

Summary of Discipline Committee Hearing

DR. JONATHAN MITELMAN

Hearing Date: April 22-24, May 26-29, June 29--30, July 2, 3, 2015



ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- failed to identify the fracture of the right femur on a timely basis;
- failed to ensure that adequate x-rays were taken on two dates; failed to adequately read or interpret the x-rays taken on one date; failed to properly examine, assess and monitor the dog, particularly in respect of swelling, pain and edema;
- failed to properly identify x-rays that were taken;
- backdated entries in the records; falsified the records;
- failed to assess or properly interpret diagnostic tests;
- failed to sufficiently inform the client of the dog's hypercalcemia and discuss further diagnostic investigations with the client;
- failed to advise the client that a veterinarian who assisted the member in the surgery was not a Board certified surgeon, and that such a referral was an option;
- failed to provide adequate pain management;
- failed to maintain the standard of practice of the profession;
- failed to make or retain the records required by the Regulation;
- falsified a record regarding professional services;
- signed or issued a veterinary certificate, report or similar document that contains a statement that the member knows or ought to know is false, misleading or otherwise improper;
- 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;
- failed to adequately monitor the dog and manage her pain during hospitalization which constitutes serious neglect;
- failed to consider the possibility that the fracture was pathologic;
- failed to advise the client that the fracture may have been pathologic;
- failed to discuss with the client the likely

outcomes of the various surgical options, or obtain the client's informed consent;

- proceeded with the surgical repair of the right femur without orthogonal views of the fracture site;
- failed to take appropriate post-operative x-rays; used an exceedingly long pin for the surgery; improperly placed the pin; and,
- performed the surgery knowing the client believed another veterinarian would be performing it, and knowing the client believed that veterinarian was an orthopedic surgeon.

BRIEF SUMMARY

This case concerned a 13-year-old dog who needed emergency care as a result of an altercation with another dog. The client took the dog to the member's hospital as it was located nearby and open 24 hours.

The dog could not stand on her own and was favoring her right hind leg. The dog was diagnosed with a neurological disease in conjunction with severe arthritis. The dog was admitted to the hospital.

The next day, the dog was still holding up her rear right leg and unable to walk. The member advised the client the dog had degenerative myelopathy and osteoarthritis in the knees. He suggested an MRI and a neurological consultation.

The day after, when the client went to the hospital, the dog's right hind leg was significantly swollen. The dog's other leg also later swelled up. The member's hospital arranged an appointment at an emergency clinic for an MRI and a neurological consultation the next day.

When the client arrived to bring the dog to the appointment, Veterinarian X spoke with the client. After discussing the dog's x-rays with her, Veterinarian X suggested there was no point proceeding with an MRI, or with a neurological consultation. After discussing the possibility of euthanasia, Veterinarian X suggested the dog be seen by an orthopedic surgeon who would be at the hospital the following day.

The next day, Veterinarian X called the client and reported further x-rays were taken and the orthopedic surgeon diagnosed the dog with a

spiral fracture of the right femur. The fracture was surgically reduced the next day with placement of an intramedullary (IM) pin and cerclage wires. The surgery was performed by the member, who was assisted by Veterinarian Y, neither of whom is an orthopedic surgeon.

For the next six days, the member and Veterinarian X insisted the dog remain at the hospital to be monitored, during which time both of the dog's legs remained swollen.

After a total of nine days in the hospital, the dog was discharged without any pain medication and she was still unable to walk.

Shortly after discharge, a fistula developed at the incision site which continuously oozed blood and puss. The IM pin also began to protrude out of the dog's hip, causing significant irritation.

The dog was seen by Veterinarian Z at an emergency clinic approximately five weeks later. Veterinarian Z subsequently removed the pin, which had migrated, and replaced it with a bone plate. Veterinarian Z determined the dog's fracture was pathologic, secondary to an osteosarcoma. He also noted the previous repair site was severely infected.

The dog was ultimately euthanized several weeks later.

The member and Veterinarian X later attempted to obtain information concerning the dog from subsequent treating veterinarians. Among other things, the member posed as the dog's ongoing veterinarian and Veterinarian X was both misleading and belligerent to other veterinarians.

