BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

IN THE MATTER OF THE PETITION FOR REINSTATEMENT OF

SANDHU BALPAL

Vet Board Case No. 4602025000207
Office of Administrative Hearings Case No. 2025030752

HEARING EXHIBITS INDEX

EX. #	DOCUMENT	I.D.	ADMIT
1	Notices of Hearing and Proofs of Service		
2	Certification of License History		
3	Prior Discipline: • Decision and Revocation Order, Veterinary Medical Board Case No. 4602021000085, effective April 27, 2021 • Accusation and Petition to Revoke Probation Case No. 4602021000085, filed November 4, 2019 • Decision and Order in Case No. AV 2015 22, effective April 29, 2016, adopting the Stipulated Settlement and Disciplinary Order and placing Petitioner's licenses on probation for 3 years • Accusation Case No. AV 2015 22, filed May 4, 2015		
4	Cost Certification		
5	Petition for Reinstatement		
6	Petitioner's Written Statement		
7	Letters of Recommendation		
8	Continuing Education Information		
9	Request for Live Scan		

EXHIBIT 1

ROB BONTA
Attorney General of California
KAREN R. DENVIR
Supervising Deputy Attorney General
STEPHANIE ALAMO-LATIF
Deputy Attorney General
State Bar No. 283580
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-6112
Facsimile: (916) 327-8643
E-mail: Stephanie.AlamoLatif@doj.ca.gov
Attorneys for Complainant

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition for Reinstatement of: **BALPAL S. SANDHU,** Petitioner.	Case No. 4602025000207 OAH No. 2025030752 **NOTICE OF HEARING** [Gov. Code, § 11509] Hearing: Thursday, April 17, 2025

YOU ARE HEREBY NOTIFIED that a hearing in this matter will commence on **Thursday, April 17, 2025**, at **9:00 a.m.** before the Veterinary Medical Board, Department of Consumer Affairs, at the address listed below.

Department of Consumer Affairs Hearing Room
1625 N. Market Blvd.
Sacramento, CA 95834

The hearing will be conducted before the Veterinary Medical Board by an Administrative Law Judge of the Office of Administrative Hearings, upon the information contained in the Petition for Reinstatement.

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If you object to the place of hearing, you must notify the presiding officer within ten (10) days after this notice is served on you. Failure to notify the presiding officer within ten (10) days will deprive you of a change in the place of hearing.

You have the right to be represented by an attorney at your own expense. You are not entitled to the appointment of an attorney to represent you at public expense. You are entitled to represent yourself without legal counsel. You may present any relevant evidence, and will be given full opportunity to cross-examine all witnesses testifying against you. You are entitled to the issuance of subpoenas to compel the attendance of witnesses and the production of books, documents, or other things by applying to the Office of Administrative Hearings, 2349 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833.

INTERPRETER: Pursuant to section 11435.20 of the Government Code, the hearing shall be conducted in the English language. If a party or a party's witness does not proficiently speak or understand the English language and before commencement of the hearing requests language assistance, an agency subject to the language assistance requirement in section 11435.15 of the Government Code shall provide a certified interpreter or an interpreter approved by the administrative law judge conducting the proceedings. The cost of providing the interpreter shall be paid by the agency having jurisdiction over the matter if the administrative law judge or hearing officer so directs, otherwise by the party for whom the interpreter is provided. If you or a witness requires the assistance of an interpreter, ample advance notice of this fact should be given to the Office of Administrative Hearings so that appropriate arrangements can be made.

CONTINUANCES: Under section 11524 of the Government Code, the agency may grant a continuance, but when an administrative law judge of the Office of Administrative Hearings has been assigned to the hearing, no continuance may be granted except by him or her or by the presiding Administrative Law Judge for good cause. When seeking a continuance, a party shall apply for the continuance within ten (10) working days following the time the party discovered or reasonably should have discovered the event or occurrence which establishes good cause for the continuance. A continuance may be granted for good cause after the ten (10) working days have

lapsed only if the party seeking the continuance is not responsible for and has made a good faith effort to prevent the condition or event establishing the good cause.

Continuances are not favored. If you need a continuance, immediately write or call the Office of Administrative Hearings: 2349 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833, telephone: (916) 263-0550.

Dated: March 20, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
KAREN R. DENVIR
Supervising Deputy Attorney General

Stephanie Alamo-Latif
Digitally signed by Stephanie Alamo-Latif
Date: 2025.03.20 13:26:09 -07'00'

STEPHANIE ALAMO-LATIF
Deputy Attorney General
Attorneys for Complainant

SF2025400330
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DECLARATION OF SERVICE BY CERTIFIED MAIL AND FIRST CLASS MAIL
(Separate Mailings)

Case Name: **In the Matter of the Petition for Reinstatement of Balpal S. Sandhu**

No.: **2025030752**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business.

On March 20, 2025, I served the attached **NOTICE OF HEARING** by placing a true copy thereof enclosed in a sealed envelope as certified mail with return receipt requested, and another true copy of the **NOTICE OF HEARING** was enclosed in a second sealed envelope as first class mail in the internal mail collection system at the Office of the Attorney General at 1300 I Street, Suite 125, P.O. Box 944255, Sacramento, CA 94244-2550, addressed as follows:

Balpal S. Sandhu
[redacted]
Petitioner
Certified #9414 7266 9904 2238 7189 67

Bonnie L. Lutz
Attorney at Law
Klinedinst Attorneys PC Irvine
2 Park Plaza, Suite 1250
Irvine, CA 92614-2556
Attorney for Respondent
Certified #9414 7266 9904 2238 7189 74

I declare under penalty of perjury under the laws of the State of California and the United States of America the foregoing is true and correct and that this declaration was executed on March 20, 2025, at Sacramento, California.

Susan Heaton	Susan Heaton
Declarant	Signature

SF2025400330
38886554.docx

Veterinary Medical Board
BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • VETERINARY MEDICAL BOARD
1747 North Market Blvd., Suite 230, Sacramento, CA 95834-2987
P (916) 515-5520 | Toll-Free (866) 229-6849 | www.vmb.ca.gov

VIA ELECTRONIC MAIL, CERTIFIED MAIL AND REGULAR MAIL

March 14, 2025

Dr. Balpal S. Sandhu
[redacted]

Bonnie Lutz
Klinedinst Law
2 Park Plaza, Suite 1250
Irvine, CA 92614
blutz@klinedinstlaw.com

RE: HEARING NOTICE
OAH Case No. TBD
Petition for Reinstatement or Modification of Penalty – Dr. Balpal S. Sandhu

Dear Dr. Balpal S. Sandhu:

You are hereby notified that a hearing will be held before the Veterinary Medical Board, Department of Consumer Affairs:

Date: **Thursday, April 17, 2025**
Time: **9:00 AM Pacific Time**
Location: **Department of Consumer Affairs**
Hearing Room
1625 N. Market Blvd
Sacramento, CA 95834

Alternatively, in lieu of attending in-person at this hearing in the Sacramento office, you may attend and participate virtually via Webex:

Event address:
https://dca-meetings.webex.com/dca-meetings/j.php?MTID=m27e911ca6d05a227f3d2f3fce8dcee08

Event number: **2485 497 9048**
Event password: **VMB417**

Phone audio conference: **(415) 655-0001**
Access code: **2485 497 9048**
Passcode: **862417**

The hearing will be conducted before the Veterinary Medical Board, Department of Consumer Affairs and an administrative law judge of the Office of Administrative Hearings, who will preside over the Petition for Reinstatement or Modification of Penalty.

You may be present at the hearing. You have the right to be represented by an attorney at your own expense. You are not entitled to the appointment of an attorney to represent you at public expense. You are entitled to represent yourself without legal counsel. You may present any relevant evidence and will be given full opportunity to cross-examine all witnesses testifying against you. You are entitled to the issuance of subpoenas to compel the attendance of witnesses and the production of books, documents, or other things by applying to:

Office of Administrative Hearings
Attn: General Jurisdiction
2349 Gateway Oaks, Suite 200
Sacramento CA 95833

INTREPRETER*:* Pursuant to section 11435.20 of the Government Code, the hearing shall be conducted in English language. If a party or party's witness does not proficiently speak or understand the English language and before commencement of the hearing requests language assistance, an agency subject to the language assistance requirement in section 11435.15 of the Government Code shall provide a certified interpreter or an interpreter approved by the administrative law judge conducting the proceedings. The cost of providing the interpreter shall be paid by the agency having jurisdiction over the matter if the administrative law judge or hearing officer so directs, otherwise by the party for whom the interpreter is provided. If you or a witness requires the assistance of an interpreter, ample advance notice of this fact should be given to the Office of Administrative Hearings so that appropriate arrangements can be made.

CONTINUANCES*:* Under section 11524 of the Government Code, the agency may grant a continuance, but when an administrative law judge of the Office of Administrative Hearings has been assigned to the hearing, no continuance may be granted except by him or her or by the presiding judge for good cause. When seeking a continuance, a party shall apply for the continuance within 10 working days following the time the party discovered or reasonably should have discovered the event or occurrence which establishes good cause for the continuance. A continuance may be granted for good cause after the 10 working days have lapsed only if the party seeking the continuance is not responsible for and has made a good faith effort to prevent the condition or even establishing the good cause.

Please visit the Board's website at www.vmb.ca.gov to view a copy of the agenda or you may contact me at (916) 905-5434 or via email at Alexander.Juarez@dca.ca.gov.

Sincerely,

SIGNATURE ON FILE

Alexander A. Juarez
Probation Monitor
Veterinary Medical Board

cc: Stephanie Alamolatif, Deputy Attorney General
Bonnie Lutz, Petitioner's Counsel

EXHIBIT 2

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • VETERINARY MEDICAL BOARD
1747 North Market Blvd., Suite 230, Sacramento, CA 95834-2978
P (916) 515-5220 | Toll-Free (866) 229-0170 | www.vmb.ca.gov

CERTIFICATION OF LICENSE HISTORY

This is to certify that I, Ashley Sanchez, Enforcement Manager at the Veterinary Medical Board (Board), Department of Consumer Affairs, State of California, share the responsibility of maintaining control and custody of the official records of the Board. I made or caused to be made a diligent search of the files and records concerning the license history of Dr. Balpal Sandhu. I have determined that the official records prepared by Board employees, acting within the scope of their duties, show the dates and time periods listed herein for the issuance, expiration, periods of invalidity, and renewals of the license, as well as citations issued and periods of formal Board discipline:

VET No. 13678:
Balpal S. Sandhu
AV Veterinary Center
1055 W Columbia Way Ste. 103
Lancaster, CA 93534-8155

First Issued:	June 14, 1999
Expiration:	May 31, 2021
Status:	Revoked
Secondary Status:	N/A

HSP No. 6152:
All Creatures Veterinary Center
1055 W Columbia Way Ste. 103
Lancaster, CA 93534-8155

First Issued:	February 23, 2006
Expiration:	May 31, 2021
Status:	Revoked
Secondary Status:	N/A

HSP No. 6663:
AV Veterinary Center
1055 W Columbia Way Ste. 103
Lancaster, CA 93534-8155

First Issued:	November 6, 2009
Expiration:	May 31, 2021
Status:	Revoked
Secondary Status:	N/A

HSP No. 5668:
Canyon Country Veterinary Hospital
1055 W Columbia Way Ste. 103
Lancaster, CA 93534-8155

First Issued: March 25, 2002
Expiration: May 31, 2022
Status: Revoked
Secondary Status: N/A

Discipline:

On May 4, 2015, the Board filed Accusation (Case No. AV 2015 22) against Respondent. On April 29, 2016, the Board ordered a Stipulated Settlement and Discipline Order in the matter of the Accusation (Case No. AV 2015 22) against Respondent, AV Veterinary Center, and All Creatures Veterinary Center, effective May 29, 2016. On November 4, 2019, the Board filed an Accusation and Petition to Revoke Probation (Case No. 4602016000085) against Respondent (VET 13678), AV Veterinary Center (HSP 6663), All Creatures Veterinary Center (HSP 6152), and Canyon Country Veterinary Hospital (HSP 5668). On April 27, 2021, the Board ordered a Proposed Decision (Case No. 4602016000085) revoking Respondent's license (VET 13678), AV Veterinary Center (HSP 6663), All Creatures Veterinary Center (HSP 6152), and Canyon Country Veterinary Hospital (HSP 5668) effective May 27, 2021.

Dated at Sacramento, California, this 7th day of February 2025

SIGNATURE ON FILE

Ashley Sanchez, Enforcement Manager

EXHIBIT 3

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against:

BALPAL S. SANDHU, DVM,

Veterinarian License No. VET 13678,

AV VETERINARY CENTER,

BALPAL S. SANDHU, DVM, Managing Licensee,

Premises Registration No. HSP 6663,

ALL CREATURES VETERINARY CENTER,

BALPAL S. SANDHU, DVM, Managing Licensee,

Premises Registration No. HSP 6152,

and

CANYON COUNTRY VETERINARY HOSPITAL,

BALPAL S. SANDHU, DVM, Managing Licensee,

Premises Registration No. HSP 5668,

Respondents.

Agency Case No. 4602016000085

OAH No. 2020021167

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge (ALJ) is hereby accepted and adopted by the Veterinary Medical Board as its Decision in the above-entitled matter, except that, pursuant to Government Code section 11517, subdivision (c)(2)(B), and Business and Professions Code section 125.3, subdivision (d), the prosecution costs totaling $61,565 are reduced by $14,052.89 to reflect the fourteenth and fifteenth causes for discipline and third cause for revocation of probation that were stricken by complainant at hearing, the finding of duplicative causes for discipline (second and twenty-fourth) alleged in the Accusation, and Respondents' successful challenge to the third, thirteenth, sixteenth, twenty-fifth, twenty-sixth , and twenty-ninth, paragraph b, causes for discipline under Business and Professions Code section 4883, subdivisions (g), (i), (j), and (o), reducing the total amount of prosecution costs ordered to be paid by Respondents, as a condition of reinstatement, from $61,565 to $47,512.11, and, pursuant to Government Code section 11517, subdivision (c)(2)(C), the following minor and technical errors are corrected:

1. Page 2, second paragraph:

    a. After "General," insert "Office of the Attorney General, Department of Justice, State of California, appeared and"

    b. After "(complainant)," insert "in her official capacity as"

2. Page 2, third paragraph, line 2, remove and replace "Canyon Country Veterinary Center" with "Canyon Country Veterinary Hospital"

3. Page 19, paragraph 34, line 10, insert "be" before "able"

4. Page 133, paragraph I, line 4, remove and replace “implement” with “implementing”.

This Decision shall become effective on May 27, 2021.

IT IS SO ORDERED on April 27, 2021.

SIGNATURE ON FILE

Mark Nunez, DVM, President
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against:

BALPAL S. SANDHU, DVM

Veterinary License No. VET 13678,

AV VETERINARY CENTER, BALPAL S. SANDHU, DVM, Managing Licensee

Premises Registration No. HSP 6663

ALL CREATURES VETERINARY CENTER, BALPAL S. SANDHU, DVM, Managing Licensee

Premises Registration No. HSP 6152, and

CANYON COUNTRY VETERINARY HOSPITAL, BALPAL S. SANDHU, DVM, Managing Licensee

Premises Registration No. HSP 5668

Respondents.

Agency Case No. 4602016000085

OAH No. 2020021167

PROPOSED DECISION

Ji-Lan Zang, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter from September 14 to October 2, and December 1 to 2, 2020, by videoconference in Los Angeles, California.

Nancy A. Kaiser, Deputy Attorney General, represented Jessica Sieferman (complainant), Executive Officer of the Veterinary Medical Board (Board), Department of Consumer Affairs.

George Wallace, Attorney at Law, represented AV Veterinary Center (AVVC), All Creatures Veterinary Center (All Creatures), Canyon Country Veterinary Center (Canyon Country), and Balpal S. Sandhu, D.V.M. (respondent), in his individual capacity and as the managing licensee of AVVC, All Creatures, and Canyon Country (collectively, respondents). Respondent appeared and was present throughout the hearing.

At the hearing, complainant amended the Accusation/Petition to Revoke Probation by interlineation. Respondents did not object to the amendments. A copy of the interlineated Amended Accusation/Petition to Revoke Probation was marked for identification as Exhibit 86.

Oral and documentary evidence was received. The record was held open until January 29 and February 19, 2021, for complainant and respondents to submit written closing briefs, respectively, and March 12, 2021, for complainant to submit a reply

brief. Complainant timely submitted her closing brief (marked for identification as Exhibit 87). Respondents timely submitted their closing brief (marked for identification as Exhibit D). Thereafter, complainant timely submitted a reply brief (marked for identification as Exhibit 88).

Respondents, in their closing brief, objected to the admission of complainant's expert reports and all of the medical records for the animal patients at issue based on hearsay. (Ex. D, p. 11.) The ALJ construes this objection as a motion for reconsideration and denies the motion. These documents were admitted at the hearing as direct evidence, without objection from respondents. All objections, therefore, were waived. The record was kept open only for the submission of closing arguments from both parties, not for reconsideration of previously admitted evidence. Furthermore, it is unduly prejudicial to complainant to reconsider the admissibility of the expert reports and the medical records, given that the evidentiary hearing has concluded and complainant no longer has an opportunity to respond to any perceived objectionable shortcomings.

The record was closed and the matter was submitted for decision on March 12, 2021.

SUMMARY

Complainant seeks to revoke respondent's veterinarian license and the premises registrations for AVVC, All Creatures, and Canyon Country on the following grounds: (1) violations of statutes of the Veterinary Medicine Practice Act (Act) (Bus. & Prof.

Code,[1] § 4800 et seq.) and its regulations, in connection with respondent's care of 15 animal patients; (2) violations of the Act's statutes and regulations regarding minimum standards for veterinary practices, in connection with the Board's premises inspections of AVVC, All Creatures, and Canyon Country; and (3) respondent's violation of various terms of his probation. Complainant established a vast majority of the causes for discipline and all of the causes to revoke probation set forth in the Amended Accusation/Petition to Revoke Probation. The record established that, in his treatment of his animal patients, respondent committed numerous acts of negligence, incompetence, unprofessional conduct, and inadequate recordkeeping. In his capacity as the managing licensee of AVVC, All Creatures, and Canyon Country, respondent failed to comply with regulations concerning radiation safety, sterility of surgery rooms, and accountability in controlled substance dispensation logs. Respondent also violated the terms of his probation by failing to obey all laws and to submit quarterly reports, proof of completion of community service, and proof of completion of continuing education courses. Respondent's testimony at the hearing was less than candid, and he presented little evidence of rehabilitation. Considering the number and the gravity of the violations, respondent's prior disciplinary history, and the insufficiency of rehabilitation evidence, the only recourse for the protection of the public is the revocation of respondent's veterinarian license and the premises registrations for AVVC, All Creatures, and Canyon Country.

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[1] All further statutory references shall be to the Business and Professions Code, unless otherwise indicated.

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 14, 1999, the Board issued Veterinarian License Number VET 13678 to respondent. The Veterinarian License was in full force and effect at all times relevant herein and will expire on May 31, 2021, unless renewed.

2. A. Since November 6, 2009, respondent has been associated as the managing licensee of AVVC, Premises Registration Number HSP 6663, located in Lancaster, California. This registration is current and will expire on May 31, 2021, unless renewed.

B. Since May 14, 2012, respondent has been associated as the managing licensee of All Creatures, Premises Registration Number HSP 6152, located in Santa Clarita, California. This registration is current and will expire on May 31, 2021, unless renewed.

C. Since April 15, 2012, respondent has been associated as the managing licensee of Canyon Country, Premises Registration Number HSP 5668, located in Santa Clarita, California. This registration is current and will expire on May 31, 2021, unless renewed.

3. In Case Number AV 2015 22, the Board issued a Decision and Order, effective May 29, 2016, in which respondent's veterinary license and premises registrations for AVVC, All Creatures, and Canyon Country, were revoked. However, the revocations were stayed, and the veterinarian license and premises registrations were placed on probation for three years under certain terms and conditions. Condition 12 of the probationary terms provides that if an accusation or petition to revoke

probation is filed against respondent during his probation, the period of probation shall be extended until the accusation or petition to revoke probation is resolved. Respondent's license and premises registrations therefore remain on probation until the effective date of the decision in this proceeding.

4. On November 4, 2019, complainant filed the Accusation and Petition to Revoke Probation in her official capacity. Respondent timely filed a Notice of Defense. This hearing ensued.

Background

5. Respondent received his doctor of veterinary medicine degree from India in 1990. In 1995, respondent came to the United States, passed the National Board Examination, and subsequently completed a one-year rotation at the University of Missouri. In 1997, respondent became a licensed veterinarian in the State of Washington, and he worked in that state from 1998 to 1999. Since 1999, respondent has been licensed and working as a veterinarian in California. Respondent opened AVVC as a new practice in 2009 and acquired All Creatures and Canyon Country in 2010 and 2012, respectively. He is the owner and licensee manager of all three veterinary centers. In addition, respondent is the owner of Porter Veterinary Center located in the City of Northridge and Selma Veterinary Clinic located in Fresno.

6. A. AVVC is the largest veterinary practice in the Antelope Valley, and it is also the only 24-hour emergency care veterinary hospital in the area. In the last four years, AVVC served approximately 68,000 patients. AVVC is also respondent's primary practice. Although he sometimes works the day shift, respondent regularly works six to seven night shifts totaling 70 hours per week at AVVC.

B. All Creatures is the only 24-hour emergency care veterinary center in the Santa Clarita Valley. In the last four years, All Creatures served approximately 41,090 patients.

C. Canyon Country is a day practice that does not perform any specialty surgeries. In the last four years, Canyon Country served approximately 15,199 patients.

Respondent's Treatment of Animal Patients

THE EXPERTS

7. Beth Parvin, D.V.M., testified as complainant's expert witness regarding respondent's treatment of the 15 animal patients at issue. Dr. Parvin obtained her bachelor of science degree from California State University in 1974 and her doctorate in veterinary medicine from the University of California at Davis (UC Davis) in 1978. She also holds a certification in veterinary acupuncture from the Chi Institute of Chinese Veterinary Medicine. Dr. Parvin was a practicing veterinarian from 1978 to 2018. During this period, Dr. Parvin worked at different clinics in various capacities, including serving as the manager and the practicing veterinarian of an emergency veterinary clinic for two years. From December 2009 to December 2018, Dr. Parvin worked for the Board as a veterinary hospital inspector, and from October 2010 to the present, she has served as a consultant and subject matter expert for the Board.

8. Dr. Alan Schulman, D.V.M., testified as respondent's expert witness regarding respondent's treatment of the 15 animal patients at issue. Dr. Schulman obtained his bachelor of science degree from Cornell University in 1978 and his doctorate in veterinary medicine from Cornell University in 1983. From 1983 to 1984, Dr. Schulman worked as a rotating intern at California Animal Hospital, and he served

as the hospital's chief resident in surgery from 1984 to 1987. From 1987 to the present, Dr. Schulman has been a practicing veterinarian at his own practice, Veterinary Surgical Referral Service.

9. Drs. Parvin and Schulman are equally qualified to render their opinions in this matter, as they both possess abundant knowledge, experience, and expertise in veterinary medicine. However, where the opinions of Drs. Parvin and Schulman diverge, one expert's opinion is credited over the other, depending on the circumstances presented in each animal patient's case.[2] The opinions of Dr. Parvin are based on her written reports and her testimony at the hearing. Dr. Schulman did not submit any written reports, and his opinions, therefore, are based solely on his testimony at the hearing.

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[2] The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. *(Wallace v. Pacific Elec. Ry. Co.* (1930) 105 Cal.App. 664, 671.)

LUNA, THE YOUNG TERRIER

Treatment at AVVC

10. On January 16, 2016, A.T.[3] took Luna, a young Terrier, to AVVC because she was suffering from a lack of appetite and vomiting. (Ex. 18, AGO 2965.) The next day, respondent performed a physical examination of Luna. Respondent found Luna's abdomen to be "[d]istended and painful upon palpation." (*Id.* at AGO 2971.) Respondent ordered blood tests for Luna, the results of which were normal except for a decreased white blood cell count. (*Id.* at AGO 2968.) However, the results of a SNAP assay[4] revealed that Luna tested positive for canine parvovirus enteritis (CPV), a highly contagious virus that spreads from dog to dog. (*Id.* at AGO 2969.) Luna's medical records indicate that her working diagnosis was "Parvo," and her prognosis was "guarded." (*Id.* at AGO 2970.)

11. From January 17, 2016, to January 19, 2016, Luna was hospitalized for treatment of CPV at AVVC under respondent's care. (Ex. 18, AGO 296-2994.) Throughout her three-day hospitalization, Luna's medical records are filled with whiteboard note[5] entries. The whiteboard notes consist of respondent's instructions to

[3] Initials are used to protect the privacy of pet owners.

[4] A SNAP assay is an in-house device that performs an immunoassay for the detection of a specific antigen or antibody.

[5] Whiteboard notes are the digital form of notes written by healthcare workers on white dry-erase boards to communicate with each other about information relating to the care and treatment of patients. Whiteboard notes contain directions by the

his veterinary assistant on symptomatic treatment of Luna. However, respondent did not document any daily progress notes evaluating Luna's medical status. There is no indication in Luna's medical records that after her initial examination on January 17, 2016, she was evaluated again by respondent or any other veterinarian.

12. On the evening of January 19, 2016, AVVC released Luna to her owner. (Ex.18, AGO 2994.)

Dr. Parvin's Opinions

13. Dr. Parvin opined that animals with CPV are prone to developing secondary problems, including dehydration, electrolyte and blood chemistry imbalances, and bacterial infections. Patients suffering from CPV require daily evaluation by a veterinarian to change or adjust the treatment protocol depending on his or her assessment of the patient. These daily evaluations should be documented in the medical records in the form of daily progress notes describing the patient's vital signs and clinical status. Dr. Parvin also opined that complete and accurate documentation of a patient's medical records is critically important in veterinary practice. The purpose of recordkeeping in veterinary practice is to protect the public. According to Dr. Parvin, if a veterinarian fails to document certain procedures in the medical records, it must be assumed that the procedure did not occur.

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treating veterinarian to the veterinary assistant and notes by the veterinary assistant indicating that a particular task has been carried out.

Respondent's Testimony

14. At the hearing, respondent asserted that he conducted physical evaluations of Luna but documented those evaluations as whiteboard notes. As an example, respondent pointed to whiteboard note entries on January 17, 2016, showing that respondent instructed the registered veterinary technician (RVT) to administer plasma to Luna because he evaluated Luna and observed that she needed plasma. However, Luna's medical records do not indicate an evaluation took place. The whiteboard note entry simply states, "Special orders: Give 0.6ml, 30 mg IM Once 30 mins before Plasma." (Ex. 18, AGO 2974.) Respondent also claimed that he was concerned about Luna's heart rate and performed auscultation during her hospitalization. However, Luna's medical's records contain only whiteboard notes of Temperature, Pulse, and Respiration (TPR) taken by veterinary assistants during her three-day hospitalization. When pressed on these issues during the cross-examination, respondent was unable to identify anywhere in Luna's medical records where he documented a physical evaluation of the patient after the initial examination of January 17, 2016. Furthermore, Dr. Parvin, in her rebuttal testimony, emphasized that whiteboard notes are not equivalent to daily progress notes because they are not completed by veterinarians and do not contain details about the patient's vital signs and clinical status.

Summary Findings re Luna

15. Dr. Schulman did not render an opinion with regards to Luna. Dr. Parvin's opinions relating to respondent's treatment of Luna are uncontroverted, consistent with the evidence in the case, and afforded significant weight.

16. Therefore, it was established that respondent failed to document daily progress notes of his evaluations of Luna while she was hospitalized for treatment of PVC.

MICKEY, THE ELDERLY TERRIER

Treatment at All Creatures

17. On January 22, 2016, at approximately noon, J.C. took Mickey, a 17-year-old terrier, to All Creatures because Mickey suffered from dark watery diarrhea, vomiting, and decreased appetite. (Ex. 23, AGO 3023.) Mickey's primary veterinarian, the Veterinary Care Center, faxed to All Creatures Mickey's medical records. Respondent performed Mickey's initial physical exam and noted that the patient was pale in appearance. (*Id.* at AGO 3020.) Based on his physical exam and the records from the Veterinary Care Center, respondent assessed Mickey with the following conditions: "Geriactric [*sic*], CHF [Congestive Heart Failure], Possible hip arthritis, [and] Dental disease." (*Id.* at AGO 3021.)

18. Respondent ordered a blood test for Mickey, which was performed in-house at All Creatures using a blood analyzer called HemaTrue. (Ex. 23 at AGO 3019.) The results of the blood test show that Mickey suffered from severe anemia with an elevated white blood cell count. (*Ibid.*) A computer-generated note at the end of the blood test results indicates, "HCT [hematocrit]: Anemia; evaluate RBC [red blood count] on slide." (*Id.* at AGO 3019-3020.) The phrase "evaluate RBC on slide" refers to a reticulocyte count, or a count of new red blood cells in a blood sample. The HemaTrue blood analyzer does not perform a reticulocyte count. A veterinarian can perform a reticulocyte count either by placing a drop of blood in a slide and manually counting the reticulocytes under a microscope (slide review or blood smear test) or by sending a

blood sample to an outside laboratory for an automated count. The purpose of the reticulocyte count is to determine the nature of the anemia, whether it is responsive or non-responsive. The presence of increased numbers of reticulocytes indicates that the patient's bone marrow has released immature red blood cells. Thus, the anemia is responsive, meaning the body has identified the anemia and is responding by attempting to correct the deficit. The absence of increased numbers of reticulocytes indicates non-responsive anemia, where the bone marrow is unable to generate more cells.

19. Respondent did not perform a reticulocyte count, either by performing a blood smear or test or by sending a blood sample to an outside laboratory. In addition, respondent did not document in Mickey's medical records an evaluation of the blood test results. There is also no notation in the medical records of Mickey's diagnosis for anemia, an assessment of the possible causes of his diarrhea and anemia, or a prognosis for his condition.

20. Based on Mickey's blood test results, respondent recommended for Mickey to undergo a blood transfusion, but J.C. declined. (Ex. 23, AGO 3021.) Mickey was treated at All Creatures with subcutaneous fluids and Convenia, an injectable antibiotic, to prevent vomiting. (*Ibid.*) Mickey was checked out of All Creatures on the same date, January 22, 2016, although the exact time of the checkout was not established by the record. Subsequently, J.C. took Mickey back to his primary veterinarian at the Veterinary Care Center, where Mickey followed a conservative course treatment, and his anemia resolved without complication. (Ex. 24.)

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Dr. Parvin's Opinions

21. Dr. Parvin opined that respondent's failure to perform a reticulocyte count is below the standard of care. According to Dr. Parvin, a reticulocyte count is significant because it can determine whether Mickey was suffering from nonresponsive or responsive anemia, which in turn, affects Mickey's prognosis. Generally, the prognosis is better for a dog with responsive anemia.

22. Dr. Parvin also opined that respondent's failure to document his evaluation of Mickey's blood test results violates the Board's regulations requiring proper maintenance of medical records. According to Dr. Parvin, after performing a blood test on a patient, a veterinarian must document his or her clinical observations and concerns. In this instance, respondent did not even document that Mickey had anemia. In Mickey's medical records, under the title "Diagnostics," respondent wrote the word, "none." (Ex. 23, AGO 3021.)

Respondent's Testimony

23. At the hearing, respondent conceded that he did not perform a reticulocyte count with Mickey's blood sample because the HemaTrue blood analyzer he uses at All Creatures does not do so. However, he explained that Mickey came to All Creatures only for an examination and he was not hospitalized. Respondent testified that he would have conducted a reticulocyte count for Mickey to determine the nature of his anemia if he were hospitalized, but a reticulocyte count was not necessary at Mickey's initial presentation on January 22, 2016. Respondent stated that if he were to have sent Mickey's blood sample to an outside laboratory for a reticulocyte count, the turn-around time would have been 24 hours. Thus, he would not have obtained the results within the less than 12 hours that Mickey was in his care.

Respondent asserted that the absence of the reticulocyte count did not affect his judgment regarding his course of treatment for Mickey.

24. During cross-examination, respondent claimed that his evaluation of Mickey's blood test results and his diagnosis and prognosis can be inferred from the medical records. Respondent also asserted that the automatically generated note from the HemaTrue blood analyzer, "HCT: Anemia; evaluate RBC on slide" constituted his diagnosis of anemia for Mickey. However, respondent was unable to identify any entries in Mickey's medical records where he documented an evaluation of Mickey's blood test, the diagnosis of anemia, an assessment of the possible causes of Mickey's anemia, or a prognosis for Mickey's condition.

Dr. Schulman's Opinions

25. Dr. Schulman testified that few veterinary facilities have in-house machinery to perform reticulocyte counts. Dr. Schulman opined that it is within the standard of care for a veterinarian to proceed with treatment for anemia, without performing a reticulocyte count. According to Dr. Schulman, the priority in Mickey's case is to treat his anemia aggressively, regardless of whether the anemia is responsive or not. The veterinarian can always perform a reticulocyte count after initiating treatment. Dr. Schulman opined that the lack of a reticulocyte count did not affect the effectiveness of respondent's treatment of Mickey, which is within the standard of care. Dr. Parvin did not refute Dr. Schulman's opinions in her rebuttal testimony.

26. The medical records indicate that Mickey was under respondent's care at All Creatures for less than 12 hours, as he checked in at noon on January 22, 2016, and checked out sometime later on the same date. He underwent a physical examination, a blood test, and received some treatment at All Creatures, but he was not hospitalized.

The turn-around time for an outside laboratory to conduct a reticulocyte count would have taken more than 24 hours. Given that Mickey was not hospitalized and he spent a limited amount of time under respondent's care, Dr. Schulman's opinion that a veterinarian may initiate treatment without conducting a reticulocyte count is persuasive.

Summary Findings re Mickey

27. Thus, it was not established that respondent's failure to perform a reticulocyte count to determine the nature of Mickey's anemia falls below the standard of care.

28. Dr. Schulman did not render any opinions regarding respondent's recordkeeping practices in Mickey's case. Based on the medical records and Dr. Parvin's credible testimony regarding proper recordkeeping practices, it was established that respondent failed to include the following information in Mickey's medical records:

- An evaluation of Mickey's blood test results, which showed severe anemia;
- An assessment for the possible causes of Mickey's diarrhea and anemia; and
- a prognosis for Mickey's condition.

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PRINCESS, THE LABRADOR RETRIEVER

Treatment at AVVC

29. On January 31, 2016, at 7:59 p.m., R.M. took Princess, his eleven-year-old Labrador Retriever, to AVVC because she was lethargic and had not eaten for four to five days. (Ex. 27, AGO 3100.) At approximately 8:15 p.m., diagnostic testing, including blood tests, a SNAP cPL test,[6] and radiographs, were performed on Princess. (*Id.* at AGO 3101.) At approximately 9:33 p.m., Princess's vital signs were taken. (*Id.* at AGO 3100.) However, respondent's physical examination of Princess, diagnosis of Princess's condition, assessment of the diagnostic results, and treatment plan are documented in the medical records sometime after the vital signs were taken. (*Id.* at AGO 3100.) In a sworn statement, Princess's owner, R.M. corroborates the timeline in the medical records that diagnostic tests were conducted on Princess before respondent's physical examination. (Ex. 26, AGO 3073.)

30. The results of diagnostic tests indicated that Princess was suffering from pyometra, a bacterial infection of the uterus resulting in the uterus filling with purulent fluid. At around midnight on January 31, 2016, she underwent surgery at AVVC to remove her uterus. (Ex. 27, AGO 3093.) Princess remained hospitalized at AVVC until February 2, 2016.

31. During Princess's hospitalization, she was administered intravenous (IV) fluids, antibiotics, anti-nausea medication, and a constant rate infusion[7] of HLK. HLK is

[6] A SNAP cPL test is used in veterinary medicine to confirm pancreatitis in dogs.

[7] Constant rate infusion is the administration of a drug, or drugs, as an IV infusion at a specific rate over a prolonged period of time.

a combination of Hydromorphone (an opiate analgesic), Lidocaine, (a local anesthetic), and Ketamine (a dissociative anesthetic), administered as a constant IV infusion to control pain associated with a medical condition or surgical procedure. Respondent's order was for Princess to be started on an HLK of 6 mg of hydromorphone, 400 mg of lidocaine, and 200 mg of ketamine added to a liter of saline, administered at a rate of 15 ml per hour. (Ex. 27, AGO 3101.) Princess's medical records indicate that post-surgery, HLK was initially administered to Princess at the rate of 15 ml per hour (*Id.* at AGO 3094), but later increased to 20 ml per hour. (*Id.* at AGO 3085-3088, 3092.) However, even at this higher rate of 20 ml per hour, the constant rate infusion of HLK administered to Princess was 0.003 mg/kg/hr of Hydromorphone, 0.210 mg/kg/hr of Lidocaine, and 0.105 mg/kg/hr of Ketamine. This HLK constant rate infusion was far below the recommended range to provide effective analgesia. For a dog of her size (84 pounds), Princess was administered an amount of HLK that was less than one-tenth of the low end of the recommended HLK constant rate infusion range, according to an online constant rate infusion calculator maintained by the Veterinary Anesthetic and Analgesia Support Group (VASG). (Ex. 29, AGO 3109.)

32. Throughout Princess's post-surgery hospitalization, the medical record notation consists of whiteboard notes regarding medication administration, TPR, and clinical observations entered by veterinary assistants. However, Princess's medical records do not show any post-surgery evaluation by a veterinarian. There is no indication that a veterinarian monitored Princess's heartrate by palpation or her level of hydration. Additionally, there is no indication in the medical records that a similar evaluation of Princess's condition was performed by a veterinarian before her release to her owner on February 2, 2016.

