

**BEFORE THE MINNESOTA
BOARD OF VETERINARY MEDICINE**

In the Matter of
William N. Dudley, D.V.M.
License No. C0858

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND FINAL DECISION AND ORDER**

On September 16, 2005, the Complaint Review Committee ("Committee") of the Minnesota Board of Veterinary Medicine ("Board") initiated the above-entitled contested case proceeding against William N. Dudley, D.V.M. ("Respondent"), at the State Office of Administrative Hearings by serving and filing a Notice and Order for Prehearing Conference and Hearing. The matter came on for hearing before Administrative Law Judge Beverly Jones Heydinger ("ALJ") on March 6, 7, and 8, 2007. On June 4, 2007, the ALJ issued Findings of Fact, Conclusions, and Recommendation ("ALJ's Report"). The ALJ's Report is incorporated as modified herein and attached as Exhibit A. Each rejection or modification of a Finding of Fact or Conclusion of Law has been made because the finding or conclusion was not germane to the Board's ultimate decision in this matter except for such findings and conclusions modified or rejected for reasons expressly stated herein. The ALJ's Report incorporated an Order on Motion for Partial Summary Disposition and accompanying Memorandum issued in the proceeding on May 19, 2006. The ALJ's Order on Motion for Partial Summary Disposition and Memorandum, as redacted in Exhibit B, is attached and incorporated herein.

The matter came on for hearing by the Board on July 18, 2007. Tamar N. Gronvall, Assistant Attorney General, presented oral argument on behalf of the Committee. Susan E. Damon, Assistant Attorney General, was also present on behalf of the Committee. Robert E. Kuderer, Esq., presented oral argument on behalf of Respondent.

Board members present who considered this matter were John Lawrence, D.V.M., Board Vice President; Meg Glattly, D.V.M., Board Secretary Treasurer; Mike Murphy, D.V.M.; Frederick Mehr, D.V.M.; Susan Osman; and Jeremy Geske. Committee member Joanne Schulman, D.V.M., did not participate in deliberations or vote in the matter. Daphne A. Lundstrom, Assistant Attorney General, was present as legal advisor to the Board.

Based upon all of the files, records, and proceedings herein and upon the ALJ's Report, the Board makes the following:

FINDINGS OF FACT¹

1. The ALJ's Findings of Fact numbers 1, 3-26, 28-29, 31-37, 39-43, 45-59, and 61-68 are adopted and incorporated herein in their entirety.

2. The Board modifies Finding of Fact 2 as follows: ~~Between 1980 and 2000, the Board received approximately 13 complaints about Respondent and his competency to practice veterinary medicine.² While the seven complaints received prior to 1989 were dismissed, the remaining complaints resulted in Respondent being called before the Complaint Review Committee. The Board issued stipulations and orders in 1991, 1992, 1998, and 2001, which subjected Respondent to multiple conditional license requirements.~~

3. The Board modifies Finding of Fact 27 as follows: If a veterinary clinic pre-mixes medications for use and maintains a record of the amounts and proportions of the medications in the mix, the medical record may properly refer to the amount of the mix that was given to the animal.³ There was no evidence that the Complaint Committee was provided with information from the Respondent about the standard mixture of Acepromazine, Atropine and

¹ New language is underlined. Deleted language is noted by a strike through.

² ~~Order on Motion for Partial Summary Disposition, dated May 19, 2006.~~

³ T. 155.

Ketaset that he administered. Recording that Diazepam was administered "to effect" met the standard of care.⁴

4. The Board strikes Finding of Fact 30:⁵ ~~The use of Lasix to counteract the effect of the Acepromazine was not an effective means to wash the Acepromazine out of Sasha's system because Acepromazine is metabolized in the liver and broken into inactive components. The Lasix works in the kidney and thus would not counteract the Acepromazine. Dr. Larry did not offer an opinion about Sasha's care or about the effectiveness of Lasix to counter act the effect of Acepromazine.~~⁶

5. The Board modifies Finding of Fact 38 as follows: The standard of care requires that the tourniquet be removed immediately, within a few minutes, after the declaw of each individual paw, that the animal be checked promptly following surgery, that a general anesthesia and regional block⁷ be used to conduct the surgery, that post-surgery pain medication be prescribed, that the error should have been accurately and completely documented in Guido's record, and the circumstances explained to Guido's owners. Discharging Guido to the owners without discussing the mistake that occurred and the possible consequences, arranging for, at a

⁴ T. 156. Although Dr. Levine testified that administering Lasix was not the appropriate method to counteract the effect of the Acepromazine, ~~and that Sasha should have been under a 24-hour seizure watch~~, those allegations were not included in the Notice and Order for Hearing.

⁵ Finding of Fact 30 is stricken because the Board determined that this fact was not shown to be evidence of failure to meet the standard of care by a preponderance of the evidence.

⁶ T. 156, 165-166. ~~This allegation was first raised in the Board's disclosure of Dr. Levine's testimony in January 2007.~~

⁷ The Board rejected the ALJ's finding that the standard of care required the use of a regional block during this declaw procedure because it determined that the finding was not established by a preponderance of the evidence.

minimum, a recheck the following day, and discharging without pain medication was not consistent with the standard of care.⁸

6. The Board modifies Finding of Fact 44 as follows: ~~It is not clear that the standard of care prevents combining a tail amputation and dental cleaning in all circumstances. Dr. Levine does not believe that the two should be combined.⁹ Dr. Larry would be willing to combine the two for a healthy, young animal with no sore or infection.¹⁰ There are some savings from doing only one pre-surgical work up and administration of anesthesia. Although there was evidence that Dewey had been biting his tail, it is not clear from the record that he had a sore or infection on his tail. If he did, Respondent's expert would concur that it was inappropriate to combine the two surgeries because of the high risk of infection.¹¹ Regardless, Dr. Larry routinely dispenses post-surgical antibiotics and pain medication after a surgical procedure, including a tail amputation.¹² Although Dr. Levine did not believe that the proper amount of tail was removed, he Dr. Levine agreed that sometimes the spot is selected for aesthetic reasons, and the record is unclear as to what additional portion of the tail should have been removed.~~

7. The Board modifies Finding of Fact 60 as follows: ~~The Respondent's use of an electro-surgery machine does not meet the standard of care for declawing.¹³ Suturing following~~

⁸ T. 157-162; Respondent's expert did not testify concerning the standard of care other than to corroborate that a veterinarian is responsible for the care provided by employees. ~~Dr. Levine also testified that Respondent should have sought expert assistance upon discovering that the tourniquet was left on to minimize any damage. That allegation was not included in the Notice and Order for Hearing.~~

⁹ ~~T. 165.~~

¹⁰ ~~T. 295-97.~~

¹¹ ~~T. 295-97.~~

¹² T. 328.

¹³ This finding was stricken because the Board did not find that the use of an electro-surgery machine failed to meet the standard of care by a preponderance of the evidence.

declawing may not violate the standard of care, but most veterinarians do not suture.¹⁴ Antibiotics should have been administered pre- and post-surgery, and pain medication prescribed. Upon Lucy's return because of paw soreness, the standard of care would not be to cut all four feet to check for remaining nails. The standard of care would include pain medication.¹⁵ Respondent was not able to identify the precise type of electro-surgery machine used or provide other information about it. ~~Using a standard abbreviation for a spay procedure met the standard of care.~~¹⁶

Based upon the foregoing Findings of Fact, the undisputed facts set forth in the Memorandum accompanying the Order on Motion for Partial Summary Disposition, and upon the ALJ's Report, the Board makes the following:

CONCLUSIONS OF LAW

8. Conclusions of Law numbers 1-4, 6-7, and 9-12 of the ALJ's Report (Exhibit A) and the conclusions of violations set forth in the Order on Motion for Partial Summary Disposition (Exhibit B) are adopted and incorporated herein in their entirety except that the references to Minn. Stat. § 147.091 in Conclusions 1 and 2 of the ALJ's Report are corrected and changed to Minn. Stat. §§ 156.081 and 156.127.

9. The Board modifies Conclusion of Law 5 as follows: The Board has proved that Respondent departed from or failed to conform to the minimum standards of acceptable and prevailing medical practice, in violation of Minn. Stat. § 156.081, subd. 2 (11), with regard to:

¹⁴ T. 187.

¹⁵ T. 183-87, 231, 315. Dr. Larry did not testify about the care given to Lucy.

¹⁶ T. 184.

a.¹⁷ Francie: ~~Failure to take radiographs showing two views; Failure to offer adequate pain medication. Although the Board failed to show that Respondent maintained two sets of records, it~~ The Board did show that Respondent's records were poorly maintained and incomplete.

b. Gage: Improper surgery, resulting in a severed urethra and prostate gland; Failure to biopsy the mass removed during surgery; Failure to recognize that lab equipment was malfunctioning; Failure to monitor the patient to observe urination; Failure to monitor the patient between January 10, 2004, at 11:00 p.m. and January 11, 2004, at 7:00 a.m.—~~Although it may have been appropriate to seek a consultation when Gage was clearly dying, the Board failed to show by a preponderance of the evidence that in violated the minimum standard of acceptable and prevailing practice not to refer the patient to an emergency facility.~~

e. ~~Sasha: Inappropriate administration of Lasix.~~¹⁸

d. Guido: Failure to promptly remove tourniquet following declaw procedure; Failure to conduct prompt post-surgery examination; Failure to use general anesthesia and regional block¹⁹ during the declaw procedure; Failure to prescribe post-surgery pain medication; Failure to keep accurate progress notes. ~~The Board failed to offer evidence that Respondent failed to fully remove Guido's claw.~~

¹⁷ The Board rejected this conclusion in part because it was not shown by a preponderance of the evidence that taking one view in this case was below the standard of care.

¹⁸ The Board rejected this conclusion because it did not find that the administration of Lasix in this case was shown to violate the standard of care.

¹⁹ The Board rejected the conclusion that failure to use a regional block during this declaw procedure is a violation based on its finding that the applicable standard of care does not require the use of a regional block.

e. Dewey: Failure to provide the owner with post-surgery instructions for the tail surgery, antibiotics or pain medication.²⁰ ~~The Board failed to prove by a preponderance of the evidence that it is inappropriate to combine tail amputation and dental cleaning in all instances or that Respondent removed an improper amount of the tail.~~

f. Rocky: Failure to stabilize the fracture or reduce the fracture; Failure to provide pain medication; Failure to place the cast properly.

g. Lucy: Failure to properly declaw; Failure to provide follow-up care instructions; Failure to provide anti-inflammatory medication or pain medication following surgery on June 22, 2006; Failure to properly remove sutures; Failure to offer pain medication, anti-inflammatory medication or antibiotics on June 29, 2006.

10. The Board has modified Conclusion of Law 8 as follows: The Board has demonstrated that Respondent engaged in medical practice that was professionally incompetent, in that it may create unnecessary danger to a patient's life, health, or safety, with regard to Gage, Guido, Dewey, Rocky and Lucy, in violation of Minn. R. 9100.0700, subp. 1 C, and Minn. Stat. § 156.081, subd. 2 (12).²¹

Based upon the foregoing Conclusions of Law and upon the Recommendation of the ALJ, the Board issues the following:

ORDER

1. Respondent's license to practice veterinary medicine in the State of Minnesota is hereby REVOKED, effective immediately.

²⁰ The Board rejected in part this conclusion that failure to provide the owner with post-surgery instructions was established as a violation of the standard of care.

²¹ The Board rejected this conclusion with respect to Dewey because it did not find that it was supported by a preponderance of the evidence.

2. Respondent shall surrender to the Board all Minnesota certificates of licensure by this Board within ten days of the date of this Order. The certificates shall be mailed or delivered to the Minnesota Board of Veterinary Medicine, c/o John King, D.V.M., Executive Director, 2829 University Avenue S.E., #540, Minneapolis, MN 55414-3250.

3. Pursuant to Minn. Stat. § 156.127, subd. 1 (7), Respondent shall pay to the Board an administrative penalty of \$18,029.05.

Dated: 8/22/2007

MINNESOTA BOARD
OF VETERINARY MEDICINE

By: 
JOHN LAWRENCE, D.V.M., Vice President

AG: #1834640-v2

EXHIBIT

tabbles®

A

THIS DOCUMENT IS NOT PUBLIC

OAH Docket No. 15-0908-16849-2

**STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS**

FOR THE BOARD OF VETERINARY MEDICINE

In the Matter of William N. Dudley,
D.V.M.
License No. C0858

**FINDINGS OF FACT,
CONCLUSIONS, AND
RECOMMENDATION**

The above matter came on for hearing before Administrative Law Judge Beverly Jones Heydinger on March 6, 7, and 8, 2007. The OAH hearing record closed on April 20, 2007, upon receipt of the post-hearing briefs.

Tamar N. Gronvall, Assistant Attorney General, 445 Minnesota Street, Suite 1400, St. Paul, MN 55101-2131, appeared on behalf of the Minnesota Board of Veterinary Medicine's Complaint Review Committee (Board).

Robert E. Kuderer, Esq. and Stacey A. Molde, Esq., Johnson and Condon, P.A., 7401 Metro Boulevard, Suite 600, Minneapolis, MN 55439-3034, appeared for William N. Dudley, D.V.M. (Respondent).

STATEMENT OF ISSUES

1. Did Respondent's conduct constitute incompetence in the practice of veterinary medicine, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice, in violation of Minn. Stat. § 156.081, subd. 2 (11); Minn. R. 9100.0700, subps. 1A, B, and C; and Minn. R. 9100.0800, subp. 1?

a. Francie: Radiographs showed one view and not two; Maintaining two sets of records; Failure to offer adequate pain medication;

b. Gage: Improper surgery, resulting in a severed urethra and prostate gland; Failure to biopsy the mass removed during surgery; Failure to recognize that lab equipment was malfunctioning; Failure to monitor patient to observe urination; Failure to refer patient to an emergency facility; Failure to monitor the patient between January 10, 2004, at 11:00 p.m. and January 11, 2004, at 7:00 a.m.

