RCVS | SETTING VETERINARY STANDARDS

ROYAL COLLEGE OF VETERINARY SURGEONS
INQUIRY RE:

DR KATHERINE SARAH POWER MRCVS (Respondent)

DECISIONS AND REASONS ON FINDINGS OF FACT

Charges (annotated to show withdrawn charges)

1. The Respondent faced the following charges:

That, being registered in the Register of Veterinary Surgeons, and whilst in practice at Vets 1, Kings Lynn, Norfolk:

(A) In relation to laryngeal surgery performed by you on 29 March 2018 to Harvey ("the March 2018 surgery"), a Tibetan Terrier belonging to TC, you:

1) Between 29 January 2018 and 1 April 2018, failed to provide appropriate and adequate care to Harvey, more particularly in that you:

a) failed to undertake adequate investigations and/or reviews and/or assessments of Harvey before proceeding to the March 2018 surgery; **NOT PROVED**

b) failed to offer a referral for Harvey and/or to give adequate consideration to such a referral prior to the March 2018 surgery; **NOT PROVED**

c) Failed to undertake pre-operative radiographs before proceeding to the March 2018 surgery; **PROVED**

d) Failed to perform the surgery appropriately in that you ~~(i) made the incision further down the neck then was appropriate~~ **WITHDRAWN BY THE COLLEGE** (ii) dissected excessive tissue; **PROVED** and (iii) inappropriately placed sutures in a position that engaged the left side of the cricoid cartilage; **PROVED**

e) Undertook the March 2018 surgery when it was outside your competence; **PROVED**

f) ~~Failed to ensure that Harvey was hospitalised overnight from 29 March 2018 to 30 March 2018 following the March 2018 surgery~~; **WITHDRAWN BY THE COLLEGE**

g) Discharged Harvey to his owner's care on 29 March 2018 when Harvey was unfit to be so discharged; **NOT PROVED**

2) Between 29 January 2018 and 30 March 2018, failed;

a) adequately to communicate the extent of risks and/or complications of the March 2018 surgery; **NOT PROVED**

b) adequately to communicate the alternative options to the March 2018 surgery; **NOT PROVED**

c) to obtain fully informed consent to the March 2018 surgery; **NOT PROVED**

3) Prior to the surgery, failed to communicate adequately with TC with regards to Harvey and/or exerted undue pressure on TC and/or TC's husband in relation to going ahead with the March 2018 surgery, more particularly in that you:

a) On 30 January 2018, told TC words to the effect that:

(i) there was no such thing as "early-stage" laryngeal paralysis; **NOT PROVED**

(ii) that Harvey had right side laryngeal paralysis and that the left side could "*go at any time*" causing Harvey to die; **NOT PROVED**

(iii) treatment by nonsurgical means was not a realistic option and/or that tie-back surgery was the only option that would work; **NOT PROVED**

(iv) laryngeal tie-back surgery would prevent breathing problems for Harvey; **NOT PROVED**

(v) the surgery would be a simple operation and leave Harvey with a wound and nothing more; **NOT PROVED**

b) On 1 February 2018, sent an email to TC in response to her query regarding how Harvey would be post-operatively, stating:

"*so it should just be a wound on his neck and nothing more";* **NOT PROVED**

c) On 7 February 2018, sent an email to TC stating;

"*There is no other option for laryngeal paralysis. The only option is surgery";* **NOT PROVED**

~~d) On 20 February 2018, sent an email to TC stating that if the March 2018 surgery failed, Harvey would return to how he was before the operation;~~ **WITHDRAWN BY THE COLLEGE**

e) On 21 February 2018, sent an email to TC stating that:

(i) There was not really an early or late stage of laryngeal paralysis; **NOT PROVED** and

(ii) If the surgery failed then Harvey would just be back to the same condition he was pre-surgery; **NOT PROVED**

f) On 29 March 2018, told TC and/or her husband words to the effect that:

(i) Harvey had to have the surgery if TC did not want him to die; **NOT PROVED**

(ii) After the surgery Harvey would never have breathing problems; **NOT PROVED**

(iii) Surgery was the only option; **NOT PROVED**

4) After the surgery, failed to communicate adequately with TC more particularly in that you:

a) On 30 March 2018, told TC that:

i. Harvey did not have aspiration pneumonia; **NOT PROVED** and

ii. You would not undertake post-operative radiographs, despite TC requesting these; **NOT PROVED**

b) On 31 March 2018, told TC that Harvey had had a peaceful night and was on track for recovery, when this was not the case; **NOT PROVED**

~~**5)** Between 1 April 2018 and 12 February 2021 made alterations to the clinical records for Harvey, by way of additions to the records for 31 March 2018;~~ **WITHDRAWN BY THE COLLEGE**

6) Your conduct at 3(f)(i) and/or 4(b) ~~and/or 5 above was~~ above was dishonest; **NOT PROVED**

   ~~a) Dishonest and/or~~

   ~~b) Misleading;~~

~~7) Your conduct at 5 above was:~~

   ~~a) Dishonest; and/~~or **WITHDRAWN BY THE COLLEGE**

   ~~b) Misleading~~ **WITHDRAWN BY THE COLLEGE**

(B) In relation to oesophageal surgery performed by you on or around 6 October 2018~~-~~(“the October 2018 surgery”) to Boss, a boxer dog belonging to HS, you:

1) Between 5 October 2018 and 6 October 2018, failed:

   a) to obtain fully informed consent for the October 2018 surgery; **NOT PROVED**

   b) adequately to communicate the extent of risks and all complications of the October 2018 surgery; **NOT PROVED**

   c) adequately to communicate alternative options to the October 2018 surgery; **NOT PROVED**

   d) adequately to communicate the outcome of the October 2018 surgery and/or Boss’ condition after the surgery; **NOT PROVED**

2) In relation to a CT scan of Boss’ oesophagus on 6 October 2018 before the October 2018 surgery:

   a) failed to seek appropriately skilled assistance with regards to interpretation of the said scan; **NOT PROVED**

   b) told HS that you would seek appropriately skilled assistance with regards to interpretation of the said scan but failed to do so; **NOT PROVED**

   c) failed to identify oesophageal changes visible on the said scan; **NOT PROVED**

   d) failed to inform HS of the oesophageal changes visible on the said scan and/or inform HS of the increased risks associated with those changes if Boss were to have the October 2018 surgery; **NOT PROVED**

3) On or around 5 and/or 6 October 2018, failed to provide appropriate and adequate care to Boss, more particularly in that you:

a) subjected Boss to an excessive period of anaesthesia; **PROVED**

b) having failed to retrieve by oesophagoscopy a foreign body in Boss' oesophagus, failed to give adequate consideration to and/or offer other treatment options and/or referral for Boss prior to commencing the October 2018 surgery; **NOT PROVED**

c) ~~undertook the October 2018 surgery when it was outside your competence~~; **WITHDRAWN BY THE COLLEGE**

~~d) failed to place a thoracostomy tube and/or a gastronomy following oesophagotomy;~~ **WITHDRAWN BY THE COLLEGE**

~~4) Between 6 October 2018 and 31 October 2018, made clinical notes for Boss indicating that he had sustained an iatrogenic pneumothorax during the surgery and that he would be cared for by veterinary surgeons RD and AM on 6 October following the October 2018 surgery when:~~

~~a) you did not on 6 October 2018 inform either HS or RD (the veterinary surgeon taking over Boss's care from you) that Boss had sustained an iatrogenic pneumothorax, and you therefore:~~

~~i. failed to communicate fully and openly with HS and/or RD;~~ **WITHDRAWN BY THE COLLEGE**

~~ii. failed to provide adequate and appropriate care to Boss by ensuring HS and RD were fully informed as to his condition;~~ **WITHDRAWN BY THE COLLEGE** ~~or~~

~~b) You were not aware that Boss had sustained an iatrogenic pneumothorax at the point when care was handed over to RD, and your clinical notes were therefore~~

~~i. misleading and/or~~ **WITHDRAWN BY THE COLLEGE**

~~ii. dishonest;~~ **WITHDRAWN BY THE COLLEGE**

~~5) Failed to make adequate clinical records for Boss;~~ **WITHDRAWN BY THE COLLEGE**

6) Between 5 October 2018 and 31 October 2018, failed to provide a referral report and/or clinical records for Boss to Best Friends Holbeach veterinary practice following its referral of Boss to you on 5 October 2018, despite requests for the same; **PROVED**

AND that in relation to the above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect.

