Summary of Discipline Committee Hearing

DR. AHMAD BADRI

Hearing Date: April 11, 2016

THE COLLEGE OF VETERINARIANS OF ONTARIO

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Case 1:

- failed to obtain the client's informed consent before collecting a urine sample for urinalysis by urethral catheterization
- failed to discuss complications in removing the catheter or the possibility of a urethal blockage, or recommend the client take the cat to the clinic if he shows signs of distress, swelling or problems with urination
- failed to report test results in a timely manner or at all
- failed to promptly return the client's phone calls when the client called with concerns
- failed to follow-up with the client to ensure there were no complications after catheterization
- failed to advise the client of the urgency of the cat's situation
- advised the client the cat's injuries could have been prevented with the use of a buster collar
- failed to maintain the standards of practice
- failed to provide a report requested by a client within a reasonable time
- failed to make or retain records required by the Regulation

Case 2:

- failed to obtain informed consent to remove all of the dog's teeth and failed to post-operatively advise that the extraction sites were not sutured
- failed to provide adequate or appropriate pain relief
- inappropriately used Consil on the unsutured extraction sites
- failed to maintain the standards of practice of the profession
- failed to make or retain records required by the Regulation
- an act or omission relevant to the practice of veterinary medicine that, having regard to the circumstances, would be regarded by members as unprofessional

BRIEF SUMMARY

Case 1:

A cat was taken to a clinic for consultation about aggressive behavior and vaccines. With the exception of sedation and bloodwork, the client advised the clinic that no one was to perform additional services without consent. Despite the client's instructions, the member collected urine using a urinary catheter, to perform a urinalysis. The member had difficulty removing the catheter.

When the cat was discharged that day, the member did not advise the client of the extent of the difficulty removing the catheter.

Later that day, the client noticed a red lump in the cat's groin. Two days later, the client contacted the clinic as the cat was experiencing severe swelling, and had been crying, licking the area frequently, constantly urinating and urinating outside of the litter box. The client inquired about the bloodwork and urinalysis.

The member did not return the client's call until three days later. He indicated he would go to the client's home to examine the cat and offered to keep the clinic open late if the client preferred to bring the cat in. The client asked the member to come to her home the next day to examine the cat and provide anti-inflammatory medication. The member did not warn the client of the possibility of a urethral blockage.

The next day when the member was at the client's home, the cat's crying had increased, he was growling in pain and bleeding from the groin area. The member took the cat to the clinic believing he may have suffered from a urethral blockage.

Over the next two days, the cat's condition continued to deteriorate. The urinary catheter was not emptying the bladder and cystocentesis was required to remove urine using a needle. The cat was motionless, in respiratory distress and had an increased heart rate. The member was not in the clinic and in his absence, no one from the clinic contacted the client. Upon his return to the clinic, the member called the client. At this time, the cat was in critical condition. The member advised the client the cat required a urethrostomy and criticized the client for not providing a buster collar, which could have prevented the cat's injuries. The cat died 90 minutes later.

Case 2:

A dog was taken to the veterinary clinic for a dental cleaning. The dog was examined by another veterinarian and scheduled for a dental cleaning to be performed by the member.

Later that day, the member's auxiliary called the client and left a message that multiple tooth extractions were required. One of the clients called back and was advised the member had extracted a number of teeth and that most, if not all, would need to be extracted due to severe periodontal disease.

That afternoon, the clients went to the clinic. The member told the clients all of the dog's teeth had been extracted. The clients were shocked as they had not been told in advance that so many teeth would need to be extracted. The member said it was necessary due to severe periodontal disease.

The member advised the clients the dog would be fine within a few days after the gums healed, but offered no further advice. He also did not inform the clients he had not sutured the gums but had used Consil to fill the gaps from the extractions.

The member told the clients the dog could go home and could be given soft foods. The clients were concerned and asked if they could leave the dog overnight, at which point the member informed them no one would be at the clinic in the evening. He offered no other options, so the clients left the dog at the clinic overnight.

The next day the clients had the dog transferred to a hospital where he was diagnosed with severe osteomyelitis, a possible fracture of the right mandible, and open dental flaps upper and lower gums bilaterally. Surgery

was performed to suture the gums and the dog had an uneventful recovery.

PLEA AND DECISION

The member admitted the allegations as outlined in the Agreed Statement of Facts, including an admission of professional misconduct.

PENALTY

- Reprimand
- Suspension of the member's licence for three months, one month of which to be suspended if the member completes the ProBE course, a half-day mentorship on the use of catheters and a paper of at least 1,500 words with a focus on learnings from the mentorship, at least nine hours of continuing education on veterinary dentistry procedures, and a paper of at least 1,500 words with a focus on consent, pain management and suture use.
- The member must also provide his medical records for up to eight patients which will be reviewed by a peer reviewer.
- The member will pay costs to the College of $7,000.

PANEL'S REASONING

The panel accepted the member's admissions of professional misconduct and found that the member had engaged in professional misconduct.

The College and the member made a joint submission as to an appropriate penalty and costs order. The Panel was mindful that a joint submission should be accepted unless doing so would be contrary to the public interest and/or bring the administration of justice into disrepute.

The Panel reviewed similar cases and considered whether the proposed penalties were consistent with the penalties ordered in the cases presented for review.

Relevant penalty principles considered by the Panel were specific and general deterrence, protection of the public, rehabilitation of the member, maintaining the integrity of the profession and public confidence in self-regulation. The Panel felt the penalty sends a strong message to members of the profession regarding the significance of informed consent and professional communication.

The Panel believed the penalty would reinforce to the member the significance of competently performing dental procedures. Furthermore, the Panel was confident that the mentorship session will provide the member with an opportunity to improve his urethral catheterization techniques and clarify indications for use of this technique.

The Panel found that the penalty and costs order jointly proposed was consistent with the public interest, and were appropriate in the circumstances for the case. The member has already taken steps to improve his practice and is remorseful for his conduct and the outcome of the two cases.

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