A-1

c. Sasha: Failure to document contents of Ketaset, Acepromazine and Atropine mixture; Inappropriate administration of Lasix;

d. Guido: Failure to promptly remove tourniquet following declaw procedure; Failure to conduct prompt post-surgery examination; Failure to use general anesthesia and a regional block during the declaw procedure; Failure to prescribe post-surgery pain medication; Failure to keep accurate progress notes; Failure to fully remove the claw;

e. Dewey: Failure to provide the owner with post-surgery instructions for the tail surgery, antibiotics or pain medication; Inappropriate combination of tail surgery and dental cleaning, and removal of improper amount of tail

f. Rocky: Failure to stabilize the fracture or reduce the fracture; Failure to provide pain medication; Failure to place the cast properly;

g. Lucy: Failure to properly declaw; Failure to provide follow-up care instructions; failure to provide anti-inflammatory medication or pain medication following surgery on June 22, 2006; Failure to properly remove sutures; Failure to offer pain medication, anti-inflammatory medication or antibiotics on June 29, 2006.

2. Did Respondent's conduct as set forth in paragraph 1 violate any statute or rule promulgated by the Board or any Board Order, in violation of Minn. Stat. § 156.081, subd. 2 (12)?

3. Did Respondent engage in conduct as set forth in paragraph 1 likely to harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient, in violation of Minn. Stat. § 156.081, subd. 2 (12), and Minn. R. 9100.0700, subp. 1B?

4. Did Respondent engage in veterinary practice as set forth in paragraph 1 that is professionally incompetent, in that it may create unnecessary danger to a patient's life, health, or safety, in violation of Minn. Stat. § 156.081, subd. 2 (12), and Minn. R. 9100.0700, subp. 1C?

5. Did Respondent fail to prepare and maintain written veterinary medical records, in violation of Minn. Stat. § 156.081, subd. 2 (12), and Minn. R. 9100.0800, subp. 4A?

a. Gage: Failure to document post-surgery urination;

b. Guido: Failure to accurately document progress notes;

c. Sasha: Failure to document the proportions contained in the mixture of Acepromazine/Atropine/Ketaset; Failure to document the amount of Diazepam administered;

d. Dewey: Failure to document that use of a tail cone and pain medication were discussed with owner;

e. Lucy: Failure to document spay procedure.

6. The Board has agreed to withdraw the allegation that Respondent improperly misrepresented himself as a different veterinarian, in violation of Minn. R. 9100.0700, subp. 1F.

As more fully set forth below, the Board has demonstrated by a preponderance of the evidence one or more of the allegations of each violation.

Based upon the entire record, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Respondent is a veterinarian licensed to practice in Minnesota since 1958. He received his veterinary training at Tuskegee School of Veterinary Medicine in Tuskegee, Alabama, and earned a degree in 1957.¹ Since 1959, Respondent has been a solo practitioner at the Brooklyn Pet Hospital where he serves an underprivileged community.² Respondent also provides veterinary services at Allcare Veterinary Clinic in St. Paul.

2. Between 1980 and 2000, the Board received approximately 13 complaints about Respondent and his competency to practice veterinary medicine.³ While the seven complaints received prior to 1989 were dismissed, the remaining complaints resulted in Respondent being called before the Complaint Review Committee. The Board issued stipulations and orders in 1991, 1992, 1998, and 2001, which subjected Respondent to multiple conditional license requirements.

3. The 2001 Stipulation and Order, which amends the 1998 Stipulation and Order, conditioned Dr. Dudley's license on compliance with various requirements and required him to: 1) keep records on all patients in accordance with the record keeping requirements of Minn. R. 9100.0800, subp. 4, specifically by "recording in the patient record of each hospitalized patient daily examination findings and any medication or treatment provided" (paragraph V.A.1); 2) comply with any written request for information or documentation by the Board within 30 days of the date of the request (para. V.A.3); and 3) obtain

¹ Transcript ("T.") at 340.

² T. at 35-36.

³ Order on Motion for Partial Summary Disposition, dated May 19, 2006.

informed consent from the patient's owner prior to hospitalizing overnight critically ill or injured patients (para. V.A.6). The informed consent may be written or oral, but oral consent and the scope of the consent must be noted in the patient record in detail.

4. Since 2001, the Board has received several additional complaints against Respondent regarding his care of seven different patients, Francie (cat), Gage (dog), Sasha (cat), Guido (cat), Dewey (dog), Rocky (dog), and Lucy (cat).

Care of Francie

5. Respondent cared for Francie, a two-year-old cat, at his clinic from May 16-20, 2003. Upon arrival, Francie was experiencing rapid weight loss and had vomited rubber bands on or about May 10, 2003.

6. Respondent palpated the cat's stomach and felt a lump. No survey x-ray was taken. Respondent performed a barium series lateral radiograph to determine if an obstruction was present. He took only one view. The lateral radiograph revealed an obstruction and Respondent decided to operate on the cat to remove it. Respondent did not perform a ventral radiograph, because it would have required him to anesthetize Francie twice and he did not wish to subject the cat to the risks of anesthesia more than once if possible.⁴

7. The standard of care requires that a survey x-ray be performed prior to a barium series and that two different views are the minimum required.⁵ Respondent acknowledged that two radiographs are the standard.⁶

8. Prior to performing the surgery, Respondent did not complete a blood profile of the cat. Respondent performed the surgery on May 17, after administering a pre-made anesthesia mixture consisting of Ketaset, Atropine, and Acepromazine.⁷ He successfully removed a bracelet and a metal earring and provided Francie with post-operative antibiotics.⁸ Respondent did not administer any additional pain medication because he did not want the cat sedated, but rather up and moving around.⁹ Francie stayed overnight at the clinic while she recovered, and Respondent discharged her on May 20. At that

⁴ T. 437.

⁵ T. 137; the Respondent's expert did not offer an opinion concerning the standard for taking radiographs.

⁶ T. 39.

⁷ The pre-made mixture consisted of 1 cc of Acepromazine, 1 cc of Atropine, and 10 cc's of Ketaset.

⁸ Ex. 11. Respondent administered Penicillin on May 17, and Baytril on May 18 and 20.

⁹ Failure to perform the blood profile prior to surgery, failure to properly sedate during surgery and failure to prescribe appropriate antibiotics and pain medication were not included in the Notice and Order for Hearing.

time Respondent did not provide pet owners with a guide to measure the possibility that the pet was experiencing pain.¹⁰

9. Respondent made brief notes in Francie's record while in the treatment room with the cat, then later re-wrote those notes to make them more legible. Respondent's standard office procedure is to make the first set of records by hand and then pass them off to his receptionist to be typed.¹¹

10. On May 26, 2003, Francie was admitted to the Affiliated Emergency Veterinary Service with an abscess on her abdomen from the surgery.¹²

11. The standard of care for surgery is to offer pain medication to be administered to the animal following discharge. Pain medication can be administered so that the animal is not sedated and can be up and walking.¹³

12. On August 28, 2003, the Board received a complaint against Respondent regarding his treatment of Francie, and an investigation by the Board ensued.¹⁴

Care of Gage

13. On January 9, 2004, Gage, a six-month-old Siberian Husky, presented at Respondent's clinic for a canine neuter procedure. Upon examining the dog, Respondent discovered that Gage was cryptorchid, meaning one testicle had not descended. Respondent contacted the owners to inform them of the extra cost of locating the undescended testicle, and the risks involved if it was not located and removed.¹⁵ The owners were unable to give immediate permission to perform the surgery, but phoned back approximately 15 minutes later and granted permission.¹⁶

14. Respondent began the surgery by cutting into the abdominal cavity and then proceeded to the pelvic cavity.¹⁷ Respondent did not cut into the pelvic bone to gain access to the pelvic cavity. During the surgery, Respondent discovered a small mass attached to the dog's spermatic cord, which attaches to the prostate gland, and removed the mass along with the two testicles. The urethra runs through the prostate gland, and at some point during the surgery, Respondent unknowingly cut the urethra prior to closing up the incision. He sutured the cut to prevent hemorrhage.¹⁸

¹⁰ T. 543.

¹¹ T. 41. Ex. 11.

¹² Ex. 10.

¹³ T. 137, 265. Respondent's expert offered no opinion about Francie's treatment.

¹⁴ Ex. 8.

¹⁵ T. 362.

¹⁶ T. 54.

¹⁷ T. 483.

¹⁸ T. 494-95.

15. Post-surgery, Respondent cut into the mass, which was 0.5 to 1 centimeter in diameter, removed what he thought was largely fat, and performed a gross examination. Respondent retained the mass for a few days but did not send the mass to another laboratory for testing, in large part because it resembled a lymph gland.

16. Following the surgery, Gage stayed in the clinic overnight. The dog did not eat, drank little if any water, and did not urinate. The morning of January 10, 2004, Gage's owner returned to the clinic to pick him up. Respondent did not provide post-operative antibiotics or pain medication to be administered at home.¹⁹ At that time, Gage had a slight temperature. Respondent discharged Gage to the owner's care. Once home, Gage remained groggy and withdrawn, did not want to eat, and only drank water. When he started vomiting, the owner called Respondent, who told her to bring the dog back into the clinic that evening.²⁰

17. Once Gage returned to the clinic, Respondent put the dog on antibiotics and IV fluids and performed a blood profile.²¹ Several parts of the test results, including the protein, globulin, and phosphate readings, were widely skewed outside the acceptable range for a living animal. However, Respondent failed to realize that his laboratory testing equipment was not working properly.²² Instead, Respondent focused on the blood urea nitrogen ("BUN") and creatinine results. These two results and the dog's failure to urinate alerted Respondent that Gage was seriously ill.

18. At approximately 11:00 p.m., Respondent removed the IV fluids and catheterized Gage. By midnight, Gage had still not urinated and Respondent knew that urine was leaking into the dog's abdomen.²³ Respondent hypothesized that Gage's ureter had been cut,²⁴ and knew that the dog's death was imminent but he did not call the owners or make an emergency referral.²⁵ Respondent asked the individual living in the apartment above the clinic to look in on the dog and went home. The medical record does not show that anyone checked on Gage during the early morning hours or whether the dog urinated.

19. When Respondent returned to the clinic between 6:00 and 7:00 a.m. the following morning, Gage was still alive. Respondent encouraged the dog to get up and walk around. Shortly thereafter, Gage went into shock and died at approximately 8:00 a.m.²⁶

¹⁹ T. 497-98.

²⁰ Ex. 15.

²¹ T. 56.

²² Ex. 18.

²³ T. 488-89.

²⁴ T. 487.

²⁵ T. 491.

²⁶ Exs. 18 and 19.

20. On January 14, 2004, the Board received a complaint against Respondent regarding his treatment of Gage, alleging that mistreatment or malpractice had occurred and questioning Respondent's competency to practice veterinary medicine.²⁷

21. The Respondent acknowledged that he now realizes that the urethra was cut during surgery and the prostate removed. This did not comport with the standard of care, as he acknowledged and both experts testified. The standard of care also required that the Respondent prescribe post-surgical antibiotics and pain medication, send the mass to be tested, that Respondent recognize that his equipment was malfunctioning when it gave impossible results for a living animal, that he monitor Gage's urination following the surgery, that Gage be monitored continually between 11:00 p.m. and 7:00 a.m., and that he refer Gage to an emergency facility when it was apparent that urine was not passing through Gage's body.²⁸

22. All three doctors agreed that once the urethra was cut, a portion removed, and urine passed into the abdomen, Gage's chances of recovering to live a normal life were nil.

23. The standard of practice is to administer post-operative antibiotics for several days. As Dr. Larry stated: "Any time you're going to cut or create anything that leads to potential infection, you need to cover that with antibiotics."²⁹ There is no evidence that Gage was sent home with post-surgical antibiotics.³⁰

Care of Sasha

24. On June 30, 2004, Respondent provided care to Sasha, a nine-month-old cat. Sasha's owner brought her in to All Care Veterinary Clinic and Hospital in St. Paul to be spayed. That day the owner signed a Treatment Consent Form authorizing Respondent to spay Sasha and administer a distemper shot.³¹

25. Prior to performing the procedure, Respondent gave Sasha 2 cc's of the pre-made anesthesia mixture of Acepromazine, Atropine, and Ketaset. He noted this information in the cat's medical record.³² Approximately 15 minutes after administering the anesthesia, Sasha began to have a seizure. Respondent

²⁷ Ex. 15.

²⁸ T. 141-55, 221-25. Although Dr. Larry questioned how the urethra was cut because the autopsy report was not clear about whether Respondent had cut into the pelvic canal, she agreed that the urethra was cut. She offered no opinion concerning the biopsy of the mass, the malfunctioning lab equipment, the need to observe for urination or to refer the pet to an emergency facility.

²⁹ T. 315.

³⁰ Exs. 16, 18.

³¹ Ex. 23.

³² Ex. 23. T. 72-73.

administered Diazepam to Sasha until the seizure subsided. He then transported the cat to his Brooklyn Center office. The seizures recurred a short time later, and Respondent again administered Diazepam until the seizing subsided.³³ Respondent noted in his records that he had given Sasha Diazepam "to effect" but did not record the exact dosage. Sasha was given Lasix, a diuretic, to wash the Acepromazine out of her system.³⁴

26. Sasha spent two nights in Respondent's clinic. The records state that on the first night Respondent or one of his staff "gave lactated ringers through the night and removed urine when bladder was distended." There is no documentation of overnight monitoring or care for the second night. Sasha was discharged on July 2, at which time Respondent instructed her owners to give her syrupy water. Respondent spoke to the owner by phone on July 4 and was told that Sasha was doing okay. Respondent never performed the spay procedure.

