Summary of Discipline Committee Hearing

DR. ALEX HELMI

Hearing Date: August 15, 2013

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

• failed to chart performance of an adequate pre-surgical examination
• failed to perform the spay surgery appropriately thereby failing to maintain the standard of practice of the profession
• failed to administer appropriate pain relief following the spay surgery
• failed to perform the second exploratory surgery appropriately in that he failed to provide fluid therapy for the second surgery
• dispensed inappropriate medication following the second surgery and failed to provide adequate pain relief
• provided inappropriate advice to the client following the surgery
• failed to make or retain records

BRIEF SUMMARY

The member performed a spay on a 16-month-old dog, as well as a second surgery after bleeding was noticed 4-6 hours following the spay. The dog was discharged the next day, her condition deteriorated and she died the following evening.

A subsequent autopsy indicated the cause of death was exsanguinations from the left ovarian pedicle. In addition, a transmural enterotomy incision mid-jejunum was found containing three ligatures, four ligatures were noted in the mesentry and a tracheal perforation with subcutaneous and mediastinal emphysema was also observed.

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

• Verbal reprimand
• Impose a condition and limitation on the member’s licence to practise veterinary medicine for 30 days, requiring the member to notify the Registrar of his return and place of practice in Ontario at least 30 days before he intends to return.
• Suspension of the member’s licence to practise veterinary medicine for two months, one month to be remitted if the member is mentored and watches a variety of surgeries, including spay surgeries, and is mentored on all aspects of practice including informed consent, pre-operative assessments, surgical technique and post-operative management. The member and the mentor provide a report on the activities.
• The member will complete a CVO Medical Records workshop.
• The member will pay costs to the College of $3,000.
• Pursuant to legislation, this matter is published including the member’s name.

PANEL’S REASONING

The Panel finds the member engaged in professional misconduct by failing to chart performing an adequate pre-surgical examination.

In performing the surgery, the member:
• failed to provide adequate pain management pre-surgically;
• cut part of the dog’s intestines;
• tore the mesentery;
• failed to document either complication in the medical record; and
• failed to inform the clients of the complications.

Post-mortem findings indicated the absence of ligatures on the left ovarian pedicle and that two ligatures were free-floating in the abdomen. The member failed to properly manage the dog after the spay surgery. The member applied a narcotic patch rather than administering more appropriate pain relief.

The member failed to perform the second exploratory surgery appropriately by not providing any fluid therapy.

The member failed to properly manage the dog after the second surgery, in that the member:
• dispensed acepromazine, which was contraindicated in this patient; and
• failed to provide adequate pain relief.

Despite the complications, the member advised the client the dog could either go home or stay at the clinic under the supervision of non-veterinarian staff.

The member failed to make or retain appropriate records.

The member engaged in professional misconduct by failing to maintain the standard of practice of the profession, failing to make or retain the required records, and an act or omission relevant to the practice of veterinary medicine that, having regard to the circumstances, would be regarded by members as disgraceful, dishonourable or unprofessional.