STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION, BOARD OF VENTERNARY MEDICINE, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 00-2357 |
| WALTER H. DORNBUSCH, D.V.M., | ) | |
| Respondent. | ) | |
| DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION, BOARD OF VETERINARY MEDICINE, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 00-2358 |
| WALTER H. DORNBUSCH, D.V.M., | ) | |
| Respondent. | ) | |

## RECOMMENDED ORDER

A formal hearing in the above-styled cases was held before Daniel M. Kilbride, Administrative Law Judge, Division of Administrative Hearings, on September 25, 2000, in Viera, Florida. The hearing was concluded September 28, 2000, via video teleconference, with Petitioner and the Administrative Law Judge in Tallahassee, Florida and Respondent and his witnesses in Orlando, Florida.

## APPEARANCES

For Petitioner: Robert H. Horsay, Esquire
Department of Business and
Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-2202

For Respondent: Walther H. Dornbusch, D.V.M., pro se
1117 Malabar Road Northeast
Palm Bay, Florida 32907

## STATEMENT OF THE ISSUES

Whether disciplinary action should be taken against Respondent's license as a veterinarian based on alleged violations of Section 474.214, Florida Statutes (1997), as charged in the Administrative Complaints filed against Respondent in this proceeding.

Count I of the Administrative Complaint in Case No. 00-2357 charged Respondent with a violation of Section 474.214(1)(r), Florida Statutes (1997): being guilty of incompetence or negligence by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.

Count II of the Administrative Complaint charged Respondent with a violation of Section 474.214(1)(ee), Florida Statutes (1997): failing to keep contemporaneously written medical records as prescribed by Rule 61G18-18.002(3), Florida Administrative Code.

The Administrative Complaint in Case No. 00-2358 charged Respondent with a violation of Section 474.214(1)(r), Florida Statutes (1997): being guilty of incompetence or negligence by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.

## PRELIMINARY STATEMENT

On April 6, 2000, Petitioner filed a two-count Administrative Complaint, DBPR Case No. 98-11323 (DOAH Case No. 00-2357), against Respondent, alleging violations of Chapter 474, Florida Statutes (1997).

On October 6, 1999, Petitioner filed an Administrative Complaint, DBPR Case No. 98-21230 (DOAH Case No. 00-2358), against Respondent alleging violations of Section 474.214, Florida Statutes (1997).

Respondent disputed the allegations contained in both of the Administrative Complaints and elected a formal administrative hearing for each. Consequently, each case was transferred to the Division of Administrative Hearings on June 6, 2000, to conduct hearings pursuant to Section 120.57, Florida Statutes (1997). The cases were consolidated at the Division of Administrative Hearings on September 14, 2000, and this hearing followed.

During the hearing, Petitioner offered the testimony of three witnesses: Maryjane Greene (owner of "Midnight"); Erich Scherer, Investigator for the Department of Business and Professional Regulation; and Jerry Alan Greene, D.V.M. (expert witness). Petitioner offered seven Exhibits, all of which were received into evidence. Respondent presented the testimony of two witnesses: Richard George, D.V.M. (limited expert witness) and Diana Morisseau (Respondent's former employee). Respondent also testified on his own behalf. Respondent offered two Exhibits, both of which were received into evidence.

The Transcript of the hearing was filed on October 27, 2000. Petitioner filed its post-hearing submittals on November 20, 2000. Respondent submitted a post-hearing memorandum on October 19, 2000. Both parties' proposals have been given careful consideration in the preparation of this order.

## FINDINGS OF FACT

Based on the evidence and testimony of the witnesses presented and the entire record in this proceeding, the following facts are found:

1. At all times material, Respondent was a licensed veterinarian, having been issued license number VM 0003822.

### Facts relating to Case No. 00-2357

2. On or about March 5, 1998, Respondent performed a spay on "Midnight," a dog owned by Maryjane Greene and her husband.

3. On or about March 8, 1998, "Midnight" expired at the Greene's home.

4. When Mrs. Greene dropped off "Midnight," she was not sufficiently informed by Respondent about her option to have a pre-anesthesia lab work-up performed.

5. There is no indication of an offer to perform a pre-anesthesia lab work-up, nor an indication that Mr. or Mrs. Greene declined such an offer, nor a consent form declining such a work-up, noted in the medical records kept by Respondent for "Midnight."

6. It is a deviation from the standard of care to fail to offer a pre-anesthesia lab work-up.

7. The anesthetic protocol used by Respondent during the spay of "Midnight" included Xylzine (a.k.a. Rompun) a drug with a profound and potentially deleterious effect on the heart which may cause a first degree or second degree heart block.