33. After her release from AVVC, Princess was lethargic and refused to get up when coaxed by her owner, R.M. (Ex. 26, AGO 3074.) With no after-hours veterinary care available in his small hometown, R.M. called another veterinary practice 30 minutes away, but Princess developed convulsions and died before transport. (*Ibid.*)

Veterinarian-Client-Patient Relationship

34. Dr. Parvin opined that respondent's failure to conduct a physical examination of Princess before administering blood tests and radiographs constitutes treatment of the patient without establishing a Veterinarian-Client-Patient Relationship (VCPR.) A VCPR is the relationship formed between veterinarian and client concerning the animal patient. According to Dr. Parvin, a VCPR is established only when the veterinarian examines that animal in person. It is inappropriate for a veterinarian to conduct diagnostic tests before a physical examination of the animal patient because not all medical conditions require diagnostic tests. Only by performing a physical examination, communicating with the client, and taking the animal's medical history, does the veterinarian become familiar enough with that animal patient to able to conduct diagnostic tests and then treat its medical conditions. Exceptions to this rule exist. For example, in an emergency situation where an animal must be treated immediately, a veterinarian may conduct diagnostic tests before a physical examination without first establishing the VCPR. However, such an exception does not apply in Princess's case.

35. At the hearing, respondent disputed the timeline in the medical records and claimed he had conducted a physical examination of Princess before ordering diagnostic testing. However, this assertion is not credible because it is contradicted by Princess's medical records and R.M.'s sworn statement. (See *ante*, Factual Finding 29.)

36. Dr. Schulman did not render any opinions on the VCPR issue, and Dr. Parvin's opinions are reasonable, uncontroverted, and consistent with the evidence.

Inadequate Administration of HLK[8]

37. Dr. Parvin opined that the amount of HLK administered to Princess was inadequate to minimize her pain and distress while she was hospitalized. Dr. Parvin explained that several online constant rate infusion calculators are available for veterinarians to calculate the recommended range of constant rate infusion for effective analgesia. To use the constant rate infusion calculator, a veterinarian inputs the animal's weight and other information, and the calculator computes a recommended effective rate range. The recommended constant rate infusion is presented as a range, with a low end and a high end, to allow the veterinarian to adjust the medication upward or downward according to patient needs. The VASG online calculator Dr. Parvin used is one of the most reliable, although insignificant variations exist between different calculators for the recommended range of constant rate infusion. Dr. Parvin stated that these recommended ranges are based on clinical studies and are proven to be effective and therapeutic. According to Dr. Parvin, following the recommended range is extremely important because monitoring pain in animals is often difficult, requiring the veterinarian to assess the animal's color, respiratory rate, and mucus membrane. Dr. Parvin indicated it would not be much of a concern if the HLK administered to Princess was slightly lower than the low end of the

[8] These factual findings relating to the inadequate administration of HLK also apply to Rosie, Enzo, and Pooh, as the Amended Accusation/Petition to Revoke Probation alleges the same causes for discipline for incompetence due to a failure to administer adequate HLK.

recommended constant rate infusion range. However, in Princess's case, respondent administered less than one-tenth of the low end of the recommended constant rate infusion range, which Dr. Parvin believes was insufficient to achieve pain relief for the animal patient after a painful surgery to remove her uterus.

38. According to Dr. Parvin, a knowledgeable veterinarian would know that for effective pain control, HLK must be administered within the recommended constant rate infusion range. Moreover, Dr. Parvin found in her review of three additional cases (Rosie, Enzo, and Pooh), respondent administered HLK at far below the recommended constant rate infusion range to provide effective analgesia. (See *post*, Factual Findings 51, 57D, 93, 98A, 111, and 112B.) This pattern demonstrates respondent's lack of knowledge about using constant rate infusion delivery of HLK for effective pain control.

39. At the hearing, respondent claimed that he had administered the appropriate amount of HLK to Princess for pain management. Respondent asserted that he determined the constant rate infusion based on an animal patient's bloodwork results, radiographic findings, and body weight. Respondent initially made no references to the online calculators in determining the appropriate HLK constant rate infusion. He testified that he changes the constant rate infusion based on his observations of the animal patient's condition. In Princess's case, respondent explained that he increased the HLK constant rate infusion to 20 ml per hour after observing Princess did not have any renal complications. Respondent reported that he checks on his animal patients at least every two hours, sometimes on the hour. Respondent asserted that he did not observe Princess experience any pain during her hospitalization.

40. On cross-examination, respondent conceded that animal patients do not always exhibit external signs of pain. Neither could respondent point to anywhere in the medical records where he documented his observations or evaluations of Princess. Upon further questioning, respondent asserted that he also uses online constant rate infusion calculators for determining the appropriate constant rate infusion of HLK. According to respondent, he does not always use the recommended constant rate infusion range, but he considers the recommendations in his pain management decisions. However, respondent provided no explanation as to why, if he used the online constant rate infusion calculators and considered the recommendations, he would administer HLK at a rate that was one-tenth of the low end of the recommended range.

41. Dr. Schulman testified that while the standard in veterinary care is to alleviate the pain and to provide humane care to the animal patient, dosing of pain-relieving medication is up to a veterinarian's discretion and can vary between individual veterinarians. According to Dr. Schulman, the recommended constant rate infusion ranges are guidelines, and even the recommended low end of the constant rate infusion range may not be appropriate for a patient depending on the age, the degree of debilitation, and overall condition of the animal. The primary method by which a veterinarian determines whether a pain control dosage is through consistent observation of the animal patient's behavior, including its eating and drinking pattern, its mobility, whether it is wagging its tail, its lucidity, and other external displays of pain or discomfort, such as crying or howling.

42. Dr. Schulman opined that in Princess's case, he assumed that the pain medication administered by respondent to be adequate because he did not see any veterinarian's notation indicating Princess was in pain. Thus, Dr. Schulman based his

opinion on the absence of any evaluation of Princess's condition by respondent. On cross-examination, however, Dr. Schulman conceded that the medical records in Princess' case were not "descriptive" and "left a lot to be desired" (his words.) Furthermore, Dr. Schulman testified that he did not perform any research on the drug formulary used by respondent in Princess's case and he did not consult the online constant rate infusion calculators to determine the effective recommended constant rate infusion ranges for HLK before rendering his opinion. Dr. Schulman's opinion is premised entirely on the assumption that respondent would have documented any pain experienced by Princess, an assumption which Dr. Schulman himself admitted to be unreliable given the deficiencies in respondent's recordkeeping practices.

43. For these reasons, Dr. Parvin's opinions on the issue of the adequacy of the HLK administration are deemed to be more credible than those of Dr. Schulman.

Failure to Evaluate Princess

44. Dr. Parvin also opined that respondent's failure to evaluate Princess post-surgery and before her release to her owner falls below the standard of care. Dr. Parvin explained that Princess was an old, seriously sick dog who had just undergone surgery. The standard of care requires the monitoring of her clinical symptoms, including hydration, temperature, color, and heart rate. Dr. Parvin stated that although general monitoring may be performed by veterinarian assistants, other duties, such as palpation and monitoring the animal patient's heartrate and hydration, requires veterinary training and must be performed by a veterinarian. In Princess's medical records, however, there is no notation of an actual physical evaluation by respondent or any other veterinarian post-surgery. All post-surgery notations were written by unlicensed veterinary assistants in the form of whiteboard notes. Dr. Parvin emphasized that the whiteboard notes do not constitute documentation of a

veterinarian's evaluations because they are not completed by a veterinarian and do not contain an animal patient's clinical status.

45. At the hearing, respondent claimed that he evaluated Princess every two hours for 48 hours and that he documented his evaluations in the whiteboard notes to his veterinarian assistants. Respondent testified that after the initial physical examination, he does not document any further examinations or evaluations that he performs. He only documents those subsequent examinations in whiteboard notes to his veterinarian assistants. Respondent disagreed with Dr. Parvin's opinion that the whiteboard notes are insufficient to constitute proper documentation of evaluations by a veterinarian. According to respondent, the whiteboard notes are sufficient for recordkeeping purposes because they show that he is checking on the animal patient. When questioned about the absence in the whiteboard notes for any explanation for the increase in the HLK administration from 15 ml per hour to 20 ml per hour, respondent expressed his belief that he does not need to document any explanations for changing or maintaining a medication's dosage.

46. Dr. Schulman testified that the standard of care for the treatment of a hospitalized animal is for a veterinarian to consistently assess that patient's status. Consistent assessments mean checking on the animal every hour or half-hour, either by an RVT or a veterinarian. A physical examination, including palpation and taking of vital signs, must be conducted. Notation of findings from the physical examination and amendments to the treatment regimen must be documented in the medical records. Princess's medical records, Dr. Schulman conceded, did not contain such notations.

47. Drs. Parvin and Schulman's opinions on this issue are consistent, persuasive, and accorded significant weight.

Summary Findings re Princess

48. Therefore, it was established that (1) respondent's failure to evaluate Princess post-surgery and before her release to her owner is below the standard of care; and (2) by administering an inadequate amount of HLK to Princess, respondent demonstrates a lack of knowledge regarding the constant rate infusion delivery of pain control medications. It was also established that (1) by requiring Princess to undergo diagnostic testing before he examined Princess, respondent treated Princess without first establishing a VCPR; and (2) respondent failed to provide effective pain control for Princess before and after her surgery.

ROSIE, THE CHIHUAHUA

Treatment at AVVC

49. On May 7, 2016, at 10:13 a.m., D.M. took her three-year-old Chihuahua, Rosie, to AVVC because the animal was unable to use her hind legs. (Ex. 31, AGO 3330.) Rosie was transferred from Quartz Hill Veterinary Clinic, where she was seen the previous day for rear quarter discomfort. (*Id.* at AGO 3326.) Respondent performed an initial physical examination of Rosie shortly after her check-in. In Rosie's medical records documenting this physical examination, under the title, "Presenting Complaint," respondent wrote, "Cant [*sic*] use back legs." (*Id.* at AGO 3330.) Under the title "Physical Examination," respondent wrote, in relevant part, "Musculoskeletal: Non ambulatory x4 –unable to use hind limbs, front limbs deformed. [¶] Neurological: No Deficits." (*Id.* at AGO 3327.)

50. Between 10:13 a.m. and 5:00 p.m., Rosie was hospitalized after the initial physical examination, and blood tests were performed. (Ex. 31 at AGO 3328-3329.) She received no other medical intervention during this period. Around 5:00 p.m., about

seven hours after her initial check-in, Rosie was administered multiple drugs and underwent a computerized tomography (CT) scan. (*Ibid.*) The CT scan revealed that Rosie had compression of her spinal cord due to a ruptured intervertebral disc at L5-6.[9] (*Id.* at AGO 3327.) From 12:20 a.m. to 12:50 a.m. on May 8, 2016, respondent performed a hemilaminectomy.[10] (*Id.* at AGO 3328-3332.) There is no documentation in the medical records that respondent communicated with D.M. about Rosie's neurological status and her prognosis before performing these procedures. Rosie was hospitalized from May 8 to May 14, 2016, at AVVC.

51. Before and after her spinal surgery, Rosie was placed on a constant rate infusion delivery of HLK. Per the medical record, Rosie was administered HLK (1.5 mg hydromorphone, 100 mg Lidocaine, 50 mg Ketamine, put into 250 milliliters of saline), at a rate of 3 ml per hour. (Ex. 31 at AGO 3327.) This HLK constant rate infusion was inadequate to provide effective pain control. For a dog of her size (11.2 pounds), Rosie was administered an amount of HLK less than one-third of the low end of the recommended HLK constant rate infusion range, according to the VASG online constant rate infusion calculator. (Ex. 33, AGO 3347.)

52. During Rosie's seven-day hospitalization after her back surgery, there is no notation in her medical records showing that respondent performed an evaluation

[9] L5-6 is used to delineate a lesion between the fifth and sixth lumbar vertebrae.

[10] Hemilaminectomy is a surgical procedure performed in animals with ruptured or herniated intervertebral discs. The surgery involves removal of part of the bony lamina (a thin layer or plate) that surrounds the spinal cord, allowing decompression of the damaged spinal cord.

of her condition. The records contain no daily progress notes and no indication that respondent had monitored Rosie for pain or her neurological status.

53. On May 8, 2016, five radiographs were taken of Rosie's spine. (Ex. 32.) Three radiographs show Rosie's back without any staples. (*Id.* at AGO 3335-3337.) Two additional radiographs show Rosie's back with staples on it, but the staples are positioned on different sites of her back on each radiograph. (*Id.* at AGO 3338-3339.) However, there is no documentation in Rosie's medical records that respondent had evaluated these radiographs for their significance. Nor is there an explanation as to why respondent took these two sets of radiographs.

54. On May 13, 2016, Rosie stopped eating and drinking; she became lethargic and disoriented; and her temperature dropped. (Ex. 31, AGO 3287-3289.) She underwent two blood tests, the results of which showed that Rosie was anemic with a hematocrit value of around 28 percent (normal values are 37.3 percent to 61.7 percent). (*Id.* at AGO 3288, 3283.) There is no indication in the medical records that respondent evaluated the results of these blood tests. Nor is there an indication that respondent pursued the cause of Rosie's deterioration or the cause of her anemia. Instead, respondent provided symptomatic treatment by administering dexamethasone, Benadryl, and Epogen[11] and ordering blood transfusions for Rosie. (*Id.* at AGO 3279-3285.) Rosie's medical records also do not include any assessment or indication for the administration of Epogen and the blood transfusion.

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[11] Epogen (erythropoietin) is a hormone that regulates production of red blood cells. It is typically used to treat anemia associated with chronic renal failure.

55. By 2:30 a.m. on May 14, 2016, Rosie developed respiratory distress, and the blood transfusion was stopped. (Ex. 31, AGO 3277.) At 3:00 a.m., Rosie passed away. (*Id.* at AGO 3278.)

56. After Rosie's death, D.M. requested her medical records from AVVC. On May 24, 2016, AVVC provided a copy of Rosie's medical records to D.M., but those records did not include any daily progress notes or evaluations of radiographs and blood test results. (Ex. 30.)

Dr. Parvin's Opinions

57. Dr. Parvin opined that respondent's treatment of Rosie is below the standard of care or demonstrates a lack of knowledge, based on the following acts:

A. On May 7, 2016, respondent failed to provide appropriate initial medical treatment for Rosie before her surgery. Almost seven hours elapsed from the time of Rosie's check-in at AVVC at 10:13 a.m. on May 7, 2016, and the administration of drugs and the performance of a CT scan at approximately 5:00 p.m. According to Dr. Parvin, the standard of care for animals such as Rosie who exhibit clinical signs of paralysis from intervertebral disc disease includes timely assessment and medical treatment to slow the cascade of secondary injury, such as edema and necrosis, to the spinal cord. The seven-hour delay in the initiation of medical intervention is below the standard of care.

B. On May 7, 2016, respondent failed to perform an initial neurological examination of Rosie. The documented examination states, "Neurological: No Deficits." (Ex. 31, AGO 3327.) However, Rosie was clearly neurologically compromised. According to Dr. Parvin, evaluation of animals such as Rosie must include a thorough neurologic exam, including evaluations of reflex and deep pain

perception, to determine the level of impairment before initiating treatment. A basic neurological examination also helps to locate Rosie's lesion (the disc rupture) and allows the veterinarian to determine if medical or surgical treatment should be used. Respondent did not assess Rosie's neurological status, and he did not indicate whether or not she was in pain. Respondent simply hospitalized Rosie and started her on HLK and performed a CT scan. Failing to perform a neurological exam under these circumstances is below the standard of practice.

C. Respondent demonstrates a lack of knowledge by performing spinal surgery on Rosie without considering known options regarding the prognosis for an L5-6 intervertebral disc rupture. Dr. Parvin opined that unlike disc ruptures higher in the spinal canal (T3-L36), which usually are associated with more serious neurological deficits and benefit from timely surgery, disc ruptures at L4 caudally (toward the tail), as with Rosie's documented L5-L6 disc rupture, frequently cause paraparesis (partial paralysis), but the animal may respond to medical treatments without surgical intervention. Dr. Parvin testified that just because Rosie was unable to use her rear legs did not mean surgery was an absolute necessity. However, because respondent did not perform a neurological examination, there is insufficient information in the medical records to determine the degree of Rosie's neurological impairment and whether surgical treatment was necessary. Dr. Parvin opined that by performing spinal surgery on Rosie without a neurological examination, respondent did not realize that medical intervention, rather than surgery, was also an option.

D. Respondent demonstrates a lack of knowledge by administering to Rosie an amount of HLK that was significantly lower than the low end of the recommended HLK dose range before and after her spinal surgery.

E. After performing spinal surgery, respondent failed to monitor Rosie for neurological status and pain. The standard of care after a spinal surgery involves close monitoring, neurological evaluation, and medical intervention if needed. Rosie was not evaluated and monitored by respondent. She was only evaluated by veterinary assistants until she became anemic and died on May 14, 2016. The lack of post-surgery evaluation by a veterinarian is below the standard of care.

F. Respondent failed to evaluate the radiographs of Rosie's spine taken after her spinal surgery and failed to indicate in the medical records why these radiographs were necessary. According to Dr. Parvin, all five radiographs taken by respondent on May 8, 2016, showed Rosie had calcification of several discs. These are significant changes for a young dog, suggesting intervertebral disc degeneration and an increased risk of additional disc rupture in the future. However, there is no notation in the medical records by respondent that he had evaluated the significance of these radiographs. In addition, because the second set of radiographs show Rosie's back with staples on it, Dr. Parvin assumed that they were taken post-surgery. Radiographs are typically taken before a CT scan and surgery. There is also no reason given in the medical records for respondent to take a second set of radiographs after Rosie's spinal surgery was completed. These failures are below the standard of care.

G. On May 13, 2016, respondent failed to pursue the cause of Rosie's deterioration and provided only symptomatic treatment. On that date, Rosie's condition was deteriorating. She was not eating or drinking, and she was lethargic and disoriented. Rosie's results on blood tests indicated she had anemia. According to Dr. Parvin, there are multiple causes why a dog may be suffering from anemia, including internal bleeding. However, there is no indication in the medical records that respondent evaluated Rosie's blood test results or made any attempt to determine the

cause of her anemia and deterioration. Instead, respondent administered Epogen and a blood transfusion as symptomatic treatments. These failures are below the standard of care.

H. Respondent demonstrates a lack of knowledge by giving Rosie a blood transfusion, without medical indication that it was necessary, on May 13, 2016. Respondent did not investigate the cause of Rosie's anemia, but there is also no evidence in the medical record that she was actively bleeding. According to Dr. Parvin, Rosie's hematocrit value of 28 percent, without obvious continuous blood loss, is not life-threatening. Blood transfusions, on the other hand, are associated with numerous adverse reactions that can be fatal. Transfusions should not be administered without indication that the benefit outweighs the risk to the patient. In Rosie's case, her anemia was not severe enough to have justified a transfusion on May 13, 2016.

58. Additionally, Dr. Parvin testified that respondent's performance of a CT scan and spinal surgery on Rosie without conducting a neurological assessment constitutes treatment of a patient without establishing a VCPR. Dr. Parvin opined that the establishment of a VCPR requires a complete in-person examination and communication with the client, Rosie's owner, about Rosie's neurological status and prognosis. Respondent's failure to conduct a neurological assessment of Rosie and to communicate with D.M. regarding Rosie's status and prognosis means a VCPR was not established, and respondent should not have proceeded with Rosie's treatment.

Respondent's Testimony

59. At the hearing, respondent claimed that he had performed a neurological examination of Rosie by assessing her skin sensitivity to pain, her deep pain perception, and her withdrawal reflex. However, when asked to identify in Rosie's

medical records the documentation of this neurological examination, respondent claimed that his notation, "Musculoskeletal: Non ambulatory x4 –unable to use hind limbs, front limbs deformed," was a part of his findings from the neurological examination. (Ex. 31, AGO 3327.) He averred that his assistant, who was inputting his notes into the electronic records, had mistakenly typed the notation as a musculoskeletal finding when it should be been entered as a neurological finding. Nevertheless, respondent had no explanation for his notation for Rosie's neurological examination, which stated, "No deficits." (*Ibid.*)

60. Respondent claimed that Rosie responded well to the HLK and that he never observed her in pain. This assertion is contradicted by the medical records, which show that on May 12, 2016, RVT Amy McFarland noted Rosie may be in pain and she would discuss this concern with respondent (Ex. 31, AGO 3292.) However, no follow-up to this note is documented in the medical records.

61. Respondent explained that all five radiographs of Rosie's spine were taken before her surgery. (Ex. 32.) The two radiographs showing Rosie with staples on her back were taken to help respondent identify the location of his incision. The two radiographs show the staples at different sites because he had positioned the staples at the incorrect site in the first radiograph (*Id.* at AGO 3338), and the second radiograph shows the staples positioned at the correct surgical site (*Id.* at AGO 3339.) This portion of respondent's testimony is credible. However, respondent did not address Dr. Parvin's concerns that the radiographs showed calcification in Rosie's discs. Respondent also provided no explanation as to the absence of documentation regarding his reasons for taking the radiographs, his evaluation of the radiographs, and his understanding of their significance.

62. Respondent averred that another veterinarian had ordered Rosie's blood tests on May 13, 2016, which is the reason why he did not evaluate the results indicating anemia. However, the medical records show respondent's initials as the veterinarian who had ordered the tests. (Ex. 31, AGO 3287.) Respondent also claimed that prior to Rosie's surgery, he considered and discussed with D.M. medical treatment options, such as using muscle relaxants and anti-inflammatory medication as alternatives to surgery. Nevertheless, he recommended surgery because Rosie was paralyzed in the hind legs. Respondent asserted that he evaluated Rosie after surgery, testing for her range of motion every four to six hours. None of these claims are deemed credible because none of the actions respondent purportedly took are documented in the medical records.

63. Respondent admitted at the hearing that the blood infusion for Rosie was not medically necessary. Respondent claimed that he performed the blood infusion because Rosie's owner called him four to five times a day insisting on the blood infusion, and he eventually acceded to her demands.

Dr. Schulman's Opinions

64. At the hearing, Dr. Schulman testified that although it is the standard of care for a non-ambulatory animal such as Rosie to get a physical and neurological examination upon presentation, a CT scan is a necessary diagnostic test regardless of whether a neurological examination was performed or not. Dr. Schulman opined that based on Rosie's CT scan result showing a compressive lesion or compression of the spinal cord due to disc rupture, it is within the standard of care to perform an immediate surgical decompression.

65. On cross-examination, however, Dr. Schulman conceded that for a L5-6 disc rupture, surgery is the "preferred option" (his words), if there is significant neurological loss. Dr. Schulman admitted that he did not see any indication in Rosie's records of any neurological examination, which involves a complete evaluation of an animal's ability to walk, its tone and reflexes, its deep pain perceptions in the affected limbs, and a grade from 1 to 5 of its neurological deficit. Despite Dr. Schulman's failure to see any notation regarding any of these aspects of Rosie's neurological status, he opined that she was a "grade 2" case, based solely on the fact that she was non-ambulatory. Dr. Schulman stated that, given the results of the CT scan, surgery was "the primary treatment" (his words) for Rosie's condition.

66. Dr. Schulman's opinions about the propriety of Rosie's spinal surgery do not refute those of Dr. Parvin. Dr. Parvin did not opine that respondent's opting for surgery rather than medical treatment in Rosie's case is below the standard of care. Because respondent did not perform a neurological examination and Rosie's neurological deficits are unknown, Dr. Parvin was unable to form this opinion. However, in Rosie's medical records, the lack of any mention of alternatives to surgery and the absence of any explanation by respondent for selecting surgery over medical treatment suggest that he did not even consider alternative medical treatments for Rosie. Even if surgery is the preferred or the primary treatment for Rosie's condition, it was necessary for respondent to demonstrate his knowledge that medical alternatives exist for a L5-6 disc rupture and to explain why he chose surgery over those alternatives due to Rosie's condition.

Summary Findings Re Rosie

67. Dr. Schulman did not proffer any other opinion concerning Rosie's case. Because Dr. Parvin's opinions are well-reasoned and consistent with the evidence, her

findings relating to respondent's treatment of Rosie are deemed as established by the record.

68. Based on Rosie's medical records, it was also established that respondent did not include the following information in the medical records:

- Daily updates, assessments regarding Rosie's pain level, her neurological status, and her deterioration throughout her eight-day hospitalization;
- Evaluation of the blood tests conducted on May 13, 2016;
- Evaluation of radiographs taken on May 8, 2016; and
- An assessment or indication for the May 13, 2016 administration of Epogen and blood transfusion.

MR. CHOW, THE PUG

69. On April 9, 2017, M.H. took Mr. Chow, her pug, to All Creatures because Mr. Chow was restless and not urinating. (Ex. 34, AGO 3351.) Mr. Chow was appropriately treated at All Creatures for pancreatitis. (*Ibid.*) On April 11, 2017, Mr. Chow was transferred to AVVC for surgery by respondent. (*Ibid.*)

70. On April 27, 2017, the Board sent a letter to respondent requesting medical records for Mr. Chow from both AVVC and All Creatures. (Ex. 35, AGO 3358-3359.) After not receiving a response, on June 5, 2017, the Board sent respondent a second request for records. (*Id.* at AGO 3360-3361.) On June 8, 2017, the Board received medical records for Mr. Chow from All Creatures but did not receive any medical records from AVVC. On September 27, 2017, the Board sent to AVVC by fax, a third request for Mr. Chow's records, but AVVC did not respond to the request. (*Id.* at

AGO 3368-3369.) As of the date of the hearing, the Board has not received a copy of Mr. Chow's medical records from AVVC. Therefore, it was established that AVVC failed to provide Mr. Chow's medical records to the Board despite multiple requests.

71. At the hearing, respondent claimed that he has not seen any of the three Board requests for Mr. Chow's AVVC records. Respondent reported he has no information about whether Mr. Chow's AVVC records were ever sent to the Board, neither has he made any inquiries about what occurred to those records. Respondent blamed his business manager for the failure to provide Mr. Chow's AVVC records to the Board.

SAMMY, THE BULLDOG

72. On April 30, 2016, M.S. took Sammy, his five-year-old Bulldog, to All Creatures for a nail trim. What occurred to Sammy during and after this nail trim is recorded in a three-page note by an individual with the initials "E.M." in Sammy's medical records. (Ex. 39, AGO 3429-3431.)

73. According to E.M.'s note, Sammy became distressed during her nail trim. (Ex. 39, AGO 3429.) She bit the nail trimmer and, in the process, cut her upper lip, causing profuse bleeding. Sammy also experienced episodes of vomiting and regurgitated bloody foam. (*Ibid.*) E.M. initially attempted to stop the bleeding with pressure and surgical glue. (*Ibid.*) When the bleeding could not be controlled, Sammy's owner, M.S., approved sedation. (*Ibid.*) Following sedation between 9 a.m. and 9:30 a.m., Sammy's bleeding was controlled, but she was described as "still agitated." (*Ibid.*)

74. At 11 a.m., Sammy collapsed and became cyanotic.[12] (Ex. 39, AGO 3430.) She was immediately placed on oxygen, and chest radiographs were taken. (*Ibid.*) E.M. then called respondent, who recommended the administration of dexamethasone (a steroid medication), famotidine (a gastrointestinal antihistamine used as an antacid), and Urasyn (an antibiotic combination drug). (*Ibid.*) At 11:45 a.m., 12:20 p.m., and 12:22 p.m., E.M. administered dexamethasone and famotidine to Sammy based on dosages that she determined. (*Id.* at AGO 3431.) At 12:45 p.m. Sammy began to experience respiratory and cardiac arrest. (*Ibid.*) E.M. started resuscitation attempts, including Cardiopulmonary Resuscitation (CPR). (*Ibid.*) At 1:05 p.m., Sammy had another cardiac arrest. (*Ibid.*) Respondent arrived while E.M. was initiating CPR. (*Ibid.*) However, Sammy did not respond to CPR, and she died. (*Ibid.*)

75. At the hearing, Dr. Parvin based her opinions on the assumption that E.M. was a veterinarian assistant named Elizabeth Margis. Dr. Parvin opined that because E.M. was a veterinarian assistant, respondent aided or abetted unlicensed activities by allowing his staff to practice veterinary medicine, including sedation, critical care, and CPR for Sammy with only minimal indirect supervision. In addition, respondent committed the following acts that are below the standard of care: (1) ordering Urasyn to be administered to Sammy without any clinical indication that the antibiotic was needed and (2) allowing E.M., a veterinarian assistant, to determine the dosage of dexamethasone administered to Sammy.

76. At the hearing, respondent explained that in All Creatures' electronic medical record system, the initials "E.M." designate Eliana Mejia, a licensed

[12] Cyanotic means blue discoloration of the tongue and oral mucosa due to inadequate oxygenation of blood delivered to the tissues.

veterinarian. Elizabeth Margis uses the initials "E.G.M." Respondent, therefore, was not the veterinarian involved in Sammy's care. He consulted with Dr. Mejia on the phone regarding the medication to be administered to Sammy, but by the time that he arrived at All Creatures, Sammy had already passed away. Respondent's testimony on this issue is credible, as it is corroborated by medical records showing that whiteboard entries completed by Elizabeth Margis use the initials "E.G.M." (Ex. 52, AGO 3818.)

77. Because Dr. Mejia, not a veterinarian assistant, provided care to Sammy, the following allegations were not established by the record: (1) respondent ordered a veterinarian assistant to administer Urasyn to Sammy; (2) respondent allowed a veterinarian assistant to determine the dosage of dexamethasone administered to Sammy; and (3) respondent aided or abetted unlicensed activities by allowing his staff to practice veterinary medicine on Sammy.

CHELSEA, THE CHIHUAHUA

Treatment at AVVC

78. On April 30, 2017, J.A. took Chelsea, her 5-year-old Chihuahua, to AVVC as an emergency, because Chelsea was lethargic, hacking, and gagging. (Ex. 42, AGO 3470.) Respondent at the hearing admitted that he performed Chelsea's initial examination on April 30, 2017. However, Chelsea's medical records do not identify the name of the staff member who performed the examination or the date it was performed. The physical examination noted that Chelsea suffered from dental disease and a heart murmur; harsh airway sounds were audible; and Chelsea exerted increased respiratory effort. (Ex. 45, AGO 3605.) The tentative diagnosis was pneumonia or bronchial inflammation. (*Ibid.*) Two radiographs (Radiographs #1 and #2, *id.* at AGO 3614-3615) were taken and showed "increased right lung lobe density [and] lack of

detail/consolidation." (*Id.* at AGO 3604.) According to respondent, Chelsea's hospitalization and treatment began on April 30, 2017. However, the only entry in Chelsea's medical records for April 30, 2017, consists of a whiteboard note that read, "AVER New Visit-CLOSED 05/15/2017." (*Id.* at AGO 3606.)

79. On May 1, 2017, Chelsea underwent blood tests. (Ex. 45, AG0 3606.) Although Chelsea's medical records include the results of those tests, an evaluation by a veterinarian of the blood test results is not documented.

80. Respondent's treatment plan for Chelsea included fluid therapy and injection of dexamethasone (a steroid) and furosemide (a diuretic). (Ex. 45, AGO 3604.) It is unclear from the medical records, which, if any, of these treatments were administered to Chelsea because from April 30 to May 2, 2017, there are no notations regarding the drugs, drug dosages, and fluid therapy that were administered. However, at the hearing, respondent admitted he had administered furosemide to Chelsea to address the edema in her lungs and dexamethasone as an anti-inflammatory for respiratory inflammation. According to respondent, both medications were meant to treat Chelsea's pneumonia.

81. On May 2, 2017, two additional radiographs, Radiograph #3 and Radiograph #4, were taken of Chelsea at 7:38 a.m. and 7:39 a.m., respectively. (Ex. 45, AGO 3616-3617.) Both radiographs showed significant pleural effusion[13] and consolidation of the right middle lung lobe. However, respondent did not identify these changes in his radiographic findings. After a recheck of the radiographs,

[13] Pleural effusion (or pleural fluid) is fluid that accumulates between the lung tissue and the chest wall, restricting the ability of the lungs to function normally.

respondent documented in the medical records: "Radiographic findings: Significant improvement in density as compared to original radiographs. Lung lobes are less dense/less consolidated. Landmarks are more prominent on the right side." (*Id.* at AGO 3608.) In a Subjective, Objective, Assessment and Plan (SOAP) note dated May 2, 2017, respondent wrote, "right side lungs improved compared to when p [Chelsea] presented. P continues to improve. . . ." (Ex. 46, AGO 3607.) On the same date, at a time not established by the record, Chelsea was released to J.A. for home care.

82. On May 3, 2017, at 3 a.m., J.A. brought Chelsea back to AVVC because Chelsea was still experiencing labored breathing. (Ex. 46, AGO 3608.) Respondent did not examine Chelsea because he was in surgery. (*Ibid.*) Veterinarian assistant Heather Cole wrote this note in the medical records: "Per [respondent] recommended another 48 hours of hospitalization with medication due to p condition. . . ." (*Ibid.*) J.A. left with Chelsea without further treatment at AVVC.

83. Chelsea was diagnosed elsewhere with a blood clotting disorder caused by rat bait poisoning. (Ex. 44.) After treatment, she eventually made a full recovery. (*Ibid.*)

Dr. Parvin's Opinions

84. Dr. Parvin opined that respondent's treatment of Chelsea is below the standard of care or demonstrates a lack of knowledge, based on the following acts:

A. From April 30 through May 2, 2017, respondent's treatment of Chelsea with multiple injections of furosemide and dexamethasone, drugs not indicated for the treatment of pneumonia, is below the standard of care. Dr. Parvin explained that furosemide is a diuretic that dehydrates the body and makes it harder

for the lungs to clear out fluids. Dexamethasone is a steroid drug, but it is also not meant to treat pneumonia.

B. Respondent's release of Chelsea to her owner without an adequate evaluation is below the standard of care. Respondent's evaluation of Chelsea on May 2, 2017, noted that her right side lung showed improvement. This evaluation is incorrect. Chelsea's chest radiographs (Radiographs #3 and #4) on the morning of May 2, 2017, show significant pleural effusion and consolidation of the right middle lung lobe. According to Dr. Parvin, Chelsea should not have been released to her owners for home care with this lung pathology.

C. Respondent's failure to diagnose obvious pleural effusion based on the radiographs taken of Chelsea on May 2, 2017, demonstrates a lack of knowledge. In Dr. Parvin's opinion, as a veterinarian with training in radiology, respondent should have easily recognized Radiographs #3 and #4 showed pleural effusion and not an improvement in Chelsea's condition.

D. Respondent's recommendation on May 3, 2017, when Chelsea returned to AVVC with labored breathing, to continue with 48 hours of hospitalization without first conducting an examination is below the standard of care. According to Dr. Parvin, Chelsea's return to AVVC suffering from respiratory distress soon after her release by respondent indicates respondent's prior diagnosis of pneumonia or bronchial inflammation should have been reassessed, and further evaluation was needed.

Respondent's Testimony

85. At the hearing, respondent claimed that he had correctly evaluated Radiographs #3 and #4 and that Chelsea's release to her owner on May 2, 2017, was

appropriate. Respondent asserted that Radiographs #3 and #4 showed improvement in Chelsea's condition, even though she was not cured. Respondent testified that he identified the pleural effusion on the radiographs but did not believe the finding was significant. This testimony is not corroborated by the medical records, as respondent did not indicate the presence of pleural effusion in his radiographic findings of Radiographs #3 and #4.

86. Respondent admitted that when Chelsea returned to AVVC on May 3, 2017, he did not examine her because he was in surgery with another patient. However, he contended that Heather Cole's note in the medical records regarding his recommendation for an additional 48 hours of hospitalization was not accurate because he had also recommended further diagnostic testing.

Dr. Schulman's Opinions

87. At the hearing and during direct examination, Dr. Schulman initially opined that he did not see any worsening of Chelsea's condition based on the radiographs taken on April 30, 2017 (Radiographs #1 and #2), and the follow-up radiographs taken on May 2, 2017 (Radiographs #3 and #4). He testified that assuming Chelsea exhibited no clinical signs of debilitation, it is not below the standard of care for Chelsea to be released to her owners in her condition on May 2, 2017. However, on cross-examination, when questioned about Radiograph #3 (Ex. 45, AGO 3616), Dr. Schulman admitted that he recognized the presence of pleural effusion on the radiograph and that the standard of care under these circumstances is continued hospitalization. On redirect, Dr. Schulman testified that it is within the standard of care to release a patient whose pleural effusion has not been completely cleared. Nevertheless, Dr. Schulman did not repudiate his opinion that given the presence of

pleural effusion in Radiograph #3, Chelsea should not have been discharged on May 2, 2017.

Summary Findings Re Chelsea

88. Dr. Schulman did not proffer any other opinion concerning Chelsea's case. Because Dr. Parvin's opinions are unrefuted and well-reasoned, her findings concerning Chelsea's case are deemed as established by the record.

89. Based on Chelsea's medical records, it was also established that respondent did not include the following information in the medical records:

- The identity or the name of the staff member who performed Chelsea's initial physical examination;
- The date Chelsea was initially hospitalized and treated at AVVC;
- An evaluation of Chelsea's May 1, 2017 blood test results; and
- The drugs, drug dosages, and the amount of fluid therapy administered to Chelsea on May 1 and May 2, 2017.

ENZO, THE GERMAN SHEPHERD

Treatment at AVVC

90. On June 29, 2017, D.G. took Enzo, a two-year-old German Shepherd, to AVVC because she witnessed the dog getting hit by a truck. (Ex. 47, AGO 3628.)

Radiographs were taken, which showed right tibia and fibula[14] fracture and luxation[15] of the left hip joint. (Ex. 49, AGO 3756.) Enzo was hospitalized.

91. On June 30, 2017, respondent examined Enzo, after which Enzo underwent pre-surgical blood tests, and medications were administered. At 11:30 a.m., Nirip Shokar, D.V.M., a veterinarian at AVVC, performed a surgical repair of the femoral fracture. (Ex. 49, AGO 3752.) Enzo continued to be hospitalized at AVVC until July 2, 2017. Throughout his hospitalization, except for the surgery performed by Dr. Shokar, respondent is documented in the medical records as Enzo's treating veterinarian.