College applications to withdraw charges

At the outset of the hearing

2. At the outset of the hearing, on 7 November 2022, Mr Mant, on behalf of the College, applied to withdraw the following charges: (A)(3)(d); (A)(6); (B)(3)(d); (B)(4); and (B)(5).

3. In relation to charge (A)(3)(d), Mr Mant explained that this had been added in error, as there was no 20 February 2018 email. Mr Jamieson, on behalf of the Respondent, did not object to the application to withdraw.

4. In relation to charge (A)(6), Mr Mant explained that he wished to amend the charge to the extent that the allegation of misleading was withdrawn in respect of (A)(3)(f)(i) and (A)(4)(b), and a new charge (A)(7) would allege that the conduct at (A)(5) was dishonest and/or misleading. Mr Mant submitted that the stem of the allegations in (A)(3) and (A)(4), which both alleged a failure to communicate adequately, encompassed misleading and so it did not need to be separately charged. Mr Jamieson did not object the application.

5. In relation to charge (B)(3)(d), (B)(4), and (B)(5), Mr Mant explained that the College was withdrawing these charges having considered the Respondent's evidence, in particular that of the expert instructed on her behalf. Mr Jamieson did not object to the application.

6. Having heard and accepted the advice of the Legal Assessor, the Committee decided to allow Mr Mant's application to withdraw the charges as set out. It was satisfied that there would be no injustice to the Respondent in allowing the application.

At the close of the College's case

7. At the close of the College's case, on 22 November 2022, Mr Mant withdrew charges (A)(5) and (A)(7) in light of the evidence given by Dr Dudley regarding when he had printed out the clinical records for Harvey. Mr Mant conceded that the College could not prove whether or not the additions may have been made later on 31 March 2018. Mr Mant also withdrew charge (A)(1)(d)(i). He explained that the evidence indicated that the incision was made caudally and not ventrally, which, he conceded would not be a failure in care. Mr Jamieson did not object to the application.

8. Having heard and accepted the advice of the Legal Assessor, the Committee agreed to Mr Mant's application. It was satisfied that the evidence adduced by the College was insufficient to support the charges.

At the close of all the evidence

9. At the close of all the evidence, Mr Mant withdrew charges (A)(1)(f) and (B)(3)(c).

10. In relation to charge (A)(1)(f), Mr Mant, in his closing submissions, explained that the College's case in respect of this charge had been that it was always necessary to

hospitalise dogs post tie-back surgery. In evidence, Professor Williams, the expert called on behalf of the College, accepted that it was not mandatory in all cases. Mr Jamieson supported the application.

11. In relation to charge (B)(3)(c), Mr Mant, in his closing submissions, explained that in his evidence, Professor Hall, the expert witness for the Respondent, was of the opinion that there was no evidence of incompetence demonstrated in the October 2018 surgery by the Respondent. In cross examination, Dr Hattersley, the veterinary surgeon who had taken over the care of Boss, accepted that she did not criticise the manner of the surgery which had been performed by the Respondent. Mr Jamieson supported the application.

12. Having heard and accepted the advice of the Legal Assessor, the Committee was satisfied that the expert evidence adduced by the College was insufficient to support these charges.

College application to add a new allegation

13. At the outset of the case, Mr Mant applied to add a new charge (A)(1)(h), to allege that the Respondent "undertook the March 2018 surgery at a time when surgery was not clinically indicated or appropriate".

14. Mr Mant, on behalf of the College, submitted that it was implicit within charges (A)(1)(a) and (A)(2)(b) that it would be necessary to look at the clinical treatment given to Harvey in the context of what was standard. He submitted that the addition of the charge would provide clarity as a separate and distinct matter, given the overriding duty of the Committee to have regard to the public interest in the promotion of animal welfare. He submitted that the Respondent's own expert, Professor Hall, had considered the clinical treatment given to Harvey when giving his opinion on charge (A)(1). Mr Mant submitted that there would be no prejudice to the Respondent if the addition were permitted.

15. Mr Jamieson, on behalf of the Respondent, objected to the application. Whilst he accepted that adding a charge would be within the Committee's general powers, he submitted that such a late application would cause injustice to the Respondent and should not be permitted. He submitted that there was no reason for the lateness of the application, pointing out that the charges dated back to 2018 and there had been a Case Management Conference (CMC) on 17 October 2022. Mr Jamieson submitted that the additional proposed charge would add complexity to the case but add nothing to the substance. Mr Jamieson submitted that the additional proposed charge would change the way in which the case was put, and it would be unfair to the Respondent to adjust the charges at the door of the hearing.

16. The Committee heard and accepted the advice of the Legal Assessor. It considered that the application was very late, noting that the charges dated back to 2018. It considered that the current charges were already complicated and the proposed addition would not, in the Committee's view, add clarity. The Committee agreed with Mr Jamieson that the proposed addition would alter the way in which the case was

put. Consequently, it considered that the Respondent would need to time to consider its significance if permitted, potentially adding significant further delay, which would be unfair to the Respondent. The Committee was satisfied that the current charges covered the thrust of the evidence, and therefore addressed the public interest in the promotion of animal welfare. Accordingly, the Committee refused Mr Mant's application to add a charge (A)(1)(h).

Background

17. The Respondent qualified as a veterinary surgeon in 2009. She is the owner of Vets One (the Practice), which she set up with her husband, SP (not a qualified veterinary surgeon), in 2013. The Practice started as a farm animal practice but developed into a small animal practice. The Respondent obtained the Certificate in Small Animal Surgery in late 2017 and started accepting referrals (for surgery) in 2018.

18. The inquiry concerns the Respondent's treatment of two dogs:

    - Harvey, a Tibetan Terrier, who, on 29 January 2018, was diagnosed by the Respondent as having right-sided laryngeal paralysis. He underwent tie-back surgery, carried out by the Respondent, on 29 March 2018; and

    - Boss, a Boxer dog, who underwent endoscopic and surgical procedures for retrieval of a foreign body on 6 October 2018.

<u>Harvey</u>

19. Mrs TC and Mr TC were the owners of the Tibetan terrier dog named Harvey, who they had owned since he was a puppy. Harvey was around 10 years old in August 2017, when Mrs TC first noticed that Harvey's bark had changed, as if he had a sore throat.

20. On 13 January 2018, Mrs TC took Harvey to the Practice reporting concerns about the changed bark. Harvey was examined by Dr Edward Johnson, a qualified veterinary surgeon at the Practice, and booked for an endoscopy.

21. On 30 January 2018, Mrs TC took Harvey to the Practice for endoscopy under a light plane of anaesthesia (light plane endoscopy). The procedure was performed by the Respondent who diagnosed right-sided laryngeal paralysis and booked Harvey for surgery.

22. Professor Williams explained that in simple terms the larynx is a cylindrical-like structure at the cranial end of the trachea and situated at the back of the pharynx. It acts as a valve for air inflow and outflow and prevents accidental inhalation of food or fluids.

23. Between 30 January 2018 and 29 March 2018, emails and telephone calls were exchanged between Mrs TC and the Respondent about Harvey, including the necessity and appropriateness of surgery. Mrs TC cancelled and rescheduled the

surgery a number of times. The email correspondence between the two included the following:

- 30 January 2018 – a telephone call between Mrs TC and the Respondent in which it is alleged the Respondent told Mrs TC the matters alleged in charge (A)(3)(a)(i) to (v);

- 1 February 2018 – an email sent by the Respondent to Mrs TC in response to Mrs TC's query regarding how Harvey would be post-operatively, as alleged in charge (A)(3)(b);

- 7 February 2018 – an email sent by the Respondent to Mrs TC stating that there was no other option for laryngeal paralysis and that the only option was surgery, as alleged in charge (A)(3)(c); and

- 21 February 2018 – an email sent by the Respondent to Mrs TC stating the matters alleged in charge (A)(3)(e)

24. On 29 March 2018, Mrs TC and Mr TC took Harvey to the Practice for the tie-back surgery, arriving at around 1pm. It is alleged that before surgery, while in the waiting room, the Respondent told Mrs TC and Mr TC words to the effect that Harvey had to have the surgery if they did not want him to die; that after the surgery Harvey would never have breathing problems; and that surgery was the only option.

25. On that same day, 29 March 2018, the Respondent performed right laryngeal tie-back surgery on Harvey. In respect of the surgery itself, it is alleged that the Respondent failed to perform the surgery appropriately in that she dissected excessive tissue and inappropriately placed sutures in a position which engaged the left side of the cricoid cartilage. It is further alleged that the Respondent undertook this surgery when it was outside of her competence.