27. If a veterinary clinic pre-mixes medications for use and maintains a record of the amounts and proportions of the medications in the mix, the medical record may properly refer to the amount of the mix that was given to the animal.³⁵ There was no evidence that the Complaint Committee was provided with information from the Respondent about the standard mixture of Acepromazine, Atropine and Ketaset that he administered. Recording that Diazepam was administered "to effect" met the standard of care.³⁶

28. Although the mix of Acepromazine, Atropine and Ketaset was acceptable, it is an out-of-date form of anesthesia. At the present time, over 99 percent of veterinarians would use a general anesthesia to perform a spay procedure.³⁷

29. Paragraph V.A.1. of the 2001 Amended Stipulation and Order required compliance with the record keeping requirements of Minn. R. 9100.0800, subp. 4, specifically by "recording in the patient record of each hospitalized patient daily examination findings and any medication or treatment provided."³⁸ The most relevant portion of Minn. R. 9100.0800, subp. 4, requires documentation of "medication and treatment, including amount and frequency." While the references in Sasha's patient record to the amount of pre-made anesthesia mixture and prescribing Diazepam "to effect" are consistent with generally accepted practice, the Amended Stipulation and Order required greater specificity.

³³ Ex. 23. T. 76.

³⁴ T. 73.

³⁵ T. 155.

³⁶ T. 156. Although Dr. Levine testified that administering Lasix was not the appropriate method to counteract the effect of the Acepromazine, and that Sasha should have been under a 24-hour seizure watch, those allegations were not included in the Notice and Order for Hearing.

³⁷ T. 205.

³⁸ Ex. 5.

30. The use of Lasix to counteract the effect of the Acepromazine was not an effective means to wash the Acepromazine out of Sasha's system because Acepromazine is metabolized in the liver and broken into inactive components. The Lasix works in the kidney and thus would not counteract the Acepromazine. Dr. Larry did not offer an opinion about Sasha's care or about the effectiveness of Lasix to counter act the effect of Acepromazine.³⁹

31. On August 20, 2004, Sasha's owner filed a complaint about Respondent's treatment of Sasha and questioned his competency to practice veterinary medicine.⁴⁰

Care of Guido

32. On January 7, 2005, Guido, a ten-month-old cat, was brought to Respondent's clinic for a declaw procedure. The procedure, an onychectomy, involved removal of the third digit, a very painful procedure.⁴¹ Immediately before the surgery, Respondent administered general anesthesia to Guido consisting of 2 cc's of Acepromazine, Atropine, and Ketaset. The declaw procedure required Respondent to place a tourniquet on the cat's leg to control excess bleeding. Following the procedure, Respondent left the cat with his assistant who was to remove the tourniquet and bandage the cat's paws.

33. Later that day, a staff member discovered that the tourniquet had been left on Guido's front leg for several hours. Respondent administered Vetalog, an anti-inflammatory medication, in an attempt to stimulate circulation and reduce the swelling. Guido stayed overnight at the clinic to recover.⁴² There is no evidence in the record that Guido received any pain medication or antibiotics during this time.

34. The following morning Guido's owners returned to the clinic to pick him up. Respondent discharged the cat at that time and pointed out that the left front leg was swollen but did not explain why it was swollen. Respondent asked the owners to return Guido to the clinic for a check-up in a couple of days and sent home some Prednisone.⁴³ Prednisone is an anti-inflammatory medication that will reduce swelling but does not directly address pain.⁴⁴

35. Respondent stated that the owners declined to elect post-surgical pain medication, but he acknowledged that all owners should be offered pain medication and that these owners were unaware of possible nerve damage to

³⁹ T. 156, 165-166. This allegation was first raised in the Board's disclosure of Dr. Levine's testimony in January 2007.

⁴⁰ Ex. 21.

⁴¹ T. 158.

⁴² T. 429.

⁴³ Ex. 24; T. 90.

⁴⁴ See, T. 166 and 181 (testimony regarding Vetalog).

the leg from the tourniquet.⁴⁵ Respondent mistakenly believed that Ketaset given during surgery would remain in the system and blunt the pain,⁴⁶ but the half-life of Ketaset is one hour. Respondent's expert offered no testimony that Ketaset as anesthesia was an adequate method to control post-operative pain.

36. Guido's owners were concerned about the pain that Guido was experiencing and the care that he had received from Respondent. Later that same day, they took the cat to another veterinarian for a second opinion. Ultimately, Guido suffered irreparable nerve damage and his left front leg had to be amputated. On January 29, 2005, Guido's owners filed a complaint with the Board regarding Respondent's treatment of the cat.⁴⁷

37. Respondent acknowledges that he is responsible for the actions and mistakes of those individuals employed in his clinic.

38. The standard of care requires that the tourniquet be removed immediately, within a few minutes, after the declaw of each individual paw, that the animal be checked promptly following surgery, that a general anesthesia and regional block be used to conduct the surgery, that post-surgery pain medication be prescribed, that the error should have been accurately and completely documented in Guido's record, and the circumstances explained to Guido's owners. Discharging Guido to the owners without discussing the mistake that occurred and the possible consequences, arranging for, at a minimum, a recheck the following day, and discharging without pain medication was not consistent with the standard of care.⁴⁸

Care of Dewey

39. Dewey is a five-year-old dog brought to Respondent at the St. Paul clinic on June 15, 2005, for a partial tail amputation and a dental cleaning.⁴⁹ The owners requested the partial tail amputation because, despite the use previously of a head cone, Dewey had been biting at his tail repeatedly.⁵⁰ Immediately before performing the two procedures, Respondent administered a Lidocaine epidural, and two other short-term painkillers.⁵¹ Respondent completed both procedures and afterward Dewey was given an antibiotics injection. An antibiotic

⁴⁵ T. 540-41 (all owners should be offered the option of pain medication); T. 429-31 (Respondent admitted that he didn't tell the owners what he knew about Guido's leg).

⁴⁶ T. 158; At his deposition, Respondent stated that he relied on the anesthesia's lasting effects to address pain. Ex. 7 at 41-42.

⁴⁷ Ex. 27.

⁴⁸ T. 157-162; Respondent's expert did not testify concerning the standard of care other than to corroborate that a veterinarian is responsible for the care provided by employees. Dr. Levine also testified that Respondent should have sought expert assistance upon discovering that the tourniquet was left on to minimize any damage. That allegation was not included in the Notice and Order for Hearing.

⁴⁹ T. 93.

⁵⁰ T. 469.

⁵¹ T. 94.

cream, Furacin, may have been used when the tail was wrapped, but it was not documented.⁵² Respondent discharged Dewey to his owners the day of the surgery.

40. Invoices issued to Dewey's owners do not contain any reference to antibiotics sent home with the dog. Respondent's care instructions in the patient record address only the dental cleaning and not the tail amputation. Respondent does not routinely send antibiotics home with clients for non-infected surgeries like tail amputations.⁵³

41. The following day, June 16, Dewey and his owner returned to the clinic because Dewey had chewed his tail bandages off. Respondent re-bandaged the dog's tail and kept Dewey overnight to monitor whether a tail cone he had placed on the dog would protect the wound on the tail. Dewey went home the following day with a "Bite-Not" collar and a tail cone.⁵⁴

42. The owner had difficulty keeping the tail cone on Dewey and called Respondent. Respondent inquired as to whether the tail wound was bleeding, and when the owner responded that it was not, Respondent told him to bring Dewey in the next morning.⁵⁵ During the night, Dewey's tail began bleeding and his owner took him to another veterinarian who removed another vertebra of the tail.⁵⁶

43. The standard of care requires pre- and post-operative administration of antibiotics for surgery such as the tail removal, and particularly when combined with dental cleaning because of its corresponding release of bacteria. In addition, pain medication is necessary following the tail amputation.⁵⁷

44. It is not clear that the standard of care prevents combining a tail amputation and dental cleaning in all circumstances. Dr. Levine does not believe that the two should be combined.⁵⁸ Dr. Larry would be willing to combine the two for a healthy, young animal with no sore or infection.⁵⁹ There are some savings from doing only one pre-surgical work-up and administration of anesthesia. Although there was evidence that Dewey had been biting his tail, it is not clear from the record that he had a sore or infection on his tail. If he did, Respondent's expert would concur that it was inappropriate to combine the two surgeries because of the high risk of infection.⁶⁰ Regardless, Dr. Larry routinely dispenses post-surgical antibiotics and pain medication after a surgical procedure, including

⁵² T. 532.

⁵³ Exs. 29 and 30.

⁵⁴ Ex. 30.

⁵⁵ T. 470.

⁵⁶ Ex. 31.

⁵⁷ T. 328-332 (Dr. Larry); T. 168-71.

⁵⁸ T. 165.

⁵⁹ T. 295-97.

⁶⁰ T. 295-97.

a tail amputation.⁶¹ Although Dr. Levine did not believe that the proper amount of tail was removed, he agreed that sometimes the spot is selected for aesthetic reasons, and the record is unclear as to what additional portion of the tail should have been removed.

45. On June 22, 2005, the Board received a complaint from Dewey's owner regarding the treatment the dog received from Respondent.⁶²

Care of Rocky

46. On September 30, 2005, at the St. Paul clinic, Respondent treated Rocky, a 13-month-old dog, for an injured left front leg that had been caught in a sewer grate. Respondent took two radiographs of the leg and determined that Rocky had a Salter fracture, meaning his leg was broken at the "elbow" joint.⁶³ Respondent informed the owner that it was a bad break. In order for the bone to have a chance to heal properly, the appropriate treatment requires that screws be surgically implanted in the bone. This surgery costs approximately \$800-\$1000 and still may result in restricted movement of the leg.⁶⁴

47. It is not clear from the medical record whether Respondent fully explained that surgery was the most effective method to treat the fracture. Rocky's owner asked what other options were available for the dog.⁶⁵ Respondent explained that he could place a cast on the dog's leg to stabilize it, and that while casting was not the proper method, he had achieved good results using this technique in the past.⁶⁶ The owner consented to the cast and Respondent set the cast on Rocky's left front leg and administered Vetalog, an anti-inflammatory drug, and Penicillin. Respondent sent Rocky home with another antibiotic called Clindamycin and asked the owner to bring the dog in for a re-check in a few days because Rocky could develop sores on his leg from the cast rubbing on it.⁶⁷ Rocky was given Vetalog, an anti-inflammatory medication, but did not receive any medication specifically for pain.⁶⁸

48. On October 11, 2005, after a few calls from Respondent to check on Rocky's leg, Rocky's owner (the father of the family) returned the dog for a

⁶¹ T. 328.

⁶² Ex. 29. There was testimony that performing a dental cleaning at the same time that the tail was amputated violated the standard of care. The allegation was not included in the Notice and Order for Hearing but was included in the expert witness disclosure in January 2007.

⁶³ T. 401.

⁶⁴ T. 401-03.

⁶⁵ At the hearing, Respondent acknowledged that the only good way to treat this fracture is with surgery, but maintained that the client could not pay for that. This is not consistent with his deposition (Ex. 7 at 71-8), Rocky's medical record, or his admission that he told the owner he had used a cast with good results with other similar fractures. He testified that he explained the risk to the pet owner, but there is no evidence in the record to support his statement at hearing.

⁶⁶ T. 103-05 and 402-03.

⁶⁷ Ex. 34.

⁶⁸ T. 514-15, 517.

check-up with Respondent. By this time, Rocky had developed a sore at the top of his cast. Respondent re-taped and re-padded the cast so it would no longer rub on Rocky's leg.⁶⁹ There is no evidence that Respondent discussed the possibility of surgery to correct Rocky's break during that visit, or explained to the owner that chance of recovery without surgery was limited.

49. Several days later, Rocky's leg looked and smelled infected and his owner took him to another veterinary clinic. The veterinarian cut the cast off of Rocky's leg, treated the infected wounds, and placed a splint on the dog's leg to stabilize the fracture.⁷⁰ This veterinarian informed the owner of three treatment options – immediate surgery, amputation of the leg, or euthanasia.⁷¹

50. The standard of care for a joint injury requires that the bones in the joint be aligned and that the joint be immobilized. Dr. Dudley agreed at the hearing that surgery was the preferred method of treatment and that the only way that the fracture could mend would be to immobilize the joint above and below the fracture, but he stated that the joint above the fracture could not be immobilized in this case.⁷² A cast would not help heal the break unless the joints above and below the break were immobilized. The cast placement did not benefit the dog and may have been worse than no cast. The standard of care required rechecking the cast sooner than 12 days, and pain medication was required. Prescribing Vetalog did not meet the standard of care because it does not address pain and may inhibit bone growth.⁷³

51. Rocky's owners filed a complaint with the Board on October 20, 2005, alleging substandard care of Rocky, and an investigation by the Board ensued.⁷⁴

52. On October 28, 2005, Rocky was taken to the University of Minnesota Veterinary Medical Center for a surgical consultation to determine whether surgery could improve the dog's quality of life.⁷⁵ Due to significant financial constraints and concern for the dog's quality of life, Rocky's owners requested that the dog be placed for adoption or euthanized. In the end, Rocky was euthanized at the University's Veterinary Medical Center.

Care of Lucy

53. Lucy is a one-year-old cat who was brought to Respondent's clinic on June 22, 2006, to be declawed (all four paws) and spayed. Prior to performing the two procedures, Respondent administered Lidocaine, Ketaset,

⁶⁹ T. 102, 104.

⁷⁰ T. 403-04.

⁷¹ Ex. 32.

⁷² T. 513.

⁷³ T. 175-81, 212-15. Dr. Larry did not testify concerning Rocky.

⁷⁴ Ex. 32.