92. Radiographs were also taken of Enzo post-surgery. Although Enzo's pre-surgery radiographs showed a normal-appearing right hip joint, one of the post-surgery radiographs showed a complete luxation of the right hip joint. (Ex. 49, AGO 3773.) However, there are no evaluations of the post-surgery radiographs documented in Enzo's medical records. Additionally, nowhere in Enzo's medical records is the luxation of the right hip joint documented.

93. Before and after surgery, Enzo was placed on HLK constant rate infusion, with no adjustment for pain. Per the medical records, Enzo was administered HLK (6 mg hydromorphone, 400 mg Lidocaine, 200 mg Ketamine, put into 1 liter of saline), at a rate of 17 ml per hour. (Ex. 49, AGO 3734, 3745-3746, 3756-3757.) This HLK constant rate infusion was far below the recommended range to provide effective analgesia. For a dog of his size (70 pounds), Enzo was administered an amount of HLK that was less

[14] The tibia and fibula are the two bones that make up the lower rear leg.

[15] Luxation means a complete dislocation of a joint.

than one-tenth of the low end of the recommended HLK constant rate infusion range, according to the VASG online constant rate infusion calculator. (Ex. 50, AGO 3780.)

94. In a SOAP note dated July 1, 2017, respondent wrote, "P [Enzo] resting comfortably but currently unable to walk." (Ex. 49, AGO 3745.) In another SOAP note dated the same day, respondent wrote, "P resting comfortably but is painful when tries to walk." (*Id.* at AGO 3744.) In a SOAP note dated July 2, 2017, respondent again wrote, "P resting comfortably but is painful when tries to walk." (*Id.* at AGO 3734.)

95. At 7:00 p.m. on July 2, 2017, Enzo was released to D.G. Respondent discharged Enzo with medications, including an antibiotic, a non-steroidal anti-inflammatory drug, and 50 mg of tramadol[16] to be administered three times a day for pain. (Ex. 49, AGO 3735)

96. On July 9, 2017, respondent treated Enzo because he ripped out his sutures. (Ex. 49, AGO 3729.)

97. On July 15, 2017, D.G. took Enzo to another veterinarian, Diana Chandler, D.V.M., for a second opinion. (Ex. 48, AGO 3710-3711.) Dr. Chandler requested Enzo's medical records from AVVC and identified the luxation of the right hip joint in the post-surgery radiograph. (*Id.* at AGO 3709.) On July 17, 2017, Dr. Chandler spoke to respondent by phone about her finding of Enzo's right hip joint luxation. (*Id.* at AGO 3708.) Enzo eventually underwent surgery at another veterinary hospital and was able to walk normally after a long recovery. (Ex. 47, AGO 3628.)

[16] Tramadol is an opioid analgesic used to relieve pain.

Dr. Parvin's Opinions

98. Dr. Parvin opined that respondent's treatment of Enzo is below the standard of care or demonstrates a lack of knowledge, based on the following acts:

A. Respondent demonstrates a lack of knowledge by administering to Enzo an amount of HLK significantly lower than the low end of the recommended range of HLK constant infusion rate before and after his surgery.

B. On July 1 and 2, 2017, respondent's failure to alter Enzo's treatment protocol to address documented pain and inability to walk is below the standard of care. Dr. Parvin testified that respondent, as Enzo's treating veterinarian after surgery, did not evaluate the post-surgical radiographs showing the complete luxation of the right hip joint. Respondent documented in Enzo's medical records that Enzo was either unable to walk or in pain trying to walk. Nevertheless, he did not alter Enzo's treatment protocol, and Enzo was discharged with a condition that should have been addressed.

C. Respondent's prescription of 50mg of tramadol three times a day for Enzo at his discharge on July 2, 2017, is below the standard of care. Dr. Parvin explained that for a dog of Enzo's size, 150 to 300 mg of tramadol three times a day is the low end of the recommended dosage range. Thus, respondent prescribed less than half of the low end of the recommended dose range of tramadol, which does not provide effective pain relief.

Respondent's Testimony

99. At the hearing, respondent blamed Dr. Shokar for the below-standard care rendered in Enzo's case. Respondent claimed that Dr. Shokar, as the surgical

veterinarian, was responsible for reviewing Enzo's post-surgical radiographs and providing pain management. Respondent asserted that he only followed Dr. Shokar's instructions for pain management and that he did not review Enzo's post-surgical radiographs until July 17, 2017, when Dr. Chandler called him to discuss her findings of right hip luxation. However, when shown a whiteboard note bearing his initials dated June 30, 2017, which stated, "Radiograph-Follow up . . . obtained post-op rads" (Ex. 49, AGO 3751), respondent insisted that Dr. Shokar reviewed the post-surgical radiographs but somehow used respondent's initials when entering the note in the medical records.

100. Respondent's testimony about who was responsible for Enzo's discharge on July 2, 2017, is also full of contradictions. Respondent admitted that he was the doctor "on the shift that day" (his words) and that Enzo was under his treatment. However, he maintained that he made the decision to discharge Enzo jointly with Dr. Shokar. Respondent testified that he released Enzo on Dr. Shokar's instructions and that Dr. Shokar dictated the prescriptions for the medications and dosages, including the dosage for the tramadol, at Enzo's discharge.

101. Respondent's testimony is inconsistent, uncorroborated, and not supported by the medical records, which show only respondent's initials as the treating veterinarian during Enzo's post-surgery hospitalization. Additionally, respondent's repudiation of his responsibilities as the treating veterinarian was refuted by Dr. Parvin, who opined that both the surgeon and the post-surgery treating veterinarian are responsible for reviewing post-surgery radiographs. According to Dr. Parvin, because respondent was the veterinarian who was on site after Enzo's surgery, he is the one responsible for the examination and care of Enzo.

Summary Findings re Enzo

102. Dr. Schulman did not proffer any opinions concerning Enzo's case. Because respondent's testimony was not credible and Dr. Parvin's opinions are unrefuted and well-reasoned, her findings concerning Enzo's case are deemed as established by the record.

103. Based on Enzo's medical records, it was also established that respondent did not include an evaluation of the post-surgical radiographs in the medical records.

POOH, THE BEAGLE

Treatment at AVVC

104. On August 6, 2017, K.D. took Pooh, her 14-year-old Beagle, to AVVC because he was having difficulty walking. (Ex. 51, AGO 3784.) Bhupinder Gahra, D.V.M., a veterinarian at AVVC, evaluated Pooh. After the initial physical examination, Dr. Gahra tentatively diagnosed Pooh with "bilateral tightrope repair."[17] (Ex. 52, AGO 3840.)

105. On August 10, 2017, at 6 p.m., K.D. dropped Pooh off for surgery. (Ex. 52, AGO 3840.) On August 11, 2017, respondent performed a physical examination of Pooh. He documented a normal examination except for "grade 2 dental disease" and "limping on rear limbs." (*Id.* at AGO 3836.) Pooh underwent blood tests, but his surgery was postponed until August 12, 2017. (*Id.* at AGO 3835.)

[17] Tightrope is a surgical system developed to treat cranial cruciate ligament (a ligament inside the canine knee joint) injuries in dogs.

106. On August 12, 2017, at 9:05 a.m., Dr. Shokar performed a dental procedure and tightrope surgery on both of Pooh's hind legs. (Ex. 52, AGO 3830.) From August 12 to August 16, 2017, Pooh remained hospitalized at AVVC, and according to the medical records, respondent was Pooh's treating veterinarian during this period.

107. On August 13, 2017, at 2 a.m., Pooh's IV catheter was removed. (Ex. 52, AGO 3825.) Shortly after, Pooh began to vomit. (*Id.* at AGO 3824.) Radiographs were taken, which showed that Pooh had developed pneumonia. (*Id.* at AGO 3821.) Pooh was treated for pneumonia, including nebulizer treatments with a bronchodilator.[18] (*Ibid.*) Furosemide, a diuretic, was also administered. (*Ibid.*) However, during this time, Pooh was not receiving IV fluid therapy, and there is no notation in the medical records that he was drinking water.

108. At 11:00 a.m. on August 13, 2017, respondent administered Plasma Rich Protein (PRP) to Pooh. (Ex. 52, AGO 3823.) PRP is a biological product, consisting of concentrated platelets and growth factors derived from the patient's blood, that is injected to diminish the inflammatory response in the lining of the joint, the joint capsule, ligaments, cartilage, and bone. The patient's blood must be drawn and processed to concentrate the platelets and growth factors. There are several different methods of preparing PRP. However, Pooh's medical records contain no information about how the PRP was prepared, the amount of blood drawn from Pooh for the PRP, and the volume of PRP product injected into Pooh.

[18] Nebulizer treatment with a bronchodilator is the administration of medications to widen the airways by using a device that changes the medication into a mist form for inhalation.

109. On August 14, 2017, respondent continued to administer various medications to Pooh, including furosemide. (Ex. 52, AGO 3812-3813.) However, there is no indication in the medical records that Pooh was receiving IV fluid therapy. According to the whiteboard notes, Pooh was in pain, and his back legs were bothering him. (*Id.* at AGO 3810.) Although respondent was documented in the medical records as the treating veterinarian, an entry on August 14, 2017, notes that at 9:55 p.m., Maria Abalos, D.V.M., examined Pooh, who was demonstrating abnormal disoriented behavior and "respirator[*sic*] pattern." (*Ibid.*) At 10:20 p.m., Dr. Abalos "checked heart and lung sounds and was alarmed by the wheezing/cracking sounds." (*Ibid.*) She ordered radiographs, which showed pulmonary congestion. (*Ibid.*) Pooh was placed in an oxygen cage. (*Ibid.*)

110. On August 15, 2017, Pooh remained under respondent's care. According to a SOAP note entered by respondent, Pooh remained in an oxygen cage. (Ex. 52, AGO 3805.) At 7 a.m., Pooh began IV fluid therapy. (*Id.* at AGO 3807.) Pooh was described in several whiteboard notes as experiencing labored breathing and unable to walk, not feeling well in his legs, and unable to walk well. (*Id.* at AGO 3803, 3805.) In a client communication note entered by a veterinarian assistant at 6:36 p.m., Pooh was documented as "not wanting to stand, not even wanting to really lift head." (*Id.* at AGO 3802.) At midnight on August 16, 2017, Pooh was found deceased. (*Id.* at AGO 3800.)

111. During his post-surgery hospitalization from August 12 to August 16, 2017, Pooh was placed on HLK constant rate infusion. Per the medical records, Pooh was administered HLK (6 mg hydromorphone, 400 mg Lidocaine, 200 mg Ketamine, put into 1 liter of saline), at a rate of 9 ml per hour. (Ex. 52, AGO 3813, 3821, 3827, 3834, 3839.) This HLK constant rate infusion was far below the recommended range to provide effective analgesia. For a dog of his size (35 pounds), Pooh was administered

an amount of HLK that was less than one-tenth of the low end of the recommended HLK constant rate infusion range, according to the VASG online constant rate infusion calculator. (Ex. 53, AGO 3848.) Pooh's condition was described in two whiteboard notes on August 14, 2018, as "painful" and "too painful to walk." (Ex. 52, AGO 3811, 3813.) As described above, other entries in the medical records demonstrate that Pooh was unable to stand or walk. However, there is no indication in the medical records that respondent monitored Pooh for his level of pain or adjusted his analgesia protocol.

Dr. Parvin's Opinions

112. Dr. Parvin opined that respondent's treatment of Pooh is below the standard of care, based on the following acts:

A. Respondent's failure to include information about PRP preparation and administration is below the standard of care. According to Dr. Parvin, although the method of PRP preparation varies, most preparation methods involve harvesting blood from the patient, separating the platelets, and concentrating the platelets by centrifugation. The concentrated platelets are combined with the remaining plasma or blood, and injected into the patient. There are a variety of commercial kits available for the preparation of PRP, but many kits are developed for use in humans and may or may not be as effective for canine blood. In addition, several factors can affect the effectiveness of the preparation. Some methods of preparation result in high concentrations of red and white blood cells which can have inflammatory properties when injected outside the vascular system. Due to these variations and the potential side effects, the standard of care requires the documentation of the preparation and administration of PRP in the medical records.

B. Respondent's failure to monitor pain and adjust Pooh's analgesia after orthopedic surgery is below the standard of care. Throughout Pooh's hospitalization from August 12 to August 16, 2017, respondent administered to Pooh an inadequate amount of HLK significantly lower than the low end of the recommended range of HLK constant infusion rate. According to Dr. Parvin, orthopedic surgery is known to be extremely painful, but for post-surgery recovery, the patient should be able to ambulate slowly without pain. The standard of care after the type of surgery Pooh underwent is to provide adequate pain medication to allow the patient to ambulate without pain. However, in Pooh's case, the medical records note that throughout hospitalization after surgery, he could not stand or walk, and both of his hind legs were in pain.

C. Respondent's failure to maintain Pooh on IV fluids for treatment of aspiration pneumonia on August 13 and August 14, 2017, is below the standard of care. On August 13, 2017, Pooh's IV catheter was removed at 2:00 a.m. Shortly after, Pooh vomited, and radiographs showed that he developed pneumonia. On August 13 and August 14, 2017, respondent also administered a diuretic, furosemide, to Pooh. However, there is no documentation in the medical records that Pooh was administered IV fluid therapy from 2 a.m. August 13, 2017, until 7 a.m. on August 15, 2017. Dr. Parvin opined that appropriate fluid therapy is an important part of the treatment of pneumonia, especially for an animal receiving diuretic medications such as furosemide. Fluids maintain perfusion and prevent dehydration in debilitated patients. Hydration thins the viscosity of respiratory secretions and helps patients with pneumonia to expel these secretions to the airways. Dehydrated patients have thick, sticky secretions that cannot be easily coughed up.

D. Respondent's administration of furosemide to Pooh as a treatment for aspiration pneumonia is below the standard of care. After Pooh began coughing and began treatment for pneumonia, respondent administered IV injections of furosemide, a diuretic. During this time Pooh was not receiving fluid therapy, and there is no indication he was drinking. According to Dr. Parvin, the use of diuretics under these circumstances further dehydrates the patient's tissue, resulting in thicker, sticky secretions that are difficult to expel from the airways.

Respondent's Testimony

113. At the hearing, respondent disclaimed responsibility for Pooh's care on August 13, 2017, contending that Dr. Gahra was the treating veterinarian on that date. Specifically, respondent reported he had taken the day off on August 13, 2017, according to an internal calendar he supposedly maintained, and Dr. Gahra, who supposedly was on shift that day, used respondent's initials to make entries in the medical records. Respondent blamed Dr. Gahra for maintaining Pooh on an inadequate amount of HLK, discontinuing Pooh's IV fluid therapy, and administering furosemide to Pooh. This testimony is not credible for several reasons. First, respondent did not submit a copy of his internal calendar to corroborate his testimony. Second, when shown a SOAP note dated August 13, 2017, respondent admitted he had examined Pooh and entered the note. (Ex. 52, AGO 3820-3821.) Third, respondent also admitted he had prepared and administered the PRP to Pooh on August 13, 2017. (*Id.* at AGO 3820-3821.)

114. With respect to the preparation and administration of the PRP, respondent asserted there is only one method of preparing PRP, although he conceded multiple commercial kits are available from different companies. The kit that respondent uses requires preparation of the PRP according to the weight of the animal

patient. Respondent reported he followed the kit's instructions for the preparation and the administration of PRP to Pooh.

115. With respect to the adequacy of HLK administered to Pooh, respondent claimed that Drs. Shokar and Gahra were responsible for Pooh's pain management on August 13 and that Dr. Abalos was responsible for Pooh's pain management on August 14, 2017. Respondent further claimed that Drs. Gahra and Abalos used respondent's initials to make entries in the medical record on August 13 and 14. Although respondent admitted that he was on the day shift for August 14, 2017, he averred that he did not change Pooh's HLK protocol because Pooh did not display any signs of pain. These assertions were contradicted by the medical records, which show that respondent was Pooh's treating veterinarian for August 13 and 14, 2017, and that Pooh was noted to be in pain in several whiteboard notes.

Dr. Schulman's Opinions

116. Dr. Schulman explained that a few commercial companies sell kits for making PRP. Each company provides special tubes for obtaining blood serum from the patient and requires the blood serum to be centrifuged in order to concentrate the platelet-rich plasma. He testified that although there are some variations, there is only one way to prepare the PRP. However, Dr. Schulman testified that the PRP kits he uses do not differentiate between the weight of the animal patients.

117. Dr. Schulman's testimony only confirmed PRP preparations differ depending on the type of kits used, since respondent and Dr. Schulman reported different PRP preparation methods. Furthermore, Dr. Schulman did not refute Dr. Parvin's opinion that the standard of care requires the document the preparation and administration of PRP in the medical records.

Summary Findings re Pooh

118. Dr. Schulman did not proffer any other opinions concerning Pooh's case. Because respondent's testimony is not credible and Dr. Parvin's opinions are unrefuted and well-reasoned, her findings relating to respondent's treatment of Pooh's are deemed as established by the record.

DEAN, THE CAT

Treatment at All Creatures

119. On October 3, 2017, C.M. took Dean, his 6-year-old cat, to All Creatures because Dean vomited after eating, lacked appetite, and was lethargic. (Ex. 54, AGO 3852.) Zacharias Gardenfors, D.V.M., a veterinarian at All Creatures, examined Dean. (Ex. 56, AGO 3892-3893.) The physical examination showed that Dean had low body temperature, but he was otherwise considered normal. (*Ibid.*) However, Dr. Gardenfors did not perform any blood tests on Dean. Instead, Dean was treated with subcutaneous fluids, Cerenia (a medication for vomiting and nausea), and Buprenex (pain medication), and he was discharged the same day. (*Ibid.*)

120. Two days later, on October 5, 2017, Dean was brought back to All Creatures in worse condition. (Ex. 56, AGO 3891.) He is described in a medical record entry as not eating or drinking, "drooling excessively, very lethargic, and having a hard time standing/walking." (*Ibid.*) Dr. Shokar took radiographs and performed blood tests. (*Ibid.*) The results of the blood test showed elevated potassium levels, which are known to cause cardiac arrhythmias. Other values obtained from the blood tests were consistent with renal failure. In an addendum to his October 5, 2017 entry, Dr. Shokar indicated his concern that Dean may be in end-stage renal failure. (*Id.* at AGO 3895.)

Nevertheless, Dr. Shokar did not intervene with appropriate treatment or monitoring for Dean for severe renal failure.

121. At 8:00 a.m. on October 6, 2017, Dean's care was transferred to Yuseung An, D.V.M., another veterinarian at All Creatures. (Ex. 56, AGO 3890.) Dr. An treated Dean with insulin and dextrose solution to help lower the highly elevated potassium level noted in the blood test results from the previous day. (*Id.* at AGO 3890.) Dr. An also continued to treat Dean with Cerenia, famotidine (an antacid), and Buprenex. (*Id.* at AGO 3890.) Blood tests were repeated on October 6 and 7, 2017. (*Id.* at AGO 3888-3889.) According to an entry by Dr. An, at 5 p.m. on October 6, 2017, medical care for Dean was transferred to "Dr. Kim." (*Id.* at AGO 3890.) However, Dr. Kim is not identified in the list of individuals responsible for Dean's medical care (*Id.* at AGO 3887), and there is no indication in the medical records that Dr. Kim provided any medical treatments for Pooh.

122. Around 5:25 a.m. on October 8, 2017, Dean developed nystagmus (abnormal rhythmic involuntary eye movements), followed by open-mouth breathing. (Ex. 56, AGO 3889.) A whiteboard note entered by Monica Thomson, RVT, reads, "Attempted to place endotracheal tub. P went into cardiac and respiratory arrest. Started CPR. After almost 2 minutes of chest compressions, and mask with ambu bag, P showed no response. . . . " (*Id.* at AGO 3888.) There is no indication in the medical records that a veterinarian supervised the CPR Ms. Thompson performed. Dean died at 6:32 a.m. (*Ibid.*)

Dr. Parvin's Opinions

123. Dr. Parvin opined that Drs. Gardenfors, Shokar, and An provided inadequate care, far below the standard of care, to Dean, who was suffering from

severe renal failure. In addition, on October 7, 2017, Ms. Thompson, who is an RVT and not a veterinarian, performed inadequate CPR on Dean, and there is no indication in the medical records that a veterinarian was available to direct CPR. Intubation and ventilation, the hallmark of CPR, were not performed, and appropriate medication for resuscitating Dean was not administered. Dr. Parvin believes that respondent, as the owner and licensee manager of All Creatures, must ensure the availability of reasonably competent veterinarians who are capable of managing critical care cases at his practice. In Dr. Parvin's opinion, All Creatures, which holds itself out as a 24-hour emergency facility, is held to an even higher standard. Therefore, Dr. Parvin concluded that respondent's failure, as the licensee manager of All Creatures, to ensure that adequate care was provided to Dean is below the standard of care.

Respondent's Testimony

124. At the hearing, respondent initially asserted that Dean was appropriately treated for renal failure. He later stipulated that the care Dean received at All Creatures was inadequate, but respondent contended that he, as the licensee manager of All Creatures, is not liable for the negligence of veterinarians he employs. Respondent explained that Dr. Kim is a relief veterinarian, whom All Creatures uses only when there is a need for coverage. Respondent testified that All Creatures' policy is to have relief veterinarians report to its business manager, Lillian Camacho. Respondent reported that he has never received any complaints about Drs. Gardenfors, Shokar, An, or Kim before October 2017.

125. Given that respondent admitted to All Creatures having provided below-standard care to Dean, the issue of whether respondent, as the licensee manager of All Creatures, is liable for the actions of the veterinarians he employs is a question of law, which is addressed below in Legal Conclusions 26 to 27.

FIONA, THE CHIHUAHUA MIX

Treatment at AVVC

126. On September 4, 2018, at approximately 2:00 p.m., E.F. took Fiona, his 3-year-old Chihuahua mix, to AVVC because she was attacked by a German Shepherd. (Ex. 58, AGO 3925.) Eliana Mejia, D.V.M., a veterinarian at AVVC, was in surgery at the time of Fiona's check-in, and she directed AVVC staff members to conduct diagnostic testing. (Ex. 60, AGO 4154.) Radiographs taken of Fiona showed intestinal herniation. (*Ibid.*) Around 3:00 p.m., Dr. Mejia examined Fiona, noting that the patient sustained a 15-centimeter right shoulder wound, ventral abdominal hernia, bruising of skin, and multiple puncture wounds on her body. (*Id.* at AGO 4153.) Dr. Mejia assessed Fiona's condition as "critical." (*Id.* at AGO 4154.) Antibiotics and pain medication were administered to Fiona, and an IV catheter was inserted into a vein in her left foreleg. (*Ibid.*)

127. Around 6:00 p.m. on September 4, 2018, Fiona's care was transferred to respondent, who took over the night shift until 8:00 a.m. on September 5, 2018. (Ex. 60, AGO 4167.) At 6:00 p.m. on September 4, 2018, respondent wrote in a note: "Dr. Mejia performed rounds – pet critical [¶] Multiple bite wounds [¶] Hernia [¶] Evaluated rads [radiographs] & blood panel . . . ." (*Ibid.*) At 8:00 p.m., respondent wrote a note describing Fiona's condition as "lateral recumbency,[19] painful, shock." (*Id.* at AGO 4167.) However, there is no documentation in the medical records that respondent performed an examination of Fiona after she was transferred to his care. Specifically,

[19] Lateral recumbency refers to when an animal is unable to rise from lying on its sides.

there is no indication that respondent evaluated Fiona for changes in her respiratory and heart condition by auscultation. Also absent from respondent's entries in the medical records are a prognosis for Fiona's condition and an evaluation of the radiographs with a finding of intestinal herniation.

128. During her hospitalization, Fiona received IV fluid therapy, but it is unclear from the medical records when fluid therapy was initiated. A whiteboard note at 8:22 p.m. on September 4, 2018, states that "IVF [intravenous fluids] not hooked up at this time" (Ex. 60, AGO 4150), but another whiteboard note at 12:00 a.m. on September 5, 2018, states, "Fluids running . . ." (*Id.* at AGO 4149.) Presumably then, IV fluid therapy for Fiona began sometime between 8:22 p.m. on September 4, 2018, and 12:00 a.m. on September 5, 2018, more than six hours after Fiona's arrival at AVVC. The IV fluid rate was maintained at 10 ml per hour, at 12 a.m., 4 a.m., and 8 a.m. on September 5, 2018. (*Id.* at AGO 4147-4149.) The rate of fluids administered to Fiona, 10 ml per hour, was at the low end of the maintenance rate required to maintain fluid balance. There is no indication that Fiona was ever administered a fluid bolus, i.e., an immediate, rapid administration of fluids to animals in shock.

129. Respondent continued to treat Fiona with antibiotics and fluids. In a note dated September 4, 2018, but with no time stamp, respondent wrote, "Temp dropping/ getting hypothermia [¶] Warm blankets to maintain body temperature [¶] Continue monitoring [¶] Temp start improving early morning." (Ex. 60, AGO 4165.) In another undated note with no time stamp, respondent wrote, "Morning pet improving [¶] Clean wounds & apply ointment/ body temp improving [¶] continue treatment to further stabilize pet for surgical procedure [¶] Transfer to Dr. Hall." (*Ibid.*)

130. At approximately 8:00 a.m. on September 4, 2018, Fiona's care was transferred to Kelly Hall, D.V.M., another veterinarian at AVVC. At 1:55 p.m. on

September 5, 2018, Dr. Hall anesthetized Fiona and performed surgery. (Ex. 60, AGO 4144.) Dr. Hall found extensive injuries, including "hematomas[20], necrosis. 2 loops of jejunum[21] were strangulated through the abdominal hernia." (*Id.* at AGO 4145.) Dr. Hall recommended euthanasia. (*Ibid.*) E.F. elected to transport Fiona to Acute Critical Care and Emergency Surgical Service (ACCESS) in Los Angeles. (*Ibid.*) Fiona was closed up mid-procedure and brought to ACCESS. (*Ibid.*) At ACCESS, Fiona underwent emergency exploratory laparotomy and surgery to repair the damage. (Ex. 59.) Fiona's prognosis was poor, and she was provided with supportive care. (*Ibid.*) On September 9, 2018, Fiona deteriorated, and her owners elected humane euthanasia. (*Ibid.*)

Dr. Parvin's Opinions

131. Dr. Parvin opined that respondent's treatment of Fiona is below the standard of care or demonstrates a lack of knowledge, based on the following acts:

A. Respondent's failure to expedite exploratory surgery for Fiona is below the standard of care. Dr. Parvin testified that radiographs taken of Fiona showed obvious intestinal herniation. Intestines caught in a hernia can become strangulated and cut off from blood supply, causing organ death. According to Dr. Parvin, it is well known in veterinary medicine that when small animals are attacked by large dogs (in Fiona's case, a German shepherd), significant abdominal organ damage is likely. This consideration, when taken along with the obvious herniated intestine shown in radiographs, necessitated timely surgical exploration to address the strangulated

[20] A hematoma is an area of blood that collects outside of the larger blood vessels.

[21] Jejunum is a part of the small intestines.

intestine and prevent organ death. Delaying surgery under these circumstances is below the standard of care. If surgery could not be performed within a reasonable timeframe, Fiona should have been referred to a specialty practice. Dr. Parvin believes the delay in performing Fiona's surgery caused her condition to deteriorate and is a contributing factor in her death.

B. Respondent's failure to immediately start an appropriate rate of IV fluids to stabilize Fiona when she was in a critical condition on September 4, 2018, is below the standard of care. Dr. Parvin explained that animals in shock after sustaining massive injuries, such as Fiona, experience many difficulties, including a lack of oxygen, which contributes to the deterioration of tissue. The standard of care requires an animal in shock to be administered a fluid bolus, an immediate, rapid administration of fluids to elevate the patient's blood pressure. In Fiona's case, she was not administered a fluid bolus. Instead, Fiona was placed on only a maintenance rate of fluids, which was not initiated until more than six hours after she arrived at AVVC.

C. In addition, respondent demonstrates a lack of knowledge by his administration of IV fluids at an inadequate maintenance rate to support Fiona while she was in shock. Dr. Parvin opined that the 10 ml per hour of IV fluids administered to Fiona was at the low end of the recommended maintenance rate, suggesting respondent's knowledge about fluid therapy is lacking.

D. Respondent's failure to evaluate radiographs of Fiona showing a herniated intestine loop is below the standard of care. While a notation in Fiona's medical records shows that respondent reviewed her radiographs, there is no documentation of his findings based on the radiographs. There is no indication in the medical records that respondent recognized the intestinal herniation presented in Fiona's radiographs.

Respondent's Testimony

132. At the hearing, respondent testified that he delayed Fiona's surgery because she was not initially responsive to anesthesia and because she had hypothermia. Respondent pointed to entries in the medical record that overnight from September 4 to September 5, 2018, Fiona's body temperature had dropped to 96.8 and 95.5 degrees. (Ex. 60, AGO 4149-4150.) According to respondent, the ideal body temperature for Fiona to proceed with surgery was 101 to 102.5 degrees. By around 4:00 a.m. on September 5, 2018, Fiona's body temperature increased to 97.7 degrees, and she became more alert. (*Id.* at AGO 4148.) Respondent reported that at that time, he felt optimistic Fiona might able to handle surgery, although her body temperature was not sufficiently high for him to perform the surgery.

133. Respondent contended that he recognized the herniated intestines in Fiona's radiographs, but he provided no explanation as to why there was no documentation of his finding in the medical records. Respondent claimed that the IV fluid therapy he administered to Fiona was adequate because he purportedly monitored Fiona's condition every hour, even though the medical records do not reflect any assessment by respondent of the adequacy of the IV fluid therapy. Moreover, respondent did not refute Dr. Parvin's opinions that a fluid bolus should have been administered to Fiona or that the IV fluid maintenance rate was administered to Fiona was at the low end of the recommended rate. Respondent insisted that he evaluated Fiona when she was transferred to his care at 6 p.m. on September 4, 2018, and that he listened to Fiona's heart and lungs by auscultation. However, he could only point to entries written by veterinarian assistants recording Fiona's TPR to support this assertion. Dr. Parvin credibly opined in her rebuttal testimony that TPR taken by untrained assistants is not an appropriate substitute for a

veterinarian's evaluation of heart and lungs by stethoscope, especially in the case of a critical patient such as Fiona.

Dr. Schulman's Testimony

134. Dr. Schulman opined that although Fiona's condition was "absolutely life-threatening" (his words), it was not appropriate to rush Fiona into surgery. It is within the standard of care to weigh the benefits of immediate surgery against the patient's receptivity to surgery, which includes factors such as hypothermia and the ability to withstand extensive anesthesia. Dr. Schulman testified that delaying the surgery for a day to stabilize Fiona did not have any negative impact on her condition.

135. During cross-examination and redirect, Dr. Schulman stated that the standard of care requires a veterinarian taking over a shift from another to perform fresh sets of neurological and physical examinations. According to Dr. Schulman, any veterinarian taking over the care of an animal must be intimately familiar with the records and the conditions of the animal patient. Rather than relying on the assessment of the prior veterinarian, a personal evaluation by the treating veterinarian is warranted, especially in the case of a critical care patient. However, Dr. Schulman conceded that "the extent of [respondent's] involvement [in Fiona's case] is hard to determine due to the state of the recordkeeping" (his words).

136. Furthermore, Dr. Schulman confirmed Dr. Parvin's opinion that the standard of care requires Fiona to be administered a fluid bolus immediately upon presentation, and then to be supported at an adequate maintenance rate of fluid therapy. Dr. Schulman did not proffer any other opinions concerning Fiona's case.

137. In her rebuttal testimony, Dr. Parvin agreed with Dr. Schulman to the extent that the decision to proceed with Fiona's surgery requires a cost-benefit

analysis. Dr. Parvin opined that even if Fiona's body temperature was not ideal, surgery should have proceeded if her condition was deteriorating. Both Dr. Parvin and Dr. Schulman's opinions on the issue of whether the delay in Fiona's surgery was within the standard of care are credible. However, the medical records in Fiona's case are so lacking that there is no entry documenting respondent's purported concern about Fiona's responsiveness to anesthesia, nor is there any entry documenting respondent's monitoring of Fiona's condition for her stability. While there are references in the medical records to hypothermia, there is no documentation that this was a factor in respondent's decision to delay surgery for Fiona. In other words, there is no evidence in the medical records of a cost-benefit analysis by respondent to support his conclusion that concerns about Fiona's receptivity to surgery outweighed the risks of delaying her surgery for a life-threatening condition.

Summary Findings re Fiona

138. Because Dr. Parvin's opinions are well-reasoned and consistent with the evidence, her findings concerning Fiona's case are deemed as established by the record.

139. Based on Fiona's medical records, it was also established that respondent failed to include the following information in the medical records:

- A physical examination of Fiona after she was transferred to respondent's care on September 4, 2018; and
- A prognosis of Fiona after she was transferred to respondent's care on September 4, 2018.

SOFIE AKA SOFEY, THE PIT BULL

Treatment at AVVC

140. On October 13, 2018, at approximately 10:00 a.m., M.H. took Sofie, also known as Sofey, his three-year-old Pit Bull, to AVVC for emergency care because she was unable to eat or drink without vomiting. (Ex. 62, AGO 4184.) Respondent examined Sofey and noted she had a tense painful abdomen. (Ex. 64, AGO 4251.) Based on Sofey's blood tests, respondent found leukocytosis (elevation in white blood cell count) and polycythemia (increase in red blood cell mass) due to dehydration, along with mild elevation of renal values, elevated calcium and protein, and low potassium levels. (*Ibid.*) A SNAP cPL1 (a test to confirm pancreatitis) was abnormal. (*Id.* at AGO 4252.) Based on radiographs taken of Sofey, respondent found "[p]ossible foreign body," meaning that a foreign object was obstructing Sofey's stomach. (*Ibid.*) In a section of the entry entitled "Client Education," respondent wrote:

> Owner was told that the stomach was distended. Owner was told that we are suspecting that the cause for the symptoms could be caused by gastroenteritis, pancreatitis and/or a foreign body. Owner was told that the foreign body could be from Sofey ingesting tissue or plastic, owner agreed due to possible access to garbage. . . . .

(*Ibid.*)

141. Sofey began treatment with IV fluids and antibiotics, gastrointestinal antacids, and anti-nausea and pain medication. (Ex. 64, AGO 4251.) In addition, respondent performed a barium series to rule out a foreign body obstruction. A barium series requires the administration of barium sulfate (a contrast medium that is

easily visible on a radiograph) to a patient and taking a series of radiographs over time to observe its passage through the intestinal tracks. The barium series was initiated at 4:14 p.m. on October 13, 2018. (*Id*. at AGO 4246-4247.)

142. In a SOAP note dated October 14, 2018, respondent wrote, "The barium is moving through Sofey's stomach and small intestines. There was distension visible at the ileocecal junction[22] at the 2:52 AM and 4:15 AM radiographs, barium able to move through the ileocecal junction. The 6:15 AM radiogaph [*sic*] showed barium moving to colon. . . ." (Ex. 64, AGO 4239.) Although respondent described the movement of barium through Sofey's stomach, he did not document any evaluation of the barium series. That is, respondent did not document his findings from the barium series, such as whether the results were normal or abnormal, and whether or not a foreign body obstruction was present.

143. In the evening of October 14, 2018, Craig Maloney, D.V.M., a veterinarian at AVVC, took over the overnight shift. Dr. Maloney performed an examination of Sofey. He palpated Sofey and found "[m]oderately loose, gas- and fluid-filled loops of bowel" in her abdomen. (Ex. 64, AGO 4234.) He also noted, "Pet received a barium series overnight. The barium fully passed to the colon with no obstruction." (*Ibid*.) Dr. Maloney diagnosed Sofey with "[g]astroenteritis, pancreatitis", but not foreign body obstruction. (*Ibid*.)

144. On October 15, 2018, Dr. Mejia performed an examination of Sofey. (Ex. 64, AGO 4234.) Her October 15, 2018 SOAP note indicates that Sofey's abdomen was

[22] The ileocecal junction is a segment of the intestines.

"Soft; non-painful; no obvious masses or organomegaly[23] palpated." (*Ibid.*) Follow-up blood tests were administered to Sofie, and the results were normal. Sofie was discharged the same afternoon. In a discharge summary, respondent wrote, "Recommended O to feed P a bland diet for next 7-10 days. . . . " (*Id.* at AGO 4252.)

145. The only notation reflecting communication between respondent and Sofey's owner, M.H., regarding the results of the barium series is a whiteboard note entered at 9 a.m. on October 14, 2018, by a veterinarian assistant, which reads, "[Respondent] feel[s] like the barium [*sic*] will move with help from barium and ad [a/d, a prescription dog food] that wont [*sic*] be offered until after 5pm today due to the pancreatitis O [Owner] understood." (Ex. 64, AGO 4239.) Respondent admitted during his testimony at the hearing that based on the barium series, he saw a foreign body obstruction at the ileocecal junction. According to respondent, he believed the barium helped the foreign body obstruction to move out of Sofey's stomach, and he communicated this belief to M.H., which is documented by the October 14, 2018 whiteboard note. Respondent reported that he released Sofey to her owner while the foreign body obstruction was still in her body because he felt comfortable Sofey would pass it out because he saw it had moved to her colon in the radiographs. Respondent's admissions on this issue are deemed credible because they are against his self-interest.

146. On October 26, 2018, Sofey was seen by another veterinarian at Palmdale Veterinary Hospital because she had vomited several times. (Ex. 63, AGO 4234.) Sofey suffered another bout of pancreatitis, as a SNAP cPL showed abnormal results. (*Ibid.*)

[23] Organomegaly is the abnormal enlargement of organs.

Sofey recovered after being treated with antibiotics, anti-nausea medication, and a bland diet. (*Ibid.*)

Dr. Parvin's Opinions

147. Dr. Parvin opined that respondent's treatment of Sofey is below the standard of care, based on the following acts:

A. Respondent's failure to correctly update his client, M.H., regarding the results of the barium study is below the standard of care. Dr. Parvin opined that respondent misdiagnosed Sofey with a foreign body obstruction and told M.H. that the barium would help move the obstruction out of Sofey's stomach when there was no actual obstruction.