26. Later that same day, at around 7pm on 30 March 2018, Harvey was discharged home back to Harvey's owners. It is alleged that the Respondent failed to ensure that Harvey was hospitalised overnight following the surgery and that she discharged Harvey home to his owners' care when he was unfit to be discharged. At home, Mrs TC and Mr TC contacted the Practice raising concerns about Harvey's breathing; they also took a video of his laboured breathing, taken some time after he was discharged. At around 11pm Harvey was re-admitted to the Practice and was received by Dr Robert Dudley. Overnight, Dr Dudley, a veterinary surgeon employed by the Respondent at the Practice, undertook left laryngeal tie-back surgery.

27. On the morning of 31 March 2018, the Respondent spoke to Mrs TC in a telephone call. It is alleged that in this call, the Respondent said that Harvey had had a peaceful night and was on track for recovery. It is alleged that this statement and the statement to the effect that if Harvey did not have the surgery he would die, were untrue and so by saying them to Harvey's owners, the Respondent's actions were dishonest.

28. On 31 March 2018, Harvey was transferred to Dick White Referrals (DWR) veterinary surgery, where he underwent further treatment performed by Dr Rachel Hattersley. The further treatment included a permanent tracheostomy.

<u>Boss</u>

29. HS, a qualified veterinary nurse, was the owner of Boss, a nine year old Boxer dog that she had had since a puppy. On 5 October 2018, at about 1pm, HS gave Boss a "Whimzee" dental chew, which was in the shape of a toothbrush. She had given Boss such chews before and at the time noticed nothing out of the ordinary. During the evening, HS noticed that Boss gulped a couple of times as if trying to swallow and did not eat his dinner, but she did not think anything more of it.

30. The next day, 6 October 2018, Boss did not eat his breakfast or dinner. At around 7pm HS gave Boss some bread which he tried to eat but could not and was salivating quite heavily. At around 8pm, HS contacted a vet at the practice where she worked in Holbeach, Moritz Huber, who agreed to examine Harvey. Harvey was assessed at around 9:10pm, and Moritz Huber advised that Harvey needed to be examined further with diagnostic equipment which was not available at the Holbeach Practice. He therefore referred Boss to the Respondent's Practice. HS arrived at the Practice with Boss at around 10:30pm.

31. On arrival at the Practice, the Respondent examined Boss and proposed an x-ray as a first step. HS signed a consent form in respect of Boss, dated 6 October 2018.

32. On 7 October 2018, the chronology is as follows:

    - At around midnight, Boss was placed under a general anaesthetic;
    - At around 12:30am, an x-ray was taken, and the Respondent discussed the results with HS, stating she was concerned about a possible mass and proposed a CT scan;
    - HS left the Practice to return home at around 12:44am;
    - Between 1-1:20am, Boss underwent a CT scan;
    - The Respondent interpreted the CT images herself without referral to a specialist, and identified a foreign body;
    - The Respondent proceeded to use an endoscope to try to remove the foreign body;
    - Between 2am and 7am, the Respondent continued her attempts to remove the foreign body endoscopically;
    - The Respondent decided to proceed to surgery and at 7:10am the operation commenced;
    - At 8:55am, Boss was taken for post-surgery x-rays;
    - At 9:35am, Boss was taken off the general anaesthetic;
    - At around midday, veterinary surgeon, Dr Robert Dudley arrived at the Practice and took over from the Respondent. Boss started to deteriorate and x-rays showed a pneumothorax which Dr Dudley was unable to resolve;
    - At around 8:20pm, Dr Dudley transferred Boss to DWR where Boss received emergency treatment.

33. On 16 October 2018, HS authorised Boss to be euthanised after nine days of intensive treatment at DWR.

Summary of Evidence

34. The College called the following witnesses in support of its case:

- Mrs TC, joint owner of Harvey, together with her husband;

- Mr TC, joint owner of Harvey, together with his wife;

- Dr Robert Dudley BVetmed PgC(SAS) PgC(SAC) MRCVS, a veterinary surgeon, who qualified in 2014 and joined the Respondent's Practice in August 2017 as a salaried partner. He was involved in taking over Harvey's care from the Respondent after the right-sided tie-back surgery performed by the Respondent. When Harvey's condition deteriorated, he performed a second tie-back surgery on Harvey's left side. He also performed an emergency tracheostomy before referring Harvey to DWR. He was also involved in Boss's care, having been asked to attend the Practice to take over from the Respondent. As Boss's condition deteriorated, Dr Dudley continued to monitor and provide care. He was involved in liaising with the owner and DWR and the transfer of Boss's care to DWR;

- Dr Edward Johnson, BVM&S MRCVS, a veterinary surgeon who qualified in 2016 and joined the Respondent's Practice in May 2017. He was the veterinary surgeon who examined Harvey on 13 January 2018 and recommended the endoscopy to check Harvey's larynx as Dr Johnson was concerned about the possibility of laryngeal paralysis;

- HS, the owner of Boss, and also a qualified veterinary nurse (RVN);

- Dr Rachel Hattersley, BVetMed(Hons) CertSAS DipECVS MRCVS, a specialist veterinary surgeon who qualified as an MRCVS (Member of the Royal College of Veterinary Surgeons) in 2003 and as a diplomate of the ECVS (European College of Veterinary Surgeons) in 2012.Since March 2018 she had worked at DWR employed as a specialist in small animal surgery working within the soft tissue surgery team. Dr Hattersley was involved in the care and treatment of both Harvey and Boss following their surgery at the Respondent's Practice;

- EB, a registered veterinary nurse (RVN), who qualified in 2018 and registered with the College in March 2019. She had been employed by the Respondent's Practice since February 2018 and was involved in the care of Boss. On Saturday 6 October 2018, after she had left the Practice at around 8:30/9pm, she was called back to the Practice. EB was the veterinary nurse assisting the Respondent with Boss's anaesthesia for the duration of the endoscopic procedure and surgery;

- Dr Moritz Huber BVSc MRCVS, a veterinary surgeon who qualified in 2016, and registered with the College in 2018 when he came to the United Kingdom. He was the sole veterinary surgeon at the Holbeach Practice where HS also worked as a registered veterinary nurse. He first examined Boss on the evening of 6 October 2018 and suspected a foreign body was present. He considered that further investigations were required to confirm it, which the Holbeach Practice was not equipped to undertake and the referral was made to the Respondent's Practice;

- Professor Williams MA VetMB LLB CertMedLaw CertVR DipECVS and fellow of the Royal College of Veterinary Surgeons (FRCVS). He is a College recognised Specialist in Small Animal Soft Tissue Surgery and recognised European Specialist in Small Animal Surgery. He is the veterinary surgeon instructed on behalf of the College to provide an expert opinion on the standard of care and treatment provided to both Harvey and Boss.

35. The College provided a bundle of evidence in support of its case, which included the following:

    - Statements of witnesses not called, including veterinary nurses at the Practice;
    - Consent forms relating to Harvey for 30 January 2018 and 29 March 2018;
    - Videos with audio for Harvey before surgery and after surgery;
    - The Practice's animal history and clinical notes relating to Harvey;
    - Email correspondence between the Practice and Mrs TC;
    - DWR's diagnostic imaging and clinical notes relating to Harvey;
    - DWR letter from Dr Hattersley to the Practice relating to Harvey;
    - Dr Hattersley's surgical report, dated 1 April 2018, in respect of her surgical procedure on Harvey;
    - The Holbeach Practice's animal history and clinical notes relating to Boss;
    - The Practice's consent form relating to Boss, dated 6 October 2018;
    - The Practice's animal history and clinical notes relating to Boss;
    - X-rays and CT images taken of Boss while at the Practice;
    - DWR's consent form relating to Boss, dated 7 October 2018; and
    - Relevant email correspondence.

36. The Respondent called the following witnesses in support of her case:

    - Dr Katherine Power BVetMed PgC GPAdvCert(STS) MRCVS, the Respondent, a veterinary surgeon who qualified in 2009 and in 2013 set up the Practice with her husband;

    - SP, the Respondent's husband, a non-clinical Director at the Respondent's Practice. He and the Respondent set up the Practice together in 2013 and at the relevant time was the Commercial Director at the Practice;

    - CJ, a positive character referee who was a pet owner who had previously taken animals for treatment at the Respondent's Practice;

- Professor Hall MA VetMB CertSAS DipECVS SFHEA (Senior Fellow of the Higher Education Academy) FRCVS. He is the expert instructed on behalf of the Respondent.