8. The anesthetic protocol used by Respondent during the spay of "Midnight" also included Ketamine, which is not approved for use in dogs. When used as an anesthetic protocol, it is considered an extra-label use of the drug.

9. An extra-label use of a drug means that there have been no safety studies completed, and it cannot be adequately predicted what effects the medication will have on an animal on a consistent basis.

10. There is no indication in Respondent's records for "Midnight" that Mrs. Greene was informed regarding the use of Ketamine in her dog's procedure.

11. It is a deviation from the standard of care not to make a client aware of the use of an extra-label drug and not to have the client sign a consent form.

12. Xylazine and Ketamine are both cardiac depressants. When used in combination they each make the other more of a cardiac depressant, thus requiring the administration of another drug, such as Atropine, to minimize the cardiac depressant effect.

13. There is no indication in Respondent's medical records for "Midnight" that Atropine or any other drug was administered, other that the Xylazine and Ketamine.

14. Respondent's failure to administer Atropine or any other drug to minimize the cardiac depressant effects of Xylazine and Ketamine was a deviation from the standard of care.

15. Respondent's failure to administer Atropine or any other drug to minimize the cardiac depressant effects of Xyalzine and Ketamine played a substantial role in "Midnight's" demise.

16. Upon picking up "Midnight," Mrs. Greene was given limited post-operative instructions. She was told not to give "Midnight" water until he could walk a straight line; not to

give food until he could hold water down; only leash walks for 10 days; and no baths for 7-10 days.

17. Respondent's post-operative discharge instructions given to Mrs. Greene did not comply with the standard of care in veterinary medicine.

Facts relating to Case No. 00-2358

18. On or about August 25, 1998, Respondent performed surgery to remove a mass from the perineal area of "Snoopy," a nine-year-old obese Beagle belonging to Juan Ferras.

19. There is no indication in Respondent's records for "Snoopy" that the surgery was performed due to an emergency, although the credible testimony indicated that it was an emergency.

20. Given "Snoopy's" age (nine years) and weight (60 lbs.), it would be in the dog's best interest to perform a pre-anesthesia lab work-up, or to at least offer one to the owner.

21. Respondent did not indicate in his medical records that he offered to perform a pre-anesthesia lab work-up on "Snoopy."

22. In view of the emergency nature of the surgery, it was not a deviation from the standard of care to fail to offer a pre-anesthesia lab work-up.

23. The anesthetic protocol used by Respondent during the procedure on "Snoopy" included Ketamine, which is not approved

for use in dogs. When used, it is considered an extra-label use of the drug.

24. Ketamine should be used with extreme caution in dogs for which the veterinarian is unaware of the renal function or the liver function of the dog.

25. It is a deviation from the standard of care not to make a client aware of the use of an extra-label drug, and not to have the client sign a consent form.

26. There is no indication in Respondent's records for "Snoopy" that Juan Ferras was informed regarding the use of Ketamine in his dog's procedure.

27. Upon picking up "Snoopy," Mr. Ferras was given limited post-operative instructions.

28. Respondent's failure to give specific post-operative discharge instructions to Mr. Ferras constituted a deviation from the standard of care.

29. After discharge, "Snoopy" began vomiting and was readmitted to Respondent's facility on or about August 27, 1998.

30. On or about August 28, 1998, "Snoopy" expired at Respondent's facility.

31. There is no indication in Respondent's records on "Snoopy" that upon "Snoopy's" readmission to Respondent's facility, on or about August 27, 1998, Juan Ferras refused to pay or was only willing to pay a small portion of any treatment

rendered to "Snoopy." Because of this finding it is unnecessary to address whether refusal to pay a fee is an appropriate defense by Respondent.

32. Upon "Snoopy's" readmission to Respondent's facility, on or about August 27, 1998, "Snoopy" was determined to be approximately 11 percent dehydrated and in a state of shock.

33. In order to correct the dehydration and maintain "Snoopy," it would have been required to administer approximately 4300-4400 ccs of fluid.

34. Respondent's records indicate that only 800 ccs of fluids were administered to "Snoopy." This left "Snoopy" with a tremendous deficit of fluids.

35. Respondent's explanation as to the reason for the small amount of fluid shown on "Snoopy's" chart is not credible.

36. Respondent's failure to administer the correct amount of fluids constitutes a deviation from the standard of care.

37. Upon readmission to Respondent's clinic, Respondnet did not draw blood or perform any type of bloodwork on "Snoopy."

38. Respondent's failure to draw blood or perform any type of bloodwork on "Snoopy" after being readmitted for dehydration and vomiting and shock constitutes a deviation from the standard of care.

