

Summary of Discipline Committee Hearing

DR. SHAMMI DHAWAN

Hearing Date: February 3, 4, 6, 2014



ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- failed to investigate the cause of the dog's bleeding
- failed to properly interpret the results of the blood analysis, or failed to recognize the significance of the dog's severe thrombocytopenia
- ordered the administration of pre-anesthetic and anesthetic agents before obtaining the results of the blood testing
- failed to inform the client that the dog had thrombocytopenia and failed to treat the condition
- failed to maintain the standard of practice of the profession
- 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

The clients brought their dog to the clinic after noticing some blood that appeared to be coming from his mouth. Dr. Dhawan (the member) examined the dog's mouth and noted severe gingivitis, dental tartar, and blood stained gums.

The member presented a treatment plan and estimate to the client that included blood tests, general anesthetic, dental cleaning and possible tooth extractions. The dog was given a sedative injection, a blood sample was collected, and blood tests were performed on in-house equipment. Those test results indicated that instead of having a platelet count within the normal range of 200-460, the dog's platelet count was 17, a condition called thrombocytopenia.

There was disagreement between the member and other witnesses with regard to when the member saw the lab results, when the dog was anesthetized, and when Dr. Harjinder Singh, who performed the surgery, saw the dog and the lab results.

When Dr. Singh saw the consent form/estimate, he realized the estimated extractions were insufficient and he called the client. Both he and the member spoke to the client and explained the dental disease was worse than expected and most of the teeth would have to be removed. After verbal consent was obtained, Dr. Singh continued with

the dental extractions.

Dr. Singh testified that he asked the member twice about the status of the blood results and each time he responded that the dog had mild anemia, likely due to the bleeding. The dental procedure was completed and excessive bleeding continued. The dog had a prolonged recovery from the anesthetic and was not fully recovered when the client arrived. The client was advised that the dog needed to go to an emergency hospital for further care. The dog was admitted and kept overnight for treatment at the emergency hospital. The next day, the dog was transferred to another clinic for further treatment.

The diagnosis provided by the clinic was immune mediated thrombocytopenia. The dog recovered but requires lifelong medication and blood monitoring.

The medical records were deemed by the panel to be unreliable after October 28, 2010. The panel accepted only the copy of the medical records that were sent to the emergency hospital at the time of the dog's discharge.

The panel found there was sufficient evidence in the witness testimony and in the records submitted to the emergency hospital to make a decision in this case.

PLEA AND DECISION

The member denied the allegations as set out in the Notice of Hearing. The member was found guilty of professional misconduct in failing to meet the standard of practice of the profession.

PENALTY

- Reprimand
- The member will pay costs to the College of \$36,000

PANEL'S REASONING

The panel found expert witness submissions were contradictory on the relationship between the oral bleeding observed by the owners and the presence of dental disease observed by the member. One expert's opinion was that stage 3 periodontal disease could present with spontaneous oral bleeding, whereas it was another's opinion that there need not be an assumption of periodontal disease and that immune mediated thrombocytopenia should have

been considered.

The first allegation concerned whether the bleeding coming from the dog's mouth should have been investigated medically. The panel found the member not guilty of professional misconduct on this allegation. The panel agreed with the opinion of one expert that the dog had sufficient history and clinical symptoms to justify an assumption of periodontal disease as the cause of his oral bleeding. The panel further agreed immune mediated thrombocytopenia is a relatively rare disease and it typically presents with a high incidence of nosebleed, bruising, blood in stool and petichiae.

The next allegation concerned whether the member failed to properly interpret the blood analysis. The member said he never saw the blood test results. However, the panel believed the witness who said she handed him the lab results and saw him look at them. Another witness said she saw the member look at the documents. The panel felt the member's testimony was inconsistent.

The medical records indicate that the member ordered the pre-anesthetic blood tests. The panel concluded the member failed to accurately interpret the dog's blood tests and had failed to recognize the significance of the abnormal results. For these reasons, the panel found the member had failed to maintain the standard of practice of the profession and his actions would be regarded as unprofessional.