37. The Committee heard and accepted the advice of the Legal Assessor.

<u>Standard of Competence</u>

38. At the outset of its deliberations, the Committee considered the standard of competence by which to assess the Respondent. The question arose as to whether she should be assessed with reference to the standards to be expected of a reasonably competent veterinary surgeon in general practice, or to a higher standard either because she held the Certificate in Small Animal Surgery or ran a referral practice.

39. The Committee noted that whilst the RCVS maintained a register of specialist veterinary surgeons, it did not maintain a similar register for a referral centre veterinary surgeon. Therefore, the Committee was of the view that whilst a referral centre might have an implied higher level of proficiency, this was not borne out in the College's registration requirements. The Committee bore in mind that the Respondent was qualified as a veterinary surgeon, with a Certificate in Small Animal Surgery. The Committee did not consider that by virtue of this certificate, it would be fair to hold her to a higher standard of competence. Consequently, the Committee concluded that the appropriate standard of competence by which to assess the Respondent was that to be expected of a reasonably competent veterinary surgeon.

(A) Harvey

40. At the start of its deliberations in respect of Harvey, the Committee noted the common ground between the parties as follows:

    - Both experts agreed that tie-back surgery was generally a salvage procedure;
    - It would be very unusual to have unilateral right-sided laryngeal paralysis;
    - The Respondent had subsequently accepted that she was not competent to carry out the tie-back surgery;
    - The Respondent accepted that she had not performed the tie-back surgery itself appropriately, having dissected excessive tissue and having placed the sutures inappropriately; and
    - Mrs TC was a concerned dog owner who was extremely worried about the risks to Harvey.

In relation to laryngeal surgery performed by you on 29 March 2018 to Harvey ("the March 2018 surgery"), a Tibetan Terrier belonging to TC, you:

1) Between 29 January 2018 and 1 April 2018, failed to provide appropriate and adequate care to Harvey, more particularly in that you:

41. The Committee had regard to the stem of charge 1, and that in respect of each example cited within the sub-charges, the overall allegation was that the Respondent had failed to provide appropriate and adequate care to Harvey. The Committee took account of the legal advice which had been provided in respect of charges where a failure was alleged, namely that it was an allegation that the Respondent was under a duty to act in a certain way but did not do so.

a) failed to undertake adequate investigations and/or reviews and/or assessments of Harvey before proceeding to the March 2018 surgery;

42. The Committee finds charge A(1)(a) not proved.

43. Mrs TC gave evidence to the Committee that there had never been any suggestion to her of further scoping or other tests or x-rays to confirm the diagnosis of right-sided laryngeal paralysis.

44. Professor Williams, the expert instructed by the RCVS, gave evidence that tie-back surgery, regardless of when it was performed, was always a salvage operation, and a cough alone was not, in his opinion, an indication for surgery. He said that right-sided laryngeal paralysis on its own was extremely rare, and laryngeal paralysis would usually start on the left side and might progress to bilateral laryngeal paralysis. Accordingly, surgery, even in bilateral cases, would ordinarily first be performed on the left-side. Therefore, in his opinion, the Respondent's diagnosis of such an unusual condition ought to have prompted her to carry out further investigations to determine the underlying cause. It was his view that in undertaking surgery on the right-hand side based on what the Respondent saw at the initial endoscopic examination, with no further investigation, the Respondent fell far below the standard to be expected of a reasonably competent veterinary surgeon.

45. Professor Hall, the expert instructed on behalf of the Respondent, stated that laryngeal paralysis was not a reversible condition, and once the diagnosis was made (if accurate), it was his opinion that there was little benefit in repeated examination. He was also of the view that light plane endoscopy was the key diagnostic test for ascertaining whether or not a dog had laryngeal paralysis.

46. The Committee noted that the light plane endoscopy had taken place on 29 January 2018, but the surgery, which had been cancelled several times due to Mrs TC's anxiety over surgery, took place on 29 March 2018, some two months after the initial diagnosis. The Committee bore in mind that the Respondent had recently obtained a certificate in small animal surgery in 2017 (the PGC GP Cert (SAS)) and would have expected the Respondent to have realised that unilateral right-sided laryngeal paralysis was extremely rare, although her evidence was that she did not realise this.

47. The Committee noted that both Professor Williams and Professor Hall, together with Dr Rachel Hattersley had all told the Committee that they would have carried out a further endoscopy (re-scoped) on the day of surgery due to the two month lapse between diagnosis and surgery. It was apparent to the Committee that by not re-scoping, the Respondent had missed a potential opportunity to check whether her

initial diagnosis was, in fact, accurate and to re-evaluate the dog's condition, especially as laryngeal paralysis is a progressive disease.

48. The Committee considered that on the day of surgery, the evidence indicated that there were no further clinical signs to put the Respondent on notice that she ought to re-scope or carry out further testing or review her initial diagnosis before surgery. Whilst the Committee was of the view that it might have been prudent to undertake a further scoping on the day of surgery, given the amount of time which had elapsed since the light plane endoscopy in January 2018, it did not consider that made the initial investigations inadequate. The Committee, therefore, was not satisfied so that it was sure, that the Respondent was under a duty to carry out further investigations, reviews or assessments. Accordingly, the Committee was not satisfied to the required standard that the College had proved that the Respondent had failed to undertake adequate investigations, reviews or assessments before proceeding to surgery.

b) failed to offer a referral for Harvey and/or to give adequate consideration to such a referral prior to the March 2018 surgery;

49. The Committee finds charge A(1)(b) not proved.

50. The Committee bore in mind the evidence of Professor Hall, instructed on behalf of the Respondent, to the effect that if an owner requested a referral then they should not be declined. It noted that this position was also set out in the RCVS Code Service Supporting Guidance: Referrals and Second Opinions. Therefore, if the Committee was satisfied so that it was sure that Mrs TC had requested a referral and the Respondent had declined to accede to the request, then the charge would be made out.

51. The Committee considered that this allegation rested on the credibility of Mrs TC's account of the discussions she had with the Respondent about referral. The Committee was mindful that Mrs TC was recounting discussions which would have occurred some four years earlier. Mrs TC had told the Committee of her research for information on the internet, including her involvement with an online forum. It was apparent to the Committee that she had been reliant on the opinions and views of the members of the forum with whom she had interacted. The Committee also considered that there were some inconsistencies between Ms TC's oral evidence and her witness statement, and her recollection now may not necessarily be reliable.

52. Given these observations, the Committee considered that it was important to treat Mrs TC's evidence with caution and not simply rely upon her uncorroborated account, but to look to see where it was supported by contemporaneous documentation or other independent evidence. The Committee had the benefit of reading many of the email exchanges between Mrs TC and the Respondent between January and March 2018. It noted that there was nothing in the emails which supported Mrs TC's account that she had been concerned to refer Harvey to a more specialised veterinary surgeon. It also considered that the tone of the emails between them was far more measured than the telephone conversations or in person conversations, which Mrs TC had described. The Committee noted Mrs TC's oral evidence in which she had said that

on the day of surgery she had asked whether Harvey should be referred. The Committee was of the view that this was distinct from requesting a referral.

53. The Committee had regard to the evidence of the Respondent. She told the Committee that had Mrs TC asked for a referral she would have referred Harvey, but no referral was requested. The Respondent also told the Committee that at the time she had considered herself competent to carry out the surgery, as she had previously carried out left-sided laryngeal tie-back surgery successfully, although she had subsequently come to appreciate that she had not been competent to perform the right-sided tie-back procedure. The Committee preferred the Respondent's evidence over that of Mrs TC in this regard.

54. The Committee considered that if the Respondent had been competent to carry out the surgery or had genuinely considered herself to be competent to carry it out, then there was no duty on her to refer Harvey's case if referral was not requested. The Committee therefore considered whether the Respondent's belief at the time that she was competent, was genuine and reasonable in the circumstances. It noted that she had been awarded the Certificate in Small Animal Surgery, as well as practising the surgery on cadavers. The Committee was not satisfied that it was unreasonable for the Respondent to have considered herself competent to carry out the surgery at the time.

