

Summary of Discipline Committee Hearing

DR. KEVIN BACON

Hearing Date: November 18, 2013



ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- failed to obtain informed consent before excising the gland on the dog's third eyelid
- failed to obtain informed consent before performing a corneal debridement
- failed to recommend or dispense any pain medication post-operatively
- failed to maintain the standard of practice of the profession
- failed to make or retain required records
- 12 additional allegations were withdrawn

BRIEF SUMMARY

A dog with a history of "cherry eye" was taken to the clinic. In the year prior, the repair surgery had been performed but the prolapse had returned. After trying to manage the condition on their own, the clients brought the dog to the clinic.

In one version of the clinic's chart, the examining veterinarian states, "gland is large and looks firm, conjunctiva appears normal ... Discussed: cherry eye removal which is the sx. done here as opposed to tacking down." The veterinarian described the gland as "very prominent and firm looking, but normal colour, etc., and did not appear to be bothering the dog, i.e. no conjunctivitis, blepharospasm, etc."

An examining veterinarian at the clinic discussed some of the surgery risks but the member who was performing the surgery did not speak to the client before surgery.

During surgery, the member removed the third gland of the dog's right eye and debrided a corneal ulcer discovered immediately before the surgery.

The member discharged the dog without any pain medication and without discussing the case with the client. At discharge, an auxiliary spoke to the client and indicated the member had removed the gland and had debrided a small ulcer. The client was given antibiotic medication for the dog.

The dog developed a deep corneal ulcer and chronic dry eye that has required ongoing veterinary medical management.

DECISION

The member pleaded and was found guilty with respect to the allegations. The College and the member had negotiated an Agreed Statement of Facts, including an admission of professional misconduct.

PENALTY

- Reprimand
- Suspension of the member's licence to practise veterinary medicine for three months, one month to be remitted if the member completes a research paper addressing the issues raised in the case including cherry eye, corneal ulcers and informed consent and one month to be remitted if the member attends a medical records workshop
- The member will pay costs to the College of \$2,500
- Pursuant to legislation, this matter is published including the member's name

PANEL'S REASONING

The Panel found the facts admitted amounted to professional misconduct.

There was no signed surgical consent form in the file. The surgeon does not always meet with the client(s) when another veterinarian has arranged the procedure, however, the onus is on the surgeon to ensure there is informed consent.

Prior to surgery, when the member discovered the corneal ulcer, the owner should have been contacted to discuss treatment and to be given the opportunity to consider all options. Instead, the member proceeded with a corneal debridement without the owner's consent. Clients need to be informed as to the pet's condition or if information about the condition changes.

The medical record does not indicate the member had any contact with the owner on the day of the surgery. By failing to obtain informed consent, the member failed to maintain the standard of practice of the profession.

It is an accepted standard of care that patients are provided with appropriate pain control after a painful procedure. Corneal ulcers are painful and corneal debridement would have created significant discomfort for the dog. The member should have told the client about the additional procedure and appropriate home care.

The Panel noted apparent changes to the medical records. It is imperative that the audit function and private passwords are utilized with electronic records to protect the public from medical records that have been altered after the fact. It also protects those entering the records from changes being made without their knowledge.

The member admitted the records provided to the client and to the College were different. In the Agreed Statement of Facts, the member confirms that "(h)ad he testified, (he) would have stated that he was not aware of the changes and neither made the changes nor instructed anyone else to make these changes." However, it remains the member's responsibility to ensure the chart cannot be modified without audit or attribution.

The member's records were lacking. There was no indication of any discussion with the client on the day of surgery, no signed surgical consent form, and no indication that a physical exam was performed on the day of surgery. The description of the surgery lacked sufficient detail and there was no indication the owner was provided with any postoperative instructions.

The member admitted that he failed to maintain adequate records and this was confirmed by the records provided.