Summary of Discipline Committee Hearing

DR. SERGIY DARIY

Hearing Date: June 15, 16, 17, July 7, 13, 2020

BRIEF SUMMARY OF ALLEGATIONS

The member treated four dogs for dental procedures. While the medical outcome for each animal varied, it is alleged the member provided inadequate treatment, both pre- and post-operatively; that all four dogs suffered unnecessary pain and distress and required emergency treatment within 3 to 48 hours of discharge. Two of the dogs died within 24 hours of the dental procedure.

Jegolo & Pepper

The first case involves two dogs who attended the member's clinic for dental procedures required as a result of moderate to severe periodontal disease. The first dog, Jegolo was not fully recovered at discharge, was lethargic and not walking in the early evening and overnight his condition worsened. The dog was returned to the clinic the following morning but died during the day. The second dog, Pepper also was not fully recovered at discharge but did improve overnight. However, Pepper developed severe periorbital swelling of the left eye within 24-48 hours of discharge - most probably related to the dental extraction. The owner took Pepper to another veterinary clinic where Pepper was treated and recovered. In both cases, no intra-oral dental radiographs were taken, no monitoring of blood pressure was done, neither dog was monitored post-surgery and both were discharged in an unsuitable condition.

Bandit

Bandit was treated for dental procedures required because of moderate periodontal disease. Again, blood pressure was not monitored during surgery. The dog developed severe bradycardia during the procedure, which was not treated. Bandit was not monitored properly post-surgery. He was discharged in an unsuitable condition and was non-responsive and extremely hypothermic by the time the owner arrived home with the dog. The owner brought Bandit to an emergency clinic that evening where Bandit was found to be extremely hypothermic with no detectable blood pressure reading, and in kidney failure. After several days of intensive veterinary care, Bandit recovered.

Loki

Loki was treated for dental procedures required because of facial swelling. Blood pressure was not monitored during anesthesia and no intra-oral radiographs were taken, despite a severe swelling on Loki's face and serious differential diagnoses considered as a cause. During surgery, the dog developed severe bradypnea, which was not treated. The dog was not monitored properly post-surgery and was discharged in an unsuitable condition. The owner contacted the clinic the following morning and was directed by a technician not to bring the dog in unless it started panting. The owner took the dog to an emergency clinic where Loki later died that day. A postmortem was performed at the Animal Health Laboratory, University of Guelph.

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- failed to maintain the standard of practice of the profession
- failed to continue to provide professional services to an animal until the services are no longer required or until the client has had a reasonable opportunity to arrange for the services of another member
- failed to make or retain the records required
- an act or omission relevant to the practice of veterinary medicine that would be regarded as disgraceful, dishonourable or unprofessional
- failed to provide within a reasonable time and without cause any certificate or report requested by a client or their agent in respect to an examination or treatment performed by the member
- conduct unbecoming a veterinarian

DECISION

The member pleaded guilty with respect to some of the allegations and denied others.

PENALTY

- Reprimand
- The member's licence to practise veterinary medicine is suspended for four months
- Before the end of the suspension, the member shall complete the following remediation:
  - A half-day assessment to evaluate the member's baseline knowledge of the issues that were raised in the cases.
  - A one-day mentorship on the issues raised in the cases. The mentor shall report to the Registrar.
  - A follow-up half-day assessment to review what the member learned in the mentorship and whether the member will change his practice as a result of the mentorship.
  - Completion of the College's online learning module on foundations for medical record keeping.
- The member must participate in a peer review of medical records at least every four months until the quality of his records improves. The results of the reviews may be reported to the Executive Committee for possible further action.
- The member will pay costs to the College of $80,000.

PANEL'S REASONING

The panel found that generally, the anesthesia of the dogs including the delivery of premedications, local and general anaesthetic procedures, was not properly managed, and the dogs' vitals were not properly monitored during and/or after the procedures. The panel also found that in two cases, informed client consent regarding declining intra-oral radiographs was not obtained; in all cases the standard of practice was not met by not performing intra-oral radiographs.

The panel also found that generally, the dogs were not discharged in an acceptable condition, and that the dogs' conditions worsened after discharge to the point of requiring emergency veterinary care and in two cases, death. The condition of the dogs at discharge was not properly assessed and recorded, and the owners' concerns were not properly addressed. The panel also found that the medical records in all cases, did not meet the standards.

For these reasons, the panel finds the member guilty of failing to maintain the standard of practice of the profession.

After discharge, the member did not properly respond to concerns voiced by the owners, thus failing to provide veterinary services until no longer required. The panel noted that this failure led to delays by the owners in seeking follow-up veterinary care either at the member's hospital or elsewhere.

For these reasons, the panel finds the member guilty of failing to continue to provide professional services to an animal until the services are no longer required or until the client has had a reasonable opportunity to arrange for the services of another member.

With regard to Pepper, the dog developed a severe, painful swelling of the left periorbital area within 24 to 48 hours of discharge, and was taken to another clinic for assessment. The records were not forwarded to this clinic within two business days. The panel did find that the records were forwarded to Pepper's owner in a timely manner and subsequently to a third clinic where Pepper was treated. The member stated that records were not forwarded because Pepper was no longer under care at the second clinic. However, the member had no way of knowing whether Pepper would return to that clinic for follow-up care.

For this reason, the panel found the member failed to provide within a reasonable time and without cause any certificate or report requested by a client or their agent in respect to an examination or treatment performed by the member.

With regard to the deficiencies in the member's record-keeping, the panel identified many deficiencies from what is required in the College's standards, including results of monitoring and details of client communications. The member mistakenly maintained that recording these identified deficiencies was not mandatory. For these reasons, the panel found the member guilty of failing to make or retain the records required by the regulation.