⁷⁵ Ex. 36.

and Penicillin as anesthesia and antibiotics.⁷⁶ Respondent performed the declaw procedure using an electro-surgery machine that uses radio frequencies to cut the cat's claws. Lucy did not receive any pain medication immediately following surgery. Lucy stayed overnight at the clinic to recover from the surgeries. Lucy's medical records do not indicate that Respondent obtained consent for the overnight stay from the owner.⁷⁷

54. When Lucy's owner picked her up from the clinic on June 23, 2006, Respondent did not give the owner any post-operative instructions and did not send pain medication home for the cat.

55. Approximately one week later, Lucy's owner brought her in to see Respondent for removal of the spay sutures and some of the sutures on the paws. Lucy's records do not reflect this office visit.

56. On August 6, 2006, Lucy's owner returned to Respondent's office because the cat was experiencing soreness in one paw.⁷⁸ Respondent felt a knot-like outgrowth on one paw and examined it. Respondent's records indicate that he anesthetized the cat again and surgically removed outer growths from at least one paw.⁷⁹ These growths were the result of incomplete removal of the nail/claw.⁸⁰ Respondent then re-bandaged the paws with heavy duty sports tape but did not administer any pain medication.

57. Respondent's office policy is to keep cats overnight after they have been declawed and then remove the bandages the following day. Accordingly, Respondent wished to keep the cat overnight to recover, but the owner signed a waiver and took Lucy home with her against advice, and with the bandages still on.⁸¹

58. A few days later, the owner removed Lucy's bandages and observed that the paws were bleeding and had open sores. She took Lucy to another veterinarian who examined the paws, found them to be open, draining, and infected, and prescribed antibiotics and pain medication.⁸²

59. Lucy's medical record stated that she was admitted for spay and declaw and recorded "Feline spay, Declaw 4 feet B.P.H. technique." There was

⁷⁶ T. 111-13. Ex. 38.

⁷⁷ Ex. 38.

⁷⁸ T. 117-18.

⁷⁹ The medical record states that Respondent removed growths from all four paw. Respondent testified at hearing that he removed a growth from just one paw, but he acknowledged that he cut all four paws in order to be sure that there were no additional growths on any of the feet. T. 507-08; Ex. 38.

⁸⁰ T. 118-19.

⁸¹ T. 507.

⁸² T. 120. Ex. 37.

no documentation of home care instructions or medications for either procedure.⁸³

60. The Respondent's use of an electro-surgery machine does not meet the standard of care for declawing. Suturing following declawing may not violate the standard of care, but most veterinarians do not suture.⁸⁴ Antibiotics should have been administered pre- and post-surgery, and pain medication prescribed. Upon Lucy's return because of paw soreness, the standard of care would not be to cut all four feet to check for remaining nails. The standard of care would include pain medication.⁸⁵ Respondent was not able to identify the precise type of electro-surgery machine used or provide other information about it. Using a standard abbreviation for a spay procedure met the standard of care.⁸⁶

61. In late-August, Lucy's owner contacted the Board to lodge a complaint against Respondent. A Board investigator interviewed the owner by telephone on August 30, 2006.⁸⁷

62. The Board's expert on the standard of care is Stephen H. Levine, DVM, MS DipACVS. Dr. Levine attended college at the University of Illinois (Chicago) and received his doctorate in veterinary medicine from the University of Illinois (Champaign) in 1979.⁸⁸ Upon receiving his DVM, Dr. Levine spent five years training in small animal surgery at the University of Minnesota and received a master's degree in that specialty. He is also board certified by the American College of Veterinary Surgeons. Dr. Levine was an Assistant Professor of Small Animal Surgery at the University of Minnesota from 1983-1989. Dr. Levine is currently Chief of Surgery at Veterinary Surgical Specialists, a private surgical referral practice in Inver Grove Heights that he owns and runs. He has published numerous articles in scientific journals and surgery textbooks and has been invited to speak at numerous veterinary conferences in the United States and Europe.

63. Respondent's expert on the standard of care is Faye N. Larry, DVM. Dr. Larry attended college at Colorado State University and received her doctorate in veterinary medicine from that same institution in 1987.⁸⁹ She worked in the Denver area for approximately one year before moving to Minnesota and becoming an associate veterinarian in Respondent's clinic in Brooklyn Park where she learned the business side of running a solo veterinary practice in addition to working with the animals. After working with Respondent for approximately one year, Dr. Larry worked at the Minnesota State Fair's

⁸³ Ex. 38.

⁸⁴ T. 187.

⁸⁵ T. 183-87, 231, 315. Dr. Larry did not testify about the care given to Lucy.

⁸⁶ T. 184.

⁸⁷ Ex. 39.

⁸⁸ Ex. 40.

⁸⁹ Ex. 47.

MVMA Surgical Suite. From 1998-2000, Dr. Larry was a part-time instructor for the Veterinary Technician Program. She is currently a solo practitioner in the same building as Respondent where the vast majority of her patients are small animals.

64. In most respects, Dr. Levine and Dr. Larry agreed on the standard of care. In particular, they agreed on the use of antibiotics prior to and after any form of invasive surgery, and the standard prescription of pain medication following surgery, including spay and declaw procedures. Dr. Larry offered no testimony concerning Francie, Sasha, Rocky or Lucy, and did not address all of the allegations concerning care of Gage, Guido or Dewey.

Procedural Findings

65. On September 16, 2005, the Complaint Review Committee served a Notice of and Order for Prehearing Conference and Hearing in response to complaints regarding Respondent's care of Francie, Gage, Sasha, and Guido.

66. On December 28, 2005, the Complaint Review Committee issued an Amended Notice of and Order for Prehearing Conference and Hearing in response to complaints regarding Respondent's care of Dewey and Rocky.

67. The Complaint Review Committee filed a motion for partial summary disposition on March 15, 2006, seeking to dispose of multiple allegations regarding six of the patients. By Order dated May 19, 2006, the Administrative Law Judge granted the motion on many of the allegations relating to each of the six patients.

68. On September 15, 2006, the Complaint Review Committee issued a Second Amended Notice of and Order for Prehearing Conference and Hearing in response to a complaint about Respondent's care of Lucy.

Based upon the above Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Board and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 147.091, 214.10, and 214.103.

2. The Board has authority to take disciplinary action against licensed physicians under Minn. Stat. § 147.091.

3. The Board gave proper notice of the hearing in this matter and has fulfilled all relevant procedural requirements of law and rule.

4. The Board has the burden of proof in this proceeding to establish the facts at issue by a preponderance of the evidence.⁹⁰

5. The Board has proved that Respondent departed from or failed to conform to the minimum standards of acceptable and prevailing medical practice, in violation of Minn. Stat. § 156.081, subd. 2 (11), with regard to:

a. Francie: Failure to take radiographs showing two views; Failure to offer adequate pain medication. Although the Board failed to show that Respondent maintained two sets of records, it did show that Respondent's records were poorly maintained and incomplete.

b. Gage: Improper surgery, resulting in a severed urethra and prostate gland; Failure to biopsy the mass removed during surgery; Failure to recognize that lab equipment was malfunctioning; Failure to monitor the patient to observe urination; Failure to monitor the patient between January 10, 2004, at 11:00 p.m. and January 11, 2004, at 7:00 a.m. Although it may have been appropriate to seek a consultation when Gage was clearly dying, the Board failed to show by a preponderance of the evidence that in violated the minimum standard of acceptable and prevailing practice not to refer the patient to an emergency facility.

c. Sasha: Inappropriate administration of Lasix.

d. Guido: Failure to promptly remove tourniquet following declaw procedure; Failure to conduct prompt post-surgery examination; Failure to use general anesthesia and regional block during the declaw procedure; Failure to prescribe post-surgery pain medication; Failure to keep accurate progress notes. The Board failed to offer evidence that Respondent failed to fully remove Guido's claw.

e. Dewey: Failure to provide the owner with post-surgery instructions for the tail surgery, antibiotics or pain medication. The Board failed to prove by a preponderance of the evidence that it is inappropriate to combine tail amputation and dental cleaning in all instances or that Respondent removed an improper amount of the tail;

f. Rocky: Failure to stabilize the fracture or reduce the fracture; Failure to provide pain medication; Failure to place the cast properly;

⁹⁰ Minn. R. 1400.7300, subp. 5.

g. Lucy: Failure to properly declaw: Failure to provide follow-up care instructions; failure to provide anti-inflammatory medication or pain medication following surgery on June 22, 2006; Failure to properly remove sutures; Failure to offer pain medication, anti-inflammatory medication or antibiotics on June 29, 2006.

6. The Board has demonstrated that Respondent has violated a rule promulgated by the Board, specifically, Minn. R. 9100.0700, subs. 1 A., B. and C., and Minn. R. 9100.0800, subp. 1, with regard to Francie, Gage, Sasha, Guido, Dewey, Rocky and Lucy, in violation of Minn. Stat. § 156.081, subd. 2 (12).

7. The Board has demonstrated that Respondent engaged in conduct likely to harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient, in violation of Minn. R. 9100.0700, subp. 1B, and Minn. Stat. § 156.081, subd. 2 (12), with regard to Francie, Gage, Guido, Dewey, Rocky and Lucy.

8. The Board has demonstrated that Respondent engaged in medical practice that was professionally incompetent, in that it may create unnecessary danger to a patient's life, health, or safety, with regard to Gage, Guido, Dewey, Rocky and Lucy, in violation of Minn. R. 9100.0700, subp. 1 C, and Minn. Stat. § 156.081, subd. 2 (12).

9. The Board has demonstrated that Respondent failed to prepare and maintain written veterinary medical records, in violation of Minn. R. 9100.0800, subp. 4, and Minn. Stat. § 156.081, subd. 2 (12), with regard to Francie, Gage, Guido, Dewey and Lucy.

10. The conclusions of violations included in the Order on Motion for Partial Summary Disposition issued on May 19, 2006, are incorporated herein.

11. The Board is not obligated to prove that the Respondent's departure from or failure to conform to the minimal standards of practice or professionally incompetent medical practice caused actual injury to any patient.⁹¹

12. As a result of these violations, the Board has the authority to take appropriate disciplinary action against the Respondent's license.⁹²

Based on the foregoing Conclusions, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

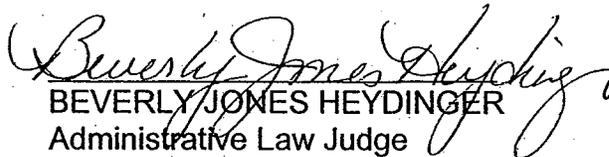
⁹¹ Minn. Stat. § 156.081, subd. 2 (11).

⁹² Minn. Stat. § 156.081.

RECOMMENDATION

The Administrative Law Judge respectfully recommends that the Board take appropriate disciplinary action against the Respondent's license to practice veterinary medicine.

Dated: June 4~~th~~ 2007.


BEVERLY JONES HEYDINGER
Administrative Law Judge

Reported: Transcribed – Three volumes.
Kirby A. Kennedy & Associates.

NOTICE

This report is a recommendation, not a final decision. The Minnesota Board of Veterinary Medicine will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61, the Board shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Board must consider the exceptions in making a final decision. Parties should contact John King, Executive Director, Minnesota Board of Veterinary Medicine, 2829 University Avenue SE, Suite 540, Minneapolis, Minnesota 55414-3246, to learn the procedure for filing exceptions or presenting argument.

If the Board of Veterinary Medicine fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Board, or upon the expiration of the deadline for doing so. The Board must notify the parties and the Administrative Law Judge of the date on which the record closes.

MEMORANDUM

The findings of fact clearly spell out areas where the Respondent's practice departs from minimum standards of acceptable and prevailing practice, and some of those departures are likely to harm the animals placed in Respondent's care. Although the Respondent surely has no intent to harm the animals, he has in fact put them at risk, or in several instances subjected them to a heightened risk of infection and unnecessary suffering.

The Respondent's record-keeping problems are clear from a cursory review of his medical records and comparison with the records of other clinics

where animals were taken for follow-up care. The record-keeping problems are long-standing, as more fully set forth in the Memorandum accompanying the Order on Motion for Partial Summary Disposition, incorporated herein. With poor record-keeping it is difficult to track the specific diagnosis and treatment plan or the implementation of that plan. When an unexpected or adverse result occurs, it is particularly important to check the records, to review the tests that were done, the diagnosis made, the options considered, and the course of action that was followed. The Respondent's poor record-keeping complicated the review of his practice in the instances where there were adverse results.

Francie

The Respondent took only one radiograph, even though he acknowledged that the standard of practice was to take two views. In this instance, his failure to take two may not have affected the care given to Francie, but it is difficult to tell because he did not have one medical record that clearly set forth his findings and his treatment plan. In addition, it would not be standard to conduct a barium series without first taking a survey x-ray. Failure to have a complete medical record places the patient's health and safety at unnecessary risk.

In this instance, as in others, the Respondent administered a form of anesthesia that, although acceptable, is out-of-date, and there is no record that he prescribed a course of antibiotics or pain medication following the surgery that his own expert, Dr. Larry, testified was the standard of care for invasive surgical procedures. His failure to prescribe antibiotics may have contributed to Francie developing an abscess.

Respondent's comments about the use of pain medication for Francie suggest that, despite Board-directed additional training about proper pain medication, he still has a poor grasp of commonly-used pain medications and the ordinary course of their administration. He stated that he did not prescribe pain medication for Francie because he wanted the cat to be up and moving around and not sedated. Dr. Levine testified that pain medication can be administered without sedating the animal, and Dr. Larry offered no opinion to the contrary.

Gage

Unfortunately Gage's urethra was severed during a cryptorchidectomy. Precisely how that occurred is difficult to determine because Respondent did not thoroughly document the steps that he took during the surgery and he did not send the mass that he removed out for testing, even though he admitted that he held it for a few days. Respondent failed to keep Gage under observation until Gage urinated, and once it was apparent that Gage was very ill, Respondent did not notify the family and offer the option of a referral to an emergency facility. Furthermore, he relied on test results from a piece of equipment that was clearly malfunctioning. It is likely that, once the urethra was cut, nothing could have

been done for Gage to return him to normal good health. However, even if all was lost for Gage, Respondent left Gage alone, and there is no evidence that he administered pain medication to blunt the effects of the dog's suffering. As Respondent properly points out, mistakes happen. In this instance, in addition to the surgical error, it was the steps that Respondent took after the surgery that compel the conclusion that he failed to conform to the minimum standards of acceptable and prevailing practice and engaged in conduct that was incompetent and harmful to Gage.