39. The fluids which were administered to "Snoopy" were administered sub-cutaneously.

40. The failure to insert an IV catheter to administer the fluids, rather than administering them sub-cutaneously, constitutes a deviation from the standard of care.

41. One way of re-hydrating a dehydrated patient is by weighing the dog and then adding enough fluids to get the patient to its normal weight.

42. There is no indication in Respondent's records that "Snoopy" was weighed at the end of the day on or about August 27, 1998, or that "Snoopy" weighed approximately 60 pounds late in the day on or about August 27, 1998.

43. Respondent's records for "Snoopy" contain a notation at 10:00 p.m. August 27, 1998, of "ADR" which means "ain't doing right."

44. A patient whose records indicate "ADR" should be continuously monitored or transferred to an emergency facility.

45. "Snoopy" was not monitored overnight and through the early hours of the next morning.

46. Had Respondent taken appropriate steps with regards to fluid resuscitation upon "Snoopy's" readmission to Respondent's facility, "Snoopy's" chance of survival would have been much higher.

## CONCLUSIONS OF LAW

47. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this

proceeding, pursuant to Sections 120.569 and 120.57, Florida Statutes (1997).

48. Petitioner, the Department of Business and Professional Regulation, is the state agency charged with regulating the practice of veterinary medicine, pursuant to Section 20.165 and Chapters 455 and 474, Florida Statutes (1997).

49. Pursuant to Section 474.214(2), Florida Statutes (1997), the Board of Veterinary Medicine is empowered to revoke, suspend, or otherwise discipline the license of a veterinarian who is found guilty of any of the grounds enumerated in Section 474.214(1), Florida Statutes (1997).

50. Petitioner has the burden of proving by clear and convincing evidence each of the allegations filed against Respondent. Section 120.57(1)(h), Florida Statutes (1997); Ferris v. Turlington, 510 So. 2d. 292 (Fla. 1987); Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d. 932 (Fla. 1996).

51. The Administrative Complaints charge that Respondent is guilty of having violated Section 474.214(1)(r), and (ee), Florida Statutes (1997), which provide, in pertinent part, as follows:

> (1) The following acts shall constitute grounds for which the disciplinary actions in subsection (2) may be taken:

* * *

(r) Being guilty of incompetence or negligence by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.

* * *

(ee) Failing to keep contemporaneously written medical records as required by rule of the board.

52. Rule 61G18-18.002(3) and (4), Florida Administrative Code, provide, in pertinent part, as follows:

(3) Medical Records shall be contemporaneously written and include the date of each service performed. They shall contain the following information:

Name of owner or agent
Patient identification
Record of any vaccinations administered
Complaint or reason for provision of services
History
Physical examination
Any present illness or injury noted
Provisional diagnosis or health status determination

(4) In addition, medical records shall contain the following information if these services are provided for occur during the examination or treatment of an animal or animals:

Clinical laboratory reports
Radiographs and their interpretation
Consultation
Treatment-medical, surgical
Hospitalization
Drugs prescribed, administered, or dispensed

Tissue examination report
Necropsy findings

53. As to Case No. 00-2357, Count I, Petitioner has proven by clear and convincing evidence that Respondent violated Section 474.214(1)(r), Florida Statutes (1997), by being guilty of incompetence or negligence by failing to practice medicine with that level or care, skill, or treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.

54. Respondent failed to offer the dog's owner a pre-anesthesia lab work-up and/or failed to note such an offer in his medical records for "Midnight." Respondent used an improper anesthesia protocol by using an extra-label drug without informing the dog's owner or obtaining her consent. Furthermore, Respondent did not administer Atropine or any other drug to minimize the cardiac depressant effects of the anesthesia utilized during the procedure. Respondent also gave the dog's owner inadequate discharge instructions.

55. As to Case No. 00-2357, Count II, Petitioner has proven by clear and convincing evidence that Respondent violated Section 474.214(1)(ee), Florida Statutes (1997), by failing to keep contemporanously written medical records as required by rule of the board.

56. Respondent did not indicate in his records for "Midnight" whether he had a pre-operative discussion with either of the Greenes regarding a pre-anesthetic lab work-up or whether either of the Greenes was informed of his intent to use an extra-label drug. Furthermore, Respondent did not adequately indicate all of the standard post-operative discharge instructions in his records for "Midnight."