B. Respondent's failure to recommend permanent dietary changes for Sofey, after she had a bout of gastroenteritis and diagnosis of pancreatitis, is below the standard of care. Dr. Parvin opined that respondent's discharge instruction for Sofey to have a bland diet for seven to ten days was insufficient to avoid another bout of pancreatitis. She explained that pancreatic enzymes are secreted in response to dietary fat, and such increases in pancreatic enzymes worsen pancreatitis. For a young dog such as Sofey, the standard of care is to recommend a bland, low-fat diet for a longer period than seven to ten days, possibly for a lifetime.

Respondent's Testimony

148. As described above, respondent admitted that he diagnosed Sofey with a foreign body obstruction based on the barium series and that he communicated this diagnosis to M.H. (See *ante*, Factual Finding 145.) This diagnosis, however, was incorrect, as there was no actual foreign body obstruction.

149. Respondent testified that he did not recommend a permanent dietary change because he believed that the most likely cause of Sofey's pancreatitis was foreign body obstruction. Respondent also stated that a recommendation for permanent dietary change was unnecessary given that Sofey was stable after her initial treatment.

Dr. Schulman's Testimony

150. After much questioning, Dr. Schulman conceded at the hearing that the radiographs from Sofey's barium series did not show any foreign body obstruction.

151. However, Dr. Schulman opined that for an emergency care case, it was within the standard of care to recommend dietary changes on a short-term basis. According to Dr. Schulman, because Sofey did not have a prior history of pancreatitis, long-term dietary changes should be determined by Sofey's regular veterinarian, after more diagnostic testing and follow-up care. Dr. Parvin did not dispute this opinion in her rebuttal testimony. Given that Sofey presented at AVVC for approximately two days for emergency care, Dr. Schulman's opinion on this issue is reasonable and accorded significant weight.

Summary Findings re Sofey

152. Therefore, it was established that respondent's failure to correctly update his client, M.H., regarding the results of the barium study is below the standard of care. However, it was not established that respondent's failure to recommend permanent dietary changes for Sofey is below the standard of care.

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153. Based on Sofey's medical records, it was also established that respondent failed to include an evaluation of the barium series performed on Sofey in the medical records.

PIERRE, THE FRENCH BULLDOG

Treatment at AVVC

154. On October 30, 2018, E.L., took Pierre, her French Bulldog, to AVVC for emergency care because he was attacked by another dog. (Ex. 66, AGO 4271.) Respondent examined Pierre. (Ex. 67, AGO 4305.) He noted that Pierre was "laterally recumbent and in critical condition." (*Ibid.*) Respondent diagnosed Pierre with bite wounds and soft tissue trauma. (*Ibid.*) Of Pierre's respiratory status, respondent wrote, "Normal sounds in all fields; eupneic.[24]" (*Ibid.*) Pierre was hospitalized and treated with pain medication, injectable antibiotics, rapid action steroids, and placed on oxygen therapy for 12 hours. (*Ibid.*) Although some of the treatments were appropriate for Pierre's condition, there is no explanation in the medical records for administering oxygen therapy to Pierre, since his respiratory status was normal. Nevertheless, E.L. was charged for the treatment. Moreover, the oxygen flow rate of the oxygen therapy administered to Pierre is not documented in the medical records.

155. Pierre also underwent blood tests on October 30, 2018. (Ex. 67, AGO 4303-4304.) The automated results of a blood chemistry test showed multiple irregularities including highly elevated total bilirubin and protein values. (*Id.* at AGO 4303.) Those results were erroneous because the sodium and potassium levels were blank, and the calcium and chloride levels were so low that they were inconsistent with

[24] Eupneic means normal, unlabored breathing.

life. (*Id.* at AGO 4303.) There is no indication in the medical records that respondent evaluated the blood test results or suspected any error. Nor is there any indication that respondent attempted to recheck the blood test results.

156. The following day, when Pierre's care was transferred to Dr. Hall, she noticed the discrepancies and rechecked the blood test results before performing surgery to suture Pierre's wounds. (Ex. 67, AGO 4296.) Pierre was released to his owner on October 31, 2018, after his surgery.

Dr. Parvin's Opinions

157. Dr. Parvin opined that respondent's administration of oxygen to Pierre is below the standard of care. Dr. Parvin noted that there is no evidence in the medical records that Pierre was in respiratory distress. During respondent's initial examination, Pierre's respiratory status was assessed as normal. In addition, throughout the extensive whiteboard notes written by veterinarian assistants, there is no reference to Pierre experiencing respiratory problems, nor are there any notations regarding respiratory monitoring of Pierre, as would be typical for a patient receiving oxygen therapy. Dr. Parvin conceded during cross-examination that Pierre is a brachycephalic breed.[25] However, she maintained that not all injured brachycephalic breeds require oxygen therapy, which is only appropriate when a patient is in distress. Dr. Parvin concluded that administering oxygen therapy to Pierre and charging the client for a treatment that was not indicated by physical assessment is below the standard of care.

[25] Brachycephalic breeds are breeds of dogs or cats prone to difficult, obstructive breathing due to their anatomy.

Respondent's Testimony

158. Respondent asserted that he administered oxygen therapy to Pierre because he is a brachycephalic breed. Respondent claimed that the oxygen therapy was intended to prevent Pierre from hyperventilating and "make it safer for the animal" (his words). Although respondent reported that he recognized Pierre's blood test results to be erroneous, he admitted he did not document his evaluation of the test results. Respondent stated that a notation in the medical records showing that oxygen therapy was administered to Pierre at "30.9 %" was the oxygen flow rate. This explanation is not credible because flow rates are expressed as the volume of fluid passing over a unit of time.

Dr. Schulman's Opinions

159. Dr. Schulman initially opined it was a reasonable and prudent exercise of a veterinarian's judgment to administer oxygen therapy to Pierre because he is a brachycephalic breed and because it was not harmful to Pierre. However, during cross-examination, Dr. Schulman admitted that it is not within the standard of care to administer oxygen therapy to all brachycephalic breeds without a medical indication. Dr. Schulman later stated that the administration of oxygen therapy to Pierre was not "actively unnecessary" (his words).

Summary Findings re Pierre

160. Dr. Schulman's testimony in Pierre's case is contradictory and labored, whereas Dr. Parvin's opinions are reasonable and consistent with the evidence in the case. Therefore, Dr. Parvin's opinions are accorded greater weight, and her findings concerning Pierre's case are deemed as established by the record.

161. Based on Pierre's medical records, it was also established that respondent failed to evaluate the erroneous blood test conducted on Pierre on October 30, 2018, and that he failed to include information regarding the oxygen flow rate administered to Pierre.

HUNNY, THE GERMAN SHEPHERD/HUSKY MIX

Treatment at AVVC

162. On or about November 7, 2018, at approximately 5:44 p.m., A.R. took Hunny, her two-year-old German Shepherd/Husky mix, to AVVC because she was drooling excessively, lethargic, and not eating. (Ex. 69, AGO 4331.) Hunny was also drinking an excessive amount of water and having bloody diarrhea. (Ex. 70, AGO 4346.) After she arrived at AVVC, Hunny had several bouts of diarrhea in the lobby. (*Ibid.*)

163. Respondent performed a physical examination and conducted blood tests. The results of the blood tests showed that Hunny suffered from dehydration and elevated blood glucose. (Ex. 70, AGO 4344.) Respondent diagnosed Hunny with diabetes, pancreatitis, and hemorrhagic gastroenteritis and gave her a "poor/grave" prognosis. (*Id.* at AGO 4346.) Although respondent included urinalysis as a part of Hunny's treatment, he did not perform the test to rule out ketoacidosis, a serious diabetic complication where the body produces excess ketones. (*Ibid.*)

164. At approximately 7:30 p.m., Jessica Sims, a veterinary assistant at AVVC, presented A.R. with an estimate of $2,900 for 24 hours of treatment, which consisted of a glucose curve,[26] IV fluids, and IV medications. (Ex. 70, AGO 4347.) A.R. declined the

[26] A glucose curve is a study to identify the effectiveness of insulin.

treatment plan because she did not have money to pay for it. (*Id.* at AGO 4347.) After A.R.'s refusal, respondent spoke to her about Hunny's diagnoses and blood test results. Respondent left A.R. briefly and returned to discuss different ways to lower the treatment costs for Hunny. Eventually, respondent offered a 12-hour treatment plan for $1,600. A.R. had difficulty paying for this treatment plan as well. She asked her mother and two sisters for financial assistance, but they were unable to come up with the $1,600. After asking around, A.R. was able to borrow the money from a family friend at approximately 9:00 p.m. A.R. had two further conversations with respondent on the night of November 7, 2018, to let respondent know that she had paid for the 12-hour treatment and to ask whether or not she could stay with Hunny. However, at no point did respondent tell A.R. that even the most intensive treatment would only be the first step of costly ongoing treatment and diagnostics, which A.R. could not afford. Nor did respondent communicate to A.R. the gravity of Hunny's condition.

165. At approximately 9:00 p.m., Hunny began IV fluid therapy at the rate of 90 ml per hour, which is the maintenance rate for a dog of Hunny's size. (Ex. 70, AGO 4346.) This maintenance rate was not adequate to address Hunny's dehydration and ongoing fluid losses from diarrhea.

166. At 12:38 a.m. on November 18, 2018, Hunny's temperature spiked up to 106.2 degrees. (Ex. 70, AGO 4340.) Approximately 45 minutes later, Hunny suffered cardiac arrest. (*Ibid.*) At 1:20 a.m., an entry in the medical records reads, "P [Hunny] became agonal[27] during hospital stay. Proceed to intubate, placed on O2, and performed chest compressions. Administered Epinephrine (1 mg/ml): 3 mls given IV, Atropine (0.54 mg/ml) : 3.0 ml given IV and Doxapram (20 mg/ml): 3.0 ml given IV. CPR

[27] Agonal breathing is gasping for air.

was unsuccessful and P passed away. . . ." (*Ibid.*) This entry in the medical records bears only the initials "A.L.," for Alexandra Lopez, RVT, and there is no indication that a veterinarian directed or supervised Hunny's treatment at this time. (*Ibid.*)

Dr. Parvin's Opinions

167. Dr. Parvin opined that respondent's treatment of Hunny is below the standard of care, based on the following acts:

A. Respondent's failure to administer appropriate fluid therapy for Hunny is below the standard of care. Dr. Parvin explained that the standard of care for fluid therapy for dehydrated dogs with ongoing fluid losses, such as Hunny, is not only to provide for maintenance needs but also to correct for fluid deficit and address ongoing losses from diarrhea. Dr. Parvin estimated that Hunny was dehydrated by eight to nine percent of her body weight based on the several bouts of diarrhea she suffered at home and in the lobby at AVVC. She was administered IV fluids at 90 ml per hour, the maintenance rate, which did not address Hunny's dehydration and ongoing fluid losses. According to Dr. Parvin, the appropriate fluid rate for Hunny in her debilitated state should have been 199 to 226 ml per hour. Thus, Hunny was administered less than half of the low end of the appropriate fluid rate range.

B. Respondent's failure to perform a urinalysis on animal patient Hunny is below the standard of care. In Dr. Parvin's opinion, an extremely important part of the diagnostic protocol when a dog presents in a severe diabetic condition is to perform a urinalysis to rule out ketoacidosis. Additionally, appropriate treatment for a sick diabetic animal varies depending on ketonuria (ketones in the urine). Although respondent included a urinalysis in Hunny's treatment plan, there is no indication in the medical records that it was ever performed.

168. Dr. Parvin also opined that respondent's failure to communicate to A.R. the expensive long-term treatment Hunny would require for her diabetes constitutes treating the patient without establishing a VCPR. Dr. Parvin asserted that part of the VCPR requires the veterinarian to communicate with the client a course of treatment appropriate to the circumstances. In this case, the circumstances involving Hunny were grave, and 12 hours of even the most intensive treatment would only be the first step of costly ongoing treatment and diagnostics. According to Dr. Parvin, there would be no point in pursuing the 12-hour treatment for Hunny if A.R. could not afford costly long-term treatments. However, respondent did not communicate this information to A.R. before treating Hunny. Therefore, respondent treated Hunny without first establishing a VCPR.

169. Dr. Parvin further opined that when Hunny became agonal at 1:20 a.m. on November 18, 2018, a veterinarian did not direct or supervise her treatment. Dr. Parvin stated that the procedures performed on Hunny, such as intubation, chest compressions, and the administration of various drugs must be directed by a veterinarian. However, the entry only bears the initials of Ms. Lopez, who is an RVT. Furthermore, the note does not include documentation of cardiac auscultation or any evaluation of cardiopulmonary status, as would be the standard of care for a veterinarian. Thus, nothing in the medical record indicates respondent's involvement in Hunny's treatment during this time.

Respondent's Testimony

170. At the hearing, respondent claimed that he only had one direct conversation with A.R., who, according to respondent, spoke only Spanish. After this single conversation, respondent asserted that his bilingual assistants relayed all communications between himself and A.R. and he cannot be certain that the bilingual

assistants relayed his advice to A.R. accurately. This testimony was refuted by A.R., who appeared at the hearing and spoke in fluent English. In fact, A.R. does not speak any Spanish and speaks only English. Furthermore, A.R. credibly testified that she had four separate conversations with respondent on the night of November 18, 2018. However, respondent did not, at any point, discuss with her the expenses of long-term treatment for Hunny, nor did he communicate to A.R. Hunny's precarious condition.

171. Respondent initially claimed that he had taken a urine sample from Hunny for urinalysis. However, because he had to send the sample to an outside laboratory for the test and Hunny passed away within four hours of her treatment at AVVC, there was not enough time to conduct the urinalysis. When questioned further about the urine sample that he purportedly took from Hunny, respondent could not be sure whether it was stored in the refrigerator. Respondent later changed his testimony and stated he could not be sure if the urine sample was ever collected. He asserted that he gave directions to the veterinarian assistant to collect the urine sample, but he was unable to identify any whiteboard note containing these supposed directions. Respondent claimed the IV fluid therapy administered to Hunny was adequate, but he did not provide any explanation or support for this claim. Respondent testified he directed Ms. Lopez to administer drugs and CPR on Hunny when she became agonal, but this testimony too was uncorroborated by documentary or testimonial evidence.

172. Overall, respondent's testimony regarding his treatment of Hunny is full of prevarications and contradictions and therefore deemed not credible.

Dr. Schulman's Opinions

173. Dr. Schulman opined that for IV fluid therapy, it is up the discretion of the veterinarian to determine the starting fluid rate. However, Dr. Schulman explained that if the veterinarian starts at the maintenance rate, the IV fluids must be quickly ramped up to what he called the "restorative rate," which is the fluid rate to restore fluid losses suffered by the patient. When questioned further, Dr. Schulman conceded that given Hunny's debilitated condition, the administration of the restorative rate or even a bolus of fluid was warranted.

174. Additionally, Dr. Schulman testified that it is within the standard of care for respondent to use an outside laboratory to perform a urinalysis and for respondent to advise A.R. of a short-term plan for Hunny without recommending a long-term plan. These opinions are given little weight, as they do not address the issues presented in this case. First, the issue is not whether the performance of a urinalysis at an outside laboratory is within the standard of care. Hunny's case is distinguishable from that of Mickey, who was not hospitalized at AVVC, and the standard of care for performing a diagnostic test (in Mickey's case, a reticulocyte count) is in dispute. (See *ante*, Factual Findings 17 to 27.) Hunny was hospitalized at AVVC for what was intended to be a 12-hour treatment. In addition, neither Dr. Schulman nor respondent disputed that the standard of care is to perform a urinalysis, regardless of whether it is done in-house or at an outside laboratory. Respondent included the urinalysis as a part of his treatment plan, a tacit acknowledgment of the standard of care required of him. However, even assuming respondent was going to have an outside laboratory conduct the urinalysis, there is no evidence that he collected a urine sample from Hunny for the test.

175. Second, the issue is not the standard of care for advising a long-term treatment plan for a patient to be discharged after receipt of emergency services, as it

was in Sofey's case. (See *ante*, Factual Findings 140 to 152.) The issue here is whether respondent established a VCPR by failing to advise A.R., before she decided to embark on the 12-hour treatment for Hunny, about the long-term expense of diabetic treatments, given Hunny's poor prognosis. In this case, the extent and the expense of long-term treatments for Hunny directly impacted A.R.'s decision to pursue the short-term treatment, especially because A.R. had difficulty paying for even the 12-hour treatment. Respondent should have communicated this information to A.R. as a part of a course of treatment appropriate to the circumstances, and respondent's failure to do so constitutes a failure to establish the VCPR.

Summary Findings re Hunny

176. Therefore, Dr. Parvin's opinions regarding respondent's treatment of Hunny are accorded significant weight, and her findings are deemed as established by the record.

CLAY AKA CLAYZIE, THE CAT

Treatment at AVVC

177. On November 18, 2018, S.M. took Clay also known as Clayzie, her 11-year-old cat, to AVVC because he was unable to urinate. (Ex. 72, AGO 4369.) Dr. Abalos conducted a physical examination. (Ex. 75, AGO 4537-4538.) She found Clay was essentially normal, except for a tense painful abdomen and a full bladder; she suspected urinary obstruction. (*Id.* at AGO 4537.) Clay underwent blood tests, which showed mild elevations in ALT (a liver enzyme), BUN (Blood Urea Nitrogen, a kidney function test), and blood glucose level. (*Id.* at AGO 4535-4536.) Clay was anesthetized for placement of a urinary catheter and treated with antibiotics, pain medication, and Prazosin, a medication to minimize urethral spasm. (*Id.* at AGO 4538.)

178. The next day, on November 19, 2018, at a time not noted in the medical records, another veterinarian, Dr. Mejia, evaluated Clay and did not find any abnormalities. (Ex. 72, AGO 4526.) S.M. asked to take Clay home. (*Id.* at AGO 4527.) Shortly before S.M. was to pick up Clay, Dr. Mejia palpated Clay's bladder and found it to be full and painful. (*Ibid.*) When S.M. came to pick up Clay at 5 p.m., Dr. Mejia explained to S.M. that Clay was obstructed again and recommended surgery. (*Ibid.*) As of November 19, 2018, no radiographs had been taken of Clay at AVVC.

179. After Clay's release from AVVC at 6:38 p.m., S.M. took Clay to Sears Veterinary Hospital (Sears) where she consulted Dr. Sandeep Cheema for a second opinion. (Ex. 73, AGO 4465.) On examination, Dr. Cheema palpated a moderately enlarged, painful bladder, but the medical records from Sears (Sears medical records) do not reflect any diagnostic testing performed on Clay. (*Ibid.*) In a SOAP note describing this visit, Dr. Cheema wrote under "Plan":

> Gave O [S.M.] option of going to specialty clinic O.D.
>
> [¶] ...[¶]
>
> Discussed with O tha[t] P [Clay] will need overnight supervision and since we are closing soon will need to transfer the P to emergency clinic for supervision.
>
> O elects to take the P to AVVC for further diagnostics/treatment. . . .

(*Id.* at AGO 4466.)

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180. In another entry bearing the time stamp of 7:13 p.m., Dr. Cheema wrote,

> I called AVVC and personally spoke to [respondent] and informed him that we are referring "Clayzie" back to him for further diagnostics and care. Informed [respondent] P's status and that P seems to be blocked again and no diagnostics or treatment have been performed by us today. He said he will take over from here.

(Ex. 73, p. AGO 4466.)

181. A. According to an entry in AVVC's medical records, S.M. returned to AVVC with Clay at 8 p.m. This 8 p.m., November 19, 2018 note read:

> Owner returned after Sears Veterinary recommended that the surgery be performed here. rDVM [referring veterinarian, i.e. Dr. Cheema] spoke with [respondent] and said that he is also recommending a PU [perineal urethrostomy[28]] surgery to be performed based off of kidney and bladder stones present, he agreed that the surgery would better allow the removal of the granual [*sic*] sized uroliths [bladder stones].

(Ex. 75, AGO 4524.)

[28] Perineal ureterostomy is a surgical procedure performed to alleviate urethral obstruction in animals with complicated or recurrent urethral obstruction.

B. The authenticity of this medical entry is suspect for several reasons. To begin with, this entry, although dated November 19, 2018, is not listed chronologically among other entries of the same date, but inserted into other entries dated November 20, 2018. (*Ibid.*) This is the only November 19, 2018 entry that appears out of chronological order in AVVC's medical records for Clay. In addition, as of November 19, 2018, no radiographs had been taken of Clay at AVVC, so respondent could not have known that Clay had kidney and bladder stones. Dr. Cheema also specified in his note that during Clay's brief visit to Sears, he did not conduct any diagnostics, an assertion corroborated by the Sears medical records lacking documentation of any radiographs. Because no radiographs had been taken of Clay either at Sears or at AVVC, Dr. Cheema also could not have known about the presence of kidney and bladder stones at the time of his conversation with respondent on November 19, 2018. Therefore, Dr. Cheema could not have recommended a perineal urethrostomy due to the presence of kidney and bladder stones that were unknown to him.

182. At 10:15 p.m. on November 19, 2018, respondent administered general anesthesia to Clay in preparation for surgery, but there is no documentation that any physical examination of Clay was conducted 12 hours before this procedure. (Ex. 75, AGO 4528.) At 10:40 p.m., without conducting a physical examination or further diagnostic testing of Clay and without discussing other treatment options with Clay's owner, respondent performed a perineal urethrostomy. (*Id.* at AGO 4527-4528.)

183. Post-surgery, respondent administered to Clay Buprenex for pain management. (Ex. 75, AGO 4525.) The dosage was 0.3 ml injection of Buprenex at 0.15 mg/ml, equivalent to 0.045 mg of the medication every eight hours. (*Ibid.*) For a cat of

Clay's size (13.4 pounds), he received three-quarters of the lowest recommended dosage of Buprenex for pain control. (Ex. 76, AGO 4547.)

184. From November 19 to November 23, 2018, Clay remained hospitalized at AVVC. During this period of post-surgery recovery, there are numerous entries in the medical records stating that Clay showed no interest in food or refused to eat. (Ex. 75, AGO 4493-4526.) There is no indication that Clay ate at all during this period. On November 22, 2018, respondent wrote in a SOAP note, "If Clay is still drinking on his own discontinue IV fluids at midnight." (*Id.* at AGO 4498.) However, no entries indicate that Clay was drinking on his own before his IV fluid therapy was disconnected at 11:57 p.m. on November 22, 2018. (*Id.* at AGO 4496.)

185. On November 23, 2018, sometime after 11:00 a.m., Clay was discharged from AVVC. (Ex. 75, AGO 4491.) Although respondent had authorized Clay's discharge, he did not perform an evaluation of Clay before releasing him to go home. Between 2:30 and 3:00 p.m. later that day, S.M. called AVVC because Clay was breathing heavily about 20 minutes after he was taken home. (*Id.* at AGO 4488.) At 7:40 p.m., S.M. took Clay back to AVVC because he was not doing well. (*Id.* at AGO 4490.) Respondent examined Clay and found him laterally recumbent with dilated pupils and breathing with open mouth. (*Id.* at AGO 4490.) Ten minutes later, Clay became agonal and went into cardiac arrest. (*Ibid.*) He died after unsuccessful resuscitation efforts. (*Ibid.*)

186. At 9:27 p.m., after Clay died, respondent, for the first time, took radiographs of Clay. (Ex. 75, AGO 4540-4541.) Respondent documented his findings of these radiographs as follows: "pulmonary congestion, kidney stones, bladder stones, liver WNL [within normal limits], spleen WNL, stomach WNL, musculoskeletal WNL." (*Id.* at AGO 4489.) However, the two whole-body radiographs taken of Clay by

respondent also showed obvious pleural effusion, which respondent did not identify in his radiographic findings.

187. Respondent, nevertheless, wrote in the medical records: "Suspect saddle thrombus as cause of death and discussed this with O." (Ex. 75, AGO 4490.) Saddle thrombus is caused by a blood clot from the heart that lodges in the aorta cutting off blood supply to the animal's back legs. Respondent also noted in the medical records that Clay was unable to walk and his hind limbs were paralyzed after he returned to AVVC on November 23, 2018. (*Ibid.*)

188. On November 24, 2018, Larry Bosma, D.V.M., of North Valley Veterinary Clinic (North Valley) performed a necropsy of Clay, which revealed that Clay's heart was normal but his chest cavity was filled with fluid. (Ex. 74, AGO 4480.) The left lung appeared abnormal with a splotchy blackish pattern. (*Ibid.*) On November 30, 2018, Dr. Blake,[29] another veterinarian at North Valley informed S.M. of the results of the necropsy. When asked about saddle thrombus as a possible cause of death, Dr. Blake stated that it could not be ruled out because Clay's heart tissue was not sent to an outside laboratory as part of the necropsy. (*Id.* at AGO 4481.)

Dr. Parvin's Opinions

189. Dr. Parvin opined that respondent's treatment of Clay is deceptive or below the standard of care, based on the following acts:

A. Respondent's November 19, 2018 entry, claiming Dr. Cheema referred Clay to respondent for perineal urethrostomy due to the presence of bladder

[29] Dr. Blake's first name was not established by the record.

and kidney stones, is deceiving. Dr. Parvin pointed out that there is no mention of kidney and bladder stones and no mention of recommending a perineal urethrostomy in Clay's medical records from Sears. Significantly, it is impossible for Dr. Cheema and respondent to have known about Clay's kidney and bladder stones on November 19, 2018, because no radiographs were taken as of that date, and the only radiographs showing the presence of kidney and bladder stones in Clay were taken post-mortem, on November 23, 2018.

B. Respondent's failure to examine Clay and discuss treatment options regarding lower urinary tract disease with his owner is below the standard of care. When S.M. brought Clay back to AVVC after her consult with Dr. Cheema on November 19, 2018, the only documentation in AVVC's medical records is the major surgery report for the perineal urethrostomy. There is no documentation of a physical examination by respondent pre-surgery or any client communication between respondent and S.M. regarding Clay's clinical condition. According to Dr. Parvin, surgery in this case was not an absolute necessity on November 19, 2018, because no radiograph had been taken and the presence of kidney and bladder stones was unknown. Hospitalization with re-catheterization for two to three days with appropriate treatment was an acceptable option, which respondent did not discuss with S.M., and the failure to do so is below the standard of care.

C. Respondent's proceeding immediately to surgery without a medical evaluation of Clay and further diagnostics testing is below the standard of care. Dr. Parvin testified that Dr. Cheema had recommended Clay to undergo further diagnostic testing and overnight supervision. Respondent, however, did not perform a physical examination of Clay and did not perform any further diagnostic testing, such

as radiographs and additional blood tests. Instead, respondent immediately proceeded with the surgery.

D. Respondent's discharge of Clay on November 23, 2018, in a severely debilitating condition, is below the standard of care. AVVC's medical records show that by November 23, 2018, Clay had not eaten for at least five days, and there is no indication Clay was drinking water before he was taken off fluid therapy on November 22, 2018. Additionally, Clay developed respiratory distress about 20 minutes after he was sent home. Furthermore, Clay's post-mortem radiographs show pleural effusion. These factors in totality support Dr. Parvin's opinion that Clay was in an extremely debilitating condition when he was released from AVVC.

E. Respondent's failure to evaluate Clay before his discharge on November 23, 2018, is below the standard of care. Although respondent authorized Clay's discharge, there is no documentation of an evaluation by respondent before Clay's release from medical care.

F. Respondent's failure to provide appropriate pain control for Clay throughout his hospitalization following his surgery is below the standard of care. In Dr. Parvin's opinion, perineal urethrostomy in male cats is a very invasive and painful surgery involving incising the penis and urethra, opening the penile/pelvic urethra, and amputation of the distal penis. Pain control is extremely important for the patient during this procedure. According to AVVC's medical records, Buprenex at a dose of 0.3 ml (at 0.15mg/ml), equivalent to 0.045 mg, was administered to Clay every eight hours throughout his hospitalization. For a cat of Clay's size (13.4 pounds), the appropriate dosage should be 0.06 mg to 0.18 mg every six to eight hours. Given that perineal urethrostomy is known to be an extremely painful procedure, the upper end of the

dosage range was needed to control pain in Clay's case. However, Clay received only 0.045 mg, or three-quarters of the lowest recommended dosage, every eight hours.

G. Respondent's failure to adequately evaluate the radiographs taken of Clay on November 23, 2018, is below the standard of care. Two whole body radiographs were taken of Clay postmortem on November 23, 2018. Respondent found pulmonary congestion, kidney stones, and bladder stones on the radiographs, but he failed to find the obvious pleural effusion present in Clay's lungs. This radiographic change is important, especially in a patient with respiratory distress, but was not recognized by respondent. The gross necropsy performed by Dr. Bosma confirmed the presence of pleural effusion.

190. Dr. Parvin also opined that respondent performed surgery on Clay on November 19, 2019, without establishing a VCPR because he did not examine Clay and communicate with his owner before surgery. Dr. Parvin testified that knowledge about an animal patient through an examination, and communication with the owner regarding treatment appropriate for the circumstances, is necessary to form a VCPR. In this case, there is no documentation of a pre-surgery examination or any communication with S.M. by respondent. Furthermore, Dr. Parvin stated that Clay was not examined by a veterinarian within 12 hours of undergoing general anesthesia at 10:15 p.m. on November 19, 2018. Respondent did not perform any pre-surgery examination of Clay. Although Dr. Mejia performed an examination sometime in the morning of November 19, 2018, the time of that examination is not documented in the medical records. Therefore, it cannot be concluded that Clay was examined by a veterinarian within 12 hours before anesthesia.

Respondent's Testimony

191. At the hearing, respondent asserted that the November 19, 2018 entry, claiming Dr. Cheema referred Clay to respondent for perineal urethrostomy due to the presence of bladder and kidney stones, is accurate. Respondent insisted that he proceeded with Clay's surgery based on Dr. Cheema's recommendation and referral. Respondent reported that Dr. Cheema took an ultrasound of Clay, found bladder and kidney stones in the ultrasound, and discussed the issue with respondent during their conversation on November 19, 2018. This testimony is not credible and it is contradicted by Clay's medical records from Sears, which do not show that an ultrasound, or any other diagnostic testing, was performed by Dr. Cheema.

192. When questioned about whether he performed a pre-surgery examination of Clay, respondent was unable to located any documentation of such an examination in AVVC's medical records. Respondent testified that he did not recommend medical treatment options for Clay because surgery is the main option for urinary obstruction if dietary changes do not work. Yet, respondent was not able to show any documentation that he communicated this recommendation to Clay's owner in AVVC's medical records. Respondent claimed that the amount of Buprenex administered to Clay was adequate for pain control because he personally monitored Clay for external signs of pain, but he could not point to any documentation of such monitoring in AVVC's medical records. Respondent claimed that Clay was in an appropriate condition for release on November 23, 2018, because he simply lacked appetite, but he did not address indications in AVVC's medical records that Clay had not eaten for at least five days and the lack of notation regarding Clay's water intake before the termination of IV fluid therapy. Respondent asserted that he took radiographs of Clay postmortem and the purpose was to discover the cause of Clay's

death and therefore an evaluation was not warranted. However, he did not dispute Dr. Parvin's radiographic finding of pleural effusion.

Dr. Schulman's Opinions

193. Dr. Schulman opined that when a veterinarian takes over a shift from another veterinarian, the standard of care is for the incoming treating veterinarian to become familiar with the treatment provided by the prior veterinarian, conduct an examination of the animal personally, communicate with the client or owner personally, and make notations of the patient's progress and condition. In Clay's case, when he returned to AVVC, respondent should have assessed Clay to determine if surgery could proceed and whether surgery was recommended at all. The standard of care is to obtain the patient's prior history and results of diagnostic testing, and to discuss with the owner Clay's diagnosis, prognosis, treatment plan, and the pros and cons of perineal urethrostomy, before proceeding with surgery. Dr. Schulman conceded that based on his review of AVVC's medical records, a VCPR was not established between respondent, Clay, and S.M.

194. Dr. Schulman opined that the necropsy report is not a complete and total examination of Clay because it was performed by Dr. Bosma, who is a general practitioner and not a specialist. However, Dr. Schulman did not dispute the necropsy report's finding of pleural effusion in Clay's lungs. Dr. Schulman also opined that the perineal urethrostomy was appropriate in Clay's case and that it was not "unsafe" (his term) for Clay to proceed with surgery.

Summary Findings re Clay

195. Dr. Schulman did not proffer any other opinion in Clay's case. His testimony failed to refute, and only confirmed, Dr. Parvin's opinions. Therefore, Dr.

Parvin's opinions regarding respondent's treatment of Clay are accorded significant weight, and her findings are deemed as established by the record.

196. Based on Clay's medical records and Drs. Parvin and Schulman's creditable opinions, it was also established that (1) respondent did not document the results of a physical examination for Clay within 12 hours of administering general anesthesia, and (2) respondent performed surgery on Clay without establishing a VCPR.

Premises Inspections

AVVC Premises Inspection

197. On March 1, 2017, Keri Franco, D.V.M., conducted a premises inspection of AVVC. Dr. Franco received her bachelor of science degree from Occidental College, and she obtained her doctorate in veterinary medicine from UC Davis in 2005. Dr. Franco is currently employed at the Veterinary Care Center in Hollywood, California. She has worked as a hospital inspector for the Board for six years and conducts 40 to 45 hospital inspections every year.

198. During her inspection of AVVC, Dr. Franco found that several radiographs submitted by respondent failed to show consistent collimation, including a radiograph that was labeled as a spinal study but showed the entire body as well as a large excess of space around it. (Ex. 12, AGO 371, 377-378.) Collimation is the practice of restricting the size of the X-ray beam to a specific region of interest on the patient. Some of the radiographs also fail to identify the name of the hospital or the veterinarian's name. (Ex. 11, AGO 343.) When Dr. Franco asked the hospital manager, Amy McFarland, for documentation showing that the unlicensed staff members who assist with radiographs have safety training, Ms. McFarland was unable to locate the records

because they were purportedly stored at either All Creatures or Canyon Country. (Ex. 12, AGO 371.)

199. Dr. Franco also noticed that an ultrasound and an endoscopy unit, which are not items related to surgery, were stored in the sterile surgery room. She took photographs of the surgery room that contained the ultrasound and endoscopy machines. (Ex. 12, AGO 374-375.)

ALL CREATURES PREMISES INSPECTION

200. On March 1, 2017, Rhett Chandler, RVT, conducted an inspection of All Creatures. Ms. Chandler has been licensed in California as an RVT since 2009. She has been a hospital inspector with the Board for six years.

201. During her inspection of All Creatures, Ms. Chandler found that empty boxes and an ultrasound machine were stored in a closet in the sterile surgery room. She also found that an X-ray machine's registration with the California Department of Public Health (CDPH) had expired in 2014. (Ex. 15, 2230-2231.) Furthermore, she observed that X-ray gowns and gloves were worn and torn. (*Id.* at 2232-2233.) At the end of her inspection, Ms. Chandler provided an inspection report to All Creatures' business manager, Lillian Camacho, and requested that All Creatures provide proof of correction of these violations to the Board by April 1, 2017. However, All Creatures did not provide to the Board proof of (1) current X-ray machine registration with CDPH, (2) purchase of new x-ray gown and gloves, or (3) removal of the non-surgical equipment from the surgery room closet.

202. Ms. Chandler also obtained All Creatures' controlled substances dispensation logs for the past three years, which she forwarded to Board expert, James Patrick Howard, D.V.M., for his review.

CANYON COUNTRY PREMISES INSPECTION

203. On March 7, 2017, Dr. Franco conducted a premises inspection of Canyon Country. Among other violations, she found surgical instrument pouches that expired on September 15, 2016. (Ex. 9, AGO 173.)

204. During her inspection, Dr. Franco also obtained Canyon Country's controlled substances dispensation logs for the past three years, which she forwarded to Dr. Howard for his review.

DR. HOWARD'S OPINIONS

205. At the hearing, Dr. Howard testified as complainant's expert witness on the premises inspections. Dr. Howard obtained his bachelor of science degree from Central Missouri State University in 1979 and his doctorate in veterinary medicine from the University of Missouri in 1983. He has been a licensed veterinarian in California since 2007, and he has been a subject matter expert in hospital and facility inspections for the Board for three years.

206. At the hearing, Dr. Howard opined that collimation is an important safety measure for X-ray technicians and patients because collimation limits radiation exposure. According to Dr. Howard, most of the radiographs he reviewed from AVVC were not properly collimated, except for one radiograph for a patient named Cooper. (Ex. 11, AGO 343.)

207. A. Dr. Howard also reviewed the controlled substances dispensation logs from All Creatures and Canyon Country. He found that these controlled substance logs did not include information required by Code of Federal Regulations, title 21, section 1304.22, subdivision (c), such as the date of dispensing, the number of units or

volume dispensed, the name of the prescriber, and the name or initials of the individual who dispensed or administered the medication.

B. For controlled substances dispensation logs from Canyon Country, three entries in a dispensation log for Diazepam 5 mg/ml (Bottle #2) lacked the signature of the veterinarian who authorized the medication, and one entry lacked the signature of the prescribing doctor. (Ex. 10, AGO 227.) In another dispensation log for Euthansol (Bottle #19), the drug was indicated as a Schedule IV controlled substance when it is a Schedule III controlled substance. (*Id.* at AGO 252.) In the same log, six entries lacked information about the initial amount of the drug in the bottle, the amount used, the balance on hand, and the signature of the prescribing doctor. (*Ibid.*)

C. The controlled substances dispensation logs from All Creatures contained similar deficiencies. For example, an entry in a Phenobarbital 16.2 mg (Bottle #1) log lacked information about the amount used, the balance on hand, and the signature of the prescribing doctor. (Ex. 16, AGO 2253.) Several entries in a diazepam 5mg/ml (Bottle #95) log only documented the month and date of the dispensation, with no information on the year when the drug was dispensed. (*Id.* at AGO 2289.) Two entries in another diazepam 5mg/ml (Bottle #73) log lacked the identification number for the patient to whom the drug was dispensed. (*Id.* at AGO 2310.) In addition, the logs from All Creatures showed discrepancies reflecting significant amounts of unaccounted-for controlled substances. For example, a log for Tramadol 50 mg showed that the initial amount was 395 tablets and 10 tablets were used, but the balance on hand was recorded as 0. Thus, 385 tablets of Tramadol were unaccounted for. (*Id.* at AGO 2844.) Anther log showed a similar discrepancy where 247 tablets of tramadol were unaccounted for. (*Id.* at AGO 2856.) The logs from All Creatures showed

numerous other instances of unexplained drug loss, which, in Dr. Howard's opinion, occurred as a result of poor recordkeeping, or diversion, or a combination of both.