Sasha

Although the use of a mixture of medications to anesthetize Sasha and the administration of Diazepam to effect did not violate the standard of care, Respondent's use of Lasix to offset the effects of the Acepromazine did. Dr. Levine testified without opposition that Lasix administration was of no benefit and may have been to Sasha's detriment. As with other cases, the Respondent demonstrated little knowledge of the medications that he employed and their effectiveness for the intended purpose.

In its post-hearing brief, the Board contends that Respondent failed to place Sasha under a 24-hour seizure watch, as Dr. Levine established was the standard of care. That issue was not previously disclosed to Respondent and will not be addressed herein. However, if Respondent conducted the seizure watch, he failed to document it in Sasha's medical record.

Guido

A tourniquet was left on Guido's paw for about six hours following a declaw procedure. Once again, a mistake was made, but the aftermath of the mistake appropriately heightened the Board's concern. First, the mistake was not caught for hours. This suggests that no one checked on Guido for several hours after the surgery. Second, once it was clear that a mistake had been made, no steps were taken to determine what, if anything, might have been done to minimize the damage to the nerves in Guido's leg. There is no indication in the medical records that Respondent conducted any type of assessment to determine the extent of the damage. Third, Guido was discharged with no disclosure of the mistake to the owners and no special instructions. Respondent claimed that the owner declined pain medication, but the owner was not notified of the serious error that had been made and the high likelihood that Guido would experience severe pain because of nerve damage. Respondent gave the owner no special instructions and did not direct the owner to bring Guido back to be checked the following day. Leaving the tourniquet on for hours clearly violated the minimum standards of acceptable and prevailing practice and was incompetent, but, in addition, Respondent's actions thereafter suggest a careless disregard for the animal.

To his credit, Respondent took responsibility for the error of his assistant. However, he acknowledged that his assistant had no formal training, and Dr. Larry testified that there had been problems with the assistant in the past. Thus, Respondent should have been careful to check that the assistant had completed the necessary steps following the declaw procedure.

Although the Board alleged that Respondent failed to remove Guido's claw, it offered no evidence to support that allegation.

Dewey

The records do not clearly reflect whether Dewey had a sore or infection on his tail when his owner brought him in for a tail amputation and teeth cleaning. It is undisputed that the owner wanted the amputation because the dog had been gnawing and chewing on the tail, suggesting that there might have been a sore or open area. The Committee's expert stated that it violated the minimum standards of acceptable and prevailing practice to combine dental cleaning with invasive surgery. As Respondent's expert testified, it is not desirable to combine the procedures because of the risk of infection, and it would be unacceptable to combine the two procedures if Dewey had problems that would make him susceptible to infection because of the bacteria released during the dental cleaning. In some cases, with a young, healthy animal, Dr. Larry would consider the option of combining the two procedures to save some cost to the owner. This is another example where poor record-keeping makes it difficult to determine the appropriateness of the action that was taken.

Moreover, once the two procedures were combined, the Respondent's failure to prescribe a course of antibiotics to be administered over several days conflicted with his own expert's testimony that such administration is standard practice following invasive surgery. Failure to prescribe pain medication may have contributed to the dog chewing the remaining tail following surgery. Respondent failed to see the connection between the dog's discomfort and chewing on the tail, but it seems logical that a dog that had a history of chewing on its tail would continue to chew at it if there was pain associated with the tail amputation.

Dr. Levine concurred that the pet owner can have input into the location for the tail amputation for aesthetic purposes. Thus, leaving a portion of the tail remaining did not violate the standard of practice *per se*, but leaving some of the tail and not taking measures to reduce Dewey's pain, thus reducing the likelihood that Dewey would chew on the remaining portion, was not consistent with the standard of care.

Rocky

Again, lack of documentation raises questions about whether the owners fully understood the patient's condition, the risks associated with the possible treatment options, and the necessary steps to minimize harm to the patient. Rocky had a type of fracture that is very difficult to treat successfully without surgery. Respondent claims that he explained the options and prognosis to the owner, but at his deposition on February 21, 2006, he made no mention of doing so.⁹³ Instead, he focused on the cost of the surgery and his opinion that the pet owner could not afford it. In his deposition Respondent stated that he had used the cast some success in the past, and told the owners that the worst result from a cast was a stiff leg. This does not suggest that Respondent candidly informed the owner that a cast would do little to assist Rocky's recovery. At the deposition, Respondent also acknowledged that the whole foot should be casted, but owners want the cast cut because the animal seems to be in pain from the cast. This should have suggested to Respondent that such a fracture was painful to the animal, and that perhaps the cast was not adequately immobilizing the fracture. However, Respondent did not prescribe pain medication for Rocky.

Respondent's expert did not offer any testimony concerning Rocky, and Dr. Levine clearly stated that Rocky may have been better off with no treatment than with the application of the cast because the joints above and below the break were not stabilized, and the bones separated by the fracture were not drawn together. Thus application of the cast was of no benefit to Rocky and the failure to prescribe pain medication was detrimental to the health and welfare of the patient. Despite the serious break, the medical record indicated that Rocky should be brought back in 10 days, unless the owners noticed swelling.

Lucy

Respondent used a declaw technique that was unknown to Dr. Levine. Although Dr. Levine rarely performs declaw procedures, he is in continual contact with general-practice veterinarians and well aware of the techniques that they employ. Dr. Larry was not asked for an opinion about the procedure or about Lucy's care. Respondent was unable to recall the name of the equipment that he used or produce manufacturer's information about its proper use. In Lucy's case, the declaw procedure was not successful. Respondent's records indicate that he had to redo the declaw procedure on four paws, but he testified that he only had to redo one of the paws. Nonetheless, Respondent admitted that he cut into all four paws to check them. After re-cutting each paw, Respondent allowed the owner to take Lucy home rather than keeping her overnight as he customarily does, and the cat went home with paws bandaged with heavy-duty sports tape. It is not a violation of the standard of care to release a pet to its owner if the owner knowingly accepts the risks and is given clear instructions for follow-up care and possible complications. Respondent's practice is to remove the bandages the

⁹³ Ex. 7 at 71-86.

day prior surgery. The record shows that Lucy's owner left on the bandages for a few days. Because of the poor documentation, it is not clear that Respondent clearly instructed the owner to remove the bandages the day following release.

There is no evidence that Respondent prescribed a course of antibiotics or pain medication for Lucy after the first visit for a spay and declaw, which violates the standard of practice.

Use of Medication

The record is clear that Respondent does not prescribe antibiotics or pain medication in a manner that comports with the standard of care. Even if there is a difference among experts concerning use of pain medication in some instances, that difference does not explain Respondent's failure to prescribe pain medication following abdominal surgery, a serious fracture or serious nerve damage. Respondent's lack of understanding of the pain associated with these procedures was apparent from his testimony, and his mistaken understanding of the prolonged effect of anesthesia or Vedalog in addressing pain.

Respondent's belief that Vedalog, an anti-inflammatory drug, addressed pain was poorly grounded. He had two reasons for believing that it reduced pain. First, because animals with allergies who take Vedalog stop licking themselves, Respondent believed that the Vedalog must have reduced the pain associated with their allergies. Second, Vedalog had reduced pain in his own leg.⁹⁴ These explanations cannot withstand even minimal scrutiny. Dr. Levine was clear that Vedalog addresses swelling and that reducing swelling can reduce pain and discomfort, but it is no substitute for medication that addresses pain directly. Dr. Larry was not questioned about the use of Vedalog as pain medication.

Allegations Not Included in the Amended Notice and Order for Hearing:

Three allegations were not included in the Amended Notice and Order for Hearing: For Sasha, inappropriate administration of Lasix and for Dewey, inappropriate combination of tail surgery with dental cleaning and removal of an improper amount of the tail. Each of these allegations was disclosed to Respondent in the expert witness disclosure in January 2007, and Respondent had clear notice that his conduct was at issue. The Board failed to prove by a preponderance of the evidence the additional allegations about Dewey. As for Sasha, Dr. Levine explained clearly why Lasix administration would not counteract the effects of Acepromazine. Even if this is not considered a separate violation of the standard of care, it is additional evidence that Respondent does not fully understand the medications that he administers.

⁹⁴ T. 515-518.

Conclusion

The Board has received complaints about Respondent over many years, and given him very specific direction to maintain proper medical records and to update his knowledge of medications, including pain medications. Despite these directives, Respondent has failed to keep current. Moreover, his failure to document accurately and completely in a standard format has complicated the review of the records and left a very confusing picture of what happened to the patients in his care. As Respondent correctly states, mistakes can happen to anyone in the profession. However, Respondent failed to promptly recognize and acknowledge when mistakes occurred, to seek additional expertise when unexpected, dire circumstances arose, and he failed to fully inform the owners of what had occurred. His errors were compounded by poor charting of diagnosis and test results, treatment plan and treatment implementation. It is this combination that puts the patients at risk of harm from Respondent's continuing practice without supervision and controls.

B.J.H.

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
ADMINISTRATIVE LAW SECTION
100 WASHINGTON SQUARE, SUITE 1700
MINNEAPOLIS, MINNESOTA 55401

CERTIFICATE OF SERVICE

Case Title: <i>In the Matter of William N. Dudley, D.V.M., License No. C0858</i>	OAH Docket No. 15-0908-16849-2
---	---------------------------------------

Mary Osborn certifies that on the 4th day of June, 2007, she served a true and correct copy of the attached **Findings of Fact, Conclusions, and Recommendation**; by placing it in the United States mail with postage prepaid, addressed to the following individuals:

John King, Executive Director Minnesota Board of Veterinary Medicine 2829 University Avenue SE, Suite 540 Minneapolis, MN 55414-3246	Tamar N. Gronvall Susan Damon Assistants Attorney General 445 Minnesota Street, Suite 1400 St. Paul, MN 55101-2131
Robert E. Kuderer, Esq. Stacey A. Molde, Esq. Johnson and Condon, P.A. 7401 Metro Blvd., Suite 600 Minneapolis, MN 55439-3034	

tabbles®
EXHIBIT
 B

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE BOARD OF VETERINARY MEDICINE

In the Matter of William M. Dudley,
D.V.M.; License No. C0858

ORDER ON MOTION
FOR PARTIAL
SUMMARY DISPOSITION

The above-entitled matter came before Administrative Law Judge Beverly Jones Heydinger on the Board of Veterinary Medicine's motion for partial summary disposition, filed on March 15, 2006. Dr. Dudley submitted a reply brief on April 17, 2006. The Administrative Law Judge received the brief on April 18, 2006, and the record closed on that day.

Tamar N. Gronvall, Assistant Attorney General, 445 Minnesota Street, Suite 1400, St. Paul, Minnesota 55101-2131, represented the Board of Veterinary Medicine's Complaint Review Committee. Robert E. Kuderer, Johnson and Condon, P.A., 7401 Metro Boulevard, Suite 600, Minneapolis, MN 55439-3034, represented Licensee, Dr. William Dudley, D.V.M.

Based upon all of the files, records, and proceedings herein, and for the reasons set forth in the accompanying Memorandum, the Administrative Law Judge makes the following:

ORDER

IT IS HEREBY ORDERED:

1. The Complaint Review Committee's motion for summary disposition that Licensee violated paragraph V.A.1 of the 2001 Stipulation and Order and Minn. R. 9100.0800, subp. 4.A. is **granted** in full as to Francie, Guido, and Rocky; **granted** in part as to Sasha (Diazepam dosage) and Dewey (post-operative antibiotics sent home and not documented);
2. The Complaint Review Committee's motion for summary disposition that Licensee violated paragraph V.A.3 of the 2001 Stipulation and Order; Minn. R. 9100.0700, subp. 1.H.; and Minn. Stat. § 156.123 is **granted** in full (Gage and Rocky).
3. The Complaint Review Committee's motion for summary disposition that Licensee violated paragraph V.A.6 of the 2001 Stipulation and Order is **granted** in full (Francie, Gage, Sasha, and Dewey).

B-1
EXHIBIT

B

5. A telephone conference will be held on June 8, 2006, at 9:30 a.m. to set dates for the hearing. The Administrative Law Judge will initiate the call.

Dated this 19th day of May, 2006.


BEVERLY JONES HEYDINGER
Administrative Law Judge

MEMORANDUM

On September 16, 2005, the Board's Complaint Review Committee ("the Committee") issued a Notice and Order for Prehearing Conference and Hearing, based upon four complaints the Board had received about Licensee's care of certain cats and dogs. On December 28, 2005, the Committee issued an Amended Notice of Hearing based upon two additional complaints the Board had received about Licensee's care of two additional dogs. Licensee requested a contested case hearing involving each of the six patients. On March 15, 2006, the Committee filed its motion for partial summary disposition.

Undisputed Facts

Dr. Dudley currently practices veterinary medicine at Brooklyn Pet Hospital in Brooklyn Center, Minnesota, where he is a sole practitioner. Licensee owns the clinic with his brother, a retired veterinarian. Licensee also provides veterinary services at Allcare Veterinary Clinic in St. Paul. That practice is owned by retired veterinarian Albert Edwards, and Licensee has been the only veterinarian practicing at that clinic since February 2004.¹

Dr. Dudley has been licensed by the Board since 1958.

