Summary of Discipline Committee Hearing

DR. MORRIS BELANGER

AGREED STATEMENT OF FACTS
• failed to recommend or chart intravenous fluid therapy
• failed to discuss or chart appropriate treatment options
• led the client to believe that no treatment for leptospirosis was available; and
• failed to maintain proper records
• failed to make or retain the records required by the regulations
• 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 SYNOPSIS OF FACTS
The nine-year old dog had been previously vaccinated for rabies at another veterinary clinic.

The member examined the dog which was reported to have blood in its urine and was lethargic. The member suggested a blood test and the client left the dog at the clinic for the test.

When the client returned, the member said the dog’s kidney and liver were shutting down and the dog likely had leptospirosis or “peracute leptospirosis”.

The member advised the client the dog’s prognosis was poor and recommended the dog be euthanized. The client reluctantly agreed and the dog was humanely euthanized.

The member advised the client that leptospirosis is contagious and his/her other pets should receive shots, which were administered.

The member also advised the client to disinfect his/her property.

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

2. Penalty
• Reprimand
• Suspension of the member’s licence for two weeks. Completion of the College’s medical records webinar.
• Participation in a one day mentorship; and completion of a learnings paper.
• Provide medical records for review by a peer reviewer
• The Member shall pay all costs of the mentorship

3. Costs/Publication
• The member will pay costs to the College of $2,500
• Pursuant to the legislation, publication of this matter will include, among other things, the member’s name

PANEL’S REASONING
The Discipline Committee panel concluded the facts did in fact amount to the professional misconduct as admitted. In the panel’s view, this case resulted from the member’s failure to adequately communicate with his client, and failure to keep adequate medical records. Failure to keep proper records is a clear breach of professional standards.

The panel also concluded that the member’s failures in the circumstances, particularly around his record keeping, would be regarded by other members of the profession as “unprofessional.”

In considering the penalty, the panel was satisfied that the proposed penalty is in the public interest. This was supported by a report from the presiding pre-hearing officer.

The panel concluded that a failure to clearly communicate and a failure to properly record the events led to the misconduct in these circumstances. Clearer communication with the client would not have left the client feeling they had no other treatment options. Similarly, better medical record keeping would have confirmed that the member had considered differential diagnosis information as a tool for reviewing the facts of the presenting symptoms.

The penalty imposed focuses on remedial action of the core aspects of the case and provides for mentorship to assist the member in improving clinical practice skills.

The remedial aspects of the penalty will enhance public protection through enhanced skills in communication and record keeping.

The public reprimand and suspension of the member’s license are also effective specific deterrents, which act as a clear reminder to the member of the seriousness of this matter.