RESPONDENT'S TESTIMONY

208. At the hearing, respondent admitted that some of the radiographs taken at AVVC lacked collimation because the "technicians are in a hurry" (his words). Respondent also conceded radiographs from AVVC did not include the name of the veterinarian or of the hospital. However, respondent has reprogrammed the X-ray machines to automatically generate the name of the veterinarian and the hospital on the radiographs.

209. Respondent stated that All Creature's X-ray machines were always registered with the CDPH, but he did not post the current registration. Respondent has purchased new X-ray gowns and gloves for All Creatures since the March 2017 inspection.

210. Respondent admitted that he stored non-surgery-related items, such as the ultrasound and the endoscopy units in the surgery room, but AVVC and All Creatures now have special rooms dedicated to storing ultrasound and CT scan machines. Respondent averred that these facilities no longer store inappropriate items in the surgery room or the surgery room closet.

211. Respondent asserted that the controlled substances dispensation logs from All Creatures and Canyon Country were compliant with federal regulations, but a few logs may be "missing some entries" (his words). Respondent testified that AVVC now uses the Cubixx system, an automated medication dispensing machine, that will provide a more accurate drug log. Respondent plans to install the Cubixx system at All Creatures, although he does not anticipate Canyon Country will need a similar system.

TESTIMONY OF WENDY HAND AND AMY MCFARLAND

212. Wendy Hand, RVT, who worked at All Creatures from July 16 to October 1, 2020, testified regarding the conditions she observed at All Creatures. Ms. Hand served as a relief RVT at All Creatures for 24 day shifts from 8:00 a.m. to 4:00 p.m. Ms. Hand reported she saw a CDPH registration on the X-ray machine at All Creatures, but it lacked an expiration date. She testified that X-ray gowns at All Creatures were in disrepair, and X-ray gloves were not available for use, such that she used bare hands for taking radiographs. Ms. Hand also saw an endoscopy unit stored in a closet in the surgery suite.

213. Ms. Hand's testimony was refuted by Amy McFarland, Regional Manager for AVVC, All Creatures, and Canyon Country. Ms. McFarland conceded that non-surgery-related items may have been stored in the surgery room closet while All Creatures remodeled the nurses' stations, but all such items have since been cleared out of the closet. Ms. McFarland testified that All Creatures purchased three sets of X-ray gowns and gloves in 2017. She submitted photographs of the X-ray gowns and gloves currently in use at All Creatures. (Ex. C, p. 2-5.) She also submitted photographs showing the X-ray machine's registration with CDPH is current through April 30, 2022. (Ex. C, p. 1.) Because Ms. McFarland's testimony is corroborated by these photographs, her testimony is credited over that of Ms. Hand.

The Petition to Revoke Probation

RESPONDENT'S PRIOR DISCIPLINE

214. On May 4, 2015, the Board filed an Accusation (2015 Accusation) in Case No. AV 2015 22 (OAH Case No. 2015070157) against respondent. On February 18, 2016, respondent entered into a Stipulated Settlement and Disciplinary Order

(Stipulation) with the Board. On April 29, 2016, the Board adopted the Stipulation as its Decision and Order, effective May 29, 2016.

215. The Decision and Order revoked respondent's veterinary license and his premises registrations[30] for AVVC, All Creatures, and Canyon Country; stayed the revocation; and placed the license and registrations on three years' probation on certain terms and conditions.

216. The Decision and Order recited respondent's admission that the charges and allegations in the 2015 Accusation, if proven at a hearing, would constitute cause for discipline against his veterinary and premises registrations; that the Board could establish a factual basis for the charges; that respondent waives his right to contest those charges; and that his veterinary and premises registrations are subject to discipline. The 2015 Accusation alleged three causes for discipline: (1) negligence (in violation of section 4883, subdivision (i), in conjunction with California Code of Regulations, title 16, section 2032); (2) recordkeeping violations (in violation of section 4883, subdivision (o), in conjunction with California Code of Regulations, title 16, section 2032.3); and (3) anesthesia violations unprofessional conduct (in violation of section 4883, subdivision (o), in conjunction with California Code of Regulations, title 16, section 2032.4 subdivisions (b)(1) and (b)(2)).

[30] Although the 2015 Accusation was filed against respondent's veterinary license only, section 4853.6, subdivision (b), provides that the Board may impose discipline against the premises registrations when the managing licensee's veterinary license has been disciplined.

217. A. These three causes for discipline were based on respondent's treatment of a dog named Betty, who injured her left hind leg in a fight with another dog on August 24, 2013. (Ex. 5, AGO 139.) Radiographs taken of Betty revealed that Betty had sustained multiple fractures of the metatarsals (small bones) and dislocations in the tarsal-metatarsal joints in her left rear leg and foot. (*Ibid.*) On August 25, 2013, respondent performed surgery on Betty to repair the injuries. (*Ibid.*)

B. The first cause for discipline on the grounds of negligence was based on the following acts:

- Respondent failed to adequately repair Betty's fractured bones by surgery;
- Respondent failed to adequately fuse Betty's tarsal-metatarsal joints;
- Respondent failed to adequately interpret Betty's pre-operative radiographs and failed to recognize that she had multiple joint dislocations and fractures;
- Respondent failed to adequately monitor Betty post-surgery; and
- Post-operative radiographs taken of Betty were inadequate to assess the extent of her injuries and the effectiveness of the surgery.

(Ex. 5, AGO 140-141.)

C. The second cause for discipline on the grounds of recordkeeping violations was based on the following acts:

- Respondent failed to document treatment information and failed to adequately record the strength, dose, and frequency of all medications administered to Betty; and

- Respondent failed to properly document the surgical procedure.

(Ex. 5, AGO 141-142.)

D. The third cause for discipline on the grounds of anesthesia violation was based on respondent's failure to perform, or failed to cause to be performed, a physical exam of Betty within 12 hours of anesthesia. Respondent also failed to adequately observe Betty, or failed to cause Betty to be adequately observed, following general anesthesia. (*Id.* at AGO 142.)

RESPONDENT'S BOARD PROBATION

218. Condition 1 of the Decision and Order states:

> Respondent shall obey all federal and state laws and regulations substantially related to the practice of veterinary medicine. Further, within thirty (30) days of any arrest or conviction. Respondent shall report to the Board and provide proof of compliance with the terms and conditions of the court order including, but not limited to, probation and restitution requirements.

(Ex. 5, AGO 126.)

219. Condition 2 of the Decision and Order states:

> Respondent shall report quarterly to the Board or its designee, under penalty of perjury, on forms provided by the Board, stating whether there has been compliance with all terms and conditions of probation. In addition, the Board at its discretion may request additional in-person reports of the probationary terms and conditions. If the final written quarterly report is not made as directed, the period of probation shall be extended until such time as the final report is received by the Board. Respondent shall make available all patient records, hospital records, books, logs, and other documents to the Board, upon request.

(Ex. 5, AGO 126.)

220. Respondent failed to timely submit the following quarterly reports:

- Quarter 4 of 2016, due January 5, 2017, submitted 47 days late on March 21, 2017;
- Quarter 2 of 2017, due July 5, 2017, no report was submitted for this quarter;
- Quarter 3 of 2017, due October 5, 2017, submitted 28 days late on November 2, 2017;
- Quarter 4 of 2017, due January 5, 2018, submitted 21 days late on January 22, 2018;
- Quarter 2 of 2018, due July 5, 2018, submitted 21 days late on July 16, 2018;

- Quarter 3 of 2018, due October 5, 2018, submitted 18 days late on October 23, 2018; and

- Quarter 2 of 2019, due July 5, 2019, no report was submitted for this quarter.

221. Condition 14 of the Decision and Order states:

> Within sixty (60) days of the effective date of this decision, and on an annual basis thereafter, Respondent shall submit to the Board for its prior approval, an educational program or courses, as follows, for no less than the designated hours, for each year of probation: Orthopedic Surgery (5 hours) and Record Keeping (5 hours). Respondent shall provide proof of completion to the Board. This program shall be in addition to the Continuing Education required of all licensees. All costs shall be borne by Respondent.

(Ex. 5, AGO 130.)

222. Although respondent submitted certificates for continuing education (CE) hours in orthopedic surgery amounting to over five hours for each year of probation, he submitted only one certificate of completion for 10 CE hours in medical recordkeeping in 2019. Respondent did not submit proof of completion of five CE hours in medical recordkeeping for the following years of his probation: 2016 to 2017; 2017 to 2018; and 2019 to 2020.

223. Condition 16 of the Decision and Order states:

> Within sixty (60) days of the effective date of this decision, Respondent shall submit a community service program to the Board for its prior approval. In this program Respondent shall provide free services on a regular basis to a community or charitable facility or agency for at least fifteen (15) hours for the first year of probation. All services shall be subject to prior Board approval.

(Ex. 5, AGO 131.)

224. Although respondent submitted proof of completion of community service, he submitted the proof on March 1, 2018, ten months after the deadline set forth by the Board.

RESPONDENT'S TESTIMONY

225. Respondent blamed his business manager for the late submission of the quarterly reports and claimed a lack of any personal knowledge of quarterly reports that were submitted late. Respondent testified he failed to submit the quarterly reports and the proof of CE hours in 2019 due to a mistaken belief that his probation had terminated in May 2019. Respondent asserted that the Board did not inform him that his Board probation was extended upon the filing of the Accusation in the present matter.

226. Respondent's claims are not credible. On February 16, 2018, the Board sent to respondent a probation violation letter informing him that his quarterly reports were late; that he had not submitted proof of completion of his community service hours; and that he had not submitted proof of completion of his five CE hours for recordkeeping for the years 2016 to 2017 and 2017 to 2018. (Ex. 84, AGO 4769-4770.)

Therefore, respondent was put on notice of his probation violations, and yet he continued to commit the same violations thereafter. In addition, respondent should also have been aware that his probation was extended upon a referral of this case to the Attorney General's office, as Condition 9 of the Decision and Order states, in relevant part:

> If an accusation or petition to revoke probation is filed against Respondent during probation, or if the Attorney General's office has been requested to prepare any disciplinary action against Respondent's license, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

(Ex. 5, AGO 128.)

Additional Evidence of Rehabilitation

227. Respondent asserted that his use of HLK provided effective pain control for Princess, Rosie, Enzo, and Pooh. However, respondent averred he understands the Board's concerns and he has changed his pain management protocol. Respondent now uses a constant infusion rate flow within the range recommended by online calculators such as the Veterinary Information Network.

228. Respondent conceded that some of the medical records are problematic and that there is room for improvement for his recordkeeping practices. Respondent previously used assistants as scribes for keeping medical records, and he admitted that he did not always check the entries for accuracy. He now uses Dragon, a speech recognition software, to input medical records by himself, but respondent did not

submit any sample medical records to show improvement in his record keeping practices. Respondent claimed he has implemented a new recordkeeping protocol for all veterinarians at the three facilities at issue, but he did not submit a written copy of such a protocol at the hearing. Respondent also conceded that AVVC, All Creatures, and Canyon Country's controlled substances dispensation logs need to show more accountability, but again, he did not submit any written protocol for the dispensation of control substances at the three facilities.

229. According to respondent, AVVC is the only 24-hour hospital in the Antelope Valley, and its closure would be devastating to the community. Respondent claimed to have provided generous discounts on his services to military personnel, senior citizens, firefighters, and teachers, totaling approximately $1.9 million from 2016 to the present. Respondent has also volunteered his services during the Bobcat Fires, rescuing and sheltering 350 large animals at a facility that he partly owns. Respondent believes he provides quality services to his clients and patients and his veterinary practice is not just a business, but a true passion.

Cost Recovery

230. Complainant submitted evidence of the costs of investigation and enforcement of this matter, summarized as follows: 298.5 hours of legal services at rates ranging from $120 to $220 per hour for a subtotal of $61,565; and investigative services for a subtotal of $34,570.01. The Costs Certification for the Board's investigative services did not include any information regarding the tasks performed, the time spent on each task, and the method of calculating the cost. (Ex. 3.) Respondent did not present any evidence regarding his ability to pay recovery costs.

LEGAL CONCLUSIONS

The Accusation

STANDARDS AND BURDEN OF PROOF

1. Respondent's veterinarian license is a professional license due to his fulfillment of extensive education, training, and testing requirements. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 857.) In an action seeking disciplinary action against a professional license, complainant bears the burden of establishing cause for discipline by clear and convincing evidence. (*Ibid.*) Clear and convincing evidence requires proof that is so clear as to leave no substantial doubt and that is sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.)

2. Respondent is associated as the licensee manager on the premises permits[31] of AVVC, All Creatures, and Canyon Country. Because only a licensed veterinarian may be named as the licensee manager on a facility's premises permit (§ 4853, subd. (c); Cal. Code Regs., tit. 16, § 2030.05, subd. (a).), the clear and convincing evidence standard also applies to disciplinary actions against respondent in his capacity as the three facilities' licensee manager.

[31] The terms "premises registration" and "premises permit," and "managing licensee and "licensee manager" are used interchangeably throughout the Act's statutes and regulations.

CAUSES FOR DISCIPLINE

Luna, The Young Terrier

3. First Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(13). Complainant established by clear and convincing evidence that respondent's medical records for Luna fail to include daily progress notes evaluating patient medical status throughout her hospitalization. (Factual Findings 10 to 16.)

4. Second Cause for Discipline (Failure to Comply with Regulations). The Second Cause for Discipline alleges that respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, for failure to document updates about Luna's medical status during her hospitalization. (Ex. 86, p. 11.) Complainant cites to the same statutes and regulation as alleged in the First Cause for Discipline and does not explain how daily progress notes are distinct from updates about Luna's medical status. Therefore, the Second Cause for Discipline is deemed duplicative of the First Cause for Discipline and is not addressed.

Mickey, The Elderly Terrier

5. Third Cause for Discipline (Negligence). Section 4883, subdivision (i), authorizes the Board to deny, revoke, or suspend a license or registration or assess a fine if the licensee is found to have engaged in fraud, deception, negligence, or incompetence in the practice of veterinary medicine. The terms "negligence," "incompetence," and "deception" are not specifically defined in the Act. Thus,

standards used in other similar cases or defined in legal treatises are used here by analogy. A professional is negligent if he fails to use or exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753.) Just what that standard of care is for a given professional is a question of fact. In most circumstances, expert witnesses must prove the standard unless the conduct required by the particular circumstances is common knowledge. (*Kelley v. Trunk* (1998) 66 Cal.App.4th 519, 523; see also *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001.) Harm need not be proven to establish negligence in a license disciplinary action. (*Shenouda v. Veterinary Medical Board* (2018) 27 Cal.App.5th 500, fn. 7.)

Cause does not exist to subject respondent's veterinarian license to disciplinary action under section 4883, subdivisions (i), and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant did not establish by clear and convincing evidence that respondent committed negligence by failing to perform a reticulocyte count to determine the nature of Mickey's anemia. (Factual Findings 17 to 27.)

6. Fourth Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(6), (a)(10), and (a)(11). Complainant established by clear and convincing evidence that respondent's medical records for Mickey fail to include the following information:

- An evaluation of Mickey's blood test results which showed severe anemia, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(6);

- An assessment of the possible causes of Mickey's diarrhea and anemia, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(10); and

- a prognosis for Mickey's condition in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(11). (Factual Findings 17 to 28.)

Princess, The Labrador Retriever

7. Fifth Cause for Discipline (Negligence or Incompetence). Incompetence is considered "a lack of knowledge or ability in the discharging of professional obligations. Often, incompetence results from a correctable fault or defect." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109 (*James*).) It indicates an absence of qualification, ability, or fitness to perform a prescribed duty or function. (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 838.) Incompetence is not synonymous with negligence. "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*) A "single, honest failing in performing" licensed duties does not constitute incompetency." (*Id.* at p. 839.) When treating a single patient, a finding of "a general lack of knowledge, ability and skill" can be supported where there are several acts or decisions by a licensee which are improper, suggesting more than "a single, honest failing in performing [his] duties." (*Kearl*, *supra,* 189 Cal.App.3d at pp. 1055-1056.) Additionally, flawed reasoning which led to

incorrect decisions may also demonstrate incompetence in the proper performance of duties more so than mere remissness in discharging known duties. (*Ibid.*)

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

- Respondent committed incompetence by administering an inadequate amount of pain control medication to Princess. Respondent's repeated administration of sub-therapeutic pain control medication to several animals (Princess, Rosie, Enzo, and Pooh) suggests more than a single, honest failing in performing his duties and demonstrates a lack of knowledge regarding the use of HLK constant rate infusion.

- Respondent committed negligence by failing to evaluate Princess during her hospitalization after surgery and before her release. (Factual Findings 29 to 33; 37 to 48.)

8. Sixth Cause for Discipline (Failure to Comply with Regulations).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that respondent violated the following regulations:

- California Code of Regulations, title 16, section 2032.1 (Veterinarian-Client-Patient Relationship): By requiring Princess to undergo diagnostic testing before conducting a physical examination, respondent treated Princess without first establishing a VCPR; and

- California Code of Regulations, title 16, section 2032.05 (Humane Treatment): Respondent failed to provide effective pain control for Princess before and after her surgery, thus failing to use appropriate and humane care to minimize his patient's pain and distress. (Factual Findings 29 to 33; 34 to 43; and 48.)

Rosie, The Chihuahua

9. Seventh Cause for Discipline (Negligence or Incompetence).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

- On May 7, 2016, respondent committed negligence by failing to provide appropriate initial medical treatment for Rosie before CT scan and surgery;
- On May 7, 2016, respondent committed negligence by failing to perform an initial neurological examination on Rosie;
- Respondent committed incompetence by performing spinal surgery on Rosie without considering known options regarding the prognosis for an L5-6 intervertebral disc rupture.
- Respondent committed incompetence by administering an inadequate HLK continuous rate infusion to Rosie before and after back surgery;
- Respondent committed negligence by failing to monitor his animal patient Rosie for neurological status and pain after performing a hemilaminectomy;

- Respondent committed negligence by failing to evaluate radiographs taken on Rosie after spinal surgery and to indicate why such post-surgery radiographs were needed;

- On or about May 13, 2016, respondent committed incompetence by failing to pursue the cause of Rosie's deterioration, instead of providing only symptomatic treatment; and

- On or about May 13, 2016, respondent committed incompetence by giving Rosie a whole blood transfusion, without medical indication that it was necessary. (Factual Findings 49 to 67.)

10. Eighth Cause for Discipline (Unprofessional Conduct). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (g). Complainant established by clear and convincing evidence that respondent committed unprofessional conduct, by performing a CT scan and back surgery on Rosie without conducting a neurological assessment and establishing a VCPR.[32] (Factual Findings 49; 58 to 59; and 67.)

11. Ninth Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(6) and (a)(10). Complainant established by clear and

[32] Under California Code of Regulations, title 16, section 2032.1, subdivision (a), treatment of a patient without establishing a VCPR with the patient and the client is unprofessional conduct, except where the patient is a wild animal or the owner is unknown.

convincing evidence that respondent's medical records for Rosie fail to include the following information:

- Daily updates, assessments regarding Rosie's pain level, her neurological status, and her deterioration throughout her eight-day hospitalization;
- Evaluation of the blood tests conducted on May 13, 2016, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(6);
- Evaluation of radiographs taken on May 8, 2016, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(6); and
- An assessment or indication for the May 13, 2016 administration of Epogen and blood transfusion, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(10). (Factual Findings 49 to 68.)

12. Tenth Cause for Discipline (Failure to Comply with Regulations).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that respondent violated the following regulations:

- California Code of Regulations, title 16, section 2032.3, subdivision (b) (Record Keeping): On May 24, 2016, after Rosie's death on May 14, 2016, respondent failed to provide Rosie's owner with a copy of her medical record containing the required information;
- California Code of Regulations, title 16, section 2032.05 (Humane Treatment): Respondent failed to provide effective pain control for Rosie after her surgery, thus failing to use appropriate and humane care to minimize his patient's pain and distress;

- California Code of Regulations, title 16, section 2032.1 (VCPR): Respondent did not conduct a neurological assessment of Rosie and he did not communicate her neurological status and prognosis with his client. Thus, respondent treated Rosie without establishing a VCPR. (Factual Findings 49 to 68.)

Mr. Chow, The Pug

13. Eleventh Cause for Discipline (Failure to Comply with Record Inspection Requirements). Respondent's veterinarian license is subject to disciplinary action under section 4856. Complainant established by clear and convincing evidence that respondent failed to provide Mr. Chow's medical records to the Board despite multiple requests. (Factual Findings 69 to 71.)

14. Twelfth Cause for Discipline (Failure to Ensure Compliance as Licensee Manager). Respondent, in his capacity as the licensee manager of AVVC, is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that respondent, as licensee manager of AVVC, failed to ensure compliance with the requirements of section 4856 regarding Board inspection of patient records. (Factual Findings 69 to 71.)

Sammy, The Bulldog

15. Thirteenth Cause for Discipline (Negligence). Cause does not exist to subject respondent's veterinarian license to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant did not establish by clear and convincing evidence that respondent committed negligence in his duties as a veterinarian in Sammy's case. Because Dr. Mejia, not a veterinarian assistant, provided care to Sammy, respondent did not order a veterinarian assistant to administer Urasyn to Sammy, and Dr. Mejia,

not a veterinarian assistant, determined the dosage of dexamethasone administered to Sammy. (Factual Findings 72 to 77.)

16. Fourteenth and Fifteenth Causes for Discipline. At the hearing, complainant deleted the Fourteenth and Fifteenth Causes of Discipline by interlineation. (Ex. 86, p. 20.)

17. Sixteenth Cause for Discipline (Aiding and Abetting Unlicensed Activity). Cause does not exist to subject respondent's veterinarian license to disciplinary action under section 4883, subdivision (j), for aiding or abetting unlicensed activity. Dr. Mejia, a licensed veterinarian, provided treatment to Sammy. (Factual Findings 72 to 77.)

Chelsea, The Chihuahua

18. Seventh Cause for Discipline (Negligence or Incompetence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

- Respondent committed negligence by releasing Chelsea to her owner without adequate evaluation to ensure she was stable for home care;
- On April 30, 2017, through May 2, 2017, respondent committed negligence by treating Chelsea with multiple injections of furosemide and dexamethasone, drugs not indicated for the treatment of pneumonia;

- Respondent committed incompetence by failing to diagnose the obvious pleural effusion presented in the radiographs (Radiographs #3 and #4) taken of Chelsea on May 2, 2017; and

- On May 3, 2017, when Chelsea returned to AVVC with labored breathing, respondent committed negligence by recommending Chelsea to continue with 48 hours of hospitalization, without first conducting an examination. (Factual Findings 78 to 88.)

19. Eighteenth Cause for Discipline (Failure to Maintain Records).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(1), (a)(5), (a)(6), and (a)(8). Complainant established by clear and convincing evidence that respondent's medical records for Chelsea fail to include the following information:

- The identity or the name of the staff member who performed Chelsea's initial physical examination, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(1);

- The date Chelsea was initially hospitalized and treated at AVVC, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(5);

- An evaluation of Chelsea's May 1, 2017 blood test results, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(6); and

- The drugs, drug dosages, and fluid therapy administered to Chelsea on May 1 and May 2, 2017, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(8). (Factual Findings 78 to 89.)

Enzo, The German Shepard

20. Nineteenth Cause for Discipline (Negligence or Incompetence).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

- Respondent committed incompetence by administering an HLK continuous rate infusion to Enzo at a rate far below the recommended therapeutic range;
- On July 1 and 2, 2017, respondent committed negligence by failing to alter Enzo's treatment protocol to address documented pain and inability to walk after surgery; and
- On July 2, 2017, respondent committed negligence by prescribing 50 mg of tramadol three times a day, less than half of the low end of the recommended dosage range. (Factual Findings 90 to 102.)

21. Twentieth Cause for Discipline (Failure to Maintain Records).

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6). Complainant established by clear and convincing evidence that respondent's medical records for Enzo fail to include an evaluation of Enzo's post-operative radiographs showing a complete luxation of the right hip joint. (Factual Findings 90 to 103.)

22. Twenty-First Cause for Discipline (Failure to Comply with Regulations). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05 (Humane Treatment). Complainant established by clear and convincing evidence that respondent failed to provide effective pain control for Enzo before and after his surgery, thus failing to use appropriate and humane care to minimize his patient's pain and distress. (Factual Findings 90 to 102.)

Pooh, The Beagle

23. Twenty-Second Cause for Discipline (Negligence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed negligence in his duties as a veterinarian, as follows:

- Respondent committed negligence by failing to include information about PRP preparation and administration in Pooh's medical records on August 13, 2017;

- Respondent committed negligence by failing to monitor Pooh's pain level and adjust his post-surgery analgesia throughout his hospitalization, from August 12, 2017, through August 16, 2017;

- Respondent committed negligence by failing to ensure Pooh was maintained on IV fluids for treatment of aspiration pneumonia for over two days; and

- Respondent committed negligence by administering to Pooh furosemide as treatment for aspiration pneumonia. (Factual Findings 104 to 118.)

24. Twenty-Third Cause for Discipline (Failure to Comply with Regulations). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05 (Humane Treatment). Complainant established by clear and convincing evidence that respondent failed to provide effective pain control for Pooh before and after his surgery, thus failing to use appropriate and humane care to minimize his patient's pain and distress. (Factual Findings 104 to 118.)

25. Twenty-Fourth Cause for Discipline (Failure to Comply with Regulations). The Twenty-Fourth Cause for Discipline alleges respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05, by failing to use appropriate and humane care to minimize pain and stress for Pooh, before, during, and after orthopedic surgery. This Cause for Discipline is duplicative of the Twenty-Third Cause for Discipline, and therefore, is not addressed.

Dean, The Cat

26. Twenty-Fifth Cause for Discipline (Negligence). At the hearing, respondent stipulated that Dean received below-standard care at All Creatures. Dean's treating veterinarians were Drs. Gardenfors, Shokar, and An, and respondent was not involved in Dean's care, although he is associated as the licensee manager of All Creatures. In his closing brief, respondent contends that California Code of Regulations, title 16, section 2030.05, sets forth the responsibilities of the licensee manager, which includes ensuring the premises' compliance with laws and regulations, maintaining an appropriate physical presence within the facility, and averting unlicensed practice on the premises. Respondent asserts: "There is nothing in the rule

suggesting responsibility for the poor performance of properly licensed practitioners." (Ex. D, p. 24.)

Complainant, on the other hand, contends that respondent, as the licensee manager of All Creatures, is responsible for Dean's below-standard care at the facility. Complainant reasons that All Creatures is an emergency 24-hour facility and therefore is held to a higher standard of care than that of a general veterinary practice. (Ex. 87, pp. 25-27.) Complainant notes that under California Code of Regulations, title 16, section 2030.05, subdivision (a), an emergency veterinary clinic is required to maintain a licensed veterinarian on the premises at all times during the posted hours of operation. (*Id.* at p. 27.) However, there is no evidence that All Creatures failed to have a licensed veterinarian on its premises. It is undisputed that Drs. Gardenfors, Shokar, and An are all licensed veterinarians. Complainant cites to little legal authority in support of her position that respondent should also be held responsible for the negligent or incompetent acts of those veterinarians in his practice.

As described above, respondent's role as the licensee manager of the three facilities at issue is akin to a professional license because only a licensed veterinarian may be associated on a premises permit as the licensee manager. (§ 4853, subd. (c), Cal. Code Regs., tit. 16, § 2030.05, subd. (a); see *ante* Legal Conclusion 2.) In *James, supra,* 172 Cal.App.3d at p. 1112, the court held that professional licenses are not subject to discipline for the acts of another in the same profession based on principles of vicarious liability or respondeat superior. Moreover, California Code of Regulations, title 16, section 2030.05, subdivision (e), specifies that "[e]ach licensed veterinarian shall be responsible for their individual violations of the Veterinary Medicine Practice Act, or any regulations adopted thereunder." This regulation codifies case law barring the application of vicarious liability in disciplinary actions against professional licenses.

In other words, the licensee manager is not responsible for the violations of the individual veterinarians in his practice.

For discipline against respondent in his capacity as the licensee manager of All Creatures, respondent may only be held accountable for insufficiencies in patient care resulting from his own acts or acts of which he had knowledge and ratified. (*James*, *supra*, 172 Cal.App.3d at p. 1111.) Here, respondent was not Dean's treating veterinarian, and there is no evidence that respondent knew, or should have known, that Drs. Gardenfors, Shokar, or An are negligent or incompetent practitioners.

Therefore, cause does not exist to subject respondent, in his capacity as the licensee manager of All Creatures, to disciplinary action under section 4883, subdivision (i). Complainant did not establish by clear and convincing evidence that respondent, as the licensee manager of All Creatures, is vicariously liable for the negligent or incompetent acts of Drs. Gardenfors, Shokar, or An in connection with Dean's treatment. (Factual Findings 119 to 125.)

27. Twenty-Sixth Cause for Discipline (Unprofessional Conduct). Complainant contends that the negligent acts of Drs. Gardenfors, Shokar, and An constitute unprofessional conduct, and therefore respondent is also vicariously liable for their unprofessional conduct as the licensee manager of All Creatures. In light of the analysis set forth above (*ante*, Legal Conclusion 26), cause does not exist to subject respondent, in his capacity as the licensee manager of All Creatures, to disciplinary action under section 4883, subdivision (g), for unprofessional conduct in connection with Dean's treatment. (Factual Findings 119 to 125.)

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Fiona, The Chihuahua Mix

28. Twenty-Seventh Cause for Discipline (Negligence or Incompetence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

- Respondent committed negligence by failing to expedite exploratory surgery for Fiona;[33]
- Respondent committed negligence by failing to immediately start an appropriate rate of IV fluids to stabilize Fiona on September 4, 2018;

[33] The Amended Accusation/Petition to Revoke Probation alleges that respondent's failure to expedite exploratory surgery resulted in Fiona's deterioration and eventual death. (Ex. 85, p. 32.) In light of Dr. Schulman's credible opinion that the delay in Fiona's surgery did not have a negative impact on Fiona's condition, it was not established by clear and convincing evidence that the delay in surgery was a contributing factor in Fiona's death. However, death or harm need not be proven to establish negligence in a license disciplinary action (*Shenouda v. Veterinary Medical Board*, *supra*, 27 Cal.App.5th at p. 514, fn. 7). Thus, respondent's failure to expedite surgery for Fiona, that is, his failure to balance Fiona's need for surgery given the seriousness of her condition against the concerns of hypothermia, constitutes negligence.

- Respondent committed negligence by improperly evaluating Fiona's radiographs, failing to recognize changes consistent with a herniated intestine loop; and

- Respondent committed incompetence by administering to Fiona IV fluids at an inadequate maintenance rate to support her while she was in shock. (Factual Findings 126 to 138.)

29. Twenty-Eighth Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(7) and (a)(11). Complainant established by clear and convincing evidence that respondent's medical records for Fiona fail to include the following information:

- A physical examination of Fiona after she was transferred to respondent's care on September 4, 2018, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(7); and

- A prognosis of Fiona after she was transferred to respondent's care on September 4, 2018, in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(11). (Factual Findings 126 to 139.)

Sofie aka Sofey, The Pit Bull

30. Twenty-Ninth Cause for Discipline (Negligence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed

negligence in his duties as a veterinarian by failing to correctly update his client regarding the results of the barium study performed on Sofey. However, complainant did not establish by clear and convincing evidence that respondent's failure to recommend permanent dietary changes for Sofey constitutes negligence. (Factual Findings 140 to 152.)

31. Thirtieth Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6). Complainant established by clear and convincing evidence that respondent's medical records for Sofey fail to include an evaluation of the barium series performed on Sofey. (Factual Findings 140 to 153.)

Pierre, The French Bulldog

32. Thirty-First Cause for Discipline (Negligence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed negligence in his duties as a veterinarian by administering oxygen therapy to Pierre and charging the client for the treatment, without indication that oxygen therapy was medically necessary. (Factual Findings 154 to 160.)

33. Thirty-Second Cause for Discipline (Failure to Maintain Records). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6). Complainant established by clear and convincing evidence that respondent's medical records for Pierre fail to

include (1) an evaluation of the erroneous blood test conducted on Pierre on October 30, 2018; and (2) the oxygen flow rate administered to Pierre. (Factual Findings 154 to 161.)

Hunny, The German Shepherd Mix

34. Thirty-Third Cause for Discipline (Negligence). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed negligence in his duties as a veterinarian, as follows:

- On November 7, 2018, respondent committed negligence by failing to institute appropriate fluid therapy for Hunny; and
- On November 7, 2018, respondent committed negligence by failing to perform a urinalysis on Hunny. (Factual Findings 162 to 176.)

35. Thirty-Fourth Cause for Discipline (Unprofessional Conduct). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (g). Complainant established by clear and convincing evidence that respondent committed unprofessional conduct by treating Hunny before communicating an appropriate course of treatment to the client and establishing a VCPR. (Factual Findings 162 to 176.)

36. Thirty-Fifth Cause for Discipline (Failure to Comply with Regulations). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that respondent violated the following regulations:

- On November 7, 2018, respondent failed to communicate to his client a course of treatment appropriate for Hunny's condition and prognosis, in violation of California Code of Regulations, title 16, section 2032.1 (VCPR); and

- On November 8, 2018, respondent failed to oversee Hunny's treatment during a hyperthermic crisis and subsequent cardiopulmonary arrest, in violation of California Code of Regulations, title 16, section 2035 (Duties of Supervising Veterinarian). (Factual Findings 162 to 176.)

37. Thirty-Sixth Cause for Discipline (Aiding and Abetting Unlicensed Activity). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (j). Complainant established by clear and convincing evidence that respondent aided or abetted unlicensed activities by allowing an RVT to direct treatment of Hunny on November 8, 2018. (Factual Findings 162 to 176.)

Clay aka Clayzie, The Cat

38. Thirty-Seventh Cause for Discipline (Deception, Negligence, or Incompetence). Deception is not defined in the case law. Black's Law Dictionary defines deception as "The act of deliberately causing someone to believe that something is true when the actor knows it to be false. A trick intended to make a person believe something untrue."

Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivisions (i) and (o), in conjunction with California Code of Regulations, title 16, section 2032. Complainant established by clear and convincing evidence that respondent committed deception, incompetence, or negligence in his duties as a veterinarian, as follows:

- Respondent committed deception, in that the November 19, 2018 entry in Clay's medical records from AVVC is false. The note is inserted, out of chronological order, into the medical records. The note also states that Dr. Cheema referred Clay to respondent for perineal urethrostomy due to the presence of bladder and kidney stones, when as of November 19, 2018, no radiographs had been taken of Clay, and thus the presence of bladder and kidney stones were unknown.

- Respondent committed negligence by failing to examine Clay and discuss treatment options regarding lower urinary tract disease.

- Respondent committed negligence by immediately performing surgery on Clay without further diagnostic testing.

- Respondent committed negligence on November 23, 2018, by releasing Clay to go home in a severely debilitating condition.

- Respondent committed negligence by failing to evaluate Clay before releasing him from medical care.

- Respondent committed negligence by failing to provide appropriate pain control for Clay, throughout his hospitalization and treatment following perineal urethrostomy surgery.

- Respondent committed negligence on November 23, 2018, by failing to adequately evaluate Clay's radiographs showing pleural effusion. (Factual Findings 177 to 195.)

39. Thirty-Eighth Cause for Discipline (Unprofessional Conduct).

Respondent's veterinarian license is subject to disciplinary action under section 4883,

subdivision (g). Complainant established by clear and convincing evidence that respondent committed unprofessional conduct, by performing surgery on Clay without establishing a VCPR. (Factual Findings 177 to 196.)

40. Thirty-Ninth Cause for Discipline (Failure to Comply with Regulations). Respondent's veterinarian license is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that respondent violated the following regulations:

- Respondent failed to document the results of a physical examination of Clay within 12 hours before administering general anesthesia, in violation of California Code of Regulations, title 16, section 2032.4, subdivision (b)(1) (Anesthesia); and

- On November 19, 2018, respondent failed to examine Clay and communicate with S.M. about Clay's condition, thus failing to establish a VCPR, in violation of California Code of Regulations, title 16, section 2032.1 (VCPR). (Factual Findings 177 to 196.)

Premises Inspections

41. Fortieth Cause for Discipline (Failure to Maintain Records). Respondent, in his capacity as the licensee manager of AVVC, is subject to disciplinary action under section 4883, subdivision (o), in conjunction with California Code of Regulations, title 16, section 2032.3, subdivision (c)(2). Complainant established by clear and convincing evidence that the radiographs submitted by respondent in connection with the Board's March 1, 2017 inspection of AVVC fail to document the name of the veterinarian or veterinary hospital on the image. (Factual Findings 197 to 198.)

42. Forty-First Cause for Discipline (Failure to Maintain Records).

Respondent, in his capacity as the licensee manager of AVVC, All Creatures, and Canyon, is subject to disciplinary action under section 4883, subdivision (o). Complainant established by clear and convincing evidence that the three facilities violated the following regulations pertaining to minimum standards for fixed veterinary premises:

AVVC

- Radiographs submitted by AVVC fail to verify consistent physical collimation, in violation of California Code of Regulations, title 16, section 2030, subdivision (f)(4); and

- AVVC stored ultrasound and endoscopy units (non-surgery related items) in the sterile surgery room, in violation of California Code of Regulations, title 16, section 2030, subdivision (g)(2).