The Board issued stipulations and orders in 1991, 1992, 1998, and 2001, which subjected Licensee to multiple conditional license requirements. The 2001 Stipulation and Order, which amends the 1998 Stipulation and Order, conditioned Dr. Dudley's license on compliance with various requirements and required him to: 1) keep records on all patients in accordance with the record keeping requirements of Minn. R. 9100.0800, subp. 4, specifically by "recording in the patient record of each hospitalized patient daily examination findings and any medication or treatment provided" (paragraph V.A.1); 2) comply with any written request for information or documentation by the Board within 30 days of the date of the request (para. V.A.3); and 3) obtain informed consent from the patient's owner prior to hospitalizing overnight critically ill or injured patients (para. V.A.6). The informed consent may be written or oral, but oral consent and the scope of the consent must be noted in the patient record in detail.

Since 2001, the Board has received several additional complaints against Licensee regarding his care of six different patients, Francie (cat), Gage (dog), Sasha (cat), Guido (cat), Dewey (dog), and Rocky (dog). The undisputed facts of each situation that are relevant to this motion for partial summary disposition will be discussed below.

¹ Gronvall Affidavit, Exhibit C, pages 8-9.

A. Francie

On May 16, 2003, Licensee saw Francie, a two-year-old cat who was experiencing rapid weight loss and vomiting. Licensee performed a physical examination on the cat and felt a lump in the abdomen.² He put an indwelling catheter in Francie and kept her overnight. The medical records do not indicate whether Licensee obtained consent from Francie's owner to keep her overnight. Licensee performed two radiographs, the second of which revealed a gastrointestinal obstruction. It is unclear from the medical records whether Licensee took the radiographs on May 16 or May 17. On May 17, 2003, Licensee spoke to Francie's owner and obtained permission over the phone to perform an exploratory enterotomy. Licensee performed the operation and removed an earring and three deteriorated rubber bands.³ In all, Francie spent four nights in Licensee's clinic. None of the medical records document whether Francie was observed overnight at Licensee's clinic, whether Licensee explained the risk of leaving the cat unattended overnight, or whether Licensee provided Francie's owner with the option of taking the cat to an emergency facility. On May 26, 2003, Francie was admitted to the Affiliated Emergency Veterinary Service with an abscess from the surgery on her abdomen.⁴ In August 2003, the Board received a complaint against Licensee regarding this incident, and an investigation ensued. On September 19, 2003, Licensee provided a copy of Francie's patient record to the Complaint Review Committee. Licensee appeared before the Complaint Review Committee in November 2003.

B. Gage

Licensee treated a six-month-old dog, Gage, on January 9 and 10, 2004. A.R., Gage's owner, brought the puppy to Licensee's clinic to be neutered. Licensee performed the surgery and Gage stayed at the clinic overnight. The medical records do not reflect whether Licensee obtained verbal or written consent from Gage's owner to keep him overnight at the clinic. Licensee sent Gage home the following day. Complications arose and A.R. brought Gage back to Licensee for follow up treatment.⁵

Later in January, A.R. filed a complaint with the Board, and by letter dated January 30, 2004, the Board requested a copy of the medical records for Gage.⁶ The letter reminded Licensee that Board rules required him to respond to the request within 30 days. Licensee responded in a 2-page letter dated February 19, 2004.⁷ The letter stated "Enclosed please find all medical records in the Brooklyn Pet Hospital's possession with the [sic] respect to the care provided to Gage." No such medical records were enclosed with the letter.⁸ The Board apparently sent another letter

² Gronvall Aff., Ex. E, Bates no. 16.

³ Gronvall Aff., Ex. E, Bates no. 17.

⁴ Kuderer Aff., Ex. 3.

⁵ The details of Licensee's treatment of Gage are the subject of other charges brought by the Committee against Licensee. Those facts will not be discussed here.

⁶ Affidavit of Tamar Gronvall, Ex. I, Bates no. 90.

⁷ Gronvall Aff., Ex. I, Bates nos. 91-92.

⁸ Gronvall Aff., Ex. D, pp. 28-29.

requesting Gage's medical records on February 27, 2004.⁹ The Board received Gage's medical records from Licensee on March 8, 2004.¹⁰

C. Sasha

On June 30, 2004, Licensee provided care to Sasha, a nine-month-old cat. Sasha's owner, D.D., brought her in to Licensee's St. Paul office to be spayed. That day D.D. signed a Treatment Consent Form authorizing Licensee to spay Sasha and administer a distemper shot.¹¹ Prior to performing the procedure, Licensee gave Sasha 2 cc's of a pre-made anesthesia mixture of Acepromazine, Atropine, and Ketaset.¹² He noted this information in the cat's medical record.¹³ Approximately 15 minutes after administering the anesthesia, Sasha began to have a seizure. Licensee administered Diazepam to Sasha until the seizure subsided. He then transported the cat to his Brooklyn Center office. The seizures recurred a short time later, and Licensee again administered Diazepam until the seizing subsided.¹⁴ Licensee noted in his records that he had given Sasha Diazepam "to effect" but did not record the exact dosage. Sasha spent two nights in Licensee's clinic. The records state that on the first night Licensee or one of his staff "gave lactated ringers through the night and removed urine when bladder was distended." There is no documentation of overnight monitoring or care for the second night. Sasha was discharged on July 2, at which time Licensee instructed her owners to give her syrupy water. Licensee spoke to the owner by phone on July 4 and was told that Sasha was doing okay. In August 2004, the Board received a complaint about Licensee's treatment of Sasha.

D. Guido

On January 7, 2005, Licensee performed a declaw procedure on Guido, a ten-month-old cat. Immediately before the surgery, Licensee administered 2 cc's of the general anesthesia mixture of Acepromazine, Atropine, and Ketaset.¹⁵ Licensee's notations in Guido's medical records indicate "ketaset, 2 cc's" and "Anesthesia (Intramuscular) - Feline." During the surgery, Licensee placed a tourniquet on Guido's front leg to control bleeding. After the procedure, the tourniquet was inadvertently left on Guido's left front leg for six hours, which caused the leg to swell.¹⁶ The medical records do not include any reference to the tourniquet. On January 8, 2005, Licensee discharged the cat to his owner, explained that the left front leg was swollen, but did not say why, and told the owner to return to the clinic on January 10, 2005, for further treatment of the leg. The owner did not return Guido to the clinic as directed, and the medical records indicate that Licensee's office assistant attempted to contact the owner January 10-12, 2005, but was unable to reach the individual. Guido's leg was later amputated by another veterinarian and Licensee's insurance paid for the procedure.¹⁷

⁹ The Board's letter is not in the record, but Dr. Dudley admitted that he received another letter from the Board dated February 27, 2004. Gronvall Aff., Ex. D, p. 29.

¹⁰ Gronvall Aff., Ex. I, Bates nos. 94-97.

¹¹ Kuderer Aff., Ex. 1.

¹² The pre-made mixture consisted of 1 cc of Acepromazine, 1 cc of Atropine, and 10 cc's of Ketaset. Gronvall Aff., Ex. D, pp. 30-31.

¹³ Kuderer Aff., Ex. 1, Bates no. 249.

¹⁴ Gronvall Aff., Ex. D, pp. 34-36.

¹⁵ Gronvall Aff., Ex. D, p. 41, and Ex. F.

¹⁶ Gronvall Aff., Ex. D, pp. 39-40.

¹⁷ Gronvall Aff., Ex. D, p. 44.

Later in January, the Board received a complaint regarding Licensee's treatment of Guido. The Board commenced its investigation in March 2005.

E. Dewey

Licensee performed a tail amputation and a dental cleaning on Dewey, a five-year-old dog, on June 15, 2005, at the St. Paul clinic. Prior to the surgery Dewey received 2 cc's of Amoxicillin, 0.7 cc's of Xylazine, 10 cc's of Pentathol, and 2 cc's Lidocaine.¹⁸ This medication information appears in Dewey's medical records. Licensee discharged Dewey on the day of the surgery after successfully amputating the dog's tail. Dewey and his owner returned to Licensee's clinic the evening of June 16 because Dewey had chewed off the bandages on his tail. Licensee replaced the bandages and fashioned a plastic cone around the tail to protect the area.¹⁹ He kept Dewey overnight to monitor whether the cone tail would adequately protect the tail area.²⁰ There is no indication in the medical records that Licensee obtained written or verbal consent to keep Dewey overnight, or that Dewey was monitored overnight, but ~~the records do indicate that the cone tail and bandage were intact and in place on the~~ morning of June 17. Prior to discharging Dewey on June 17, Licensee re-examined the sutures and bandages and reapplied the tail cone along with a "Bite Not" collar. On Sunday evening, June 19, the owner called Licensee at home because Dewey had removed the tail cone. Licensee verified that there was no bleeding occurring and suggested the owner call the clinic the next morning to set up a time to bring Dewey in for a check-up. The owner did not call back. Later in June, the Board received a complaint regarding Licensee's treatment of Dewey.

F. Rocky

On September 30, 2005, at the St. Paul clinic, Licensee treated Rocky, a 13-month-old dog, for an injured left front paw. Licensee performed radiographs, administered Vetalog (an anti-inflammatory steroid) and Penicillin to Rocky, and set a cast on his left front leg.²¹ The dosages of Vetalog and Penicillin were not documented in the patient's records.²² On October 11, 2005, Rocky returned to Licensee for a check-up on his leg. Six days after, Rocky's owner called to tell Licensee that Rocky's leg appeared to be infected and that he had taken Rocky to another veterinarian.²³

On or about October 17, 2005, Rocky's owner filed a complaint with the Board, and by letter dated October 24, 2005, the Board requested, within ten days, a statement from Licensee responding to the allegations of the complaint along with a copy of the medical records for Rocky.²⁴ Licensee responded in a letter dated October 31, 2005, and indicated that upon review of Rocky's records, he noticed that the records were incomplete. Licensee enclosed the records he did have in his possession. He questioned the individual working in the clinic performing data entry, and she indicated that the hard copy of Rocky's records had been misplaced prior to

¹⁸ Gronvall Aff., Ex. G, Bates no. 396.

¹⁹ Gronvall Aff., Ex. G, Bates no. 395.

²⁰ Gronvall Aff., Ex. D, pp. 61-62.

²¹ Gronvall Aff., Ex. H, Bates no. 407, and Ex. D, pp. 68-69.

²² Gronvall Aff., Ex. H, Bates no. 407, and Ex. D, pp. 69-71.

²³ Gronvall Aff., Ex. H, Bates no. 406.

²⁴ Gronvall Aff., Ex. H, Bates no. 413.

entry into the clinic's computerized records and billing system.²⁵ On February 21, 2006, four months after the Board's request for Rocky's records, Licensee was deposed by the Board and provided a portion of an invoice from September 30, 2005, which contained home care instructions for Rocky.²⁶ Licensee could not say when this information was entered into the computerized system.²⁷

Summary Disposition Standard

Summary disposition is the administrative equivalent of summary judgment. Summary disposition is appropriate where there is no genuine issue as to any material fact and one party is entitled to judgment as a matter of law.²⁸ The Office of Administrative Hearings has generally followed the summary judgment standards developed in judicial courts in considering motions for summary disposition regarding contested case matters.²⁹ A genuine issue is one that is not sham or frivolous. A material fact is a fact whose resolution will affect the result or outcome of the case.³⁰

The moving party has the initial burden of showing the absence of a genuine issue concerning any material fact. To successfully resist a motion for summary judgment, the nonmoving party must show that there are specific facts in dispute that have a bearing on the outcome of the case.³¹ When considering a motion for summary judgment, the Court must view the facts in the light most favorable to the non-moving party.³² All doubts and factual inferences must be resolved against the moving party.³³ If reasonable minds could differ as to the import of the evidence, judgment as a matter of law should not be granted.³⁴ Summary judgment should only be granted in those instances where there is no dispute of fact and where there exists only one conclusion.³⁵

Legal Analysis

I. Record keeping requirements

The Complaint Review Committee seeks summary judgment on issues. The first involves the general record keeping requirements of veterinarians under Minn. R. 9100.0800, subp. 4.A., and the specific record keeping directives stated in the 2001 Stipulation and Order that apply to Licensee.

²⁵ Gronvall Aff., Ex. H; Bates no. 426, and Ex. D, pp. 80-81.

²⁶ Gronvall Aff., Ex. D, Deposition Exhibit 3.

²⁷ Gronvall Aff., Ex. D, p. 76.

²⁸ *Sauter v. Sauter*, 70 N.W.2d 351, 353 (Minn. 1995); *Louwegie v. Witco Chemical Corp.*, 378 N.W.2d 63, 66 (Minn. App. 1985); Minn. Rules, 1400.5500K; Minn.R.Civ.P. 56.03.

²⁹ See, Minn. Rules 1400.6600 (2004).

³⁰ *Illinois Farmers Ins. Co. v. Tapemark Co.*, 273 N.W.2d 630, 634 (Minn. 1978); *Highland Chateau v. Dep't of Public Welfare*, 356 N.W.2d 804, 808 (Minn. App. 1984).

³¹ *Thiele v. Stich*, 425 N.W.2d 580, 583 (Minn. 1988); *Hunt v. IBM Mid America Employees Federal*, 384 N.W.2d 853, 855 (Minn. 1986).

³² *Ostendorf v. Kenyon*, 347 N.W.2d 834 (Minn. App. 1984).

³³ See, e.g., *Thompson v. Campbell*, 845 F.Supp. 665, 672 (D. Minn. 1994); *Thiele v. Stich*, 425 N.W.2d 580, 583 (Minn. 1988); *Greaton v. Enich*, 185 N.W.2d 876, 878 (Minn. 1971).

³⁴ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250-251 (1986).

³⁵ *Id.*

The record keeping rule is clear that a veterinarian performing treatment or surgery on an animal shall prepare a written or computer record on each patient that includes, at a minimum, the following information:

1. name, address, and telephone number of the owner;
2. identity of the animal, including age, sex and breed;
3. dates of examination, treatment and surgery;
4. brief history of the condition of each animal;
5. examination findings;
6. laboratory and radiographic reports;
7. tentative diagnosis;
8. treatment plan; and
9. medication and treatment, including amount and frequency.