PLEA AND DECISION

The member pleaded not guilty to the allegations of professional misconduct and serious neglect. The member was found guilty with respect to the allegations of professional misconduct and serious neglect.

PENALTY

- Reprimand
- Suspension of the member's licence to practise veterinary medicine for five months, two months of which shall be suspended if the member successfully completes the ProBE

ethics course, a course in pain management, a five-day mentorship dealing with fracture cases and pain management, a 3,500-word paper relating pain management to his observations during the mentorship, and the College's record keeping webinar.

- Imposing a condition and limitation on the member's licence that a veterinarian reviewer conduct a random chart review within eight weeks of the member's return to practice for the purpose of considering the quality of the member's practice and record keeping, with attention to pain management, radiographic technique, labelling and interpretation. The reviewer shall complete three reviews within the 12 months following the member's suspension.
- All costs associated with the Order shall be borne by the member.
- The member will pay costs to the College of \$85,000.

PANEL'S REASONING

Allegation: the member failed to identify the fracture of the right femur on a timely basis.

Reasons for Decision: Radiographs were taken when the dog arrived at the hospital and a fracture of the right femur was visible. The member did not recognize this fracture until it was pointed out by another veterinarian four days later. The member admitted to this allegation and agreed the fracture should have been identified earlier.

Allegation: the member failed to ensure adequate x-rays were taken.

Reasons for Decision: Although the member was not at the hospital on the day the dog was admitted, he was present the following day. He testified he observed the dog could not stand on her own, and when assisted to stand, she was dragging her nails on one side more than the other. There was no mention in the medical record of these observations, nor was there any explanation of his thought process with regard to radiographic investigation of these physical findings. He went on to say that, although he examined the radiographs taken the previous day, he did not identify the femoral fracture.

The member admitted the radiographs he examined did not permit adequate review and he should have ensured he had a radiograph that showed the entire femur.

Allegation: the member failed to adequately interpret the x-rays.

Reasons for Decision: The panel agreed that not identifying the dog's fracture for four days when

evidence of the fracture was present on x-rays taken the first day certainly qualified as a "failure to adequately interpret" the x-rays.

Allegation: the member failed to properly examine, assess and monitor the dog while under his care, particularly in respect of swelling, pain and edema.

Reasons for Decision: The panel could find no notes in the records to indicate the dog was examined, assessed or monitored while under the member's care. The member admitted, under cross examination, the dog was not properly assessed. There were no records of the dog's continued care. There were no pain scores on treatment sheets and there was no mention of neurological status. The medical records mentioned "paralyzed rear limbs", which appeared to be an inaccurate statement, as there was never an indication in the records the dog had decreased pain sensation or paralysis. The panel noted there was no mention in the records of swelling, pain or edema, other than an entry noting "RH fracture, swollen" dated seven months after the fact.

The client mentioned several times she noted swelling in one or both of the dog's rear legs. The client was very familiar with the dog and the panel agreed it did not require any medical expertise to make a credible observation of swelling in her dog's legs. The panel felt that ultimately the question was not one of whether or not swelling was actually present, but that nothing was documented in the medical records to indicate the dog had been examined, assessed or monitored.

Allegation: the member failed to properly identify x-rays that were taken.

Reasons for Decision: The College publishes minimum standards for the veterinary facilities in the province. The member would have been aware of those standards and the hospital would have had to meet those standards to be accredited. The hospital would also have been subject to regular inspections. Those standards specify the identification of radiographs must include:

- the name of the veterinarian or the designation of the facility or both
- identification of the animal
- the date of the radiograph
- an indication of the left or right side of the animal
- an indication of time for sequential radiographic studies

The panel observed the radiographs from the hospital were not permanently labelled. They

were labelled with stick-on paper labels and did not contain the required information. At the hearing, there was frequent confusion during discussion of the radiographs that led the panel to have some concern about their accuracy.

