved amounted to disgraceful conduct in a professional respect.

College's Submissions on Disgraceful Conduct

2. Mr Mant, on behalf of the College, submitted that the facts found proved did amount to disgraceful conduct in a professional respect. He directed the Committee's attention to the case of *Macleod v RCVS PC 88 of 2005* and submitted that the Respondent's failures fell far below the standard expected of a veterinary surgeon, as identified by Professor Williams. He also drew the Committee's attention to the case of *Calhaem v GMC [2007] EWHC 2606 (Admin)*, in which it was said that negligent acts or omissions can amount to disgraceful conduct if they are particularly serious.

3. In relation to Harvey, Mr Mant submitted that the facts found proved should be considered cumulatively because:

    a. They all formed part of the same course of treatment and

    b. The clinical failings at charges A1(c) and A1(d) were reflective of the Respondent's lack of competence as found proved at charge A1(e).

4. Mr Mant submitted that the Respondent's conduct breached the following requirements of the Code:

    1.2 Veterinary surgeons must keep within their own area of competence and refer cases responsibly.

1.3 Veterinary surgeons must provide veterinary care that is appropriate and adequate.

5. Mr Mant submitted that the aggravating factors included:

    a. Actual injury to the animal: the facts found proved include removal of tissue which should not have been removed and inappropriate placing of a suture, both of which constituted direct injury.

    b. Risk of injury to the animal: performance of surgery which the Respondent was not competent to perform gave rise to serious risk of injury or death. The experts agreed that laryngeal tie-back is a difficult, high-risk procedure.

    c. Financial gain: The Respondent gained financially in that she was paid to perform a procedure that was not within her competence.

    d. The Respondent's position of increased trust and responsibility: she advertised and held herself out as a practitioner who accepted referrals and was competent to perform soft tissue surgery (including laryngeal tie-backs).

6. In relation to Boss, Mr Mant submitted that the facts found proved concerned two discrete issues which should be considered separately, although the failure to provide a report or medical records needed to be assessed against the background of earlier clinical failings.

7. Mr Mant submitted that the excessive period of anaesthesia to which Boss was subjected breached paragraph 1.3 of the Code. In addition, he submitted that the aggravating factors included:

    a. Risk of injury to the animal: the experts agreed that the longer period of anaesthesia gave rise to an increased risk of complications and death.

    b. The Respondent's position of increased trust and responsibility.

Submissions on behalf of the Respondent

8. Mr Jamieson, on behalf of the Respondent, submitted that those facts which the Committee had found proved did not amount to disgraceful conduct in a professional respect. He invited the Committee to recognise that the position at the outset of the case was very different to how it had ended up. He pointed out that the College had alleged very serious deficiencies in respect of the Respondent's probity, professional standards, and regard for those animals in her care and their owners, all of which had been found not proved. He submitted that the charges which were found proved by the Committee were clinical failings and one charge which amounted to failing to supervise an administrative function.

9. In relation to the charge of undertaking surgery in respect of Harvey, which was outside her competence, Mr Jamieson submitted that whilst the Respondent's ultimate performance of the surgery had caused her to reflect retrospectively that she had lacked the competence to perform it, it was not apparent to her at the time, and her then-held belief that she was competent had been reasonable. Mr Jamieson submitted that this was not a case of a veterinary surgeon deliberately or recklessly acting outside of their capabilities, rather it was a case where a diligent and responsible veterinary surgeon had fallen short in discrete areas of her clinical practice.

Decision and reasons of the Committee on Disgraceful Conduct in a Professional Respect

10. The Committee had regard to the written and oral submissions of both parties. It heard and accepted the advice of the Legal Assessor. The Committee understood that the test for considering whether behaviour amounts to disgraceful conduct in a professional respect, is whether the veterinary surgeon falls far short of what is expected of a member of the veterinary profession and that this decision is a matter for its independent judgement. The Committee bore in mind that not every breach of the Code will necessarily amount to disgraceful conduct in a professional respect.