Under the 2001 Stipulation, Licensee's license to practice veterinary medicine is conditioned upon his compliance with the record keeping requirements listed above and, more specifically, recording in the patient record: a) each patient visit, whether or not Licensee provided treatment at the visit; b) each telephone conversation about a patient; and c) each hospitalized patient's daily examination findings and any medication or treatment provided.

The Committee alleges that Licensee violated the 2001 Order and the rule, and seeks summary disposition with regard to Licensee's treatment of Francie, Sasha, Guido, Dewey, and Rocky.

A. Francie

The Committee argues that the records provided by Licensee are insufficient because they contain no examination findings other than the cat's temperature and a statement that the second radiograph revealed a G.I. obstruction, no surgery protocol, no treatment plan, and no notations about medication or treatment provided to Francie the day after her surgery or upon her discharge. Furthermore, there is nothing in the records to show that Francie was checked on overnight for any of the four nights she spent at Licensee's clinic, even though Licensee claims Francie was observed during the night.³⁶

Licensee responded that Francie's records contain more physical examination findings than just the cat's temperature and the G.I. obstruction. He points to the "physical exam checklist" that he filled out on May 16, 2003, when Francie first came to his office. Second, Licensee argues that because he removed the G.I. obstruction, Francie left his office in good health and no further treatment plan was necessary.

It is undisputed that when Francie came to Licensee's clinic she was critically ill, she needed surgery, and she spent four nights at the clinic. Review of the medical records submitted to the Committee by Licensee show a brief overview of the examination and treatment of Francie. The notes are handwritten and some entries are difficult to read. Licensee made one brief entry in Francie's medical records each day

³⁶ Gronvall Aff., Ex. C, pp. 22-23.

that she was hospitalized at the clinic. While it is unclear whether or how the care provided to Francie was substandard, it is clear that the medical records do not document a treatment plan or surgery protocol so as to corroborate Licensee's deposition testimony and comply with paragraph V.A.1 of the 2001 Stipulation and Order. This portion of the motion for summary disposition must be granted as it relates to Francie.

B. Sasha

Similarly, the Committee also argues that Licensee failed to document the amount of Diazepam and that this is a violation of paragraph V.A.1.

Licensee further argues that his failure to document in Sasha's records the exact dosage of Diazepam given to the cat is consistent with prevailing practices because Diazepam is a drug that is given to effect and has no standard dosage. He asserts that the dosages and drug proportions given to Sasha would be readily available in his medication log to any future provider upon request.

Minn. R. 9100.0800, subp. 4.A. requires veterinarians to document, in a written or computer record, medication and treatment given to each patient, including amount and frequency. The 2001 Stipulation and Order mandates daily findings in the patient record of medication or treatment provided.

As to the Diazepam, Licensee admits that the amount of Diazepam given to Sasha is not recorded in the one-page medical record submitted to the Board, but he has asserted that the amount of the drug administered to Sasha must have been recorded in his medication log by him or one of his office assistants. Licensee did not put the medication log into the Motion record, and therefore, has not presented any genuine issues of material fact to counter the Board's allegations that Licensee violated the standards of the 2001 Stipulation and the rule. The Administrative Law Judge finds that there are enough undefined terms and standards of practice to create genuine issues of material fact as to but not as to the Diazepam issue. Accordingly, summary disposition is granted in part as to the record keeping requirements for Sasha.

C. Guido

The Committee claims that Licensee violated the 2001 Stipulation and Order by failing to document the cause of the cat's swollen leg in the medical records. Licensee admitted in his February 21, 2006 deposition that he did not include this information.

Furthermore, the Committee alleges that Licensee failed to record the contents and appropriate proportions of the Acepromazine/Atropine/Ketaset mixture and inappropriately called it Ketaset.

Licensee responds by saying that he discussed the swollen leg with the cat's owner and documented the swelling in the records. He asserts that his failure to document the cause of the swelling is not relevant to the requirements of the 2001 Order. As for the documentation of the anesthesia mixture, Licensee again asserts that standard industry practices do not require him to document the proportions of the mixture.

By Licensee's own admission, he did not accurately document the cause of Guido's swollen leg. That he recorded the swelling is not sufficient. He made no mention of the tourniquet to the owner or in the records, and accordingly the records are incomplete in violation of paragraph V.A.1 of the Stipulation and Minnesota rules. Second, Licensee's argument about the anesthesia mixture is not convincing, because not only did he fail to record the proportion of each drug in the mixture, he simply recorded that he administered "ketaset, 2 cc's" and "Anesthesia (Intramuscular) – Feline." There is no mention of Acepromazine or Atropine, and it is not clear if the intramuscular anesthesia is part of or in addition to the 2 cc's of Ketaset. Again, Licensee did not submit the medication log and has not created any genuine fact issues. Summary disposition is granted as to the record keeping requirements for Guido because Licensee has failed to assert any genuine issues of material fact in response to the Board's allegation that he violated paragraph V.A.1 of the 2001 Stipulation and Order.

D. Dewey

The Committee alleges that Licensee admitted in his February 21, 2006 deposition that he

provided post-operative antibiotics for Dewey upon his discharge from the clinic, but that he did not document those actions in the medical record.³⁸

Licensee responds that he explained to the Board, in a letter dated June 27, 2005,³⁹ that he does not routinely send antibiotics home with patients after "non-infected" surgeries like tail amputations, but that he did give Dewey an injection of Amoxicillin at the time of surgery on June 15.

Licensee's June 27, 2005 letter to the Board indicated that he did not routinely send antibiotics home with patients after "non-infected" surgeries. Nothing in the letter directly addresses Licensee's treatment of Dewey during the time in question. However, at his deposition, Licensee discussed his treatment of Dewey, he stated that

³⁸ Gronvall Aff., Ex. D., p. 52

³⁹ Kuderer Aff., Ex. 2.

he sent post-operative antibiotics home with Dewey, and he acknowledged that the records do not reflect that information. Summary disposition is appropriate as to this portion of Dewey's records.

E. Rocky

The Committee again relies on Licensee's February 2006 deposition testimony to show that Licensee admitted to failing to document the amount and method of administering the medications noted in the medical records as well as a diagnosis for Rocky. The Committee argues that Licensee admitted to discussing a treatment plan with Rocky's owners, and then failed to document that discussion.

Licensee responds that he made a mistake when he neglected to note the dosage of the medications given to Rocky on September 30, 2005, but he states that the method of administration (injection) and the diagnosis were obvious. In addition, Licensee asserts that there is nothing in the 2001 Stipulation and Order, rule, or statute that requires Licensee to document verbatim every discussion with the owner pertaining to the treatment plan. At the time of the deposition, Licensee provided to the Board an invoice given to Rocky's owners at the time of the dog's discharge, which he claims clearly demonstrates that he provided after-care instructions to the owners.

Regardless of whether Licensee provided after-care instructions for Rocky, Licensee clearly violated paragraph V.A.1 of the 2001 Stipulation and the record keeping requirements of Minn. R. 9100.0800, subp. 4.A. when he failed to document the dosage of the medications given to Rocky on September 30, 2005. Summary disposition is granted.

II. Compliance with Board requests for information

Paragraph V.A.3 of the 2001 Stipulation and Order requires Licensee to comply with any written request for information or documentation by the Board or its designee within 30 days of the request. Minn. R. 9100.0700, subp. 1, item H imposes substantially the same requirement on all licensed veterinarians, and Minn. Stat. § 156.123 mandates cooperation with the Board during its investigation of any complaint, including providing copies of patient records. The Committee alleges that Licensee violated paragraph V.A.3 of the 2001 Order, rule, and statute, and seeks summary disposition with regard to Licensee's treatment of Gage and Rocky.

A. Gage

The Complaint Review Committee argues that Licensee's failure to provide Gage's complete medical records until March 8, 2004, one week after the 30-day deadline, is a clear violation of the 2001 Stipulation and Order, as well as Minn. R. 9100.0700, subp. 1, item H, and Minn. Stat. § 156.123.

Licensee argues that he did not fail to cooperate with the Board because the medical records for Gage were only eight days late and because he was working with

his insurance company on the complaint. He claims that he substantially complied with the Board's request and thereafter supplemented the record.

It is clear that the Board did not receive Gage's records within the 30-day deadline. Licensee admitted that he held off on sending the medical records, that his insurance agent did not advise him to hold off submitting the records, and when questioned why he did not send them, he answered, "I didn't. I just did not. That's all."⁴⁰ Furthermore, Licensee admitted that his February 19, 2004 letter did not explain to the Board that he was waiting to submit the records until he could speak to his insurance agent who was out of town at the time. Instead, the letter stated that the records were enclosed when Licensee knew that they were not. Accordingly, the Administrative Law Judge grants summary disposition with regard to the Board's request for information relating to Gage's treatment, and finds that Licensee violated Paragraph V.A.3 of the 2001 Stipulation and Order; Minn. R. 9100.0700, subp. 1, item H; and Minn. Stat. § 156.123.

B. Rocky

The Committee points to Licensee's letter to the Board, dated October 31, 2005, as a clear admission that Rocky's medical records were incomplete and not received by the Board in a timely manner. It also claims that Licensee's testimony and submission of an invoice from Rocky's patient file at the February 21, 2006 deposition further demonstrate that Licensee failed to comply with Paragraph V.A.3 of the 2001 Stipulation and Order.

Licensee concedes that he did not provide the Board with part of Rocky's medical records until February 21, 2006, well after the deadline imposed by the Board's letter (10 days) or the Committee's 2001 Stipulation and Order (30 days). But he argues that his office billing and records system was undergoing technology changes and that he provided Rocky's missing record, an invoice demonstrating that he provided after-care instructions for Rocky, as soon as it was located. According to Licensee, the evidence, when viewed in the light most favorable to him, proves that he diligently responded to the Board's inquiry and cooperated with the investigation the best that he could under the circumstances.

Licensee responded to the Board's October 24, 2005 request for information within the 10-day deadline imposed by the Board. He admitted that the records he enclosed were incomplete because they had been misplaced. Licensee then produced an invoice containing after-care instructions for Rocky at Licensee's deposition in February 2006, four months after the initial request from the Board. When questioned about the document, Licensee could not say when the document was found or when the information was entered into the office computer system. By his own admission, Licensee is in violation of paragraph V.A.3 of the 2001 Stipulation and Order, and Minnesota rule and statute.

⁴⁰ Gronvall Aff., Ex. D, p. 29.

III. Informed consent for overnight hospitalization of critically ill or injured patients

Paragraph V.A.6 of the 2001 Stipulation and Order prohibits Licensee from hospitalizing any critically ill or injured patient overnight unless Licensee first obtains the client's consent. Specifically, Licensee must: 1) inform the client that the patient will be left unattended overnight; 2) explain the risks of leaving the patient unattended; and 3) provide the client with the option of taking the animal to an emergency veterinary facility. In addition:

[Licensee] shall either provide the foregoing information to the client in writing and shall obtain the client's written consent, or shall obtain the client's verbal consent and note in the patient record what information [Licensee] provided and that the client consented to overnight hospitalization after being provided with such information.

The Committee alleges that Licensee violated the 2001 Order and seeks summary disposition with regard to Licensee's hospitalization of Francie, Gage, Sasha, and Dewey.

A. Francie

Neither of the parties dispute that Francie was hospitalized for four nights at Licensee's clinic. The Committee relies on a number of admissions made by Licensee in his January 5, 2006 deposition as proof that Licensee violated paragraph V.A.6 of the 2001 Stipulation and Order.

Licensee's defense is that he did explain the risks of leaving Francie unattended overnight and that the owner gave consent over the phone for the surgical procedure, which implied that Francie would be kept at the clinic overnight.

Licensee's testimony during his January 5, 2006 deposition is confusing and inconsistent about whether or not he explained the risks of leaving Francie alone overnight or whether the cat was actually monitored overnight. In either case, Licensee plainly admitted that he did not document any of this information in the record.⁴¹ Furthermore, Licensee admitted that he did not give the owner the option of taking Francie to an emergency facility. And when asked whether he wrote in Francie's patient record that the owner consented to overnight hospitalization, he answered, "I don't think so."⁴² A review of the records demonstrates that the owner consented to the surgery over the phone, but the records do not contain any documentation consistent with the requirements of paragraph V.A.6 of the 2001 Stipulation and Order. Summary disposition is clearly appropriate under these circumstances.

B. Gage

Neither of the parties dispute that Gage was hospitalized for one night at Licensee's clinic. The Committee relies on statements made by Licensee during his February 21, 2006 deposition as proof that Licensee violated paragraph V.A.6.

Again, Licensee argues that consent to overnight hospitalization is implied in consent to a surgical procedure. And he states that Gage was attended overnight, but

⁴¹ Gronvall Aff., Ex. C, pp. 22-24.

⁴² Gronvall Aff., Ex. D, p. 23.

acknowledges that the records do not reflect that information because he did not record that type of information in 2004.

Licensee admitted in his February 21, 2006 deposition that: 1) he did not obtain the owner's informed consent prior to the hospitalization; 2) he did not document in the medical record whether or not he obtained the informed consent; 3) he may have checked on the dog overnight, but he did not document if and when this occurred; and 4) he did not provide the option of an emergency facility to Gage's owner.⁴³ Licensee's actions as to Gage's hospitalization are in direct violation of paragraph V.A.6 of the 2001 Stipulation and Order. No genuine issues of material fact remain and summary disposition is appropriate.

C. Sasha

The arguments of the parties as to Sasha are similar to those stated above. During his deposition, Licensee admitted that he did not obtain consent for overnight hospitalization of Sasha.⁴⁴ A review of the medical records demonstrates that Sasha's owner did sign a consent form, but confirms that the form makes no reference to the consent requirements as set forth in the 2001 Stipulation and Order.⁴⁵ Licensee has presented no material fact issues and summary disposition is granted.