Rather than accept responsibility for the deficiencies, the member attempted to deflect blame onto an employee. As a practice owner, the member had a responsibility for ensuring hospital procedures met the minimum requirements. The panel agreed the quality of the radiographic labeling fell below the standard of practice and constituted a failure to make or retain the required records.

Allegation: the member failed to make or retain records in accordance with the regulations.

Reasons for Decision: The College's expert witness testified he felt no confidence in knowing how the case was managed by the content of the medical records. The panel had little confidence in the medical records. The panel found the violations of the standards for medical records were consistent, numerous, and blatant.

The panel concluded the member had recorded little documentation concerning his thought processes, decisions, judgements, actions and interactions with the client or with his veterinary colleagues. As a practice owner, the member has a responsibility to ensure the record keeping of the hospital met all the requirements of the practice standard.

Allegation: the member made entries in the records long after the fact.

Reasons for Decision: All entries are to be made as soon as possible after interacting with the client, seeing the animal, or receiving new information. The member made an entry into the dog's medical record six months after the fact. The entry was inserted into the day of admission record, when the member was not in the hospital, indicating he provided a clinical assessment of a right hind leg fracture and swelling. The fracture was not noticed until the x-rays were examined two days later. Also, the member wrote a note concerning the patient's ability to ambulate, again entering it on the day of admission, when he wasn't there. No reason for these changes to the medical record was provided.

Allegation: the member backdated entries in the records.

Reasons for Decision: The panel relied on a



simple definition of backdating to reach its decision. The word was defined as putting an earlier date to a document or agreement, than the actual one. Two specific entries fit the panel's working definition of backdating. The panel believed the member backdated entries in the medical record for the purpose of deceiving the College during its investigation.

Allegation: the member falsified the records.

Reasons for Decision: The panel interpreted the word "falsify" as meaning to misrepresent, to give an untrue or misleading account of, or to fraudulently alter a record. It was the finding of the panel the member did make such entries, many well after the fact, to intentionally mislead.

Allegation: the member failed to assess or properly interpret diagnostic tests.

Reasons for Decision: Both expert witnesses agreed a fracture was visible on the radiographs taken on the dog's initial presentation. The panel agreed it was reasonable to expect a proper diagnosis from the radiographs - either by the doctor assessing them or by sending them for an expert opinion. The calcium level was a more complicated issue. The dog's initial calcium level was elevated but a later repeated calcium level was normal. Calcium can be elevated for many reasons and could have been further assessed by submitting blood for an ionized calcium analysis or by simply repeating the original bloodwork. Based on the member's testimony, the bloodwork was repeated and the calcium level had returned to normal, leading him to believe the hypercalcemia was benign. The panel believed that given the myriad of opinions expressed regarding the hypercalcemia, the member could not be faulted for failing to adequately assess and interpret the calcium level.

Allegation: the member failed to sufficiently inform the client of the dog's hypercalcemia and discuss further diagnostic investigation with the client.

Reasons for Decision: The medical records indicated a calcium level was performed initially and again five days later. Although there was little discussion within the medical record surrounding this topic, it did appear further investigation had been performed by virtue of the repeated test. The allegation concerned whether or not the client was informed of the hypercalcemia and its further investigation. The member testified he did discuss the hypercalcemia with the client but the panel could find no evidence in the medical records that supported this statement. The client could not recall whether or not this discussion occurred.

Insufficient evidence was presented to the panel to prove the member had failed to inform or discuss the issue of hypercalcemia with the client.

Allegation: the member failed to advise the client that Veterinarian Y was not a Board certified surgeon, and that such a referral was an option.

Reasons for Decision: The client testified that she believed Veterinarian Y was an orthopedic surgeon and she was never offered a referral to a Board certified surgeon. The member testified he did not refer to Veterinarian Y as a Board certified surgeon, but rather as a local veterinarian with a special interest in surgery. If this was accurate, the panel was of the opinion it was reasonable the client might make a lateral and logical assumption to interpret that remark to mean he was a specialist.

The member testified he did not offer the client a referral to a Board certified surgeon, as he believed Veterinarian X had done so. With no explanation as to why he believed this, and no documentation to back up the claim, the panel was of the opinion he was trying to shift responsibility to Veterinarian X.