All Creatures

- All Creatures failed to provide proof of (1) current X-ray machine registration with the CDPH (in violation of California Code of Regulations, title 17, section 30255, subdivision (b)(2)), and (2) the purchase of new x-ray gowns and gloves (in violation of California Code of Regulations, title 16, section 2030, subdivision (f)(4));

- All Creatures stored boxes and an ultrasound machine in a closet in the sterile surgery room, in violation of California Code of Regulations, title 16, section 2030, subdivision (g)(2); and

- All Creatures' controlled substances dispensation logs fail to include the information required by federal regulation, in violation of California Code of Regulations, title 16, section 2030, subdivision (f)(6), and Code of Federal Regulations, title 21, section 1304.22, subdivision (c).

Canyon Country

- Canyon Country's surgical instrument pouches were expired, in violation of California Code of Regulations, title 16, sections 2030, subdivision (g)(10); and

- Canyon Country's controlled substances dispensation logs fail to include the information required by federal regulation, in violation of California Code of Regulations, title 16, section 2030, subdivision (f)(6), and Code of Federal Regulations, title 21, section 1304.22, subdivision (c). (Factual Findings 197 to 211.)

The Petition to Revoke Probation

STANDARD AND BURDEN OF PROOF

43. While a licensing board is required to prove the allegations in an accusation by clear and convincing evidence, a licensing board is only required to prove the allegations in a petition to revoke probation by a preponderance of the evidence. (*Sandarg v. Dental Bd. of California* (2010) 184 Cal.App.4th 1434, 144.) Preponderance of the evidence means "the evidence on one side outweighs, preponderates over, is more than, the evidence on the other side." (*Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 325.)

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CAUSES TO REVOKE PROBATION

44. First Cause to Revoke Probation. Respondent's probation is subject to revocation for failure to comply with Condition 1 of the Decision and Order. Complainant established by a preponderance of the evidence that respondent did not obey all laws. (Factual Findings 10 to 211; Legal Conclusions 3 to 42.)

45. Second Cause to Revoke Probation. Respondent's probation is subject to revocation for failure to comply with Condition 2 of the Decision and Order. Complainant established by a preponderance of the evidence that respondent did not submit some quarterly reports and other quarterly reports were submitted late. (Factual Findings 219 to 220; 225 to 226.)

46. Third Cause to Revoke Probation. At the hearing, complainant deleted the Third Cause to Revoke Probation by interlineation. (Ex. 86, p. 47.)

47. Fourth Cause to Revoke Probation. Respondent's probation is subject to revocation for failure to comply with Condition 16 of the Decision and Order. Complainant established by a preponderance of the evidence that respondent did not submit proof of community service until 10 months after the deadline. (Factual Findings 223 to 226.)

48. Fifth Cause to Revoke Probation. Respondent's probation is subject to revocation for failure to comply with Condition 14 of the Decision and Order. Complainant established by a preponderance of the evidence that respondent did not submit proof of completion of five CE hours in recordkeeping for each year of his probation. (Factual Findings 221 to 222; 225 to 226.)

Disposition

49. Protection of the public is the Board's highest priority in exercising its disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public is paramount. (§ 4800.1.)

50. A. The Board has established minimum and maximum penalties for disciplinary violations in the Veterinary Board Disciplinary Guidelines (July 2012) (Guidelines).

B. Under the Guidelines, the maximum penalty for deception, negligence, incompetence, general unprofessional conduct, or violations of Board regulations under section 4883 is revocation and a $5,000 fine; the minimum penalty is a stayed revocation and suspension, a two- or three-year probation, and standard terms and conditions. Maximum penalties should be considered if the acts or omissions caused or threatened harm to animals, the licensee demonstrated limited or no efforts at rehabilitation, if there are prior actions or multiple offenses, no mitigating circumstances, or if there were no attempts to remedy the violations. Minimum penalties are to be considered if the acts did not cause or threaten harm to the animals, remedial action was taken to correct the deficiencies, there is self-initiated rehabilitation, including community service and training, the licensee has fully complied with laws since the date of the violation, and there is remorse for the negligent acts. (Guidelines, pp. 3, 8, 10-11, 16.)

C. For failure to keep written records in violation of section 4855, the Guidelines recommend a maximum penalty of revocation and a $5,000 fine and a minimum penalty of a two-year probation with standard terms and conditions; factors to be considered are whether there is a lack of records or omissions that constitute

negligence or whether the omissions are due to carelessness and corrective measures have been implemented. (*Id.* at p. 17.)

D. For failure to permit the inspection of records by the Board in violation of section 4856, the Guidelines recommend a maximum penalty of revocation and a $5,000 fine and a minimum penalty of a two-year probation with standard terms and conditions; factors to be considered are whether there is a deliberate attempt to prevent access to the Board, prior discipline of the managing licensee or the premises, or whether there is mitigating circumstances at the time of the refusal. (*Ibid.*)

51. A. Based on the Guidelines, the appropriate penalty here is revocation.

B. First, respondent's offenses are numerous and serious. Complainant established 32 causes for discipline and four causes to revoke probation against respondent's veterinarian license or premises registration, with many causes involving several separate violations. As a sample of respondent's misconduct established by the record, in 13 out of the 15 cases involving animal patients, respondent initiated treatments on patients without first establishing a VCPR; administered inadequate pain control medication to patients during their hospitalization; administered treatments to patients that were not medically indicated; failed to monitor and evaluate patients after surgery; failed to recognize significant radiographic changes; failed to initiate or maintain appropriate IV fluid therapy for critical patients; and discharged patients in an unstable condition.

C. Second, respondent's repeated acts of negligence, incompetence, unprofessional conduct, and violations of Board regulations caused actual harm to his patients. For example, due to respondent's incompetence, Princess, Rosie, Enzo, and

Pooh, underwent painful surgical procedures without adequate pain management. Fiona and Hunny did not receive the appropriate IV fluid therapy given their critical condition. Chelsea and Clay went home debilitated because respondent did not recognize the pleural effusion in their radiographs. Additionally, respondent's failure to comply with Board regulations with respect to the premises also threatens harm to patients and the public. For example, a lack of collimation and damaged X-ray apparel expose patients and technicians to excess radiation; nonsterile conditions in surgical rooms risk contamination; and controlled substances logs with large discrepancies potentially indicate diversion.

D. Third, respondent's medical records contain omissions and deficiencies so numerous and varied that respondent's recordkeeping practices amount to negligence. Deficiencies existed in the medical records of nine patients (Luna, Mickey, Rosie, Chelsea, Enzo, Fiona, Sofey, Pierre, and Clay), and included omissions of daily progress notes, prognoses, diagnoses, evaluations of blood tests and radiographs, drug dosages, fluid therapy rates, and physical examinations within 12 hours before anesthesia.

E. Fourth, it can only be concluded that respondent's refusal to provide Mr. Chow's medical records is a deliberate attempt to preclude the Board from obtaining access to those records, considering the Board made three separate requests over the course of five months to obtain those records, and by respondent's own admission, he has made no efforts to ascertain their whereabouts.

F. Fifth, respondent was previously disciplined for similar acts of negligence (failure to properly evaluate radiographs and to adequately monitor patient post-surgery); recordkeeping deficiencies (failure to document drug dosages); and anesthesia violations (failure to conduct an examination within 12 hours before

anesthesia) in the case involving Betty (Case No. AV 2015 22). Yet, respondent continued to commit the same violations in his care of numerous animal patients, as demonstrated in this matter.

G. Sixth, respondent displayed a flagrant disregard for the Board's oversight by failing to comply with his probation. Respondent did not submit quarterly reports, did not submit proof of completion of community service until 10 months after the deadline, and did not obey all laws, as required by the terms of his Board probation. Of particular concern is that respondent's probation was based in part on recordkeeping violations, but he failed to complete the required CE hours for recordkeeping for three years of his probation.

H. Seventh, respondent expressed little remorse for his actions. He admitted little wrongdoing; shifted blamed to others, including his staff members, for his own actions; and was steadfast in his belief that administering one-tenth of the low end of the recommended range of HLK to his patients is adequate for pain relief and constitutes humane treatment.

I. Eighth, respondent offered little evidence of rehabilitation. Respondent has not taken any educational courses in pain management and radiography to fill in the gaps in his knowledge. Although respondent testified to implement new protocols in recordkeeping, he did not submit any such written protocol. Nor did he submit any evidence showing improved accounting of controlled substances at All Creatures and Canyon Country. While respondent submitted photographs showing current registration of X-ray machines with the CDPH and new X-ray apparel, he did not submit any sample radiographs showing proper collimation. Respondent also did not submit any reference letters attesting to his character.

J. Ninth, in aggravation, respondent exhibited a blatant level of dishonesty by submitting a deceptive entry in Clay's medical records to the Board. Moreover, at the hearing, respondent was less than candid in his testimony. For example, to conceal his failure to communicate with A.R. regarding Hunny's condition, respondent claimed A.R. only spoke Spanish and blamed any miscommunication on his assistants who purportedly interpreted on his behalf. However, A.R. appeared at the hearing as a fluent English speaker and credibly testified that she directly spoke to respondent in English four times but respondent failed to communicate to her the expensive long-term treatment Hunny would require. In other instances, respondent claimed that other veterinarians (Dr. Shokar in Enzo's case, and Dr. Ghara in Pooh's case) were responsible for the negligent treatment of animal patients, when the medical records, as well as respondent's own admissions, contradict these assertions.

52. In light of the multiple, serious violations established in this case, respondent's disregard for Board oversight and propensity for dishonesty, and the insufficiency of the rehabilitation evidence, respondent cannot be relied upon to comply with reasonable terms or conditions that would be imposed if he were allowed to operate under a probationary license. As a result, protection of the public health, safety, and welfare requires the revocation of respondent's veterinarian license and premises registrations for AVVC, All Creatures, and Canyon Country.[34] Pursuant to section 4875, and in accordance with the Guidelines, a fine of $5,000 shall be assessed against respondent in addition to the revocation of the license and premises registrations.

[34] Section 4853.6, subdivision (b), also mandates the revocation of the premises registration when the licensee manager's veterinarian license has been revoked.

Cost Recovery

53. As set forth in Factual Finding 230, the Board seeks costs of $34,570.01 in investigative costs. The Costs Certification fails to provide sufficient information to support a finding of the reasonableness of such costs. California Code of Regulations, title 1, section 1042 requires that for costs sought for the services of a regular agency employee, the certification shall describe the general tasks performed, the time spent on each task, and the method of calculating the cost. For costs sought for non-agency employees, the certification shall be executed by the person providing the service and include a general description of the task performed, the time spent on each task, and the hourly rate of the provider. No such information was provided by complainant. Accordingly, complainant's request for reimbursement of $34,570.01 is disallowed.

54. However, given the scope of this matter, complainant's cost of $61,565 for legal services is reasonable, and respondent did not present any evidence of his inability to pay. Therefore, pursuant to section 125.3, respondent shall be ordered to pay $61,565 in costs to the Board as a condition of reinstatement.

ORDER

The Accusation

1. Veterinarian License Number VET 13678, issued to respondent Balpal S. Sandhu, is revoked.

2. Premises Registration Number HSP 6663, issued to AV Veterinary Center, Balpal S. Sandhu, is revoked.

3. Premises Registration Number HSP 6152, issued to All Creatures Veterinary Center, Balpal S. Sandhu, is revoked.

4. Premises Registration Number HSP 5668, issued to Canyon Country Veterinary Hospital, Balpal S. Sandhu, is revoked.

The Petition to Revoke Probation

5. The probation, granted by the Veterinary Medical Board in Case Number AV 2015 22, is revoked. The revocation of Veterinarian License Number VET 13678 issued to respondent Balpal S. Sandhu, previously stayed, is imposed.

6. The probation, granted by the Veterinary Medical Board in Case Number AV 2015 22, is revoked. The revocation of Premises Registration Number HSP 6663 issued to AV Veterinary Center, Balpal S. Sandhu, previously stayed, is imposed.

7. The probation, granted by the Veterinary Medical Board in Case Number AV 2015 22, is revoked. The revocation of Premises Registration Number HSP 6152 issued to All Creatures Veterinary Center, Balpal S. Sandhu, previously stayed, is imposed.

8. The probation, granted by the Veterinary Medical Board in Case Number AV 2015 22, is revoked. The revocation of Premises Registration Number HSP 5668 issued to Canyon Country Veterinary Hospital, Balpal S. Sandhu, previously stayed, is imposed.

Fines and Recovery Costs

9. Respondents Balpal S. Sandhu; AV Veterinary Center, Balpal S. Sandhu; All Creatures Veterinary Center, Balpal S. Sandhu; and Canyon Country Veterinary

Hospital, Balpal S. Sandhu shall pay to the Board a fine in the amount of $5,000, pursuant to Business and Professions Code sections 4875 and 4883. Respondents shall make said payment within 30 days of the effective date of this Decision.

10. Respondents Balpal S. Sandhu; AV Veterinary Center, Balpal S. Sandhu; All Creatures Veterinary Center, Balpal S. Sandhu; and Canyon Country Veterinary Hospital, Balpal S. Sandhu shall pay $61,565 in costs to the Veterinary Medical Board as a condition of reinstatement.

DATE: Apr 12, 2021

Ji-Lan Zang

JI-LAN ZANG
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General
NANCY A. KAISER
Deputy Attorney General
State Bar No. 192083
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6320
Facsimile: (213) 897-2804
Attorneys for Complainant

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: **BALPAL S. SANDHU, DVM** 1055 W. Columbia Way, Ste. 103 Lancaster, CA 93534 **Veterinarian License No. VET 13678,** **AV VETERINARY CENTER, BALPAL S. SANDHU, DVM, Managing Licensee** 1055 W. Columbia Way, Ste. 103 Lancaster, CA 93534 **Premises Registration No. HSP 6663,** **ALL CREATURES VETERINARY CENTER, BALPAL S. SANDHU, DVM, Managing Licensee** 1055 W. Columbia Way, Ste. 103 Lancaster, CA 93534 **Premises Registration No. HSP 6152,** and **CANYON COUNTRY VETERINARY HOSPITAL, BALPAL S. SANDHU, DVM, Managing Licensee** 1055 W. Columbia Way, Ste. 103 Lancaster, CA 93534 **Premises Registration No. HSP 5668** Respondents.	Case No. 4602016000085 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. Jessica Sieferman (Complainant) brings this Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Officer of the Veterinary Medical Board, Department of Consumer Affairs.

2. On or about June 14, 1999, the Veterinary Medical Board issued Veterinarian License Number VET 13678 to Balpal S. Sandhu, DVM (Respondent). The Veterinarian License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2021, unless renewed.

3. Respondent has been associated as the managing licensee of AV Veterinary Center, Premises Registration No. HSP 6663 since November 6, 2009. AV Veterinary Center (AVVC) is located in Lancaster, California. Said registration is current and will expire on May 31, 2020, unless renewed. Respondent has been associated as managing licensee of All Creatures Veterinary Center, Premises Registration No. HSP 6152 since May 14, 2012. All Creatures Veterinary Center (ACVC) is located in Lancaster, California. Said registration is current and will expire on May 31, 2020, unless renewed. Respondent has been associated as the managing licensee of Canyon Country Veterinary Hospital, Premises Registration No. HSP 5668 since April 15, 2012. Canyon Country Veterinary Hospital (CCVH) is located in Lancaster, California. Said registration is current and will expire on May 31, 2020, unless renewed.

4. In a disciplinary action entitled "*In the Matter of the Accusation against Balpal S. Sandhu*," Case No. AV 2015 22, the Veterinary Medical Board issued a Decision and Order, effective May 29, 2016, in which Veterinary License No. VET 13678, Premises Registration No. HSP 5668, Premises Registration No. HSP 6152, and Premises Registration No. HSP 6663 issued to Respondent Balpal S. Sandhu, DVM, were revoked. However, the revocations were stayed and Respondent's Veterinarian License and Premises Registrations were placed on probation for three (3) years with certain terms and conditions. A copy of that Decision and Order is attached as Exhibit A and is incorporated by reference.

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JURISDICTION

5. This Accusation and Petition to Revoke Probation is brought before the Veterinary Medical Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code), unless otherwise indicated.

6. Section 4875 of the Code provides, in part, that the Board may revoke or suspend the license of any person to practice veterinary medicine, or any branch thereof, in this state for any causes provided in the Veterinary Medicine Practice Act (Bus. & Prof. Code, § 4800, et seq.). In addition, the Board has the authority to assess a fine not in excess of $5,000 against a licensee for any of the causes specified in section 4883 of that code. Such fine may be assessed in lieu of, or in addition to, a suspension or revocation.

7. Section 118, subdivision (b) of the Code provides, in part, that the expiration of a license shall not deprive a board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under Business and Professions Code section 4843.5, the Board may renew an expired license at any time within five years after the expiration.

STATUTES AND REGULATIONS

8. Section 4853.6 of the Code states:

> "The board shall withhold, suspend or revoke registration of veterinary premises:
> (a) When the licensee manager set forth in the application in accordance with Section 4853 ceases to become responsible for management of the registered premises and no substitution of the responsible licensee manager has been made by application as provided for in Section 4853.
> (b) When the licensee manager has, under proceedings conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the license to practice veterinary medicine, surgery, and dentistry revoked or suspended."

9. Section 4855 of the Code states:

> "A veterinarian subject to the provisions of this chapter shall, as required by regulation of the board, keep a written record of all animals receiving veterinary services, and provide a summary of that record to the owner of animals receiving veterinary services, when requested. The minimum amount of information which shall be included in written records and summaries shall be established by the

board. The minimum duration of time for which a licensed premise shall retain the written record or a complete copy of the written record shall be determined by the board."

10. Section 4856 of the Code states, in part:

"(a) All records required by law to be kept by a veterinarian subject to this chapter, including, but not limited to, records pertaining to diagnosis and treatment of animals and records pertaining to drugs or devices for use on animals, shall be open to inspection by the board, or its authorized representatives, during an inspection as part of a regular inspection program by the board, or during an investigation initiated in response to a complaint that a licensee has violated any law or regulation that constitutes grounds for disciplinary action by the board. A copy of all those records shall be provided to the board immediately upon request."

11. Section 4883 of the Code states, in part:

"The board may deny, revoke, or suspend a license or assess a fine as provided in Section 4875 for any of the following:

…

"(c) Violation or attempting to violate, directly or indirectly, any of the provisions of this chapter [the Veterinary Medicine Practice Act].

…

"(g) Unprofessional conduct, that includes, but is not limited to, the following:

…

"(i) Fraud, deception, negligence, or incompetence in the practice of veterinary medicine.

…

"(o) Violation, or the assisting or abetting violation, of any regulations adopted by the board pursuant to this chapter [the Veterinary Medicine Practice Act].

12. Section 651 of the Code states, in part:

"(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication."

13. California Code of Regulations, title 16, section 2030, states, in part:

"All fixed premises where veterinary medicine and its various branches are being practiced, and all instruments, apparatus and apparel used in connection with those practices, shall be kept clean and sanitary at all times and shall conform to or possess the following minimum standards:

…

(f) The veterinary premises shall meet the following standards:

…

(4) The veterinary premises shall have the capacity to render diagnostic radiological services, either on the premises or through other commercial facilities. Radiological procedures shall be conducted in accordance with Health and Safety Code standards.

…

(6) All drugs and biologicals shall be maintained, administered, dispensed and prescribed in compliance with state and federal laws.

…

(9) Current veterinary reference materials shall be readily available on the premises.

(10) Anesthetic equipment in accordance with the procedures performed shall be maintained in proper working condition and available at all times.

…

(g) A veterinary premises which provides aseptic surgical services shall comply with the following:

(1) A room, separate and distinct from all other rooms shall be reserved for aseptic surgical procedures which require aseptic preparation. A veterinarian may perform emergency aseptic surgical procedures in another room when the room designated for aseptic surgery is occupied or temporarily unavailable.

…

(2) Storage in the surgery room shall be limited to items and equipment normally related to aseptic surgery and surgical procedures. Equipment not normally related to surgery and surgical procedure includes, but is not limited to, equipment used for dental prophylaxis, autoclaves and non-surgical radiographic equipment."

14. California Code of Regulations, title 16, section 2030.05, states:

"(a) A Licensee Manager is the California licensed veterinarian named as the Licensee Manager on a facility's premises permit.

"(b) The Licensee Manager is responsible for ensuring that the premises for which he/she is manager complies with the requirements in sections 4853, 4854, 4855 and 4856 of the Business and Professions Code, Division 2, Chapter 11, Article 3. The Licensee Manager is responsible for ensuring that the physical and operational

components of a premises meet the minimum standards of practice as set forth in sections 2030 through 2032.5 of the California Code of Regulations, Title 16, Division 20, Article 4.

"(c) The Licensee Manager is responsible for ensuring that no unlicensed activity is occurring within the premises or in any location where any function of veterinary medicine, veterinary surgery or veterinary dentistry is being conducted off the premises under the auspices of this Premises Registration.

"(d) The Licensee Manager shall maintain whatever physical presence is reasonable within the facility to ensure that the requirements in (a) - (c) are met.

"(e) Each licensed veterinarian shall be responsible for their individual violations of the Veterinary Medicine Practice Act or any regulation adopted thereunder."

15. California Code of Regulations, title 16, section 2032, states:

"The delivery of veterinary care shall be provided in a competent and humane manner. All aspects of veterinary medicine shall be performed in a manner consistent with current veterinary medical practice in this state."

16. California Code of Regulations, title 16, section 2032.05, states:

"When treating a patient, a veterinarian shall use appropriate and humane care to minimize pain and distress before, during and after performing any procedure(s)."

17. California Code of Regulations, title 16, section 2032.1, states:

"(a) It is unprofessional conduct for a veterinarian to administer, prescribe, dispense or furnish a drug, medicine, appliance, or treatment of whatever nature for the prevention, cure, or relief of a wound, fracture or bodily injury or disease of an animal without having first established a veterinarian-client-patient relationship with the animal patient or patients and the client, except where the patient is a wild animal or the owner is unknown.

"(b) A veterinarian-client-patient relationship shall be established by the following:(1) The client has authorized the veterinarian to assume responsibility for making medical judgments regarding the health of the animal, including the need for medical treatment,(2) The veterinarian has sufficient knowledge of the animal(s) to initiate at least a general or preliminary diagnosis of the medical condition of the animal(s). This means that the veterinarian is personally acquainted with the care of the animal(s) by virtue of an examination of the animal or by medically appropriate and timely visits to the premises where the animals are kept, and(3) The veterinarian has assumed responsibility for making medical judgments regarding the health of the animal and has communicated with the client a course of treatment appropriate to the circumstance.

"(c) A drug shall not be prescribed for a duration inconsistent with the medical condition of the animal(s) or type of drug prescribed. The veterinarian shall not prescribe a drug for a duration longer than one year from the date the veterinarian examined the animal(s) and prescribed the drug.

"(d) As used herein, "drug" shall mean any controlled substance, as defined by Section 4021 of Business and Professions code, and any dangerous drug, as defined by Section 4022 of Business and Professions Code."

18. California Code of Regulations, title 16, section 2032.25, states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 of the Business and Professions Code without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a veterinarian serving in the absence of the treating veterinarian and the drugs were prescribed, dispensed, or furnished only as necessary to maintain the animal patient until the return of the originally treating veterinarian, but in any case no longer than 72 hours.

(2) The veterinarian transmitted the order for the drugs to another veterinarian or registered veterinary technician and both of the following conditions exist:

(A) The licensee had consulted with the veterinarian or registered veterinary technician who had reviewed the patient's records.

(B) The licensee was designated as the veterinarian to serve in the absence of the animal patient's veterinarian.

(3) The licensee was a veterinarian serving in the absence of the treating veterinarian, was in possession of and had reviewed the animal patient's records, and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill."

19. California Code of Regulations, title 16, section 2032.3, states:

"(a) Every veterinarian performing any act requiring a license pursuant to the provisions of Chapter 11, Division 2, of the code, upon any animal or group of animals shall prepare a legible, written or computer generated record concerning the animal or animals which shall contain the following information:

(1) Name or initials of the person responsible for entries.

(2) Name, address and phone number of the client.

(3) Name or identity of the animal, herd or flock.

(4) Except for herds or flocks, age, sex, breed, species, and color of the animal.

(5) Dates (beginning and ending) of custody of the animal, if applicable.

(6) A history or pertinent information as it pertains to each animal, herd, or flock's medical status.

(7) Data, including that obtained by instrumentation, from the physical examination.

(8) Treatment and intended treatment plan, including medications, dosages, route of administration, and frequency of use.

(9) Records for surgical procedures shall include a description of the procedure, the name of the surgeon, the type of sedative/anesthetic agents used, their route of administration, and their strength if available in more than one strength.

(10) Diagnosis or assessment before performing a treatment or procedure.

(11) If relevant, a prognosis of the animal's condition.

(12) All medications and treatments prescribed and dispensed, including strength, dosage, route of administration, quantity, and frequency of use.

(13) Daily progress, if relevant, and disposition of the case.

"(b) Records shall be maintained for a minimum of three (3) years after the animal's last visit. A summary of an animal's medical records shall be made available to the client within five (5) days or sooner, depending if the animal is in critical condition, upon his or her request. The summary shall include:

(1) Name and address of client and animal.

(2) Age, sex, breed, species, and color of the animal.

(3) A history or pertinent information as it pertains to each animal's medical status.

(4) Data, including that obtained by instrumentation, from the physical examination.

(5) Treatment and intended treatment plan, including medications, their dosage and frequency of use.

(6) All medications and treatments prescribed and dispensed, including strength, dosage, route of administration, quantity, and frequency of use.

(7) Daily progress, if relevant, and disposition of the case.

"(c) (1) Radiographs and digital images are the property of the veterinary facility that originally ordered them to be prepared. Radiographs or digital images shall be released to another veterinarian upon the request of another veterinarian who has the authorization of the client. Radiographs shall be returned to the veterinary facility which originally ordered them to be prepared within a reasonable time upon request. Radiographs originating at an emergency hospital shall become the property of the next attending veterinary facility upon receipt of said radiograph(s). Transfer of radiographs shall be documented in the medical record.

(2) Radiographs and digital images, except for intraoral radiographs, shall have a permanent identification legibly exposed in the radiograph or attached to the digital file, which shall include the following:

(A) The hospital or clinic name and/or the veterinarian's name,

(B) Client identification,

(C) Patient identification, and

(D) The date the radiograph was taken.

(3) Non-digital intraoral radiographs shall be inserted into sleeve containers and include information in subdivision (c)(2)(A)-(D). Digital images shall have identification criteria listed in subdivision (c)(2)(A)-(D) attached to the digital file.

"(d) Laboratory data is the property of the veterinary facility which originally ordered it to be prepared, and a copy shall be released upon the request of the client.

"(e) The client shall be provided with a legible copy of the medical record when the patient is released following emergency clinic service. The minimum information included in the medical record shall consist of the following:

(1) Physical examination findings

(2) Dosages and time of administration of medications

(3) Copies of diagnostic data or procedures

(4) All radiographs and digital images, for which the facility shall obtain a signed release when transferred

(5) Surgical summary

(6) Tentative diagnosis and prognosis, if known

(7) Any follow-up instructions."

20. California Code of Regulations, title 16, section 2032.4, states:

"(a) General anesthesia is a condition caused by the administration of a drug or combination of drugs sufficient to produce a state of unconsciousness or dissociation and blocked response to a given pain or alarming stimulus.

(b) When administering general anesthesia, a veterinarian shall comply with the following standards:

(1) Within twelve (12) hours before the administration of a general anesthetic, the animal patient shall be given a physical examination by a licensed veterinarian appropriate for the procedure. The results of the physical examination shall be documented in the animal patient's medical records.

(2) An animal under general anesthesia shall be observed for a length of time appropriate for its safe recovery.

(3) Provide respiratory monitoring including, but not limited to, observation of the animal's chest movements, observation of the rebreathing bag or respirometer.

(4) Provide cardiac monitoring including, but not limited to, the use of a stethoscope, pulseoximeter or electrocardiographic monitor.

(5) When administering general anesthesia in a hospital setting, a veterinarian shall have resuscitation or rebreathing bags of appropriate volumes for the animal patient and an assortment of endotracheal tubes readily available.

(6) Records for procedures involving general anesthesia shall include a description of the procedure, the name of the surgeon, the type of sedative and/or anesthetic agents used, their route of administration, and their strength if available in more than one strength."

21. California Code of Regulations, title 17, section 30255(b)(2), states:

"Conspicuously post a current copy of this regulation, a copy of applicable licenses for radioactive material, and a copy of operating and emergency procedures applicable to work with sources of radiation. If posting of documents specified in this paragraph is not practicable the user may post a notice which describes the document and states where it may be examined."

COST RECOVERY

22. Section 125.3 of the Code provides, in part, that a Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

LUNA, THE YOUNG TERRIER

23. On or about January 16, 2016, Luna, a young Terrier, was presented to AVVC because she was vomiting and had inappetence. A physical exam was not performed that day. On January 17, 2016, the medical record indicates that Respondent performed an initial examination of Luna. Luna was documented as lethargic with a distended painful abdomen.

24. Between January 17, 2016, and January 19, 2016, Luna was hospitalized at AVVC under Respondent's care. After hospitalization, blood tests were performed with normal results, except for a decreased white blood cell count. A SNAP assay[1] tested positive for canine parvovirus enteritis.

25. After Respondent's initial examination on January 17, 2016, Luna was not evaluated again by Respondent or any other veterinarian. According to the initialed instructions, symptomatic treatment was carried out by assistants. Animals with parvovirus are prone to developing secondary problems, including dehydration, electrolyte and blood chemistry imbalances, and bacterial infections. Daily evaluation by a veterinarian is needed to change or adjust the treatment protocol depending on his/her assessment of the patient.

26. On the evening of January 19, 2016, AVVC released Luna to her owner.

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[1] A SNAP assay is an in-house device that performs an immunoassay for the detection of a specific antigen or antibody.

FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

27. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(13), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patient Luna. Specifically, Respondent's medical record for Luna fails to include daily progress notes evaluating patient medical status throughout her hospitalization.

SECOND CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

28. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.3. Specifically, Respondent failed to evaluate his patient, Luna, and document updates about her medical status while she was hospitalized for treatment of Parvovirus enteritis. Complainant refers to and incorporates all the allegations contained in paragraphs 23 through 26 as though set forth fully.

MICKEY, THE ELDERLY TERRIER

29. On or about January 22, 2016, J.C. presented Mickey, his elderly Terrier, to ACVC, because he had dark watery diarrhea, vomiting, and decreased appetite. Medical records from Mickey's primary veterinarian, The Veterinary Care Center, were faxed to ACVC. On physical exam, Respondent noted that Mickey was pale and had severe dental disease and a heart murmur. Respondent's assessment included "Geriactric [*sic*], CHF (Congestive Heart Failure), Possible hip arthritis and Dental disease." Subcutaneous fluids and Convenia (an injectable antibiotic) were administered. A blood transfusion was recommended but stated to be risky due to Mickey's age. J.C. declined the transfusion. Mickey was taken home.

30. Respondent's medical record for Mickey includes blood test results that document a profound anemia. The results of the blood test are not mentioned in the medical record.

31. On or about January 23, 2016, J.C. took Mickey to another veterinarian, M.N., DVM, at The Veterinary Care Center in Los Angeles, California, because Mickey was having dark

bloody diarrhea. After reviewing the blood tests provided by Respondent, M.N., DVM, repeated blood tests and took chest radiographs. The blood tests documented a low hematocrit, RBC (Red Cell count) and hemoglobin, with an elevated reticulocyte count[2] (a responsive anemia). After a discussion with J.C. regarding Mickey's prognosis, conservative treatment was started. At rechecks over the next several weeks, Mickey improved. His anemia resolved without complication.

THIRD CAUSE FOR DISCIPLINE

(Negligence)

32. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence by failing to perform a reticulocyte count to determine the nature of Mickey's anemia. Complainant refers to and incorporates all the allegations contained in paragraphs 28 through 31, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

33. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(6), (a)(10), and (a)(11), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patients, as follows:

a. The medical record for Mickey prepared by Respondent fails to include the minimum amount of information required by the Board, including, inter alia, an evaluation of the blood test, a diagnosis, and a prognosis.

b. California Code of Regulations, title 16, section 2032.3(a)(6): Respondent's medical record for Mickey fails to include evaluation of pertinent laboratory tests that documented severe anemia.

[2] A reticulocyte count documents the number of reticulocytes (immature red blood cells) that are released into the blood from the bone marrow. If the bone marrow is healthy, the reticulocyte count increases in response to anemia. The lack of increased reticulocytes in response to anemia generally carries a poorer prognosis.

c. California Code of Regulations, title 16, section 2032.3(a)(l0): Respondent's medical record for Mickey fails to include an assessment of the cause of his diarrhea and the severe anemia documented on blood tests.

d. California Code of Regulations, title 16, section 2032.3(a)(11): Respondent's medical record for Mickey fails to include a prognosis for the geriatric anemic patient, who was experiencing diarrhea and vomiting.

Complainant refers to and incorporates all the allegations contained in paragraphs 29 through 31, as though set forth fully.

PRINCESS, THE LABRADOR RETRIEVER

34. In the evening of January 31, 2016, R.M. presented Princess, his eleven-year-old Labrador Retriever, to AVVC because she was lethargic and had not eaten for 4-5 days.

35. Before examination by Respondent, radiographs and blood tests were performed, indicating a diagnosis of pyometra.[3]

36. Princess was hospitalized and started on IV fluids, antibiotics, anti-nausea medication, and a constant rate IV infusion of HLK.[4] Around midnight Princess underwent surgery. Princess remained hospitalized until February 2, 2016, when she was released to her owner. Respondent's medical records indicate that there was no evaluation by a veterinarian throughout her post-surgery hospitalization or before being released to her owner.

37. R.M. states that Princess was very lethargic after she was released, refusing to get up when coaxed. With no after-hours veterinary care available in his small home town, R.M. called a practice 30 minutes away, but Princess developed convulsions and died before transport.

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[3] Pyometra is a bacterial infection of the uterus resulting in the uterus filling with purulent (pus containing) fluid.

[4] HLK is a combination of Hydromorphone (an opiate analgesic), Lidocaine, (a local anesthetic), and Ketamine (a dissociative anesthetic), administered as a constant IV infusion to control pain associated with a medical condition or surgical procedure.

FIFTH CAUSE FOR DISCIPLINE

(Negligence or Incompetence)

38. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed incompetence and negligence in his duties as a veterinarian, as follows:

39. Respondent committed incompetence by administering subtherapeutic pain control to Princess, demonstrating a lack of knowledge regarding the use of HLK constant rate infusion.

40. Respondent committed negligence by failing to evaluate Princess, an elderly post-surgery patient, during her hospitalization after surgery and before her release.

Complainant refers to and incorporates all the allegations contained in paragraphs 34 through 37, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

41. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating the following regulations:

a. California Code of Regulations, title 16, section 2032.1 (Veterinarian-Client-Patient Relationship): Respondent required diagnostics (blood tests, blood chemistries, radiographs) before his exam of Princess and before discussing her condition with the animal patient's owner.

b. California Code of Regulations, title 16, section 2032.05 (humane treatment): Before and after major abdominal surgery, Respondent failed to provide effective pain control for Princess.

Complainant refers to and incorporates all the allegations contained in paragraphs 34 through 40, as though set forth fully

ROSIE, THE CHIHUAHUA

42. On May 7, 2016, at approximately 10 a.m., D.M. presented Rosie, his three-year-old Chihuahua, to AVVC because she was unable to use her hind legs. The previous day, Rosie had been evaluated at Quartz Hill Veterinary Clinic, Quartz Hill, California, for rear quarter discomfort. She was still ambulatory at that time. Respondent did not perform a neurological

assessment of Rosie. Respondent hospitalized Rosie, and blood work was performed. Rosie was treated with a steroid injection, a muscle relaxant, and HLK. At around 5:00 p.m., Rosie was anesthetized for a CT scan.

43. Later that night[5], after Respondent received the radiologist report of the CT Scan, he performed a hemilaminectomy[6]. Rosie had a L5-6 intervertebral disc rupture. Rosie was hospitalized for the next seven days. Respondent did not monitor Rosie for neurological status or pain after performing a hemilaminectomy. There is no indication in Respondent's medical record for Rosie that he evaluated the radiographs that were taken after the spinal surgery, nor did he indicate in the record why radiographs after surgery were needed.

44. On May 13, 2016, Rosie stopped eating and became lethargic, disoriented, and her temperature dropped. A blood test documented that she was anemic and had an elevated white blood cell count. Respondent did not pursue the cause of Rosie's deterioration. He only provided symptomatic treatment. Rosie was treated with dexamethasone, Benadryl, and Epogen[7], and was given blood transfusions. By 2:30 a.m. the following day, Rosie was developing respiratory distress, and the transfusion was stopped. At 3:00 a.m., Rosie passed away.

45. On May 24, 2016, Respondent provided D.M. with Rosie's medical records, which failed to include, inter alia, Respondent's evaluation of significant changes documented in blood tests performed on May 13, 2016.

SEVENTH CAUSE FOR DISCIPLINE

(Negligence or Incompetence)

46. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence or incompetence in his duties as a veterinarian, as follows:

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[5] Although a hemilaminectomy is considered orthopedic surgery, Rosie's procedure was performed on May 7, 2016, before the effective date of Sandhu's probation (May 29, 2016).

[6] Hemilaminectomy is a surgical procedure performed in animals with ruptured or herniated intervertebral discs. The surgery is typically performed by orthopedic surgeons or neurologist. The surgery involves removal of part of the bony lamina that surrounds the spinal cord, allowing visualization of the spinal cord, the disc, and remove disc material to decompress the damaged spinal cord.