D. Dewey

The Committee rests its argument on Licensee's deposition testimony that he kept Dewey overnight at the clinic without obtaining the owner's direct consent and didn't explain any risks of an overnight stay.⁴⁶ Licensee's position is that the requirements of paragraph V.A.6 do not apply in this situation because Dewey was not a critically ill patient and therefore there were no risks of an overnight stay.

The record is clear that Dewey was brought back to Licensee's clinic on June 16, 2005, the day after his tail amputation, because the dog was chewing on his tail and the wound had started bleeding again. While these circumstances probably don't qualify Dewey as "critically ill," it is reasonable to say that Dewey was "injured." Licensee kept Dewey overnight to devise a method by which to stop the dog from chewing at the surgical wound. The requirements of paragraph V.A.6 apply equally to the overnight hospitalization of "critically ill and injured patients."

The Administrative Law Judge notes Licensee's frustration with the seemingly duplicative process of obtaining informed consent for a surgical procedure as well as informed consent for overnight hospitalization. But the terms of paragraph V.A.6 make it clear that the Board meant to impose more stringent requirements on Licensee due to the number of complaints against him and his practice. Licensee's signature on the 2001 Stipulation and Order binds him to the terms of that document. Accordingly, the Administrative Law Judge finds that Licensee violated the terms of paragraph V.A.6 of the 2001 Stipulation and Order and that summary disposition is appropriate.

⁴³ Gronvall Aff., Ex. D, pp. 22-24.

⁴⁴ Gronvall Aff., Ex. D, p. 36.

⁴⁵ Kuderer Aff., Ex. 1.

⁴⁶ Gronvall Aff., Ex. D, pp. 60-65.

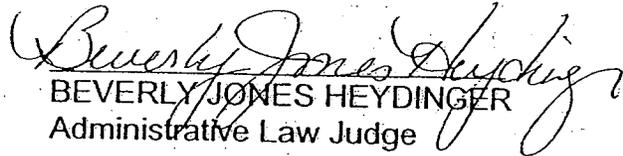
B.J.H.

B-15

RECOMMENDATION

The Administrative Law Judge respectfully recommends that the Board take appropriate disciplinary action against the Respondent's license to practice veterinary medicine.

Dated: June 4~~X~~ 2007.


BEVERLY JONES HEYDINGER
Administrative Law Judge

Reported: Transcribed – Three volumes.
Kirby A. Kennedy & Associates.

NOTICE

This report is a recommendation, not a final decision. The Minnesota Board of Veterinary Medicine will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61, the Board shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Board must consider the exceptions in making a final decision. Parties should contact John King, Executive Director, Minnesota Board of Veterinary Medicine, 2829 University Avenue SE, Suite 540, Minneapolis, Minnesota 55414-3246, to learn the procedure for filing exceptions or presenting argument.

If the Board of Veterinary Medicine fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Board, or upon the expiration of the deadline for doing so. The Board must notify the parties and the Administrative Law Judge of the date on which the record closes.

MEMORANDUM

The findings of fact clearly spell out areas where the Respondent's practice departs from minimum standards of acceptable and prevailing practice, and some of those departures are likely to harm the animals placed in Respondent's care. Although the Respondent surely has no intent to harm the animals, he has in fact put them at risk, or in several instances subjected them to a heightened risk of infection and unnecessary suffering.

The Respondent's record-keeping problems are clear from a cursory review of his medical records and comparison with the records of other clinics

where animals were taken for follow-up care. The record-keeping problems are long-standing, as more fully set forth in the Memorandum accompanying the Order on Motion for Partial Summary Disposition, incorporated herein. With poor record-keeping it is difficult to track the specific diagnosis and treatment plan or the implementation of that plan. When an unexpected or adverse result occurs, it is particularly important to check the records, to review the tests that were done, the diagnosis made, the options considered, and the course of action that was followed. The Respondent's poor record-keeping complicated the review of his practice in the instances where there were adverse results.

Francie

The Respondent took only one radiograph, even though he acknowledged that the standard of practice was to take two views. In this instance, his failure to take two may not have affected the care given to Francie, but it is difficult to tell because he did not have one medical record that clearly set forth his findings and his treatment plan. In addition, it would not be standard to conduct a barium series without first taking a survey x-ray. Failure to have a complete medical record places the patient's health and safety at unnecessary risk.

In this instance, as in others, the Respondent administered a form of anesthesia that, although acceptable, is out-of-date, and there is no record that he prescribed a course of antibiotics or pain medication following the surgery that his own expert, Dr. Larry, testified was the standard of care for invasive surgical procedures. His failure to prescribe antibiotics may have contributed to Francie developing an abscess.

Respondent's comments about the use of pain medication for Francie suggest that, despite Board-directed additional training about proper pain medication, he still has a poor grasp of commonly-used pain medications and the ordinary course of their administration. He stated that he did not prescribe pain medication for Francie because he wanted the cat to be up and moving around and not sedated. Dr. Levine testified that pain medication can be administered without sedating the animal, and Dr. Larry offered no opinion to the contrary.

Gage

Unfortunately Gage's urethra was severed during a cryptorchidectomy. Precisely how that occurred is difficult to determine because Respondent did not thoroughly document the steps that he took during the surgery and he did not send the mass that he removed out for testing, even though he admitted that he held it for a few days. Respondent failed to keep Gage under observation until Gage urinated, and once it was apparent that Gage was very ill, Respondent did not notify the family and offer the option of a referral to an emergency facility. Furthermore, he relied on test results from a piece of equipment that was clearly malfunctioning. It is likely that, once the urethra was cut, nothing could have

been done for Gage to return him to normal good health. However, even if all was lost for Gage, Respondent left Gage alone, and there is no evidence that he administered pain medication to blunt the effects of the dog's suffering. As Respondent properly points out, mistakes happen. In this instance, in addition to the surgical error, it was the steps that Respondent took after the surgery that compel the conclusion that he failed to conform to the minimum standards of acceptable and prevailing practice and engaged in conduct that was incompetent and harmful to Gage.

Sasha

Although the use of a mixture of medications to anesthetize Sasha and the administration of Diazepam to effect did not violate the standard of care, Respondent's use of Lasix to offset the effects of the Acepromazine did. Dr. Levine testified without opposition that Lasix administration was of no benefit and may have been to Sasha's detriment. As with other cases, the Respondent demonstrated little knowledge of the medications that he employed and their effectiveness for the intended purpose.

Guido

A tourniquet was left on Guido's paw for about six hours following a declaw procedure. Once again, a mistake was made, but the aftermath of the mistake appropriately heightened the Board's concern. First, the mistake was not caught for hours. This suggests that no one checked on Guido for several hours after the surgery. Second, once it was clear that a mistake had been made, no steps were taken to determine what, if anything, might have been done to minimize the damage to the nerves in Guido's leg. There is no indication in the medical records that Respondent conducted any type of assessment to determine the extent of the damage. Third, Guido was discharged with no disclosure of the mistake to the owners and no special instructions. Respondent claimed that the owner declined pain medication, but the owner was not notified of the serious error that had been made and the high likelihood that Guido would experience severe pain because of nerve damage. Respondent gave the owner no special instructions and did not direct the owner to bring Guido back to be checked the following day. Leaving the tourniquet on for hours clearly violated the minimum standards of acceptable and prevailing practice and was incompetent, but, in addition, Respondent's actions thereafter suggest a careless disregard for the animal.

To his credit, Respondent took responsibility for the error of his assistant. However, he acknowledged that his assistant had no formal training, and Dr. Larry testified that there had been problems with the assistant in the past. Thus, Respondent should have been careful to check that the assistant had completed the necessary steps following the declaw procedure.

Dewey

The records do not clearly reflect whether Dewey had a sore or infection on his tail when his owner brought him in for a tail amputation and teeth cleaning. It is undisputed that the owner wanted the amputation because the dog had been gnawing and chewing on the tail, suggesting that there might have been a sore or open area.

This is another example where poor record-keeping makes it difficult to determine the appropriateness of the action that was taken.

Moreover, once the two procedures were combined, the Respondent's failure to prescribe a course of antibiotics to be administered over several days conflicted with his own expert's testimony that such administration is standard practice following invasive surgery. Failure to prescribe pain medication may have contributed to the dog chewing the remaining tail following surgery. Respondent failed to see the connection between the dog's discomfort and chewing on the tail, but it seems logical that a dog that had a history of chewing on its tail would continue to chew at it if there was pain associated with the tail amputation.

Dr. Levine concurred that the pet owner can have input into the location for the tail amputation for aesthetic purposes.

... leaving some of the tail and not taking measures to reduce Dewey's pain, thus reducing the likelihood that Dewey would chew on the remaining portion, was not consistent with the standard of care.

Rocky

Again, lack of documentation raises questions about whether the owners fully understood the patient's condition, the risks associated with the possible treatment options, and the necessary steps to minimize harm to the patient. Rocky had a type of fracture that is very difficult to treat successfully without surgery. Respondent claims that he explained the options and prognosis to the owner, but at his deposition on February 21, 2006, he made no mention of doing so.⁹³ Instead, he focused on the cost of the surgery and his opinion that the pet owner could not afford it. In his deposition Respondent stated that he had used the cast some success in the past, and told the owners that the worst result from a cast was a stiff leg. This does not suggest that Respondent candidly informed the owner that a cast would do little to assist Rocky's recovery. At the deposition, Respondent also acknowledged that the whole foot should be casted, but owners want the cast cut because the animal seems to be in pain from the cast. This should have suggested to Respondent that such a fracture was painful to the animal, and that perhaps the cast was not adequately immobilizing the fracture. However, Respondent did not prescribe pain medication for Rocky.

Respondent's expert did not offer any testimony concerning Rocky, and Dr. Levine clearly stated that Rocky may have been better off with no treatment than with the application of the cast because the joints above and below the break were not stabilized, and the bones separated by the fracture were not drawn together. Thus application of the cast was of no benefit to Rocky and the failure to prescribe pain medication was detrimental to the health and welfare of the patient. Despite the serious break, the medical record indicated that Rocky should be brought back in 10 days, unless the owners noticed swelling.

Lucy

Respondent used a declaw technique that was unknown to Dr. Levine. Although Dr. Levine rarely performs declaw procedures, he is in continual contact with general-practice veterinarians and well aware of the techniques that they employ. Dr. Larry was not asked for an opinion about the procedure or about Lucy's care. Respondent was unable to recall the name of the equipment that he used or produce manufacturer's information about its proper use. In Lucy's case, the declaw procedure was not successful. Respondent's records indicate that he had to redo the declaw procedure on four paws, but he testified that he only had to redo one of the paws. Nonetheless, Respondent admitted that he cut into all four paws to check them. After re-cutting each paw, Respondent allowed the owner to take Lucy home rather than keeping her overnight as he customarily does, and the cat went home with paws bandaged with heavy-duty sports tape. It is not a violation of the standard of care to release a pet to its owner if the owner knowingly accepts the risks and is given clear instructions for follow-up care and possible complications. Respondent's practice is to remove the bandages the

⁹³ Ex. 7 at 71-86.

day prior surgery. The record shows that Lucy's owner left on the bandages for a few days. Because of the poor documentation, it is not clear that Respondent clearly instructed the owner to remove the bandages the day following release.

There is no evidence that Respondent prescribed a course of antibiotics or pain medication for Lucy after the first visit for a spay and declaw, which violates the standard of practice.

Use of Medication

The record is clear that Respondent does not prescribe antibiotics or pain medication in a manner that comports with the standard of care. Even if there is a difference among experts concerning use of pain medication in some instances, that difference does not explain Respondent's failure to prescribe pain medication following abdominal surgery, a serious fracture or serious nerve damage. Respondent's lack of understanding of the pain associated with these procedures was apparent from his testimony, and his mistaken understanding of the prolonged effect of anesthesia or Vedalog in addressing pain.

Respondent's belief that Vedalog, an anti-inflammatory drug, addressed pain was poorly grounded. He had two reasons for believing that it reduced pain. First, because animals with allergies who take Vedalog stop licking themselves, Respondent believed that the Vedalog must have reduced the pain associated with their allergies. Second, Vedalog had reduced pain in his own leg.⁹⁴ These explanations cannot withstand even minimal scrutiny. Dr. Levine was clear that Vedalog addresses swelling and that reducing swelling can reduce pain and discomfort, but it is no substitute for medication that addresses pain directly. Dr. Larry was not questioned about the use of Vedalog as pain medication.

Allegations Not Included in the Amended Notice and Order for Hearing:

allegations were not included in the Amended Notice and Order for Hearing: For Sasha, inappropriate administration of Lasix

Each of these allegations was disclosed to Respondent in the expert witness disclosure in January 2007, and Respondent had clear notice that his conduct was at issue.

As for Sasha, Dr. Levine explained clearly why Lasix administration would not counteract the effects of Acepromazine. Even if this is not considered a separate violation of the standard of care, it is additional evidence that Respondent does not fully understand the medications that he administers.

⁹⁴ T. 515-518.

Conclusion

The Board has received complaints about Respondent over many years, and given him very specific direction to maintain proper medical records and to update his knowledge of medications, including pain medications. Despite these directives, Respondent has failed to keep current. Moreover, his failure to document accurately and completely in a standard format has complicated the review of the records and left a very confusing picture of what happened to the patients in his care. As Respondent correctly states, mistakes can happen to anyone in the profession. However, Respondent failed to promptly recognize and acknowledge when mistakes occurred, to seek additional expertise when unexpected, dire circumstances arose, and he failed to fully inform the owners of what had occurred. His errors were compounded by poor charting of diagnosis and test results, treatment plan and treatment implementation. It is this combination that puts the patients at risk of harm from Respondent's continuing practice without supervision and controls.

B.J.H.