57. Respondent's negligence ultimately led to "Midnight's" demise.

58. As to Case No. 00-2358, Petitioner has proven by clear and convincing evidence that Respondent violated Section 474.214(1)(r), Florida Statutes (1997), by being guilty of incompetence or negligence by failing to practice medicine with that level or care, skill, or treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.

59. Although Respondent failed to offer the dog's owner a pre-anesthesia lab work-up and/or failed to note such an offer in his medical records for "Snoopy," since the operation was an emergency, such omission was not negligence.

60. Respondent used an improper anesthesia protocol by using an extra-label drug without informing the dog's owner or obtaining his consent. Respondent also gave Mr. Ferras inadequate post-operative discharge instructions.

61. Upon "Snoopy's" readmission to Respondent's facility, Respondent failed to properly rehydrate "Snoopy" and failed to draw blood. "Snoopy" was left without someone to monitor him after Respondent determined he was "ADR." Respondent's negligence ultimately led to "Snoopy's" demise.

62. Respondent's explanations to his conduct in this case is not persuasive.

63. Respondent is subject to disciplinary action by the Board of Veterinary Medicine, pursuant to Sections 455.227 and 474.214(2), Florida Statutes (1997). The disciplinary action under these statutes includes revoking or suspending the license, placing the license on probation, reprimanding the licensee, imposing an administrative fine not to exceed $1000 for each count or separate offense, restricting the authorized scope of practice, imposing costs of the investigation, and requiring remedial education.

64. Section 455.227(5), Florida Statutes (1997), states that the Administrative Law Judge, in recommending penalties in any recommended order, must follow the penalty guidelines established by the board or department and must state in writing the mitigating or aggravating circumstances upon which the recommended penalty is based.

65. Rule 61G18-30.001(2), Florida Administrative Code, provides, in pertinent part, the following guidelines that are pertinent to this proceeding:

> (r) Being guilty of incompetence or negligence by failing to practice veterinary medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent veterinarian as being acceptable under similar conditions and circumstances.
>
> The usual action of the Board shall be to impose a penalty of probation for a period of one year and a one thousand dollar ($1000) administrative fine.
>
> * * *
>
> (ee) Failing to keep contemporaneously written medical records as required by rule of the Board.
>
> The usual action of the Board shall be issuance of a reprimand plus six months probation and investigative costs.

66. Rule 61G18-30.001(4), Florida Administrative Code, provides, in pertinent part, that based upon consideration of aggravating or mitigating factors present in an individual case, the Board may deviate from the penalties recommended. The Board shall consider as aggravating or mitigating factors the following:

> (a) The severity of the offense
>
> (b) The danger to the public
>
> (c) The number of repetitions of offenses.

* * *

(e) The number of times the licensee has been previously discplined by the Board

* * *

(g) The actual damage, physical or otherwise, caused by the violation

67. Petitioner has demonstrated by clear and convincing evidence aggravating factors established in Rule 61G18-30.001(4)(a), (b), (C), (e), and (g), Florida Administrative Code. Respondent has one prior disciplinary action against him resulting from the combination of two cases, DBPR Case Nos. 95-03305 and 95-16337, whereby Respondent was placed on probation. In these two prior instances, along with the two at hand, a total of four animals have died, creating a significant risk of harm to the public.

## RECOMMENDATION

Based on the foregoing findings of fact and conclusions of law, it is recommended that a final order be render by the Board of Veterinary Medicine, as follows:

1. Finding Respondent guilty of having violated Section 474.214(1)(r), Florida Statutes (1997), as alleged in Count I of the Administrative Complaint for DOAH Case No. 00-2357 (DBPR Case NO. 98-11323).

2. Finding Respondent guilty of having violated Section 474.214(1)(ee), Florida Statutes (1997), as alleged in Count II

of the Administrative Complaint for DOAH Case No. 00-2357 (DBPR Case No. 98-11323).

3. Finding Respondent guilty of having violated Section 474.214(1)(r), Florida Statues (1997), as alleged in the Administrative Complaint for DOAH Case No. 00-2358 (DBPR Case No. 98-21230).

4. In light of these findings of guilt and aggravating circumstances, the following penalties are recommended:

a. A thirty-day suspension of licensure.

b. An administrative fine in the amount of four-thousand dollars ($4000.00).

c. Assessing costs of investigation and prosecution, in the amount of $973.24 for Case No. 00-2357 and $684.29 for Case No. 00-2358.

d. Five years of monitored probation upon such terms and conditions as the Board finds necessary and reasonable.

DONE AND ENTERED this 19th day of December, 2000, in Tallahassee, Leon County, Florida.

DANIEL M. KILBRIDE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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COPIES FURNISHED:

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## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.