[7] Epogen (Erythropoietin) is a hormone that regulated production of red blood cells. It is typically used to treat anemia associated with chronic renal failure.

a. On May 7, 2016, Respondent committed negligence by failing to provide appropriate initial medical treatment for his animal patient Rosie before CT scan and surgery.

b. On May 7, 2016, Respondent committed negligence by failing to perform an initial neurological examination on Rosie, a patient referred to him for possible back surgery.

c. Respondent committed incompetence by performing spinal surgery on Rosie without considering known options regarding the prognosis for a Ls-6 intervertebral disc rupture.

d. Respondent committed incompetence by administering sub-therapeutic HLK continuous rate infusion to Rosie before and after back surgery.

e. Respondent committed negligence by failing to monitor his animal patient Rosie for neurological status and pain after performing a hemilaminectomy.

f. Respondent committed negligence by failing to evaluate radiographs taken on Rosie after spinal surgery and failed to indicate why radiographs after surgery were needed.

g. On or about May 13, 2016, Respondent committed incompetence by failing to pursue the cause of Rosie's deterioration, instead of providing only symptomatic treatment.

h. On or about May 13, 2016, Respondent committed incompetence by giving Rosie a whole blood transfusion, without medical indication that it was necessary.

Complainant refers to and incorporates all the allegations contained in paragraphs 42 through 45, as though set forth fully.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

47. Respondent is subject to disciplinary action under section 4883, subdivision (g), for committing unprofessional conduct, by performing a CT scan and back surgery on animal patient Rosie without conducting a neurological assessment and establishing a Veterinarian-Client-Patient Relationship. Complainant refers to and incorporates all the allegations contained in paragraphs 42 through 46, as though set forth fully.

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NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

48. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(6), and (a)(10), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patients, as follows:

a. The medical record for Rosie prepared by Respondent fails to include the minimum amount of information required by the Board, including, inter alia, daily updates, and assessment regarding Rosie's pain level, her neurological status, and her deterioration throughout Rosie's 8-day hospitalization.

b. California Code of Regulations, title 16, section 2032.3(a)(6): Respondent's medical record for Rosie fails to include evaluation of significant changes documented in blood tests performed on May 13, 2016.

c. California Code of Regulations, title 16, section 2032.3(a)(6): On May 8, 2016, Respondent's medical record fails to evaluate radiographs taken after spinal surgery on Rosie.

d. California Code of Regulations, title 16, section 2032.3(a)(10). Respondent's medical record for Rosie fails to include an assessment or indication for the administration of Epogen and a blood transfusion May 13, 2016.

Complainant refers to and incorporates all the allegations contained in paragraphs 42 through 47, as though set forth fully.

TENTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

49. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating the following regulations:

a. California Code of Regulations, title 16, section 2032.3(b) (record keeping): On May 24, 2016, after Rosie's death on May 14, 2016, Respondent failed to provide Rosie's owner with a copy of her medical record containing the required information.

b. California Code of Regulations, title 16, section 2032.05 (humane treatment): Respondent failed to evaluate his post-surgery patient, Rosie, keeping her hospitalized for a week without adequate pain control, until her death on May 14, 2016.

c. California Code of Regulations, title 16, section 2032.1 (Veterinary Client Patient Relationship): On May 7, 2016, Respondent failed to perform an assessment of Rosie that was adequate to form a preliminary diagnosis and failed to communicate her neurological status and her prognosis with his client.

Complainant refers to and incorporates all the allegations contained in paragraphs 42 through 48, as though set forth fully

MR. CHOW, THE PUG

50. On or about April 9, 2017, M.H. presented Mr. Chow, his pug, to ACVC. On or about April 11, 2017, Mr. Chow was transferred to AVVC.

51. On or about April 27, 2017, the Board sent a letter to Respondent requesting medical records for Mr. Chow from both AVVC and ACVC. After not receiving a response, on or about June 5, 2017, the Board sent Respondent a second request for records. On or about June 8, 2017, the Board received medical records from ACVC but did not receive any medical records from AVVC. Despite multiple requests, AVVC did not provide the Board with any medical records for Mr. Chow.

ELEVENTH CAUSE FOR DISCIPLINE

(Failure to comply with record inspection requirements)

52. Respondent is subject to disciplinary action under sections 4856, in that he failed to provide medical records to the Board upon request, despite three separate requests to AVVC for Mr. Chow's records. Complainant refers to and incorporates all the allegations contained in paragraphs 50 and 51, as though set forth fully.

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TWELFTH CAUSE FOR DISCIPLINE

(Failure to ensure compliance as licensee manager)

53. Respondent is subject to disciplinary action under section 4880, subdivision (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2030.05, in that as licensee manager of AVVC, Respondent failed to ensure that his premise complies with requirements of section 4856 of the Code regarding inspection of records relating to Mr. Chow's treatment at AVVC. Complainant refers to and incorporates all the allegations contained in paragraphs 50 through 52, as though set forth fully.

SAMMY, THE BULLDOG

54. On April 30, 2017, Sammy, a five-year-old Bulldog, was presented to ACVC for a nail trim. During the procedure, Sammy became very distressed and bit the nail trimmer, causing an injury to the dog's upper lip. Later Sammy began vomiting/regurgitating bloody foam. When the bleeding could not be controlled, Sammy's owner, M.S., approved sedation. Following sedation, the bleeding was controlled, but Sammy was still described as agitated. Later Sammy collapsed and became cyanotic[8]. She was given oxygen and chest radiographs were taken. No veterinarian was present. Respondent was called by his staff. He ordered administration of dexamethasone (a steroid medication), Famotidine (a Gastro-intestinal antihistamine used as an antacid), and Urasyn (an antibiotic combination drug). Respondent did not inform his staff regarding the dose of dexamethasone to be administered. A technician determined the dose. These drugs were administered without a veterinarian performing even a minimal physical examination. IV fluids were started. Sammy's temperature was elevated at 105° F. A short time later it rose to 109° F. Although Sammy's temperature began to decrease, she soon experienced respiratory and cardiac arrest. A technician's attempts at resuscitation were unsuccessful and Sammy died.

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[8] Blue discoloration of the tongue and oral mucosa due to inadequate oxygenation of blood delivered to the tissues.

THIRTEENTH CAUSE FOR DISCIPLINE

(Negligence)

55. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence in his duties as a veterinarian, as follows:

a. On April 30, 2017, Respondent committed negligence by ordering Unasyn, an antibiotic, to be administered to Sammy without clinical indication that the antibiotic was needed.

b. On April 30, 2017, Respondent committed negligence by allowing his staff to determine the dosage of dexamethasone administered to Sammy, a hyperthermic bulldog in distress.

Complainant refers to and incorporates all the allegations contained in paragraph 54, as though set forth fully.

FOURTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

56. Respondent is subject to disciplinary action under section 4883, subdivision (g), for committing unprofessional conduct, as follows:

a. By treating Sammy on April 30, 2017, without establishing a Veterinarian-Client-Patient Relationship.

b. Complainant refers to and incorporates all the allegations contained in paragraphs 54 and 55, as though set forth fully.

FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

57. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.1 (Veterinarian-Client-Patient Relationship). Specifically, on April 30, 2016, Respondent failed to examine Sammy and establish a Veterinarian-Client-Patient Relationship before treatment. Complainant refers to and incorporates all the allegations contained in paragraphs 54 through 56, as though set forth fully.

SIXTEENTH CAUSE FOR DISCIPLINE

(Aiding and Abetting Unlicensed Activity)

58. Respondent is subject to disciplinary action under section 4883, subdivision (j), for aiding or abetting unlicensed activity. Specifically, on April 30, 2016, Respondent allowed his staff to practice veterinary medicine, including sedation, critical care, and CPR for animal patient Sammy with only minimal indirect supervision by Respondent. Complainant refers to and incorporates all the allegations contained in paragraphs 54 through 57, as though set forth fully.

CHELSEA, THE CHIHUAHUA

59. On April 30, 2017, J.A. presented Chelsea, her 5-year-old Chihuahua, to AVVC as an emergency, because Chelsea was lethargic, hacking, and gagging. On examination, dental disease and a heart murmur were noted, along with harsh airway sounds and increased respiratory effort. The tentative diagnosis was pneumonia or bronchial inflammation. After taking radiographs, Respondent noted increased right lung lobe density or consolidation. Chelsea was hospitalized and given fluids, diuretics, antacids, antibiotics, and nebulizer treatments. She was also given an injection of dexamethasone (a steroid), furosemide (a diuretic), and oxygen therapy.

60. On May 2, 2017, Chelsea was believed to be improved with normal respiration. Follow-up chest radiographs were taken. Respondent noted that the radiographs showed significant improvement. Chelsea was released to J.A.

61. On May 3, 2017, J.A. returned to AVVC complaining that Chelsea still had labored breathing. J.A. was told that Respondent was not able to talk with her, but was told that he recommended hospitalization for more of the same treatment.

62. J.A. left with Chelsea and later took her to be evaluated by B.S., DVM, a veterinarian at Palm Plaza Pet Hospital in Palmdale, California. On examination, B.S., DVM noted Chelsea was pale with muffled respiratory sounds on the right side of the chest. Bleeding and swelling were also noted on Chelsea's leg where the IV catheter had been removed. Radiographs showed right cranial lung lobe consolidation and free pleural fluid; blood tests documented a marked anemia.

63. Chelsea was referred to VCA Veterinary Specialists for further diagnostics, hospitalization, and a transfusion. After significantly prolonged coagulation tests were documented, a tentative diagnosis of coagulopathy (a disorder of blood clotting), secondary to rodenticide (rodent poison) toxicity was made. Chelsea received a blood transfusion and vitamin K therapy. She improved and made an uneventful recovery following treatment.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Negligence or Incompetence)

64. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence or incompetence in his duties as a veterinarian, as follows:

a. Respondent committed negligence by releasing Chelsea to her owners without adequate evaluation to assure she was stable for home care.

b. On April 30, 2017, through May 2, 2017, Respondent committed negligence by treating Chelsea with multiple injections of furosemide and dexamethasone, drugs not indicated for treatment of pneumonia.

c. Respondent committed incompetence by failing to correctly evaluate Chelsea's radiographs taken on May 2, 2017, in that he failed to diagnose obvious pleural fluid.

d. On May 3, 2017, Respondent committed negligence by recommending to continue with a prior treatment protocol, without examination, for Chelsea, a patient returning in respiratory distress.

Complainant refers to and incorporates all the allegations contained in paragraphs 59 through 63, as though set forth fully.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

65. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivisions (a)(1), (a)(5), (a)(6), and (a)(8), in that Respondent failed to properly prepare and

maintain proper medical records for the veterinary care and treatment of animal patients, as follows:

a. California Code of Regulations, title 16, section 2032.3(a)(l): Respondent's medical record for Chelsea fails to include identification of the individual responsible for medical record entries.

b. California Code of Regulations, title 16, section 2032.3(a)(5): Respondent's medical record for Chelsea on April 30, 2017, failed to include the date she was initially hospitalized and treated.

c. California Code of Regulations, title 16, section 2032.3(a)(6): Respondent's medical record for Chelsea on May 1, 2017, failed to include pertinent information from blood tests.

d. California Code of Regulations, title 16, section 2032.3(a)(8): Respondent's medical record on May l, 2017, and May 2, 2017, failed to include drugs, drug dosages and fluid therapy administered to Chelsea.

Complainant refers to and incorporates all the allegations contained in paragraphs 59 through 64, as though set forth fully.

ENZO, THE GERMAN SHEPHERD

66. On or about June 29, 2017, D.G. presented Enzo, a 2-year-old, 70 lb. German Shepherd, to AVVC because she saw the dog get hit by a truck. Radiographs were taken documenting right tibia and fibula fracture and luxation[9] of the left coxofemoral (hip) joint.

67. The next day Respondent documented a physical exam. Injections of Cefazolin (an antibiotic) and a steroid were administered and pre-surgical blood tests were performed.

68. On or about June 30, 2017, Respondent examined Enzo, pre-surgical blood tests were performed and medications were administered. Nirip Shokar, DVM, a veterinarian at AVVC, performed a surgical repair of the femoral fracture with placement of a bone plate and a femoral head osteotomy (FHO)[10]. Post-surgical radiographs were taken, and hospitalization was continued.

[9] Luxation means a complete dislocation of a joint.
[10] Hip replacement surgery.

69. Pre- and post-surgery, Enzo was placed on HLK constant rate infusion (CRI)[11], with no adjustment for pain. Per the medical record, Enzo was administered HLK (6mg hydromorphone, 400mg Lidocaine, 200mg Ketamine, put into 1 liter (L) saline), at CRI of 17ml/hr. The HLK administered to Enzo was far below the low end of the recommended rate for effective pain control.

70. Twice on July 1, 2017, and again on July 2, 2017, Respondent documents that Enzo was unable to walk and "painful when he tries to walk." On July 2, 2017, Enzo was released to D.G. with medications. There is no evidence that Enzo was able to walk when he was sent home. Respondent prescribed an antibiotic, a non-steroidal anti-inflammatory drug, and 50mg of tramadol three times a day for pain.

71. Respondent is documented as the supervising veterinarian for all of Enzo's treatment except for the surgery performed by Dr. Shokar. Respondent is documented as performing the "Daily Hospitalization SOAP" on June 30, July 1, and July 2, 2017. On July 9, 2017, Enzo was rechecked by Respondent after he "ripped out sutures."

72. On July 15, 2017, D.G. took Enzo to see D.C., DVM, a veterinarian at Sears Veterinary Hospital in Lancaster, California, for a second opinion. Enzo is described as thin with swelling at the right tibia surgery site. D.C., DVM noted that Enzo walked, but would not place full weight on the left hind leg (FHO surgery leg). The FHO incision is described as very painful with the opening of skin incision and subcutaneous tissue.

73. D.C., DVM requested medical records and pre- and post-surgery radiographs from AVVC. AVVC's radiographs taken before surgery on June 29, 2017, document a normal appearing right coxofemoral joint (hip joint). AVVC's radiographs taken after surgery on June 30, 2017, reveal a complete luxation of the right hip joint. A right hip luxation is not mentioned in the AVVC medical record for Enzo.

74. On or about July 17, 2017, D.G. brought Enzo back to D.C., DVM for the repair of the incision and follow-up radiographs. Radiographs documented luxation of the right hip. After review of the AVVC's radiographs, D.C., DVM informed D.G. that the post-operative

[11] Constant rate infusion is the administration of a drug or drugs as an intravenous infusion at a specific rate to administer the drug at a specific rate over a prolonged period of time.

radiographs taken at AVVC showed the right hip was luxated (after left FHO surgery); however, the pre-surgery AVVC radiographs documented the right hip had been firmly seated (normal). A radiologist review documented fractures of 2 tarsal bones of the left hock. The radiologist also noted a bone chip left at the left FHO site with incomplete removal of the femoral neck.

75. On August 16, 2017, Enzo underwent right-sided femoral head and neck ostectomy at another veterinary hospital. A short time later Enzo developed drainage at the left hock and was diagnosed with a secondary infection of the left tarsus at the fracture sites. The drainage was cultured, and Enzo was placed on appropriate antibiotics. After a long course of antibiotics, Enzo appeared to have recovered from his orthopedic problems. In February 2018, he was documented as ambulating normally.

NINETEENTH CAUSE FOR DISCIPLINE

(Negligence, or Incompetence)

76. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence or incompetence in his duties as a veterinarian, as follows:

a. Respondent committed incompetence by administering HLK continuous rate infusion to animal patient Enzo at a dosage rate far below the recommended therapeutic range.

b. On July 1 and 2, 2017, Respondent committed negligence by failing to alter Enzo's treatment protocol to address documented pain and inability to walk after surgery.

c. On July 2, 2017, Respondent committed negligence by prescribing 50mg of tramadol three times a day, less than half to the low end of the recommended dosage range.

Complainant refers to and incorporates all the allegations contained in paragraphs 66 through 75, as though set forth fully.

TWENTIETH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

77. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6). Specifically, medical records prepared for animal patient Enzo fail to include

evaluation of post-operative radiographs documenting luxation of the right coxofemoral joint. Complainant refers to and incorporates all the allegations contained in paragraphs 66 through 76, as though set forth fully.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Provide Humane Treatment)

78. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05 (humane treatment). Respondent failed to provide appropriate HLK constant rate infusion pre- and post-surgically to minimize pain and distress after orthopedic surgery for animal patient Enzo. Complainant refers to and incorporates all the allegations contained in paragraphs 66 through 77, as though set forth fully.

POOH, THE BEAGLE

79. On August 6, 2017, K.D. presented Pooh, her 14-year-old Beagle, to AVVC because he was having difficulty walking. Bhupinder Gahra, DVM, a veterinarian at AVVC, evaluated Pooh; the physical exam was completely normal. Gahra notes a working diagnosis of "bilateral tightrope repair."[12]

80. On August 10, 2017, in the evening, Pooh was dropped off at AVVC for the surgery. On August 11, 2017, Respondent performed a physical exam on Pooh. He documented a normal exam except for "grade 2 dental disease" and limping on rear legs. Blood was drawn for pre-surgical laboratory tests. Pooh was started on HLK constant rate infusion (CRI). Surgery was postponed until August 12, 2017.

81. On August 12, 2017, Pooh was under Respondent's care. Respondent performed a physical exam of Pooh and documents exactly the same findings, word for word, as he did for the exam on August 11, 2017. Neither of the physical exams documents Pooh's severe dental disease or the stifle abnormalities consistent with ACL rupture. On August 13, 2017, the day after

[12] "Tightrope," or TightRope, is a surgical system developed to treat stifle joint instability resulting horn rupture of the cranial cruciate ligament (CCR). The technique involves the creation of tunnels through the femur and the tibia with the insertion of a fiber tape that is stabilized and counteracts the joint instability.

surgery, Respondent told K.D. and her husband about Pooh's dental disease and the extractions. On August 12, 2017, Pooh was maintained on the same HLK CRI.

82. On August 12, 2017, at about 9:00 a.m., Pooh underwent surgery; a "tightrope repair" on both hind legs and a dental procedure. Shokar was the documented surgeon. Pooh was noted to have severe tartar and gingivitis; three extractions were performed. Grade 4 (severe) periodontal disease was documented in the medical record. Post-operative radiographs were taken. At 1:00 p.m. Shokar called K.D. from All Creatures Veterinary Hospital (ACVA), informing her the surgery went well. After surgery, Pooh was maintained on the same HLK CRI and antibiotics and an injection of Legend[13] was administered.

83. On August 13, 2017, Pooh remained under the care of Respondent. At 2:00 a.m., Pooh's IV catheter was removed. Shortly thereafter Pooh began vomiting. Radiographs document that Pooh had developed pneumonia. Pooh was started on treatment for pneumonia, including nebulizer treatments with a bronchodilator, and furosimide, a diuretic, was administered. During this time, Pooh was not receiving fluid therapy and there is no indication he was drinking. HLK was continued at the same rate and injectable prednisone was started. K.D. was informed that Respondent had diagnosed Pooh with Megaesophagus and aspiration pneumonia.

84. At or about 11:00 a.m. on August 13, 2017, Respondent administered Plasma Rich Protein (PRP)[14] to Pooh. The medical records have no indication of how the PRP was prepared, no information about the amount of blood drawn from Pooh, and no information about the volume of PRP product injected into Pooh's stifles. Famotidine (a gastric antacid) and Unasyn (an injectable combination antibiotic) were administered to Pooh.

85. On August 14, 2017, Pooh remained under the care of Respondent. Pooh was treated with Unasyn, famotidine, furosemide, prednisone, and nebulization along with HLK. Pooh is

[13] Legend (Hyaluronate sodium) is an injectable anti-inflammatory, lubricating product for the treatment of synovitis (inflammation of the joint lining) not associated with degenerative joint disease.

[14] Platelet Rich Plasma (PRP) is a biologic product (concentrated platelets and growth factors derived from the patient's blood), that can be injected to diminish the inflammatory response in the synovium (lining of the joint), the joint capsule, ligaments, cartilage and bone, PRP can be used as a treatment of an injury or to aid in healing following surgical intervention.

described as "painful" and "too painful to walk." There is no evidence in the medical records that Respondent monitored Pooh's level of pain and adjusted his analgesia protocol.

86. On August 14, 2017, although Respondent is documented as the responsible veterinarian, a medical record entry states Dr. Abalos spoke to Pooh's owner about the aspiration pneumonia. Pooh continued to be in pain, bothered by his legs. Around 9:55 p.m. Pooh was demonstrating abnormal disoriented behavior and "respirator pattern." On auscultation, Abaios was alarmed by wheezing and pulmonary crackles; radiographs were taken noting pulmonary congestion. Pooh was placed in an oxygen cage. HLK was discontinued.

87. On August 15, 2017, Pooh remained under the care of Respondent. Pooh was in an oxygen cage; treatment was continued with Unasyn, famotidine and Cerenia injections, prednisone, and nebulizer treatments. At 6:00 a.m., a hydromorphone injection was administered and IV fluids were restarted. Pooh is described as unable to walk. Client communication notes by an assistant document Pooh did not want to stand or even lift his head. Respondent communicated with K.D. stating that Pooh's "immune system is affecting the nervous system," that Pooh had not shown improvement, but was not worsening either. At 12:00 a.m. on August 16, 2017, Pooh was found deceased.

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Negligence)

88. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence in his duties as a veterinarian, as follows:

a. Respondent committed negligence by failing to include information about PRP preparation and administration in the medical record for animal patient Pooh, on August 13, 2017.

b. Respondent committed negligence by failing to monitor pain and adjust his post-op analgesia after Orthopedic surgery throughout Pooh's hospitalization, from August 12, 2017, through August 16, 2017.

c. Respondent committed negligence by, for over two days, failing to ensure his animal patient Pooh, was maintained on IV fluids for treatment of aspiration pneumonia.

d. Respondent committed negligence by administering furosemide to his animal patient Pooh, as treatment for aspiration pneumonia.

e. Throughout Pooh's hospitalization, August 12, 2017, through August 16, 2017, Respondent committed negligence by failing to monitor pain and adjust his post-op analgesia after orthopedic surgery. Throughout Pooh's hospitalization, he received HLK at an inadequate CRI. Orthopedic surgery is known to be extremely painful; Pooh underwent surgery on both his hind legs. The standard of care after any surgery is to provide adequate pain medication and monitor the patient to determine if adjustments need to be made in the analgesia protocol. This was not done for Pooh. Medical record notions note that throughout hospitalization after surgery, Pooh could not stand or walk and both hind legs were in pain.

f. On August 13, 2017, Respondent committed negligence by failing to include information about PRP preparation and administration in the medical record for animal patient Pooh.

g. Respondent committed negligence by failing to ensure his animal patient Pooh, was maintained on IV fluids for treatment of aspiration pneumonia for over two days.

h. Respondent committed negligence by administering furosemide, a diuretic, to his animal patient Pooh, as treatment for aspiration pneumonia.

Complainant refers to and incorporates all the allegations contained in paragraphs 79 through 87, as though set forth fully.

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

89. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05 (humane treatment). Specifically, Respondent failed to use appropriate and humane care to minimize pain and stress for his patient, Pooh, before, during, and after orthopedic surgery. Pooh's medical record documents that Respondent was responsible for Pooh's care from August 12, 2017, until his death on August 16, 2017. Throughout this time, Pooh was administered a CRI of HLK at a rate far

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below the standard rate for analgesia. Complainant refers to and incorporates all the allegations contained in paragraphs 79 through 88, as though set forth fully.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

90. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating California Code of Regulations, title 16, section 2032.05, by failing to use appropriate and humane care to minimize pain and stress for his patient, Pooh, before during and after orthopedic surgery. Complainant refers to and incorporates all the allegations contained in paragraphs 79 through 89, as though set forth fully.

DEAN, THE 6-YEAR-OLD CAT

91. On or about October 3, 2017, C.M. presented Dean, his 6-year-old cat, to ACVC because he was vomiting, was lethargic and had inappetence. Dean was examined by Zacharias Gardenfors, DVM, a veterinarian at ACVC. The physical exam indicated low blood temperature but was otherwise considered normal. Blood tests showed elevated potassium levels. Dean was treated with subcutaneous fluids, Cerenia (an antiemetic) and Buprenex (pain medication) and discharged. Metronidazole1 suspension was dispensed along with gastric protectant medication and a prescription "critical care" diet.

92. Two days later, on October 5, 2017, Dean was brought back to ACVC. He is described as drooling excessively, very lethargic, not eating/drinking, and having a hard time standing and walking. Dr. Shokar took radiographs and performed blood tests.

93. At 8:00 a.m. on October 6, 2017, Dean's care was transferred to Yuseung An, DVM, a veterinarian at ACVC. Dr. An treated Dean with insulin and dextrose solution to help lower the highly elevated potassium level noted on blood tests performed the previous day. Treatment was continued with Cerenia, famotidine (a GI antacid), and Buprenex. Blood tests were repeated on October 6 and 7, 2017. The medical record for animal patient Dean records that at 5 pm on October 6, 2017, medical care for Dean was transferred to "Dr. Kim." Dr. Kim is not identified in the list of individuals responsible for Dean's medical care. Around 5:25 a.m. on October 8, 2017, Dean developed nystagmus (abnormal rhythmic involuntary eye movements), followed by open-

mouth breathing. MCT (Monica Thomson, R.V.T.), a registered veterinary technician at ACVC and not a veterinarian, performed completely inadequate CPR, indicating that a veterinarian was not available to direct CPR. Intubation and ventilation, the hallmark of CPR, was not performed, and appropriate medication was not administered. Dean died. From the October 6, 2017, entry regarding "Dr. Kim" entry until Dean's death on October 8, 2017, there are no medical entries indicating a veterinarian was involved in patient care. In addition, ACVC failed to perform appropriate diagnostics and those that were performed were not evaluated, and serious abnormal findings were not addressed.

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Negligence)

94. Respondent is subject to disciplinary action under section 4883, subdivision (i), in that Respondent, as licensee manager, committed negligence by failing to ensure that Dean, an animal patient diagnosed with a severe (stage 3 or 4) renal failure, was given adequate care at ACVC. Complainant refers to and incorporates all the allegations contained in paragraphs 91 through 93, as though set forth fully.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

95. Respondent is subject to disciplinary action under section 4883, subdivision (g), in that Respondent, as licensee manager of ACVC, committed unprofessional conduct by failing to ensure that Dean was given adequate care at ACVC. Complainant refers to and incorporates all the allegations contained in paragraphs 91 through 94, as though set forth fully.

FIONA, THE CHIHUAHUA MIX

96. On September 4, 2018, at approximately 2:00 p.m., E.F. presented Fiona, her 3-year-old Chihuahua mix, to AVVC because she was attacked by another household dog, a German Shepherd. Eliana Mejia, DVM, a veterinarian at AVVC, was in surgery at the time and directed staff to start diagnostics. Radiographs document intestinal herniation. Fiona was assessed as "critical." An IV catheter was placed and antibiotics and pain medication were administered. Around 3:00 p.m., an examination was performed. According to the medical records, during

Fiona's physical exam, Fiona exhibited signs of pain, but she was also noted as BAR (Bright, Alert and Responsive). A shoulder laceration and ventral abdominal hernia along with bruising and puncture wounds are noted.

97. Around 6:00 p.m. on September 4, 2018, Fiona's care was transferred to Respondent. Respondent noted that Fiona was "critical" and evaluated the radiographs and blood panel. At 8:00 p.m. Respondent noted "lateral recumbency, painful, shock". No prognosis was noted, nor was there a reference to the herniated intestine on the radiographs. IV fluid therapy was started sometime between 8:22 p.m., when it is noted "IVF[15] not hooked up at this time," and 12:00 a.m. on September 5, 2018, when "Fluids running..." is documented in the medical record. On September 5, 2018, treatment with antibiotics and fluids was continued. Fiona's wounds were cleaned and treated with "ointment." Respondent noted that treatment was continued to "further stabilize pet for surgical procedure." Thereafter, Fiona's care was transferred to Kelly Hall, DVM, another veterinarian at AVVC.

98. At 1:55 p.m. on September 5, 2018, Fiona was anesthetized and taken to surgery. Dr. Hall found extensive injuries and recommended euthanasia. The family elected to transport Fiona to Acute Critical Care and Emergency Surgical Service (ACCESS) in Los Angeles. Fiona was closed up mid-procedure and brought to ACCESS. At ACCESS, Fiona underwent emergency exploratory laparotomy and surgery to repair the damage. The prognosis was poor. Fiona was provided with supportive care. On September 9, 2018, Fiona deteriorated, and her owners elected humane euthanasia.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Negligence or Incompetence)

99. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence or incompetence in his duties as a veterinarian, as follows:

a. Respondent committed negligence by failing to expedite exploratory surgery for animal patient Fiona, resulting in Fiona's deterioration and eventual death.

[15] Intravenous fluids.

b. Respondent committed negligence by failing to immediately start an appropriate rate of intravenous fluids to stabilize critical animal patient Fiona on September 4, 2018.

c. Respondent committed negligence by improperly evaluating radiographs taken on animal patient Fiona, failing to recognize changes consistent with a herniated intestine loop on Fiona's radiographs.

d. Respondent committed incompetence by providing inadequate intravenous fluid support to treat shock in animal patient Fiona.

Complainant refers to and incorporates all the allegations contained in paragraphs 96 through 98, as though set forth fully.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

100. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(7), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patients, as follows:

a. On September 4, 2018, Respondent failed to perform and document an appropriate examination on critical animal patient Fiona.

b. Respondent failed to document a prognosis for critical animal patient Fiona, on September 4, 2018.

Complainant refers to and incorporates all the allegations contained in paragraphs 96 through 99, as though set forth fully.

SOFIE AKA SOFEY, THE PIT BULL

101. On October 13, 2018, M.H. presented Sofie aka Sofey, his 3-year-old Pit Bull, to AVVC after she had been vomiting and unable to eat or drink without vomiting. Respondent examined Sofie noting a tense painful abdomen. Blood tests and abdominal radiographs were performed. Respondent found leukocytosis (elevation in white blood cell count) and polycythemia (increase in red blood cell mass) due to dehydration, along with mild elevation of renal values, elevated calcium and protein, and low potassium levels. A Snap cPL1 (canine

pancreatic lipase)[16] was abnormal. Respondent felt the radiographs indicated a possible foreign body (obstruction). Respondent suspected gastroenteritis, pancreatitis, and/or a foreign body (obstruction).

102. Respondent did not recommend dietary changes for Sofie. Instead, he recommended a barium study. Sofie was hospitalized and treated with IV fluids and antibiotics, gastrointestinal antacids, anti-nausea medication, and pain medication. A barium GI series was started at 4:14 p.m.

103. Evaluation on October 14, 2018, noted that Sofie was doing well with no vomiting and no abdominal discomfort. Barium was moving through Sofie's stomach and small intestine. Treatment was continued. An evening exam by Craig Maloney, DVM, a veterinarian at AVVC, is documented as normal with gas-filled loops of intestine palpated in the abdomen. Dr. Maloney noted the barium fully passed into the colon with no obstruction. An exam on October 15, 2018 was essentially normal. Sofie was offered food but did not eat. A follow-up CBC was run. Sofie was released to owner in the afternoon.

104. On October 26, 2018, Sofie was taken to S.P., DVM, a veterinarian at Palmdale Veterinary Hospital. Sofie had vomited several times and M.H. felt her abdomen was "hard." A SNAP cPL was run again and was still abnormal. Sofie was treated with antibiotics, anti-nausea medication, and a bland diet.

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Negligence)

105. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence in his duties as a veterinarian, as follows:

a. Respondent committed negligence by failing to correctly update his client regarding the results of the barium study performed on animal patient Sofie.

[16] SNAP cPL is a test to measure canine pancreatic lipase as an indication of pancreatic function in symptomatic dogs. Although the test is known to have poor accuracy, it is used as a test to help confirm pancreatitis in dogs with symptoms of pancreatitis. An abnormal SNAP cPL can be caused by a variety of gastrointestinal conditions and is not a diagnosis of pancreatitis.

b. Respondent committed negligence by failing to recommend dietary changes for animal patient Sofie, after a bout of gastroenteritis and diagnosis of pancreatitis.

Complainant refers to and incorporates all the allegations contained in paragraphs 101 through 104, as though set forth fully.

THIRTIETH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

106. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patients. Specifically, Respondent failed to properly evaluate and document information about a barium study performed on animal patient Sofie, regarding GI motility. Complainant refers to and incorporates all the allegations contained in paragraphs 101 through 105, as though set forth fully.

PIERRE, THE FRENCH BULLDOG

107. On or about October 30, 2018, Pierre, E.L.'s French Bulldog, was presented to AVVC because he was attacked by another dog. Pierre was seen by Respondent. On presentation, Pierre was stated to be laterally recumbent and in critical condition. He was diagnosed with bite wounds and soft tissue trauma. Pierre's respiratory status was assessed as normal. A complete blood count (CBC) and blood chemistry tests were performed. After hospitalization, Pierre was treated with pain medication, injectable antibiotics, rapid action steroids, and placed on oxygen. However, nothing is noted in the medical record that would indicate oxygen therapy was necessary. In addition, there is no documentation of the oxygen flow rate or the oxygen levels administered to Pierre.

108. The blood work taken on October 30, 2018, noted multiple abnormalities, including extremely low calcium and chloride levels, and highly elevated total bilirubin and total protein. Sodium and Potassium levels were blank, likely indicating an error. The calcium and chloride levels were likely to be erroneous since levels that low are inconsistent with life. There is no mention of the blood tests in the medical record prepared by Respondent.

109. The following day Pierre's care was turned over to Katherine Hall, DVM, another veterinarian at AVVC. Dr. Hall noted the "very irregular" blood tests and rechecked them before surgery to suture Pierre's wounds. Pierre was released later that day.

THIRTY-FIRST CAUSE FOR DISCIPLINE

(Negligence)

110. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence by administering oxygen to animal patient Pierre, and charging the client for oxygen therapy, without indication that oxygen therapy was necessary. Complainant refers to and incorporates all the allegations contained in paragraphs 107 through 109, as though set forth fully.

THIRTY-SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

111. Respondent is subject to disciplinary action under section 4883, subdivisions (c) and (o), in conjunction with section 4855 and California Code of Regulations, title 16, section 2032.3, subdivision (a)(6), in that Respondent failed to properly prepare and maintain proper medical records for the veterinary care and treatment of animal patients, as follows:

a. California Code of Regulations, title 16, section 2032.3(a)(6): The medical record prepared by Respondent fails to evaluate pertinent abnormalities present on blood tests performed on animal patient Pierre.

b. California Code of Regulations, title 16, section 2032.3(a)(6): The medical record prepared by Respondent fails to include information regarding oxygen flow rate or oxygen levels administered to animal patient Pierre.

Complainant refers to and incorporates all the allegations contained in paragraphs 107 through 110, as though set forth fully.

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HUNNY, THE GERMAN SHEPHERD/HUSKY MIX

112. On or about November 7, 2018, at approximately 5:44 p.m., A.R. presented Hunny, her two-year-old, 60 lb. German Shepherd/Husky mix dog, to AVVC because Hunny had been having bloody diarrhea, was drooling excessively, was lethargic, not eating, and had been drinking an excessive amount of water. Hunny was in a debilitated state when presented at AVVC. She had bouts of diarrhea in the AVVC lobby.

113. A blood test showed dehydration and elevated blood glucose. A urinalysis was not performed to rule out Ketoacidosis.[17] Hunny was diagnosed with diabetes, pancreatitis, and hemorrhagic gastroenteritis. Respondent noted that Hunny had a poor/grave prognosis.

114. AVVC offered A.R. an estimate for 24 hours of treatment, which included a glucose curve and IV fluids and IV medications. A.R. declined the service due to financial concerns. When A.R. requested to take Hunny home, Respondent made an additional estimate for 12 hours of treatment, which was initially declined due to financial limitations. At 9:00 p.m., A.R.'s family friend paid for the 12-hour treatment. Before treatment, Respondent did not inform A.R. that 12 hours of even the most intensive treatment would only be the first step of costly ongoing treatment and diagnostics, which it appears A.R. could not afford.

115. At 9:00 p.m., Hunny was treated with IV fluids started at 90 ml/hour. Maintenance fluid rate for dogs is typically 2-3 ml./kg/hr. or 55-82 ml/hr. Hunny was treated with IV fluids at basically a maintenance rate, which did not address her 8-9 percent dehydration and ongoing fluid losses. Adequate fluid therapy for a dehydrated dog with ongoing fluid losses must be appropriate to provide maintenance needs, correct the fluid deficit, and address ongoing losses from diarrhea. Hunny was also treated with glucose to counter diabetes, BG curve, and various other drugs.

116. The medical record documents "AL" Alexandra Lopez, RVT, as directing treatment when Hunny was noted as hyperthermic (T=106.2) and again about 45 minutes later when Hunny

[17] Ketoacidosis.is a severe metabolic derangement occurring in diabetic animals when excessive ketones are produced as an energy source.

became "agonal."[18] Respondent did not evaluate or direct Hunny's treatment during this time. Hunny stayed overnight and died after going into cardiopulmonary arrest.

THIRTY-THIRD CAUSE FOR DISCIPLINE

(Negligence)

117. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed negligence in his duties as a veterinarian, as follows:

a. On November 7, 2018, Respondent committed negligence by failing to institute appropriate fluid therapy for Hunny, a sick, dehydrated animal patient.

b. On November 7, 2018, Respondent committed negligence by failing to perform a urinalysis on animal patient Hunny, after she presented in a debilitating condition with signs of diabetes mellitus.

Complainant refers to and incorporates all the allegations contained in paragraphs 112 through 116, as though set forth fully.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

118. Respondent is subject to disciplinary action under section 4883, subdivision (g), for committing unprofessional conduct, by treating animal patient Hunny without first communicating an appropriate course of treatment to the client and establishing a Veterinarian-Client-Patient Relationship. Complainant refers to and incorporates all the allegations contained in paragraphs 112 through 117, as though set forth fully.

THIRTY-FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

119. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating the following regulations:

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[18] Agonal means gasping or labored breathing.

a. California Code of Regulations, title 16, section 2032.1 (Veterinarian-Client-Patient Relationship): On November 7, 2018, Respondent failed to communicate to his client a course of treatment appropriate for Hunny's condition and prognosis.

b. California Code of Regulations, title 16, section 2035 (Duties of Supervising Veterinarian): On November 8, 2018, Respondent failed to oversee the treatment of animal patient Hunny, during a hyperthermic crisis and subsequent cardiopulmonary arrest.