The panel found the member's management of all cases, had many practices that were unprofessional, specifically his failure to properly monitor the dogs during and after anesthesia, his failure in maintaining the standard of practice by not performing intra-oral radiographs when performing dental procedures, his failure to obtain informed consent from the owners regarding the risks of not performing intra-oral dental radiographs, and discharging patients in an unsuitable condition. This contributed to the improper care of the patients, two of which died the day after their procedures, and two that required intensive and prolonged veterinary care to allow for recovery.

The panel found in all cases the member, when discharging the dogs in an unsuitable condition, entered their recovery in the medical record at "P1" or normal and informed the owner that their condition was normal when it was not, even when the owners expressed concern about the condition of their dogs.

Additionally, the member recorded in the hospital chart that conversations regarding procedures had taken place in two cases (Bandit and Loki), when the evidence supports that they had not, thus some of the content of Bandit's and Loki's medical record is deceitful. The panel found these actions to be dishonourable.

The panel did not find sufficient evidence of disgraceful conduct in these cases.

For these reasons, the panel finds the member guilty of an act or omission relevant to the practice of veterinary medicine that, having regard to the circumstances, would be regarded by members as dishonourable and unprofessional.

The panel considered the facts found in this case amounted to conduct that harms the standing of the profession in the eyes of the public. In all cases, the case management did not meet the standard of practice with the result that Jegolo suffered and died subsequently to and as a result of the procedure; Pepper suffered a painful condition requiring intensive and prolonged treatment as a result of the procedure; Bandit suffered and required intensive and prolonged veterinary care as a result of the procedure; and, Loki suffered and required intensive veterinary care as a result, and ultimately died. The owners suffered marked emotional pain and stress as a result of the illness, and in two cases, the loss of their dogs.

For these reasons, the panel finds the member guilty of conduct unbecoming a veterinarian.

For the reasons set out above, the panel finds the member to have engaged in professional misconduct. The member's conduct fell well below the standard reasonably expected of a veterinarian in Ontario.

Reasons for Penalty and Costs Decision: The member's management of the cases had serious and unprofessional shortcomings.

The panel specifically noted: failures regarding anesthesia protocols that were used; failure to properly monitor anaesthesia including blood pressure and post-operative recovery; failure to record findings of monitoring that may have been performed; failure to perform intra-oral radiographs when the dentistry cases were serious thus compromising proper care of the dogs; failure to obtain informed client consent regarding the risks of not performing intra-oral radiographs; and discharging patients in an unsuitable condition. These failures resulted in the improper care of the patients, two of whom died the day after their procedures and two that required intensive and prolonged veterinary care to allow for recovery.

This was not the first finding of professional misconduct against the member. In May 2014, in an uncontested hearing, the member admitted to professional misconduct in respect of matters regarding competency in canine surgery, maintenance of medical records, client communications and the standard of ethics expected of a veterinarian. The penalty in that matter included suspension of his licence to practise veterinary medicine, mentoring in surgical technique, completion of an ethics programme, and to undergo a medical records review.

Further, in 2015, the Complaints Committee reviewed a complaint against the member which was not referred to discipline but the committee provided feedback to the member regarding their finding of substandard practices that featured poor client communications. The committee recommended the member attend a workshop on personal conduct in a professional setting and to engage a mentor to assist in improving client communications and prescribing procedures.

Further, in February 2019, the College investigated the member in response to information that some of his patients developed complications following dental procedures. The Executive Committee did not recommend that the matter go forward to the Discipline Committee but it did articulate considerable concerns regarding the member's practice of veterinary medicine. It provided a written caution and recommended voluntary remediation that included: completing a course on veterinary anaesthesia protocols; meeting with a peer to observe the member's anesthesia procedures; and, submitting a reflective paper on case situations where the member had applied his learning on anaesthesia protocols.

The panel notes the 2019 Executive Committee decision and associated remediation took place after the cases that are relevant to this hearing. It follows that that remediation would have had no impact on the cases being heard now. However, the remediation should have had an

impact on how the member viewed his previous anesthesia practices. During the initial phase of this hearing, the member defended those anesthesia practices rather than admitting they were serious issues. This suggests the member did not learn from the remediation undertaken in 2019. However, the panel notes that the member does now accept the findings of this hearing.

The panel notes the findings of the hearing of May 2014 and the Complaints Committee finding of 2015 feature similar findings to the allegations found against the member in this most recent case.

The penalty of a minimum four month continuous suspension is significant. The panel hopes this will impress upon the member how serious these latest findings of professional misconduct are and how seriously they are perceived by the panel.

The mentorship component is critical to ensuring an objective third-party assessment of the member's practice. It is in the member's interest to ensure that the most is made of this opportunity to learn and improve.

As medical records continue to be an area of concern, the module on Foundations for Medical Record Keeping: Companion Animal will provide an additional resource to assist the member with understanding the deficiencies in his records and how to effectively correct those deficiencies. The review of the member's medical records by an independent assessor will assist the member in understanding identified deficiencies.

Finally, the half-day assessment before mentorship and the subsequent follow-up will enable the College to assess the impact of this penalty order on the veterinary practices of the member.

The costs portion is commensurate with, and appropriate for, a contested hearing that involved three cases and four dogs.

Given the above, the penalty and costs proposed are appropriate and necessary. It is critical the member embrace this opportunity to improve his practice of veterinary medicine. The member's clients and their animals, as well as the public and the veterinary profession require this.