

**Oregon Veterinary Medical Examining Board**

**February 4, 2002**

**Portland, Oregon**

**FINAL MINUTES**

Present: Jo Ann Dewey (Chair)  
Drs. Bob Anderson, Jonathan Betts, Emilio DeBess,  
Martha DeWees, Leon Pielstick  
Lori Makinen, Executive Officer  
Michael Zagya, Investigator  
Carol Parks, Assistant Attorney General  
Glenn Kolb, Director, OVMA

The meeting was called to order at 8:30 a.m. The agenda was adopted as amended. December 2001 meeting minutes were approved as read.

**OLD BUSINESS**

The Board directed that legible Continuing Education information will be provided with certain complaints for review.

Relative to ongoing rule amendments, Makinen will develop proposed language that clarifies licensee responsibilities when reactivating an inactive or expired license. Attorney Parks will research statutory requirements concerning limited licensure for pathologists. The Board amendments to eligibility rules for certification as veterinary technologist. The amendments will be included and published with general amendments to the Practice Act. Consideration of supplements to the Juris Prudence Exam on tansy ragwort and salmon poisoning was postponed to the next meeting.

Attorney Parks advised the Board that there is no statutory authority to limit the number of times applicants may take the NAVLE. The Board directed Dr. Pielstick and Lori Makinen to request that the National Board of Veterinary Medical Examiners (NBVME) consider the possibility of imposing such a restriction when they attend the July AAVSB meeting in Nashville.

**NEW BUSINESS**

Dr. DeBess informed the Board that the state has a \$12 million allocation to deal with bio-hazards, and directed attention to ORS Ch. 459, which contains current disposal procedures. Dr. DeBess suggested that the profession be prepared to expect compliance requirements for veterinary facilities. Investigator will research counties' current requirements of disposal of infectious/hazardous waste.

The Board welcomed Karen Profant, PhD of the Oregon Health Division's Pesticide Poison Prevention Program. Dr. Profant gave the Board a presentation on current and future pesticide reporting requirements and resources.

The Board attended a presentation by Patrick Hearn, Executive Director of the Oregon Government Standard and Practices Commission. The presentation focused on ethics requirements for public officials.

## **EXECUTIVE OFFICER REPORT**

Makinen updated the Board on the status of the public member nomination process, the AAVSB-AVMA situation regarding foreign graduates, and the deadline for providing legislative concepts for consideration in the 03-05 Legislative session and reiterated tentative concepts.

## **COMPLAINTS/DISCIPLINE**

The Board considered the renewal application of certified veterinary technician Karen Moisant. Dr. DeBess moved, Dr. Pielstick seconded and the Board voted unanimously to deny the renewal application for violation of ORS 686.130(10) and OAR 875-010-0060(18).

The Board considered the renewal application of Dr. J. Martin McDaniel.

Dr. DeBess moved to deny the application, Ms. Dewey seconded. Drs. Anderson, Betts, DeWees and Pielstick voted nay; Dr. DeBess voted aye; Ms. Dewey abstained. Motion failed.

Dr. DeBess moved to approve the application with an amended consent agreement. Ms. Dewey seconded. Drs. Anderson, Betts, DeWees and Pielstick voted nay; Ms. Dewey abstained. Motion failed.

Dr. Pielstick moved to approve the application. Dr. Anderson seconded. Drs. Anderson, Betts, DeWees, and Pielstick, and Ms. Dewey voted aye. Dr. DeBess voted nay. Motion carried.

2001-29—Complaint alleged unsanitary facility conditions. Board decided to continue to monitor. Resolution pending.

2001-38—Complaint alleged that a laser declaw procedure was done improperly, resulting in delayed recovery and pain. Examination of the record and interview with the veterinarian revealed that the two-year old cat was extremely fractious, could not be post-surgically medicated by client, and had injured clinic staff. A board certified radiologist report did not support client's allegation. Dr. Anderson moved, Dr. Pielstick seconded and the Board voted unanimously to find no violation of the Practice Act.

2001-50—Complaint alleged that the incision of a cat brought in for emergency C-section was inadequately stapled, which resulted in infection and death, and that the veterinarian was negligent in not following up and treating the infection more aggressively. The Board examined the patient record and concluded that although communication with the client could have been better, management of the case was adequate and a likely cause of infection might have been contamination by nursing kittens. A letter of concern about improving client communication will be sent to the veterinarian. Dr. Anderson moved, Dr. DeBess seconded and the Board voted unanimously to find no violation of the Practice Act.

2001-52—Complaint alleged that the veterinarian had exaggerated the life expectancy of a dog following radiation, and neglect in allowing the dog to become dehydrated and abraded. Examination of the record

and the veterinarian's written account gave the Board no reason to believe that the case was mismanaged. Dr. Pielstick moved, Dr. Anderson seconded and the Board voted unanimously to find no violation of the Practice Act.

2001-53—Complaint alleged that the veterinarian attempted to treat a horse with suspected colic with inappropriate and alternative medications. The horse deteriorated for two days, at which time the veterinarian recommended referral to OHSU, where surgeons found severe necrosis of the intestines and colon. The horse was euthanized. The patient record revealed that the client had not provided written authorization for alternative treatment. Dr. Anderson moved, Dr. Pielstick seconded and the Board voted unanimously to find the veterinarian in violation of the Practice Act. A Notice of Proposed Discipline will be issued to Dr. Robert Hervey Anderson, including a 90-day suspension and fines.

2001-57—Complaint alleges negligent treatment of a dog taken to the veterinarian in poor condition and history of recent vomiting. The client informed the veterinarian that the dog had been given antelope bones a few days prior to presentation. Exam findings were abnormal and subsequent barium tests revealed a foreign body (bone) lodged at the base of the heart. Attempts to dislodge the bone with a nasal/gastric tube were unsuccessful, and client agreed to surgery which eventually resulted in removal of the bone. Recovery was uncomfortable and the client was given a guarded prognosis. The dog died the following day during the client's visit and client became belligerent and had to be escorted from the clinic by police officers. Examination of the patient record revealed satisfactory management of the case and no evidence of negligence. Dr. Anderson moved, De. DeBess seconded and the Board voted unanimously to find no violation of the Practice Act.

2001-58—Complaint alleges misdiagnosis of Parvo virus. The client's 'regular' veterinarian was not available. Client presented dog to Dr. X with mild fever, lymph node enlargement, no dehydration, normal abdominal palpation, low appetite. Client declined a Parvo test due to financial constraints; was given Metocolpramide and advised to return for a recheck and Clavamox. The client did not return, but instead contacted a third veterinary clinic and was advised to return to Dr. X. Dog died. Examination of records revealed that this client had a large outstanding bill and was using a different name. Dr. Pielstick moved, Dr. Betts seconded, and the Board voted unanimously to find no violation of the Practice Act.

There being no further business, the meeting was adjourned at approximately 4:30 pm.

Next meeting: April 14-15, 2002 in Eugene/Springfield.