55. In all the circumstances, the Committee was not satisfied to the required standard that the College had proved that the Respondent had failed to offer a referral for Harvey or to give adequate consideration to such a referral prior to the March 2018 surgery.

c) Failed to undertake pre-operative radiographs before proceeding to the March 2018 surgery;

56. The Committee finds charge A(1)(c) proved.

57. In reaching this finding, the Committee took account of the Respondent's admission that she had failed to undertake pre-operative radiographs before proceeding to the March 2018 surgery and that this amounted to a failure to provide appropriate and adequate care to Harvey. In light of the Respondent's admissions, the Committee considered that there was no challenge to the expert, Professor Williams, that the Respondent should have carried out a pre-operative chest x-ray as a matter of course, to assess for aspiration pneumonia.

d) Failed to perform the surgery appropriately in that you (ii) dissected excessive tissue; and (iii) inappropriately placed sutures in a position that engaged the left side of the cricoid cartilage;

58. The Committee finds charge A(1)(d)(ii) and (iii) proved.

59. In reaching this finding, the Committee took account of the Respondent's admissions that she had failed to perform the surgery appropriately in that she had both dissected excessive tissue and had inappropriately placed sutures in a position that engaged the left side of the cricoid cartilage. It also took account of her admissions that her

failure to perform the surgery appropriately amounted to a failure to provide appropriate and adequate care to Harvey. In light of the Respondent's admissions, the Committee considered that there was no challenge to the evidence of Dr Hattersley that the suture was identified as passing through the left wall of the larynx and that the anatomy on the right hand side was significantly disrupted, suggestive of excessive tissue dissection. It also concluded from the Respondent's admissions that there was no challenge to Professor Williams' opinion that, as a result, the only conclusion was that she had not performed the surgery appropriately.

(e) Undertook the March 2018 surgery when it was outside your competence;

60. The Committee finds charge A(1)(e) proved.

61. In reaching this finding, the Committee had regard to the Respondent's admission that although she had thought she was capable to perform this tie-back surgery at the time, she accepted in hindsight that the surgery was, in fact, outside of her competence.

g) Discharged Harvey to his owner's care on 29 March 2018 when Harvey was unfit to be so discharged;

62. The Committee finds charge A(1)(g) not proved.

63. The Committee had regard to the video which was taken by Mr TC and Mrs TC after Harvey had been discharged following tie-back surgery, and once he was back home with them. Both Professor Williams and Professor Hall said that in their opinion, if the state of Harvey in the video portrayed the state in which he was discharged, then he would have been unfit to be discharged. The evidence about the timing of the taking of the video was unclear, but it would seem that it was taken about two hours after Harvey had been discharged.

64. The Committee noted that whilst the written statements of Harvey's owners were that the video accurately portrayed the state of Harvey at the time of discharge, Mrs TC accepted in her oral evidence that Harvey's condition had noticeably deteriorated in the two hours between discharge and the time at which the video was taken. The Committee noted that the Respondent said that at the time of discharge, Harvey walked from the Practice to the car, was panting, but there was no significant respiratory noise. Given Mrs TC's description in her oral evidence that Harvey's condition had deteriorated, the Committee was not satisfied that it had any objective evidence of Harvey's manner of breathing at the time of discharge. Whilst the Committee considered that it may have been advisable for Harvey to be kept overnight at the Practice following surgery, it was not satisfied so that it was sure, that the Respondent had discharged Harvey into the care of the owners when he was unfit to be discharged.

Charge 2
Between 29 January 2018 and 30 March 2018, failed

a) adequately to communicate the extent of risks and/or complications of the March 2018 surgery;

65. The Committee finds charge A(2)(a) not proved.

66. The Committee had a copy of the consent form relating to the March 2018 surgery, and Mrs TC accepted it was her signature on the second page. The Committee noted the evidence of Mrs TC to the effect that it was SP, the Respondent's husband, who had completed the consent form and not the Respondent. The Committee did not accept this account as credible, noting that both SP and the Respondent said that it was the Respondent who went through the form, and that it was the Respondent's handwriting throughout the consent form.

67. The Committee had regard to the consent form itself. It noted that Mrs TC had also filled out a consent form for the endoscopy in January 2018, which used the same template and about which no complaint was made by Mrs TC that she had not been through the form on that occasion. The Committee accepted the Respondent's evidence that she had been through the consent form with Mrs TC, and that it had taken about 20 minutes. It also bore in mind that over the previous two months there had been extensive communications between Mrs TC and the Respondent about Harvey and the proposed surgery, together with a number of occasions on which Mrs TC had cancelled and re-scheduled the surgery.

68. The Committee considered that Mrs TC had signed a consent form, which, on face value, gave consent to the March 2018 surgery. The Committee noted that the form itself set out the potential risks of surgery. In addition, in the Respondent's handwriting, specific complications of treatment and/or surgery were written in as: complications of GA, anaphylaxis, seizure, coma, death, aspiration pneumonia, wound infections, wound breakdown, catheter site reaction, and fracture of cartilage.

69. The Committee did not consider that the evidence was sufficient to conclude that the Respondent had not been through the consent form with Mrs TC explaining the potential risks and complications of the surgery. It was therefore not satisfied so that it was sure that the Respondent had failed adequately to communicate the extent of risks and/or complications of the March 2018 surgery.

b) adequately to communicate the alternative options to the March 2018 surgery;

70. The Committee finds charge A(2)(b) not proved.

71. The Committee considered that over the two months between endoscopy and the surgery, the Respondent had communicated with Mrs TC about the options available. It bore in mind that Dr Johnson had prescribed a course of medication for Harvey when he had examined him on 13 January 2018. When asked about the medication, Mrs TC had said that the medication had caused diarrhoea and so she had stopped the course before completion, whereas Dr Johnson had recorded in Harvey's clinical notes that there had been a slight improvement. The Committee noted that Mrs TC had heard about a medication through the online forum and had discussed it with the Respondent. It noted that in email correspondence, the Respondent had also

discussed the option of not doing anything but pointing out that there was a small risk that the laryngeal paralysis could progress causing the dog to collapse.

72. The Committee did not consider that the evidence was sufficient to conclude that the Respondent had failed adequately to communicate the alternative options to the March 2018 surgery. It was therefore not satisfied so that it was sure that the Respondent had failed adequately to communicate the alternative options to the March 2018 surgery.

c) to obtain fully informed consent to the March 2018 surgery;

73. The Committee finds charge A(2)(c) not proved, for the same reasons as set out in charge 2(a).

Charge 3

Prior to the surgery, failed to communicate adequately with TC with regards to Harvey and/or exerted undue pressure on TC and/or TC's husband in relation to going ahead with the March 2018 surgery, more particularly in that you:

a) On 30 January 2018, told TC words to the effect that:

(i) there was no such thing as "early-stage" laryngeal paralysis;
(ii) that Harvey had right side laryngeal paralysis and that the left side could "*go at any time*" causing Harvey to die;
(iii) treatment by nonsurgical means was not a realistic option and/or that tie-back surgery was the only option that would work;
(iv) laryngeal tie-back surgery would prevent breathing problems for Harvey;
(v) the surgery would be a simple operation and leave Harvey with a wound and nothing more.

74. The Committee, having considered each in turn, finds charges A(3)(a)(i) to (v) not proved.

75. The Committee noted that the words alleged by Mrs TC to have been said by the Respondent to her, occurred in a telephone call on 30 January 2018. The Committee considered that this allegation rested on the credibility of Mrs TC's account of the telephone call she had with the Respondent. The Committee was mindful that Mrs TC was recounting discussions which would have occurred some four years earlier. Given the Committee's previously identified concerns about Mrs TC's reliability in accurately recalling the detail of her conversations with the Respondent, it treated her evidence with caution. The Committee noted that there was no contemporaneous written record of the telephone call and that the tone and contents of the telephone call described by Mrs TC were not consistent with the tone and contents of the email correspondence between Mrs TC and the Respondent at around the same time. It appeared to the Committee that the tone and content of the emails were more nuanced than the attitude described in the telephone call. The Committee was not satisfied so that it was sure that the Respondent had said the words ascribed to her

such that she failed to communicate adequately with Mrs TC or was exerting undue pressure on her and her husband to go ahead and have the surgery.

Charge 3(b)

On 1 February 2018, sent an email to TC in response to her query regarding how Harvey would be post-operatively, stating
"So it should just be a wound on his neck and nothing more";

76. The Committee finds charge A(3)(b) not proved.

77. The Committee had a copy of the 1 February 2018 email, which was sent at 18:04. The Committee noted that it was sent in response to an email sent earlier that day by Mrs TC asking whether to cancel a family visit the weekend after surgery so as not to get him excited and risk his recovery being delayed or cause problems. The Committee noted that the full email sent by the Respondent was as follows:

    "So it should just be a wound on his neck and nothing more. He should feel much better directly after the ga (general anaesthetic) wears off. I wouldn't worry about cancelling your plans for the weekend unless you are going to worry regardless about him"

78. The Committee was satisfied that the Respondent had written the email containing the words "So it should just be a wound on his neck and nothing more", and noted that the Respondent accepted that she had. It noted that over the two months between the endoscopy and the surgery, she responded to many queries from Mrs TC. The Respondent said that she had tried to remain professional and patient in response to Mrs TC's queries, and her cancelling and rescheduling of the tie-back surgery some six times due to her worries about it.