11. In relation to A1(c), the Committee had regard to the evidence of Professor Hall which stated: *"Whilst it is best practice to perform radiographs to review for causative, concurrent or disease resulting from laryngeal paralysis, this is not essential to diagnosis or in making a decision to operative* [sic]*".* The Committee considered that the Respondent's failure represented a missed opportunity to re-evaluate her decision to move to laryngeal tie-back surgery. The Committee noted that the Respondent had admitted this charge and so had not challenged Professor Williams's opinion that she should have carried out pre-operative chest x-rays as a matter of course to assess for aspiration pneumonia. In consequence, the Committee considered where, on the scale of seriousness this failure fell.

12. The Committee noted that the surgery had been cancelled and re-scheduled a number of times, and the nature of the written communications between Mrs TC and the Respondent was to the effect of Mrs TC questioning whether Harvey really needed the surgery, as opposed to identifying that there had been a change or worsening of the symptoms which Harvey was experiencing. Given that the evidence did not suggest a change or deterioration in Harvey's condition since the light-plane endoscopy, the Committee did not consider that the failure to undertake pre-operative radiographs on this occasion was a significant failing. In all the circumstances, whilst the Committee was of the view that this was a failure which fell below the standard expected, it did not, in the Committee's judgement, fall far below the expected standard.

13. In relation to charge A1(d), the Committee noted its findings of fact to the effect that the dissection of excessive tissue and inappropriate placing of sutures resulted in a failure to provide appropriate and adequate care for Harvey. In the Committee's view, these were surgical mistakes, which, as Professor Williams opined, led to his conclusion that the surgery had not been performed appropriately. The question for the Committee was whether these surgical mistakes fell so far short of the standard expected, that they amounted to disgraceful conduct in a professional respect. The Committee bore in mind that the Respondent had previously undertaken relevant training, namely the Certificate in Small Animal Surgery; had previously practised the surgery on a number of cadavers and had successfully performed left-sided tie-back surgery on live animals before. The Committee also noted that the Respondent had, at the completion of the surgery on Harvey, sought the opinion of a fellow veterinary surgeon, Dr RD, regarding the placement of the sutures [1]and he had not raised any concerns at that time.

[1] By way of clarification this means checking the lateralisation of the aryenoid cartilage from an intraoral viewpoint

14. The Committee considered that the Respondent's surgical mistakes were a matter of poor judgement by her. It appeared to the Committee that they had stemmed from her not fully appreciating the technical challenge of performing laryngeal tie-back surgery on the right-hand side as opposed to the left-hand side, which is by far the most frequent surgical approach, as unilateral left-sided paralysis is the more common clinical presentation. The Committee considered that the Respondent's surgical mistakes fell short of the standard expected of a member of the veterinary profession, but did not fall far short of that standard.

15. In relation to A1(e), the Committee had regard to the Respondent's admission that although she had thought she was capable of performing the right-sided tie-back surgery at the time, she accepted in hindsight that the surgery was, in fact, outside her competence. The Committee noted its conclusions at the fact finding stage, when it was considering the issue of whether her then-held belief that she was competent was genuine and reasonable in the circumstances. It had regard to its finding at the fact finding stage that it had been satisfied that it was not unreasonable for the Respondent to have considered herself competent to carry out the surgery at the time.

16. The Committee noted that when the post graduate Certificate in Small Animal Surgery was taught to veterinary surgeons, tie-back surgery was one of the elements which was covered. It appeared to the Committee that there was an expectation that a veterinary surgeon who had successfully completed the course would, in turn, go on to perform such surgery, as had been the position for Dr RD. In the Committee's judgement, in light of its conclusions at the fact finding stage, the Respondent had not acted recklessly with regard to her capabilities nor with a disregard to animal welfare. On the contrary, the Committee considered that the Respondent had been conscientious in her correspondence with Ms TC, accepting a number of cancellations and re-arranging the surgery to accommodate Mr and Mrs TC's wishes for Harvey. In the Committee's judgement, whilst the Respondent's actions in carrying out the surgery when it was outside her competence fell below the standard to be expected, they did not fall far below that standard in these particular circumstances.

17. Having considered the facts proved in respect of Harvey individually, given how closely linked they were, the Committee went on to consider whether, collectively, they fell far below the standard expected. In this regard, the Committee considered paragraphs 1.2 and 1.3 of the Code:

> 1.2 – Veterinary surgeons must keep within their own area of competence and refer cases responsibly;
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> 1.3 – Veterinary surgeons must provide veterinary care that is appropriate and adequate.