The panel agreed that failure to offer referral fell below the acceptable standard of practice. The discussion should have taken place, and it should have been fully documented as part of the informed consent process.

Allegation: the member failed to provide adequate pain management.

Reasons for Decision: The College's expert witness was of the opinion the dog had been provided suboptimal pain management at the time of surgery because the drug that she was given, Tramadol, was not an adequate solo pain medication for severe pain. Not only was Tramadol a poor drug choice, but the dog had only been given 1/3 of the recommended dose and only 1/3 as often as it should have been given. The dog was prescribed hydromorphone, a potent pain medication, but no evidence could be found in the records (most importantly, in the daily treatment sheets) to confirm it had actually ever been administered. Metacam, an NSAID pain medication, was started, and then stopped. Another potent pain medication, Fentanyl, was placed as a 50 ucg. patch. The College expert testified the size of the patch was too small and the effectiveness of Fentanyl can be unreliable since the patches are known to have a variable absorption rate.

The member admitted pain management was inadequate at times. The panel found it concerning that some of his drug dosages were

based on the dog's perceived level of pain and yet there was no indication pain was being assessed. It was also concerning to the panel that the

member testified several times the dog appeared comfortable, when logic dictates a fractured leg would be painful. In this respect, he supported the opinion of the panel when he testified he would have treated the dog differently had he known a fracture was present. The dog was discharged by a technician who advised the owner not to give any pain medication. The panel was of the opinion that not only was the member responsible for the actions of his subordinate, but the confusion at the time of the dog's discharge could have been avoided if the client had been provided with a written copy of discharge instructions that clearly explained the home care that she was expected to provide and the pain management protocol to be followed.

Allegation: the member's failure to adequately monitor the dog and manage her pain during her hospitalization constitutes serious neglect within the Veterinarians Act.

Reasons for Decision: The Veterinarians Act states a member or former member of the College shall be found guilty of serious neglect by the Discipline Committee if the member or former member has displayed in his or her professional care of an animal a lack of knowledge, skill or judgment or disregard for the welfare of the animal of a nature or to an extent that demonstrates the member or former member is unfit to engage in the practice of veterinary medicine or is fit to engage in the practice of veterinary medicine only subject to the conditions and limitations imposed by the Discipline Committee.

The panel felt the member displayed little sympathy for the amount of discomfort the dog had endured and he expressed little remorse for his part in allowing that discomfort to continue. The member testified it was the job of other doctors and/or technicians to assess pain and provide medications. However, the member was the dog's primary caregiver and the panel agreed it was his responsibility to supervise and manage her care. This lack of remorse, along with his blatant lack of knowledge and judgement, demonstrated to the panel a clear disregard for the welfare of his patient.

The member's lack of knowledge regarding pain medication and appropriate monitoring and charting techniques could possibly be



remediated. However, his failure to adequately monitor the dog and treat her pain, as well as his lack of remorse for this failure, showed extreme disregard for the welfare of an animal in his care.

Allegation: the member failed to consider the possibility the fracture was pathologic.

Reasons for Decision: The panel observed significant disagreement between the experts with regard to both the cause and importance of the elevated calcium level as well as disagreement with regard to the interpretation of the radiographic evidence. The panel concluded there was a professional difference of opinion regarding this issue and even though the member failed to consider the possibility of a pathologic fracture, his actions did not constitute professional misconduct.

Allegation: the member failed to advise the client the fracture may have been pathologic.

Reasons for Decision: The client testified the possibility of a pathological fracture was never mentioned in any of her discussions with the member and there is no indication in the medical record this possibility was ever discussed with her. The panel agreed this allegation was true. However, for reasons similar to those given for the previous allegation, the panel did not consider this to be professional misconduct.

Allegation: the member failed to discuss with the client the likely outcomes of the various surgical options, or obtain her informed consent.