79. The Committee referred back to the stem, which alleged a failure to communicate adequately and/or exert pressure to go ahead with the surgery. The Committee considered that the entirety of the email, placed in context with all the correspondence with Mrs TC needed to be considered, rather than the stand alone comment. The Committee concluded that from that context, the email was not intended to be an exhaustive discussion of the various risks and potential complications of surgery, which it noted had been discussed in detail in emails on several occasions. The Committee was not satisfied so that it was sure, that the comment in the email, given the context of the totality of correspondence with Mrs TC, exerted undue pressure to go ahead with the surgery, or was a failure to communicate adequately regarding Harvey.

Charge 3(c)

On February 2018, sent an email to TC stating:
"There is no other option for laryngeal paralysis. The only option is surgery";

80. The Committee finds charge A(3)(c) not proved.

81. The Committee had a copy of the email, dated 7 February 2018, sent at 08:14am. It noted that it was sent in response to Mrs TC's email sent at 07:31 that day, inquiring whether the surgery was the only way forward or whether there was an alternative by managing the condition without surgery. The Committee noted that the full response was as follows:

> *"There is no other option for a laryngeal paralysis. The only option is surgery. He can continue with it but there is a small risk that it could progress to collapse. Small but still present. And it will continue with a cough which will worsen with time.*
>
> *I'm not sure if the above helps or not but it is important that you are happy with the decision to go ahead with surgery and if that necessitates delaying it so that we can discuss things further that is also an option.*
>
> *Just let me know what is best for you*

82. The Committee was satisfied that the Respondent had written the email containing the words "There is no other option for a laryngeal paralysis. The only option is surgery" and noted that the Respondent accepted that she had. As before, the Committee was mindful that over the two months between the endoscopy and the surgery, the Respondent had responded to many queries from Mrs TC. The Committee considered that the whole email gave a wider context and offered Mrs TC the options of: having the operation; not having the operation; or delaying the operation to discuss the matter further.

83. Referring back to the stem, which alleged a failure to communicate adequately and/or exert pressure to go ahead with the surgery, the Committee considered that it was appropriate to consider the entirety of the email rather than just the stand alone comment. The Committee concluded from the context, that the selective quotation alleged at charge 3(C) removed the wider context that was given in the email. The Committee was not satisfied so that it was sure, that the comment in the email, in the context of the whole email, exerted undue pressure to go ahead with the surgery, or was a failure to communicate adequately regarding Harvey.

Charge 3(e)
On 21 February 2018, sent an email to TC stating that:
(i) There was not really an early or late stage of laryngeal paralysis; and
(ii) If the surgery failed then Harvey would just be back to the same condition he was pre-surgery;

84. The Committee finds charges A(3)(e)(i) and (ii) not proved.

85. The Committee had a copy of the email, dated 21 February 2018, sent at 09:20am. It noted that it was sent in response to Mrs TC's email sent at 09:58 the previous day, asking a series of questions as follows:

> *"Ok here are my questions and I apologise in advance if I have already asked you any feel stupid questions!*

1) is the condition bilateral for Harvey? I read on some forum that the op is only required if bilateral?

2) some people on the forum described their dogs as being in early stage of lar par (laryngeal paralysis). How would you describe Harvey's?

3) regarding food following the op. Best to ask what can't he eat? Straight after the op and after a complete recovery?

4) I currently give him his thyroid meds straight down his throat. Will this need to change? This might be a silly question!

5) if the tie back failed or broke how would we know? Would he be in immediate danger?

6) from what I have read on the forum people say their dogs start getting back end weakness. Is this the case and why? Is there a treatment for this if it occurs?

7) harvey is very slow when he walks. In fact he couldn't go any slower lis [sic] this due to his condition?

8) once he has the tie back how long is total recovery and will he feel better immediately?

9) what would be the signs of AP (aspiration pneumonia)? How would I know?

I think thats it!

Thank you so much for your time and patience"

86. The Committee noted that the full response sent by the Respondent, at 09:20 on 21 February 2018, was as follows:

"Sorry for delay. My duty was very busy last night and so never got a chance to respond to your email.

1. No unilateral. But surgery is indicated even if unilateral to prevent cough and further deterioration. If surgery is performed in bilateral cases it increases the risk of aspiration pneumonia

2. Laryngeal paralysis is just that. A paralysis. It either shows with signs or doesn't. There isn't really early or late stage.

3. So he should just be fed slowly and not allowed to eat food rapidly. I usually recommend board food for the first couple of days to encourage slow feeding

4. No this can stay the same

5. No he wouldn't be in immediate danger, he would return to how he is currently. And his symptoms would return. The suture is only nylon so can snap. As to how likely I would have to look at specific numbers.

6. So dogs with hypothyroidism have a progressive paralysis which eventually will affect his hind legs. There is no treatment.

7. Hypothyroid dogs tend to be lethargic and not the most energetic walkers. He has only been sedated recently when I've seen him but a neurological exam for his hind legs could show signs of progressive paralysis already. This would have to be performed to be sure.

8. Total recovery will be 7-14days depending on surgical site. Any coughing should be improved immediately. There may be no change to dysphonia.

9. AP would show with persistent cough, lethargy, pyrexia, inappetance and weight loss. He would be poorly with it and deteriorating. They would also be evidence on chest x-rays or chest ct.

I hope these answers help.

Am I expecting Harvey today or are you going to reschedule to the following week?"

87. The Committee was satisfied that the Respondent had written the email containing the phrases "There was not really an early or late stage of laryngeal paralysis" and "if the surgery failed then Harvey would just be back to the same condition he was in pre- surgery". It also noted that the Respondent accepted that she had sent the email containing those phrases. As before, the Committee was mindful that over the two months between the endoscopy and the surgery, the Respondent had responded to many queries from Mrs TC. The Committee considered that the whole email, in response to specific questions asked by Mrs TC, gave a wider context.

88. The Committee considered whether the phrases were, or may be regarded as, clinically accurate. In relation to charge 3(e)(i), it noted the opinion of Professor Hall to the effect that laryngeal paralysis is either present or it is not, but the severity of clinical signs may progressively worsen. It was his view that it therefore depended on the understanding of what was meant by 'early stage laryngeal paralysis', and that if talking about the diagnosis, then the phrase was broadly correct, but if talking about the 'temporal progressive onset of associated clinical signs as paralysis worsens', then the phrase would seem inaccurate. Given that on one reading of the phrase, the Respondent's expert was of the view that it was broadly correct, the Committee was not satisfied so that it was sure that use of the phrase was a failure to communicate adequately through inaccurate clinical information.

89. In relation to charge 3(e)(ii), the Committee noted the opinion of Professor Hall in his report that failure of surgery (cartilage fragmentation, suture break) would be expected to result in simply recurrence of clinical signs and in that respect the statement was accurate. The Committee noted that in his cross examination, Professor Hall agreed that the phrase, taken in isolation, was incomplete in that it gave the best case scenario and did not set out the potential other concerns or complications, and so may have the potential to mislead. The Committee considered that the Respondent's answer in her email should be seen in the context of the totality of the communications between the Respondent and Mrs TC. The Committee was not satisfied so that it was

sure, if a unilateral tie-back were to fail, that it was unreasonable for the Respondent to predict that the airway would revert to its previous state.

90. The Committee referred the two phrases back to the stem, which alleged a failure to communicate adequately and/or exert pressure to go ahead with the surgery. The Committee concluded from the context, that the quotations alleged at charge 3(e)(i) and 3(e)(ii) removed the wider context that was given in the email. The Committee was not satisfied so that it was sure, that the comment in the email, in the context of the whole email, exerted undue pressure to go ahead with the surgery, or was a failure to communicate adequately regarding Harvey.