18. In relation to paragraph 1.2, the Committee was mindful that it had not found proved the allegation that the Respondent failed to offer a referral or give adequate consideration to making a referral in respect of Harvey. Whilst the Committee had found that the Respondent had not kept to her own area of competence, it considered that her culpability was much reduced by the fact that she had genuinely and not unreasonably considered that she was competent to carry out the surgery at the time. In relation to paragraph 1.3, the Committee bore in mind its finding that the performance of the surgery had not been appropriate or adequate, as it had resulted in excessive tissue dissection and inappropriate placing of sutures. However, whilst the surgery had been poorly executed, the Committee was mindful of the additional complexities involved in performing right-sided tie-back surgery. Consequently, it concluded that whilst the Respondent had breached paragraphs 1.2 and 1.3, her actions in so doing did

not fall so far below the standard expected as to amount to disgraceful conduct in a professional respect.

19. In relation to B3(a), the Committee considered the circumstances in which the Respondent had come to treat Boss under anaesthetic. It noted that this was not elective treatment, but arising out of an emergency, because Boss had a foreign body trapped in his oesophagus, and it had been there for over 24 hours by the time he was taken to the Respondent's practice. Boss had arrived at the Respondent's practice, Vets 1, at around midnight. The Committee noted that Boss was transferred to Vets 1 because Dr MH knew that the practice had diagnostic equipment, which was not available at the Best Friends practice.

20. The Committee considered that for the period of time that Boss was under anaesthetic, he was insensible to pain, and therefore was not in distress or discomfort. It noted that aside from the excessive length of time that Boss was under anaesthetic, the evidence did not suggest that the anaesthesia itself was executed inappropriately or contributed to the complications of wound dehiscence or pneumothorax. In the Committee's judgement, the Respondent's motivation for persisting with endoscopy whilst Boss was under anaesthetic, was well intentioned, in that it was with the aim of improving the welfare of the animal.

21. The Committee considered that the Respondent had been trying to achieve a good outcome by retrieving the foreign body without having to resort to oesophagotomy, but in doing so had persisted beyond what was a reasonable length of time. The Committee was of the view that persisting for such a long time was poor judgement on her part, being misled into thinking that she was making reasonable progress because she was retrieving small pieces of the foreign body. However, in the Committee's view, this was not a case of disregarding Boss's welfare or being reckless as to the risk of harm which may result from prolonged use of anaesthetic and nevertheless going on to take that risk.

22. In relation to paragraph 1.3 of the Code, the Committee considered that there had been a breach, as the excessive period of time for which Boss was under anaesthetic did not amount to veterinary care which was either appropriate or adequate. Nevertheless, in the Committee's judgement, the Respondent's culpability stemmed from not realising at an earlier stage that the endoscopy was not going to be successful in retrieving all of the foreign body. In the Committee's view, this fell below the standard expected of a member of the veterinary profession, but it did not fall so far below the standard expected as to amount to disgraceful conduct in a professional respect.

23. In relation to B6, the Committee was mindful that the Respondent had been asked to provide clinical information, and therefore she was under an obligation to provide it. By failing fully so to do, the Committee considered that this was a breach of paragraph 1.6 of the Code as follows:

> 1.6 – Veterinary surgeons must communicate with each other to ensure the health and welfare of the animals or group of animals.

24. The Committee noted that in the circumstances of this case, the failure to provide the information did not have implications for the ongoing welfare of Boss, nor were there any findings that the delay arose from anything other than administrative shortcomings. Whilst the Committee considered that the breach fell below the expected standard, it was not satisfied that it fell far below the expected standard of a member of the veterinary profession so as to amount to disgraceful conduct in a professional respect.

25. The Committee understood that it had a responsibility to consider the wider public interest, taking into account the view of a reasonable member of the public in possession of all the relevant facts and information. The Committee considered that such a member of the public would understand that veterinary surgery is a challenging profession. It was of the view that such a member of the public would not expect perfection, but understand that any professional practitioner may make mistakes in the course of their practice.

26. It is the judgement of this Committee that the Respondent's conduct does not constitute disgraceful conduct in a professional respect.

DISCIPLINARY COMMITTEE
21 March 2023