Reasons for Decision: The client testified she signed all documents at the front desk in the presence of a technician, and the signing of the Authorization to Perform Medical Treatment or Surgery was no different. She testified further that she did not have any discussions with the member with regard to various surgical options or their corresponding potential outcomes. The member had an obligation to have a full discussion with the client about preoperative plans, surgical options, recommendations and costs. In addition, those discussions should have been documented. The panel saw no evidence there was any documentation in the record to support the member's assertions that he had any of those discussions.

The member testified the signed authorization form he had on file indicated informed owner consent. On the contrary, it was the panel's view the signing of the authorization form in the absence of a fulsome documented discussion did not constitute informed consent. It was the panel's view the signing of an authorization form is simply the final component of the process of obtaining informed consent; in other

words, the owner's signature is meant to be an acknowledgement a documented discussion has taken place and there is agreement and consent to go forward with the treatment plan.

The panel was concerned the stress the client testified she was feeling, combined with the assurance this surgery would fix the dog, may have made her even more vulnerable to signing a consent form without first reviewing it, understanding it, and being fully informed. Because he knew or should have known the client was under significant stress, the panel was of the opinion the member had a professional obligation to ensure she fully understood the consent process. Instead, he allowed her to sign the consent form with no significant discussion and he made no entries in the medical record to document any conversations concerning the consent. For these reasons, the panel was of the opinion the member had shown serious disregard for his professional obligations and had violated the principle of trust inherent in the veterinarian/client relationship.

Allegation: the member proceeded with the surgical repair of the right femur without orthogonal views of the fracture site.

Reasons for Decision: The member testified he did have orthogonal views of the fracture site prior to surgery, but both of the expert witnesses did not agree with him. The radiograph that he claimed to represent the V-D view did not illustrate the entire fracture site nor did it show all of the femur. The panel agreed this seemed to be a poor radiograph to use for pre-surgical planning purposes.

Allegation: the member failed to take appropriate post-operative x-rays.

Reasons for Decision: Although it appeared that both lateral and V-D views of the repaired femoral fracture had been obtained, the panel did not rely on its own expertise to form an opinion on whether or not those views were "appropriate". The panel relied on the expert testimony; however, the expert witnesses had differing opinions of this allegation.

The panel respected this was a professional difference of opinion and there appeared to be no clear right or wrong in this matter. Furthermore, College counsel did not present any additional evidence that would have caused the panel to favour the position of one expert over the other.

Allegation: the member used an exceedingly long pin for the surgery.

Reasons for Decision: The expert witnesses disagreed with regard to the length of the IM pin the member elected to use for the surgical repair

of the dog's femoral fracture. Again, the panel respected this was a professional difference of opinion and there appeared to be no clear right or wrong in this matter.

Furthermore, College counsel did not present any additional evidence that would have caused the panel to favour the position of one expert over the other.

Allegation: the member improperly placed the pin.

Reasons for Decision: The expert witnesses disagreed with regard to the placement of the IM pin. Again, the panel respected this was a professional difference of opinion and there appeared to be no clear right or wrong in this matter. Furthermore, College counsel did not present any additional evidence that would have caused the panel to favour the position of one expert over the other.

Allegation: the member performed the surgery knowing the client believed Veterinarian Y would be performing it, and knowing the client believed that Veterinarian Y was an orthopedic surgeon.

Reasons for Decision: The panel was of the opinion the testimony of the client and the member was consistent with regard to their understanding that both the member and Veterinarian Y would be present during the surgery. The panel also agreed that it was reasonable that a lay person would assume that an outside veterinarian referred to as an orthopedic surgeon and brought in for a fracture repair would be the one doing the surgery. Having said that, the panel was being asked to make a ruling based not on what the client believed, but what the member knew she believed - that is the wording of the allegation. The panel felt that any determination of what either was thinking or what either believed the other to be thinking was impossible to know. The panel failed to see any proof by the College that the member could know what was going on inside the mind of the client.

Penalty and Costs

The panel was advised the College and the member had reached an agreement on penalty and costs.

College counsel presented a Book of Authorities containing seven similar cases from the College of Veterinarians of Ontario, five cases from the College of Physicians and Surgeons of Ontario, and one case from the Law Society of Upper Canada. Penalties in most of those



cases included a reprimand. Periods of licence suspension ranged from two to nine months, and the majority of the licence suspensions had provisions for reduction of the suspension period if prescribed remedial measures were completed as required.