Charge 3
f) On 29 March 2018 told TC and/or her husband words to the effect that:
(i) Harvey had to have the surgery if TC did not want him to die;
(ii) After the surgery Harvey would never have breathing problems;
(iii) Surgery was the only option;

91. The Committee, having considered each in turn, finds charges A(3)(f)(i) to (iii) not proved.

92. The Committee noted that this was a conversation which took place between Mrs TC and the Respondent, with Mr TC present. The Committee considered that Mrs TC genuinely believed that each of the three phrases had been told to her by the Respondent in the consultation room before Harvey had the surgery. The first question for the Committee to resolve was whether it was satisfied so that it was sure that the Respondent had, in fact, said each of the three phrases as alleged. The Committee considered that this allegation rested on the credibility of Mrs TC's account of the conversation she had with the Respondent.

93. The Committee was mindful that Mrs TC was recounting discussions which would have occurred some four years earlier. Given the Committee's previously identified concerns about Mrs TC's reliability in accurately recalling the detail of her conversations with the Respondent, it treated her evidence with caution, and looked to see if other evidence supported her account. The Committee noted that whilst Mr TC was present during the conversation, he did not assert in evidence that the Respondent had said either 'Harvey had to have the surgery if TC did not want him to die'; or 'after the surgery Harvey would never have breathing problems'. In relation to whether the Respondent said 'Surgery was the only option', the Committee was mindful that whilst Mr TC asserted this was said in his witness statement, in his oral evidence he could not recall the details of the conversation.

94. The Committee noted that the alleged conversation prior to surgery was not consistent with the tone and contents of the email correspondence between Mrs TC and the Respondent at around the same time. It appeared to the Committee that the tone and content of the emails were more nuanced than the attitude described in the conversation, which Mr TC had described as 'dismissive'. The Committee was not satisfied so that it was sure that the Respondent had said the words ascribed to her

such that she failed to communicate adequately with Mrs TC or was exerting undue pressure on her and her husband to go ahead and have the surgery.

Charge 4

After the surgery, failed to communicate adequately with TC more particularly in that you:

a) On 30 March 2018, told TC that:

(i) Harvey did not have aspiration pneumonia; and

(ii) you would not undertake post-operative radiographs, despite TC requesting these;

95. The Committee finds, having considered each individually, charges A(4)(a)(i) and (ii) not proved.

96. In relation to charge A(4)(a)(i), the Committee noted that the evidence was to the effect that Harvey did not have clinical signs indicative of aspiration pneumonia. In particular, the contemporaneous clinical notes written by the Respondent recorded that his temperature was stable and his respiratory noise had decreased. The Committee noted that the clinical notes recorded the Respondent's opinion that although the owner was asking about aspiration pneumonia, the Respondent did not consider that Harvey had it as he had no symptoms and was on antibiotics anyway. The Committee concluded that there was no evidence that the Respondent thought that Harvey had aspiration pneumonia at that time, on the contrary, she had recorded in the clinical notes that x-rays were taken to ascertain and prove to the owner that the cause of the issue was oedema alone.

97. Referring back to the stem, given that the Respondent did not consider that Harvey had aspiration pneumonia, the Committee was not satisfied so that it was sure that the Respondent had failed to communicate adequately with Mrs TC. It considered that she had conveyed her opinion together with the reasons for it.

98. In relation to charge A(4)(a)(ii), the Committee noted that the alleged refusal to take radiographs contradicted the clinical notes which recorded that they were taken. The Respondent's evidence, which the Committee accepted as consistent with the contemporaneous clinical notes, was that chest radiographs were taken. Given that the Committee accepted the Respondent's evidence that post-operative radiographs were taken, the Committee was not satisfied that she would have told Mrs TC that she would not undertake them.

Charge 4

(b) On 31 March 2018, told TC that Harvey had a peaceful night and was on track for recovery, when this was not the case;

99. The Committee finds charge A(4)(b) not proved.

100. The Committee noted that this charge related to an early morning telephone call which took place four years earlier between Mrs TC and the Respondent. Given the Committee's previously identified concerns about Mrs TC's reliability in accurately

recalling the detail of her conversations with the Respondent, it treated her evidence with caution. The Committee noted that in her witness statement, Mrs TC said that in the call, the Respondent had told her that Harvey had had a generally peaceful night and that his chest sounded a bit crackly but that he was on track to recover fully. Her statement also mentioned that the Respondent told her that she was waiting for Dr Dudley to come in so that they could check both tie-backs together and check all was okay. In cross examination, Mrs TC did not accept that the Respondent had used the word 'distress' but she did accept that she had understood from the call that whilst Harvey was settled, there were still things to be considered. The Committee considered that the phrase about Harvey having a settled night and being on track for recovery would have been only part of a more detailed conversation between Mrs TC and the Respondent. It was of the view that it was a selective part of the conversation, given that Mrs TC confirmed that it also covered the need to wait for Dr Dudley to return so that a check-up on Harvey could take place and that the Respondent told her that she would come back to her once further investigations had been undertaken.

101. The Committee also had regard to the records in Harvey's clinical notes at around that time. It noted that the Respondent had recorded that Harvey's clinical care had been handed over to her by Dr Dudley at 07:30am and she had been advised by him that Harvey's breathing had settled but that Harvey had been sedated again in the morning as he had become stressed which had negatively impacted his respiratory effort. In relation to the call with Mrs TC, the Respondent had recorded in the clinical notes that Mrs TC had been updated and advised that Harvey would remain sedated in order to keep his respiratory rate down so that they could continue to 'limit distress and hopefully inflammation'. The Committee accepted the Respondent's account, noting that it was consistent with her records in the clinical notes, and those of Dr Dudley who had recorded that Harvey had been under sedation and may need to be placed back under sedation.

102. The Committee noted that when Mr TC had been asked about the telephone call, he said that he had not heard directly what the Respondent had said to Mrs TC, but she reported to him that the Respondent had said Harvey had had a good night, slept well and was comfortable. He did not recall her mentioning any chest crackles.

103. The Committee was not satisfied so that it was sure that the Respondent had failed to communicate adequately with Mrs TC in the early morning telephone call. It considered that the call covered a number of areas, as accepted by Mrs TC and any reference which the Respondent may have made to Harvey having had a generally peaceful night and being on track for recovery was qualified with information about sedation to limit distress and hopefully inflammation, as was recorded in the clinical notes.

Charge 6
Your conduct at 3(f)(i) and 4(b) above was dishonest

104. Charge A(6) falls away, given the Committee's findings of not proved in respect of charges A(3)(f)(i) and A(4(b) .

(B) Boss

105. In relation to HS, the owner of Boss, the Committee found her to be a truthful, and credible witness. It considered that her evidence was consistent with the contemporaneous documentation, her witness statement and the previous correspondence in which she had been involved. Nevertheless, the Committee considered that her recollection of some of the details may have been impacted by the passage of time, some four years.

In relation to oesophageal surgery performed by you on or around 6 October 2018 ("the October 2018 surgery") to Boss, a Boxer dog belonging to HS, you:
1) Between 5 October 2018 and 6 October 2018, failed:

a) To obtain fully informed consent for the October 2018 surgery;

106. The Committee finds charge B(1)(a) not proved.

107. The Committee noted HS's evidence was that by the time she reached the Respondent's Practice, Boss was salivating quite a lot. She said the Respondent told her that they needed to find out why and further investigations were required. HS explained that the approach the Respondent said she would take was to do one thing at a time and that an x-ray was the first step, and they had endoscope facilities at the practice should the x-ray reveal it was needed. She said that the Respondent did briefly mention an "ex-lap" (exploratory laparotomy, a form of surgery) as being a final option but that procedure was dependent upon whether the problem was the 'Whimzee' and where it was located. However, she had not thought it was more than a comment of a possible outcome and that the Respondent would be proceeding one step at a time. HS told the Respondent that she would not want Boss to go through surgery for a suspected mass (tumour) in his chest, which had been the initial concern of the Respondent when she obtained the first set x-rays.

108. The Committee took account of the duty upon a veterinary surgeon to obtain informed consent from an owner before embarking upon any interventions. The Committee noted that the experts were in agreement that it was acceptable to take consent for a sequence of interventions/procedures, and that if the risks were discussed and documented, then the consent would be sufficiently informed. The Committee had regard to the consent form, dated 6 October 2018, which had been initialled and signed by HS at the time. It noted that the consent form contained consent to carry out a large number of interventions, including specifically:

> *"I understand that during the performance of the procedure/surgery unseen conditions may be revealed that necessitate an extension of the operation/treatment/examination/test that are set for the above. Therefore, I consent and authorise the performance of such operation/treatment/examination/test as are necessary and are deemed necessary through the use of the veterinary surgeon's professional judgement."*

109. The Committee considered that at face value, by signing and initialling the consent form, HS had given consent for x-rays, CT scan, endoscopy, and ex-lap surgery. Whilst the Committee considered that the consent form gave technical consent to perform the endoscopy and subsequent oesophageal surgery, the Committee went on to consider whether the consent was, in fact, informed consent. The Committee noted that HS rang the Practice at around 7:10 am for an update, which was after the endoscopy. A member of staff from the Practice answered and said that Boss was still in theatre having the foreign body removed and HS did not challenge why the dog was in theatre.