The next allegation dealt with the administration of anesthetic before obtaining the results of the blood testing. The evidence confirms the dog was given hydromorphone, which is commonly used as a sedative in patients exhibiting stress. It is commonly given without any blood tests prior to its administration. If an anesthetic is given, the drug could be considered to also be a preanesthetic agent, but its administration does not obligate a veterinarian to continue with an anesthetic procedure. Expert testimony confirmed the administration of hydromorphone would not exaggerate bleeding. The panel found the member did not engage in professional misconduct by ordering the administration of the pre-anesthetic agent before obtaining the results of the blood testing.

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The next allegation concerned whether it was misconduct to continue to prepare the dog for dental procedures after becoming aware of the results of the blood test. The medical records indicate the member was the veterinarian of record at the time of the dog's initial care and he ordered pre-anesthetic blood tests as part of his treatment plan. The panel believed the member was provided with the results of the blood tests prior to the dog's anesthetic induction.

The panel agreed the member's actions in authorizing and administering the dog's general anesthetic and his supervisory role in the actions of the staff constituted "continuing to prepare the dog for dental procedures". The panel found that by allowing his staff to start the dental procedure in spite of the presence of thrombocytopenia and by failing to accurately convey that information to Dr. Singh as he took over the dental procedure, the member failed to maintain the standard of practice of the profession and his actions would be regarded as unprofessional.

The last allegation concerned whether the member failed to inform the dog's owners about thrombocytopenia and also failed to offer to treat the condition.

Witness testimony confirmed a conversation occurred between the member and the client at the time of the dog's discharge. The panel agreed there was adequate evidence based on testimony that the member had informed the client of the gravity of the dog's bleeding disorder and had recommended further medical treatment at the emergency clinic.

The panel felt the member did not fail to offer to treat the condition. By indicating to the owner the seriousness of the situation and by forwarding

medical records to the emergency clinic, the member assured continuity of treatment at a facility that was better equipped to deal with the dog's problem.

PENALTY AND COSTS DECISION AND REASONS

As a result of the panel's findings, a hearing was held on the issues of penalty and costs on February 10, 2015.

One of the issues at this hearing was the panel's jurisdiction to impose certain terms as part of its penalty order, having regard to the fact the veterinarian was no longer a member of the College. The panel heard evidence he had left Ontario and was practising in the United States. The panel was advised the veterinarian has not had a licence to practise in Ontario since 2011.

In his submissions on the matter of penalty, College counsel recommended the veterinarian be given a recorded reprimand, a three month license suspension (to be applied if/when he returns to practice in Ontario), and further conditions and limitations.

The member's counsel indicated the veterinarian had no previous history of complaints with the College.

During its deliberations, it was the initial opinion of the panel to accept the recommendation as presented by College counsel. Because the member resigned in 2011, the licence suspension would have been held in abeyance until he re-applied to practise in Ontario.

However, the panel felt the legislation did not support the imposition of licence suspension with remedial consideration as the member had resigned his licence. The panel concluded the

only options available were a fine or a reprimand.

Fines are punitive in nature and are usually reserved for particularly egregious cases or cases where a member has breached an undertaking. The panel was very disappointed as it arrived at its decision. Although the panel did not make any finding about the member's motives, his decision to relinquish his licence to practice veterinary medicine in Ontario before the complaints and discipline process was complete effectively circumvented the objective of the *Veterinarians Act*, that is, the protection of the public interest. The panel hopes that should the member ever choose to return to Ontario, a future Registration Committee will read this decision and impose conditions on the member's licence application.

College counsel asserted the total costs incurred by the College to bring this disciplinary action against the member, even after prorating the investigation costs with Dr. Singh, totalled to more than \$75,000. It is customary in self-regulated health disciplines for panels such as this to award costs in the range of 50-70% of total expenditures. He concluded by suggesting that an appropriate award of costs should be \$47,000, to be paid within three months.

The Member's counsel countered the College position by pointing out the principle of proportionality, that is, that the member was only found guilty on two of the five allegations. He concluded by suggesting that an appropriate award of costs should be no more than \$20,000, to be paid within six months.

The Discipline Committee ordered the member to pay \$36,000 in costs.