In listening to oral arguments presented by the parties and the advice of the panel's independent legal counsel, the panel was aware that it would be unusual for a Discipline panel to reject all or part of an agreed submission on penalty and costs without exceptional and compelling reasons. In this regard, the panel found that the proposed period of licence suspension generally fell within the historical range for this type of professional misconduct, however, the panel had serious concerns with regard to the scope and nature of the remedial measures that were being proposed.

In summary, the Joint Submission proposed the following remedial measures:

- the ProBE ethics course
- a one day mentorship dealing with fracture cases and pain management by a mentor to be approved in advance by the Registrar
- the College's interactive record keeping webinar
- a total of three on-site visits by a veterinarian appointed by the Registrar to conduct random chart reviews for the purpose of considering the quality of the member's practice and the nature of his record keeping

The panel agreed with the recommendations regarding the ProBE course, and the record keeping webinar. The ProBE course is a program offering education and remediation to health care professionals in the area of ethics and boundaries. The panel agreed that this was an appropriate course for the member to take. Similarly, it was felt that the records webinar offered by the College would be appropriate, and would provide the member an opportunity to upgrade his record keeping methods and skills.

The panel strongly disagreed with the proposed one day mentorship period and the general nature of the on-site visits. The panel did not feel that the Joint Submission adequately addressed the issue of the need for continuing education of the member in the area of pain management. Specifically, the panel was of the opinion that the proposed one day mentorship was not an adequate method of addressing the finding of serious neglect.

The panel suggested to the parties that enhancement of the rehabilitative intention of this proposal should be considered. In that

regard, the panel suggested lengthening the mentorship period to five days and to have this mentorship take place at an external facility that could provide a broad range of clinical experience. The panel also felt it should be stipulated the follow up on-site reviews should be conducted with special attention to pain management, radiograph technique, labelling, and interpretation.

To further rehabilitate the member with regard to the finding of serious neglect, the panel suggested the member be required to take a course in pain management and write a 3,500-word paper at the conclusion of his mentorship period, detailing what he had learned.

The panel also questioned the parties to ensure there was a clear and mutual understanding of what was meant by the concept of licence suspension. College counsel expressed the opinion that his expectation was that the member would have nothing to do with the practice, would not hold out as being a veterinarian, and would not derive any financial benefit from the practice during the period of the licence suspension. The member's counsel expressed reservations about the practicality of the financial limitation expected by the College but did make the commitment that his client would not hold himself out as a veterinarian, would not be present at any time on the property of the hospital, would not take part in any consultations with locums, would not take part in any management aspects of the practice, and would not sign any hospital cheques during the period of the suspension. The member's counsel invited the panel to provide additional guidance in its order as to what "suspension" entailed.

Reasons for Decision on penalty

The function of the College is to protect the public interest and the panel was of the opinion that the conditions of the Joint Submission, as amended following suggestions by the panel, fulfilled that mandate. The panel agreed that ongoing competence is an expectation of quality practice and there is an obligation for all veterinarians to continuously and proactively seek continuing education to ensure protection of the public interest. In this case, the public interest was protected by the strong rehabilitative focus of the penalty as amended, and it offered the member ample opportunity to improve his practice and his knowledge.

General and specific deterrence was provided by publication of the facts of the case (including publication of the member's name) and by the licence and financial penalties imposed. Specific deterrence was provided by the reprimand that

served to impress upon the member the seriousness of his misconduct and the disappointment it brought to the profession.

Reasons for Decision on costs

The panel examined the costing documents submitted by College counsel and accepted the method used to derive the final cost assessment. The panel recognized this amount had been agreed to by both parties and found the amount to be reasonable. The panel found no justification to reject this aspect of the Joint Submission. The original submission allowed the member two years to pay this levy. During the hearing, the member's counsel requested this payment period be extended to make it fall within the range of 30 to 36 months. The panel agreed to a payment period of 30 months.