110. The Committee considered that whilst it would have been preferable for the Respondent to have contacted HS before she embarked upon the surgery, to double check if the owner was content to proceed to surgery, the consent form which HS had signed did cover the eventuality of surgery, and ex-lap had been discussed with HS. Therefore, the Committee was not satisfied so that it was sure, the Respondent had failed to obtain fully informed consent for the oesophageal surgery.

b) adequately to communicate the extent of risks and/or complications of the October 2018 surgery;

111. The Committee finds charge B(1)(b) not proved, for the same reasons as for B(1)(a).

c) adequately to communicate alternative options to the October 2018 surgery;

112. The Committee finds charge B(1)(c) not proved.

113. The Committee considered that by the time the Respondent had decided to embark upon the oesophageal surgery, there were limited options available to her as Boss was in a critical condition. The Committee had regard to the evidence of Professor Hall, who did not consider that there were alternative options at that stage other than euthanasia, which had been alluded to by HS. The Committee was not satisfied that the Respondent had a duty to offer referral to a specialist at that time unless the owner specifically asked for it, or the veterinary surgeon did not consider that they were competent to carry it out. The Committee was not satisfied so that it was sure that the Respondent had failed adequately to communicate alternative options to the surgery.

d) adequately to communicate the outcome of the October 2018 surgery and/or Boss's condition after the surgery;

114. The Committee finds charge B(1)(d) not proved.

115. The Committee noted the evidence of HS that she received a telephone call from the Respondent at 9:51am. HS recounted the call, saying that the Respondent told her that she was happy with the outcome of the surgery and that she had retrieved the 'Whimzee'. HS said that in that call, the Respondent said that she had used the endoscope and had got some of the 'Whimzee' out which had taken a few hours, but she could not retrieve it all and so had surgically removed the rest of it.

116. The Committee did not identify any areas of the Respondent's account to HS which were inaccurate about what she had done. Accordingly, the Committee was not satisfied so that it was sure that the Respondent had failed adequately to communicate the outcome of the surgery or Boss's condition after it.

Charge 2

In relation to a CT scan of Boss' oesophagus on 6 October 2018 before the October 2018 surgery:

a) Failed to seek appropriately skilled assistance with regards to interpretation of the said scan'

117. The Committee finds charge B(2)(a) not proved.

118. The Committee noted that neither expert had identified a general obligation upon the Respondent to refer the CT scans for specialist interpretation. It noted the Respondent's evidence to the effect that had she identified any abnormalities for which she judged it advisable to seek assistance with the CT scan, she would have done so, but she had not seen any such indications.

119. Whilst the Committee considered that it may have been advantageous to have sought assistance in interpreting the CT scans, which may have provided useful information on the true extent of the foreign body and the attendant oesophageal changes, there was no duty upon her to have done so. Accordingly, the Committee was not satisfied so that it was sure, that the Respondent had failed to seek appropriately skilled assistance to interpret the CT scans.

b) Told HS that you would seek appropriately skilled assistance with regards to interpretation of the said scan but failed to do so;

120. The Committee finds charge B(2)(b) not proved.

121. HS's evidence was that the Respondent told her that she was comfortable reading CT scans, but would refer them to a specialist for a second opinion. The Committee noted the Respondent's evidence that she had said she would seek assistance in interpreting the scans if she found anything suspicious, which she did not. Given the passage of time, and understandable difficulties in precisely recollecting conversations not recorded at the time, the Committee was not satisfied so that it was sure that the Respondent had said she would seek assistance in interpretation without qualifying it to say if needed.

c) Failed to identify oesophageal changes visible on the said scan;

122. The Committee finds charge B(2)(c) not proved.

123. The Committee noted that the Respondent had detected changes on the scan, namely a thickening to the oesophageal wall, which, according to Professor Hall, was to be expected. The Committee bore in mind that the precise extent of the changes was not agreed between Professor Williams and Professor Hall. Given that the experts could not account for some of the changes in the scans, the Committee did

not consider that a reasonably competent veterinary surgeon could be expected to identify such changes. Accordingly, the Committee was not satisfied so that it was sure, that the Respondent failed to identify oesophageal changes visible on the CT scan

d) Failed to inform HS of the oesophageal changes visible on the said scan and also inform HS of the increased risks associated with those changes if Boss were to have the October 2018 surgery;

124. The Committee finds charge B(2)(d) not proved for the same reasons as for charge B(2)(c).

Charge 3

On or around 5 and/or 6 October 2018, failed to provide appropriate and adequate care to Boss, more particularly in that you:

a) Subjected Boss to an excessive period of anaesthesia;

125. The Committee finds charge B(3)(a) proved.

126. The Committee had regard to the experts' respective opinions as to what may amount to an excessive period for a dog to be under anaesthesia. It noted that Professor Williams was of the view that if a foreign body could not be retrieved or retropulsed in 30 – 60 minutes then the patient should be converted to surgery. He identified that Boss had been anaesthetised in total for 9 ½ hours: for seven hours before surgery including 5 hours undergoing endoscopy, which in his opinion was excessive, particularly as it was throughout the night with no significant rest periods for the Respondent. He added that it was well recognised that a surgeon could lose situational awareness, an example of which would be a loss of track of time during a complex operation because the surgeon is so focused on the task in hand.

127. The Committee noted that Professor Hall did not identify a period of time at which he would regard anaesthesia as excessive and stated that he was unable to find evidence to support Professor William's guidance of 30 – 60 minutes as a maximum. Nevertheless, he agreed that following a period of an hour, attempting to remove a foreign body endoscopically, he would encourage a different approach. He agreed that 9 ½ hours was a long time to be anaesthetised and the Respondent should have recognised that this was becoming too prolonged at some point during the night.

128. The Committee considered that a total of 9 ½ hours under anaesthesia was a very long period of time. It considered the reason for the anaesthesia, was to facilitate endoscopy and then surgery. It noted that both experts were in agreement that the endoscopy should have ended after around an hour if retrieval was unsuccessful. The Committee noted that the Respondent had carried out endoscopy for five hours before stopping, having been unsuccessful in retrieving the entirety of the 'Whimzee'. The Committee inferred from the expert evidence that the length of time of anaesthesia should be relative to the type of intervention. In all the circumstances, the Committee was satisfied so that it was sure that the Respondent had subjected Boss to an excessive period of anaesthesia.

b) **having failed to retrieve by oesophagoscopy a foreign object in Boss' oesophagus, failed to give adequate consideration to and/or offer other treatment options and/or the referral for Boss prior to commencing the October 2018 surgery;**

129. The Committee finds charge B(3)(b) not proved.

130. The Committee noted that it was 7am when the Respondent stopped the endoscopy, having not managed to retrieve the foreign body from Boss' oesophagus. At that time, the Committee considered that the options available to the Respondent were limited. It noted that Professor Hall identified the other treatment options as including: referral to a Specialist Centre for repeat endoscopy and/or surgery; euthanasia; advance the foreign body into the stomach without retrieval. He noted that the Respondent had informed the College by way of letter, dated 5 January 2020, that she had been unable to advance the foreign body into the stomach, and that Professor Williams' interpretation of the CT imaging would suggest that would not be possible.

131. The Committee considered that there was insufficient evidence to satisfy it so that it was sure that the Respondent had not adequately considered but discounted the potential options available to her following the unsuccessful retrieval by endoscopy.

Charge 6

Between 5 October 2018 and 31 October 2018, failed to provide a referral report and/or clinical records for Boss to Best Friends Holbeach veterinary practice following its referral of Boss to you on 5 October 2018, despite requests for the same;

132. The Committee finds charge B(6) proved.

133. In reaching this finding, the Committee took account of the Respondent's admission that she had failed to provide a referral report and/or clinical records for Boss to the Holbeach Practice, following its referral to her, despite requests for it. In light of the Respondent's admissions, the Committee considered that there was no challenge to this charge.

Disciplinary Committee
20 February 2023