Complainant refers to and incorporates all the allegations contained in paragraphs 112 through 118, as though set forth fully.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

(Aiding and Abetting Unlicensed Activity)

120. Respondent is subject to disciplinary action under section 4883, subdivision (j), for aiding or abetting unlicensed activity. Specifically, on November 8, 2018, Respondent allowed an RVT to direct patient treatment, aiding and abetting the unlicensed diagnosing and treatment of animal patient Hunny. Complainant refers to and incorporates all the allegations contained in paragraphs 112 through 119, as though set forth fully.

CLAY AKA CLAYZIE, THE 11-YEAR-OLD CAT

121. On November 18, 2018, S.M. presented Clay aka Clayzie, her 11-year-old cat, to AVVC because he was not able to urinate. Maria Abalos, DVM, a veterinarian at AVVC, conducted a physical exam, which found that Clay was essentially normal except for a tense painful abdomen and a full bladder; urinary obstruction was suspected. Basic blood tests showed mild elevations in ALT (a liver enzyme), BUN (blood Urea Nitrogen – a kidney function test) and blood glucose level. Clay was anesthetized for placement of a urinary catheter. Clay was treated with antibiotics, pain medication, and a medication to minimize urethral spasm (Prazosin). The next day Eliana Mejia, DVM, another veterinarian at AVVC, evaluated Clay. S.M. asked to take Clay home due to the cost of continued hospitalization. The urinary catheter was removed, and Clay was sent home on oral medications.

122. On November 19, 2018, after Clay was released from AVVC, S.M. took Clay to S.C., DVM, a veterinarian at Sears Veterinary Hospital in Lancaster, California. On physical exam, a

moderately enlarged, painful bladder was palpated. No diagnostics were performed. S.C., DVM, recommended that Clay be taken to a 24-hour facility for treatment and monitoring. S.C., DVM called AVVC, and spoke with Respondent. S.M. agreed to take Clay to AVVC for further diagnostics/treatment.

123. On November 19, 2018, after S.M. returned Clay to AVVC, Respondent did not examine the animal patient or perform further diagnostics and did not discuss treatment options with S.M. for Clay, a geriatric cat with a history of urinary tract disease. Instead, Clay was immediately taken to surgery. Respondent performed a perineal ureterostomy[19]. S.C., DVM's records document his treatment plan included further diagnostics and overnight supervision, but Respondent's medical record for Clay states the reason for the referral was "surgery".

124. The AVVC medical record on November 20, 2018, states S.C., DVM, referred to as the r-DVM (referring DVM) had spoken with Respondent on November 19, 2018, recommending a perineal urethrostomy due to the presence of kidney and bladder stones However, there is no mention of kidney and bladder stones in S.C., DVM's medical record for Clay, and no mention of recommending a perineal urethrostomy. Moreover, the only radiographs documenting the presence of kidney stones were taken at AVVC on November 23, 2018, four days after surgery, and just before Clay's death.

125. On November 19, 2018, after the surgical procedure, Respondent conducted a physical exam. Post-operative observation was that urethral incision looks "good". The only physical exam documented before surgery was performed by Dr. Eliana Mejia before Clay's release on November 19, 2018. The time of this morning exam is not noted in the medical record.

126. After the surgery, Clay was treated with Buprenex. The dosage of Buprenex administered to Clay (0.3 ml (at 0.15mg/ml =0.045 mg) three times a day is below the accepted dose for a cat after perineal urethrostomy, which is a very painful surgery.

127. After surgery, Clay would not eat and remained hospitalized under Respondent's care for several days. On November 23, 2018, Clay was released to S.M. without veterinary evaluation. The medical records indicate that Clay was in a debilitated condition and had not

[19] Peritoneal urethrostomy is a surgical procedure performed to alleviate urethral obstruction in animals with complicated or recurrent urethral obstruction.

eaten for at least 6 days. There is no indication in the medical record that Clay was drinking water, before his being taken off fluids and sent home.

128. Later that day, Clay was returned to AVVC due to signs of respiratory distress. Radiographs were taken, which showed pulmonary congestion, kidney stones, and bladder stones. Although not recognized by Respondent, the radiographs also show marked free pleural (chest) fluid, obvious on both the lateral and the ventral/dorsal views.

129. Shortly thereafter, Clay passed away. Respondent stated in the medical record he felt Clay died from a saddle thrombus[20].

130. A necropsy by consulting veterinarian, L.B., DVM, was performed, which revealed that Clay's heart appeared normal, but the chest cavity was filled with fluid. The left lung appeared abnormal with a splotchy blackish pattern. The kidneys, lungs, liver, and bladder were sent to Antech diagnostic laboratory for histopathology. The histopathology report notes renal changes consistent with chronic kidney failure, likely from chronic low-grade infection or renal toxicity. Lung tissue showed moderate to marked pulmonary congestion and edema. The bladder revealed damage consistent with infection or physical trauma. L.B., DVM, informed S.M. of the necropsy findings.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE

(Deception, Negligence, or Incompetence)

131. Respondent is subject to disciplinary action under section 4883, subdivisions (i), and (o), of the Code, in conjunction with California Code of Regulations, title 16, section 2032, in that Respondent committed deception, negligence, or incompetence in his duties as a veterinarian, as follows:

a. Respondent committed deception in that the medical record from AVVC is deceiving, claiming S.C., DVM, from Sears Veterinary Hospital, referred Clay to Respondent for perineal urethrostomy due to the presence of bladder and kidney stones.

[20] Saddle thrombus is caused by a blood clot from the heart that lodges in the aorta cutting off blood supply to the animals back legs. The condition is caused by serious underlying heart disease (hypertrophic or another cardiomyopathy) causing extreme thickening of the heart muscle, and eventually resulting in congestive heart failure and/ or a saddle thrombus.

b. Respondent committed negligence by failing to examine geriatric animal patient Clay and discuss treatment options regarding lower urinary tract disease.

c. Respondent committed negligence by failing to evaluate Clay medically and offer other options, instead, Clay was immediately taken to surgery.

d. Respondent committed negligence on November 23, 2018, by releasing Clay to go home in a severely debilitating condition.

e. Respondent committed negligence by failing to evaluate his animal patient Clay, before release from medical care.

f. Respondent committed negligence by failing to provide appropriate pain control for animal patient Clay, throughout hospitalization and treatment following perineal urethrostomy surgery.

g. Respondent committed negligence on November 23, 2018, by failing to adequately evaluate radiographs taken for animal patient Clay.

h. Throughout hospitalization and treatment following perineal urethrostomy surgery, Respondent committed negligence by failing to provide appropriate pain control for animal patient Clay.

i. Respondent committed negligence by failing to examine geriatric animal patient Clay and discuss with the client treatment options regarding lower urinary tract disease.

j. Respondent committed negligence by proceeding immediately to surgery without discussing with the client other treatment options for Clay.

k. On November 23, 2018, Respondent committed negligence by releasing Clay to go home in a severely debilitating condition.

l. On November 23, 2018, Respondent committed negligence by failing to evaluate his animal patient Clay, before release from medical care.

m. On November 23, 2018, Respondent committed negligence by failing to adequately evaluate radiographs taken for animal patient Clay.

Complainant refers to and incorporates all the allegations contained in paragraphs 121 through 130, as though set forth fully.

THIRTY-EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

132. Respondent is subject to disciplinary action under section 4883, subdivision (g), for committing unprofessional conduct, by performing surgery on animal patient Clay, without establishing a Veterinarian-Client-Patient Relationship. Complainant refers to and incorporates all the allegations contained in paragraphs 121 through 131, as though set forth fully.

THIRTY-NINTH CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

133. Respondent is subject to disciplinary action under section 4883, subdivision (o), for violating the following regulations:

a. California Code of Regulations, title 16, section 2032.4(b)(1) (Anesthesia): Respondent failed to document the results of a physical exam in the medical record for animal patient Clay, within 12 hours before anesthesia.

b. California Code of Regulations, title 16, section 2032.1 (Veterinarian-Client-Patient Relationship (VCPR)): On November 19, 2018, Respondent failed to examine Clay and communicate with S.M. about Clay's condition, failing to establish a VCPR.

Complainant refers to and incorporates all the allegations contained in paragraphs 121 through 132, as though set forth fully.

PREMISES INSPECTIONS

134. On or about March 1, 2017, Board hospital inspectors, accompanied by investigators from the Division of Investigation, Department of Consumer Affairs, conducted inspections at AVVC, ACVC, and CCVH. The Board hospital inspectors found multiple items at each facility that Respondent could not verify as being in compliance with minimum standards for a veterinary practice, as set forth in paragraphs 135 and 136, below.

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FORTIETH CAUSE FOR DISCIPLINE

(Failure to Maintain Proper Records)

135. Respondent is subject to disciplinary action under sections 4883, subdivision (o), of the Code, for violating California Code of Regulations, title 16, section 2032.3(c)(2). Specifically, the radiographs submitted by Respondent in connection with the Board's March 1, 2017, inspection of AVVC, fail to document the name of the veterinarian or veterinary hospital on the image. Complainant refers to and incorporates all the allegations contained in paragraphs 23 through 133, as though set forth fully.

FORTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Minimum Standards for Fixed Veterinary Premises)

136. Respondent is subject to disciplinary action under sections 4883, subdivision (o), of the Code, for violating the following regulations pertaining to minimum standards for fixed veterinary premises:

Antelope Valley Veterinary Center (AVVC)

a. California Code of Regulations, title 16, section 2030(f)(4) and California Code of Regulations, title 17, section 30255(b)(2): Radiographs submitted by Respondent fail to verify consistent physical collimation is used at AVVC.

b. California Code of Regulations, title 16, section 2030(g)(2): Respondent stores ultrasound and endoscopy units (non-surgery related items) in a closet in the sterile surgery room.

All Creatures Veterinary Center (ACVC):

c. California Code of Regulations, title 16, sections 2030(f)(4) and California Code of Regulations, title 17, section 30255(b)(2):

i. Respondent failed to provide proof of current X-ray machine registration with the California Department of Public Health.

ii. Respondent failed to provide proof of the purchase new x-ray gown and gloves.

d. California Code of Regulations, title 16, section 2030(g)(2) (separate surgery room): Respondent stores ultrasound and endoscopy machines in a closet in the sterile surgery room at ACVC.

e. California Code of Regulations, title 16, section 2030(f)(6) / Code of Federal Regulations, title 21, section 1304.22(c) (Drug Logs): Drug dispensation logs at ACVC fail to include the information required by federal regulation.

Canyon Country Veterinary Hospital (CCVH)

f. California Code of Regulations, title 16, sections 2030(g)(9) and (10) (Surgical Packs and Sterile Indicators): Respondent failed to verify proper use and dating of surgical instrument pouches.

g. California Code of Regulations, title 16, section 2030(f)(6) / Code of Federal Regulations, title 21, section 1304.22(c) (Drug Logs): Drug dispensation logs fail to include the information required by federal regulation.

Complainant refers to and incorporates all the allegations contained in paragraphs 134 and 135, as though set forth fully.

JURISDICTION FOR PETITION TO REVOKE PROBATION

137. This Accusation and Petition to Revoke Probation is brought before the Veterinary Medical Board (Board), Department of Consumer Affairs under Probation Term and Condition Number 9 of the Decision and Order *In the Matter of the Accusation against Balpal S. Sandhu*, Case No. AV 2015 22, effective May 29, 2016. That term and condition states:

> If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, or if the Attorney General's Office has been requested to prepare any disciplinary action against Respondent's license, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws)

138. At all times after the effective date of Respondent's probation, Condition 1 (Obey All Laws) states:

> Respondent shall obey all federal and state laws and regulations substantially related to the practice of veterinary medicine. Further, within thirty (30) days of any arrest or conviction. Respondent shall report to the Board and provide proof of

compliance with the terms and conditions of the court order including, but not limited to, probation and restitution requirements.

139. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 1, referenced above. Specifically, Respondent failed to obey all laws, in that he repeatedly violated Business and Professions Code sections 4883, and 4855. Complainant incorporates by reference paragraphs 23 through 136, above, as though fully set forth herein.

SECOND CAUSE TO REVOKE PROBATION

(Failed to Comply with Quarterly Reports Requirement)

140. At all times after the effective date of Respondent's probation, Condition 2 (Quarterly Reports and Interviews) states:

> Respondent shall report quarterly to the Board or its designee, under penalty of perjury, on forms provided by the Board, stating whether there has been compliance with all terms and conditions of probation. In addition, the Board at its discretion may request additional in-person reports of the probationary terms and conditions. If the final written quarterly report is not made 11 as directed, the period of probation shall be extended until such time as the final report is received by the Board. Respondent shall make available all patient records, hospital records, books, logs, and other documents to the Board, upon request."

141. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 2, referenced above. Specifically, Respondent failed to timely submit the following Quarterly Reports:

a. Quarter 4 of 2016, due January 5, 2017, submitted March 21, 2017;

b. Quarter 2 of 2017, due July 5, 2017, no report was submitted for quarter;

c. Quarter 3 of 2017, due October 5, 2017, submitted November 2, 2017;

d. Quarter 4 of 2017, due January 5, 2018, submitted January 22, 2018;

e. Quarter 2 of 2018, due July 5, 2018, submitted July 16, 2018;

f. Quarter 3 of 2018, due October 5, 2018, submitted October 23, 2018; and

g. Quarter 2 of 2019, due July 5, 2019, no report was submitted for quarter.

THIRD CAUSE TO REVOKE PROBATION

(Failure to File Monthly Supervisor Reports)

142. At all times after the effective date of Respondent's probation, Condition 13 (Monthly Supervisor Reports) states, in part:

> Respondent's orthopedic surgery supervisor shall file monthly reports with the Board. These reports shall be in a form designated by the Board and shall include a narrative section where the orthopedic surgery supervisor provides his or her conclusions and opinions concerning the issues described above and the basis for his or her conclusions and opinions. Additionally, the orthopedic surgery supervisor shall maintain and' submit with his or her monthly reports a log designating the name(s) of the patients and date(s) ·of orthopedic surgeries performed, patient charts reviewed, and the date(s) upon which the review occurred. If the orthopedic surgery supervisor terminates or is otherwise no longer available, Respondent shall not practice orthopedic surgery until a new orthopedic surgery supervisor has been approved by the Board.

143. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 3, referenced above. Specifically, Respondent failed to have his orthopedic surgery supervisory file monthly reports for the months of December 2016, January 2017, February 2017, March 2017, October 2018, April 2019, May 2019, June 2019, July 2019, August 2019, and September of 2019.

FOURTH CAUSE TO REVOKE PROBATION

(Failure to Submit Proof of Community Service)

144. At all times after the effective date of Respondent's probation, Condition 16 (Community Service) states, in part:

> Within sixty (60) days of the effective date of this decision, Respondent shall submit a community service program to the Board for its prior approval. In this program Respondent shall provide free services on a regular basis to a community or charitable facility or agency for at least fifteen (15) hours for the first year of probation. All services shall be subject to prior Board approval.

145. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 16, referenced above. Specifically, Respondent failed to timely submit proof to the Board that he performed the required 15 hours of community service in the first year of his

probation, which ended May 29, 2017. Respondent submitted proof of said community service, but not within the first year as required.

FIFTH CAUSE TO REVOKE PROBATION

(Failure to Complete Continuing Education)

146. At all times after the effective date of Respondent's probation, Condition 14 (Continuing Education) states, in part:

> Within sixty (60) days of the effective date of this decision, and on an annual basis thereafter, Respondent shall submit to the Board for its prior approval, an educational program or courses, as follows, for no less than the designated hours, for each year of probation: Orthopedic Surgery (5 hours) and Record Keeping (5 hours). Respondent shall provide proof of completion to the Board. This program shall be in addition to the Continuing Education required of all licensees. All costs shall be borne by Respondent.

147. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 14, referenced above. Specifically, Respondent failed to timely submit proof to the Board that he completed 5 hours of continuing education in record keeping in 2016, 5 hours of continuing education in orthopedic surgery and 5 hours of continuing education in recordkeeping in 2017, and 5 hours of orthopedic surgery in 2019. Respondent was late in submitting his proof of completion of the continuing education during these periods.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation and Petition to Revoke Probation, and that following the hearing, the Veterinary Medical Board issue a decision:

1. Revoking the probation that was granted by the Veterinary Medical Board in Case No. AV 2015 22 and imposing the disciplinary order that was stayed thereby revoking Veterinarian License No. VET 13678 issued to Balpal S. Sandhu;

2. Revoking or suspending Veterinarian License No. VET 13678, issued to Balpal S. Sandhu;

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3. Revoking the probation that was granted by the Veterinary Medical Board in Case No. AV 2015 22 and imposing the disciplinary order that was stayed thereby revoking Premises Registration No. HSP 6663 issued to AV Veterinary Center, Balpal S. Sandhu;

4. Revoking or suspending Premises Registration No. HSP 6663, issued to AV Veterinary Center, Balpal S. Sandhu;

5. Revoking the probation that was granted by the Veterinary Medical Board in Case No. AV 2015 22 and imposing the disciplinary order that was stayed thereby revoking Premises Registration No. HSP 6152 issued to All Creatures Veterinary Center, Balpal S. Sandhu;

6. Revoking or suspending Premises Registration No. HSP 6152, issued to All Creatures Veterinary Center, Balpal S. Sandhu;

7. Revoking the probation that was granted by the Veterinary Medical Board in Case No. AV 2015 22 and imposing the disciplinary order that was stayed thereby revoking Premises Registration No. HSP 5668 issued to Canyon Country Veterinary Hospital, Balpal S. Sandhu;

8. Revoking or suspending Premises Registration No. HSP 5668, issued to Canyon Country Veterinary Hospital, Balpal S. Sandhu;

9. Assessing a fine against Balpal S. Sandhu not in excess of $5,000 for any of the causes specified in Business and Professions Code section 4883.

10. Ordering Balpal S. Sandhu, AV Veterinary Center, Balpal S. Sandhu, All Creatures Veterinary Center, Balpal S. Sandhu and Canyon Country Veterinary Hospital, Balpal S. Sandhu to pay the Veterinary Medical Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

11. Taking such other and further action as deemed necessary and proper.

DATED: November 4, 2019

SIGNATURE ON FILE

JESSICA SIEFERMAN
Executive Officer
Veterinary Medical Board
Department of Consumer Affairs
State of California
Complainant

LA2018601203/53701040_4

Exhibit A

Decision and Order

Veterinary Medical Board Case No. AV 2015 22

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BALPAL S. SANDHU Canyon Country Veterinary Hospital 1055 W. Columbia Way, #103 Lancaster, CA 93534 Premises License No. HSP 5668; AV Veterinary Center 1055 W. Columbia Way, #103 Lancaster, CA 93534 Premises License No. HSP 6663; and All Creatures Veterinary Center 22722 Lyons Avenue, #5103 Newhall, CA 91321 Premises License No. HSP 6152; **Veterinary License No. VET 13678** Respondent.	Case No. AV 2015 22 OAH No. 2015070157

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Veterinary Medical Board, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on May 29, 2016.

It is so ORDERED April 29, 2016.

Mark Nunez DVM
FOR THE VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS

KAMALA D. HARRIS
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General
ELYSE M. DAVIDSON
Deputy Attorney General
State Bar No. 285842
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2533
Facsimile: (213) 897-2804
Attorneys for Complainant

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BALPAL S. SANDHU** Canyon Country Veterinary Hospital 1055 W. Columbia Way, #103 Lancaster, CA 93534 **Premises License No. HSP 5668;** AV Veterinary Center 1055 W. Columbia Way, #103 Lancaster, CA 93534 **Premises License No. HSP 6663;** and All Creatures Veterinary Center 22722 Lyons Avenue, #5103 Newhall, CA 91321 **Premises License No. HSP 6152;** **Veterinary License No. VET 13678** Respondent.	Case No. AV 2015 22 OAH No. 2015070157 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

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PARTIES

1. Annemarie Del Mugnaio ("Complainant") is the Executive Officer of the Veterinary Medical Board. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Elyse M. Davidson, Deputy Attorney General.

2. Respondent Balpal S. Sandhu ("Respondent") is represented in this proceeding by attorney Shauna Fraser, whose address is: Lewis Brisbois Bisgaard & Smith, LLP, 633 W. 5th Street, Suite 4000, Los Angeles, CA 90017.

3. On or about June 14, 1999, the Veterinary Medical Board ("Board") issued Veterinary License No. VET 13678 to Respondent Balpal S. Sandhu. The Veterinary License was in full force and effect at all times relevant to the charges brought in Accusation No. AV 2015 22 and will expire on May 31, 2017, unless renewed.

4. Respondent has been associated as the managing licensee of AV Veterinary Center, Premises License No. HSP 6663 since November 6, 2009. Said license is current and will expire on May 15, 2016, unless renewed. Respondent has been associated as the managing licensee of Canyon Country Veterinary Hospital, Premises License No. HSP 5668 since April 15, 2012. Said license is current and will expire on May 15, 2016, unless renewed. Respondent has been associated as managing licensee of All Creatures Veterinary Center, Premises License No. HSP 6152 since May 14, 2012. Said license is current and will expire on May 15, 2016, unless renewed.

JURISDICTION

5. Accusation No. AV 2015 22 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 6, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

6. A copy of Accusation No. AV 2015 22 is attached as exhibit A and incorporated herein by reference.

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ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. AV 2015 22. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

10. Respondent understands that the charges and allegations in Accusation No. AV 2015 22 if proven at a hearing, constitute cause for imposing discipline upon his Veterinary License No. VET 13678, Premises License No. HSP 6663, Premises License No. HSP 5668, and Premises License No. HSP 6152.

11. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

12. Respondent agrees that his Veterinary License and Premises Licenses are subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

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CONTINGENCY

13. This stipulation shall be subject to approval by the Veterinary Medical Board. Respondent understands and agrees that counsel for Complainant and the staff of the Veterinary Medical Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. This Stipulated Settlement and Disciplinary Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Veterinary License No. VET 13678, Premises License No. HSP 5668, Premises License No. HSP 6152, and Premises License No. HSP 6663 issued to Respondent Balpal S. Sandhu are revoked. However, the revocations are stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. **Obey All Laws.**

Respondent shall obey all federal and state laws and regulations substantially related to the practice of veterinary medicine. Further, within thirty (30) days of any arrest or conviction. Respondent shall report to the Board and provide proof of compliance with the terms and conditions of the court order including, but not limited to, probation and restitution requirements.

2. **Quarterly Reports and Interviews**

Respondent shall report quarterly to the Board or its designee, under penalty of perjury, on forms provided by the Board, stating whether there has been compliance with all terms and conditions of probation. In addition, the Board at its discretion may request additional in-person reports of the probationary terms and conditions. If the final written quarterly report is not made as directed, the period of probation shall be extended until such time as the final report is received by the Board. Respondent shall make available all patient records, hospital records, books, logs, and other documents to the Board, upon request.

3. **Cooperation with Probation Surveillance**

Respondent shall comply with the Board's probation surveillance program. All costs for probation monitoring and/or mandatory premises inspections shall be borne by Respondent. Probation monitoring costs are set at a rate of $100 per month for the duration of the probation. Respondent shall notify the Board of any change of name or address or address of record within thirty (30) days of the change. Respondent shall notify the Board immediately in writing if Respondent leaves California to reside or practice in another state. Respondent shall notify the Board immediately upon return to California.

4. **No Preceptorships or Supervision of Interns**

Respondent shall not supervise a registered intern and shall not perform any of the duties of a preceptor.

5. **Notice to Employers**

Respondent shall notify all present and prospective employers of the decision in this case and the terms, conditions, and restrictions imposed on Respondent by the decision in this case. Within thirty (30) days of the effective date of this decision and within fifteen (15) days of

Respondent undertaking new employment, Respondent shall cause his employer to report to the Board in writing, acknowledging the employer has read the Accusation and decision in this case and understands Respondent's terms and conditions of probation. Relief veterinarians shall notify employers immediately.

6. **Notice to Employees**

Respondent shall, upon or before the effective date of this decision, post or circulate a notice which actually recites the offenses for which Respondent has been disciplined and the terms and conditions of probation, to all employees, and to any preceptor, intern or extern involved in his veterinary practice. Within fifteen (15) days of the effective date of this decision, Respondent shall cause his employees to report to the Board in writing, acknowledging the employees have read the Accusation and decision in the case and understand Respondent's terms and conditions of probation.

7. **Owners and Officers (Corporations or Partnerships): Knowledge of the Law**

Respondent shall provide, within thirty (30) days after the effective date of the decision, signed and dated statements from the owners, officers, or any owner or holder of ten percent (10%) or more of the interest in Respondent or Respondent's stock, stating said individuals have read and are familiar with federal and state laws and regulations governing the practice of veterinary medicine.

8. **Tolling of Probation**

If Respondent resides out of state upon or after effective date of the decision, he must comply with the following conditions only: quarterly reports and interviews, tolling of probation, continuing education and cost recovery. If Respondent returns to California he must comply or be subject to all probationary conditions for the period of probation.

Respondent, during probation, shall engage in the practice of veterinary medicine in California for a minimum of 24 hours per week for six (6) consecutive months or as determined by the Board. Should Respondent fail to engage in the practice of veterinary medicine in California as set forth above, the time outside of the practice shall not apply to reduction of the probationary terms.

9. **Violation of Probation**

If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, or if the Attorney General's office has been requested to prepare any disciplinary action against Respondent's license, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. **Completion of Probation**

All costs for probation monitoring and/or mandatory premises inspections shall be borne by Respondent. Failure to pay all costs due shall result in an extension of probation until the matter is resolved and costs paid. Upon successful completion of probation and all payment of all fees due, Respondent's license will be fully restored.

11. **Cost Recovery and Payment of Fines**

Pursuant to Section 125.3 of the California Business and Professions Code, within thirty (30) days of the effective date of this decision, Respondent shall pay to the Board its costs of investigation and enforcement in the amount of $8,250.00 or the Respondent may make payments as follows: Thirty (30) equal consecutive monthly payments of $275.00, the first monthly payment due within thirty (30) days of the effective date of this decision.

12. **Limitation on Practice/Inspections**

During probation, Respondent is prohibited from the following:

1. Practicing veterinary medicine from a location or mobile veterinary practice which does not have a current premises permit issued by the Board; and

2. If Respondent is the owner or managing licensee of a veterinary practice, the following probationary conditions apply:

(a) The location or mobile veterinary practice must not only have a current premises permit issued by the Board, but must also be subject to inspections by a Board representative to determine whether the location or veterinary practice meets minimum standards for a veterinary practice. The inspections will be conducted on an announced or unannounced basis and shall be

held during normal business hours. The Board reserves the right to conduct these inspections on at least a quarterly basis during probation. Respondent shall pay the Board for the cost of each inspection, which is $500.

(b) As a condition precedent to any Premises Permit issued to Respondent as Owner or managing licensee, the location or mobile veterinary practice for which application is made shall be inspected by a Board representative to determine whether the location or mobile veterinary practice meets minimum standards for a veterinary practice. Respondent shall submit to the Board, along with any premises permit application, a $500 inspection fee.

13. **Supervised Practice**

Respondent shall perform orthopedic surgeries only under the supervision of a veterinarian approved by the Board. The supervision shall occur during each and every orthopedic surgery performed by Respondent during the term of probation. All costs involved with practice supervision shall be borne by Respondent.

The orthopedic surgery supervisor shall have been licensed as a veterinarian in California for at least five (5) years, and not have ever been subject to any disciplinary action by the Board. The orthopedic surgery supervisor shall be independent, with no prior business or personal relationship with Respondent and the orthopedic surgery supervisor shall not be in a familial relationship with or be an employee, partner, or associate of Respondent.

Within thirty (30) days of the effective date of the decision, Respondent shall have his orthopedic surgery supervisor submit a report to the Board in writing stating the orthopedic surgery supervisor has read the Decision and Order adopting this stipulation in Accusation Case No. AV 2015 22. Should Respondent change employment, Respondent shall have his new orthopedic surgery supervisor, within fifteen (15) days after employment commences, submit a report to the Board in writing stating the orthopedic surgery supervisor has read the decision in Case No. AV 2015 22.

In addition to being present and directly supervising each orthopedic surgery, Respondent's orthopedic surgery supervisor shall also review and evaluate all orthopedic surgery patient records of those patients for whom Respondent performs orthopedic surgery on a monthly basis

during the term of probation. The orthopedic surgery supervisor shall review these records to assess the following in his or her monthly report to the Board:

1) the medical necessity and appropriateness of Respondent's treatment;

2) Respondent's compliance with community standards of practice in the diagnosis and treatment of animal patients;

3) Respondent's maintenance of necessary and appropriate treatment;

4) Respondent's maintenance of necessary and appropriate records and chart entries; and

5) Respondent's compliance with existing statutes and regulations governing the practice of orthopedic surgery in veterinary medicine.

Respondent's orthopedic surgery supervisor shall file monthly reports with the Board. These reports shall be in a form designated by the Board and shall include a narrative section where the orthopedic surgery supervisor provides his or her conclusions and opinions concerning the issues described above and the basis for his or her conclusions and opinions. Additionally, the orthopedic surgery supervisor shall maintain and' submit with his or her monthly reports a log designating the name(s) of the patients and date(s) of orthopedic surgeries performed, patient charts reviewed, and the date(s) upon which the review occurred. If the orthopedic surgery supervisor terminates or is otherwise no longer available, Respondent shall not practice orthopedic surgery until a new orthopedic surgery supervisor has been approved by the Board.

Respondent may petition the Board for the modification of this term of probation one (1) year following the effective date of the Decision and Order adopting this stipulation upon the recommendation of the orthopedic surgery supervisor.

14. **Continuing Education**

Within sixty (60) days of the effective date of this decision, and on an annual basis thereafter, Respondent shall submit to the Board for its prior approval, an educational program or courses, as follows, for no less than the designated hours, for each year of probation: Orthopedic Surgery (5 hours); and Record Keeping (5 hours). Respondent shall provide proof of completion to the Board. This program shall be in addition to the Continuing Education required of all licensees. All costs shall be borne by Respondent.

15. **Clinical Training**

Within sixty (60) days of the effective date of this decision, Respondent shall submit an outline of a ten (10) hour orthopedic surgery intensive clinical training program to the Board for its prior approval. Respondent shall successfully complete the training program and may be required to pass an examination related to the program's contents administered by the Board or its designee. All costs shall be borne by Respondent.

16. **Community Service**

Within sixty (60) days of the effective date of this decision, Respondent shall submit a community service program to the Board for its prior approval. In this program Respondent shall provide free services on a regular basis to a community or charitable facility or agency for at least fifteen (15) hours for the first year of probation. All services shall be subject to prior Board approval.

17. **Fine**

Respondent shall pay to the Board a fine in the amount of $1,000.00 pursuant to Business and Professions Code sections 4875 and 4883. Respondent shall pay the $1,000.00 fine to the Board within ninety (90) days of the effective date of this Decision and Order.

Pursuant to Business and Professions Code Section 125.3, enforcement costs (investigative, legal, and expert review), up to the time of the hearing, can be recovered.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Shauna Fraser. I understand the stipulation and the effect it will have on my Veterinary License and Premises Licenses. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Veterinary Medical Board.

DATED: 02/18/2016

BALPAL S. SANDHU
Respondent, Managing Licensee of:
Canyon Country Veterinary Hospital, Premises License No. HSP 5668;
AV Veterinary Center, Premises License No. HSP 6663;
All Creatures Veterinary Center, Premises License No. HSP 6152.

I have read and fully discussed with Respondent Balpal S. Sandhu the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

SHAUNA FRASER
Attorney for Respondent

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Shauna Fraser. I understand the stipulation and the effect it will have on my Veterinary License and Premises Licenses. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Veterinary Medical Board.

DATED: _____

BALPAL S. SANDHU
Respondent, Managing Licensee of:
Canyon Country Veterinary Hospital, Premises License No. HSP 5668;
AV Veterinary Center, Premises License No. HSP 6663;
All Creatures Veterinary Center, Premises License No. HSP 6152.

I have read and fully discussed with Respondent Balpal S. Sandhu the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/18/16

SHAUNA FRASER
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Veterinary Medical Board.

DATED: 02/19/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General

ELYSE M. DAVIDSON
Deputy Attorney General
Attorneys for Complainant

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KAMALA D. HARRIS
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General
SYDNEY M. MEHRINGER
Deputy Attorney General
State Bar No. 245282
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2537
Facsimile: (213) 897-2804
E-mail: Sydney.Mehringer@doj.ca.gov
Attorneys for Complainant

BEFORE THE
VETERINARY MEDICAL BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BALPAL S. SANDHU** **1055 W. Columbia Way, #103** **Lancaster, CA 93534** **Veterinary License No. VET 13678** Respondent.	Case No. AV 2015 22 **ACCUSATION**

Complainant alleges:

PARTIES

1. Annemarie Del Mugnaio ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Veterinary Medical Board, Department of Consumer Affairs.

2. On or about June 14, 1999, the Veterinary Medical Board ("Board") issued Veterinary License No. VET 13678 to Balpal S. Sandhu, DVM ("Respondent"). The Veterinary License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2017, unless renewed.

3. Respondent has been associated as the managing licensee of AV Veterinary Center, Premises License No. HSP 6663 since November 6, 2009. Said license is current and will expire on May 15, 2016, unless renewed. Respondent has been associated as the managing licensee of

Canyon Country Veterinary Hospital, Premises License No. HSP 5668 since April 15, 2012. Said license is current and will expire on May 15, 2016, unless renewed. Respondent has been associated as managing licensee of All Creatures Veterinary Center, Premises License No. HSP 6152 since May 14, 2012. Said license is current and will expire on May 15, 2016, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 4875 of the Code provides, in pertinent part, that the Board may revoke or suspend the license of any person to practice veterinary medicine, or any branch thereof, in this state for any causes provided in the Veterinary Medicine Practice Act (Bus. & Prof. Code § 4800, *et seq.*). In addition, the Board has the authority to assess a fine not in excess of $5,000 against a licensee for any of the causes specified in Section 4883 of that Code. Such fine may be assessed in lieu of, or in addition to, a suspension or revocation.

6. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of its authority to institute or continue with a disciplinary proceeding during the period within which the license may be renewed, restored, reissued or reinstated. Under Section 4843.5 of the Code, the Board may renew an expired license at any time within five years after the restoration.

STATUTES AND REGULATIONS

7. Section 4883 of the Code states, in pertinent part:

"The board may deny, revoke, or suspend a license or assess a fine as provided in Section 4875 for any of the following:

. . . .

"(i) Fraud, deception, negligence, or incompetence in the practice of veterinary medicine.

. . . .

"(o) Violation, or the assisting or abetting violation, of any regulations adopted by the board pursuant to this chapter [the Veterinary Medicine Practice Act]."

8. California Code of Regulations, title 16, section 2032, states:

"The delivery of veterinary care shall be provided in a competent and humane manner. All aspects of veterinary medicine shall be performed in a manner consistent with current veterinary medical practice in this state."

9. California Code of Regulations, title 16, section 2032.3, states, in pertinent part:

"(a) Every veterinarian performing any act requiring a license pursuant to the provisions of Chapter 11, Division 2, of the code, upon any animal or group of animals shall prepare a legible, written or computer generated record concerning the animal or animals which shall contain the following information:

. . . .

"(8) Treatment and intended treatment plan, including medications, dosages and frequency of use.

"(9) Records for surgical procedures shall include a description of the procedure, the name of the surgeon, the type of sedative/anesthetic agents used, their route of administration, and their strength if available in more than one strength.

. . . .

"(12) All medications and treatments prescribed and dispensed, including strength, dosage, quantity, and frequency of use."

10. California Code of Regulations, title 16, section 2032.4 states, in pertinent part:

"(a) General anesthesia is a condition caused by the administration of a drug or combination of drugs sufficient to produce a state of unconsciousness or dissociation and blocked response to a given pain or alarming stimulus.

"(b) When administering general anesthesia, a veterinarian shall comply with the following standards:

"(1) Within twelve (12) hours prior to the administration of a general anesthetic, the animal patient shall be given a physical examination by a licensed veterinarian appropriate for the procedure. The results of the physical examination shall be documented in the animal patient's medical records.

"(2) An animal under general anesthesia shall be observed for a length of time appropriate for its safe recovery."

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

BACKGROUND FACTS

12. On the evening of August 24, 2013, a consumer, P.M., brought her dog "Betty" to AV Veterinary Center because Betty had injured her left hind leg in a fight with another dog. Radiographs were taken which revealed that Betty had sustained multiple fractures of the metatarsals (small bones) and dislocations in the tarsal-metatarsal joints in her left rear leg and foot.

13. On the evening of August 25, 2013, Respondent performed surgery on Betty to repair the injuries. Respondent placed two K-wires, which are small, stiff, pin-like wires, into two bones in the foot to stabilize the bones and applied a splint made of a tongue depressor. Betty remained hospitalized until August 27, 2013 when she was released to P.M.

14. On or about September 1, 2013, P.M. brought Betty back to AV Veterinary Center for a re-check and bandage change.

15. P.M. grew discouraged with the progress of Betty's recovery and took Betty to see another veterinarian, Dr. Freng, on September 16, 2013. Dr. Freng saw Betty several times between September and November 2013 and treated her by changing her bandages and keeping her in a splint. However, no meaningful healing progress occurred.

16. On or about November 12, 2013, P.M. found one of the K-wires that Respondent had placed in Betty's foot lying on her carpet.

17. On November 14, 2013, P.M. took Betty to a third veterinarian, Dr. Sloan, who recommended that Betty have a second surgery to repair her foot and leg. On November 15, 2013, Betty underwent a second surgery. Dr. Sloan applied pins to all the broken bones and utilized a durable splinting method. Betty has made a full recovery.

FIRST CAUSE FOR DISCIPLINE

(Negligence)

18. Respondent is subject to disciplinary action under Code section 4883, subdivision (i), in conjunction with California Code of Regulations, title 16, section 2032, on the grounds of negligence in that between August 24 through August 27, 2013, Respondent failed to deliver treatment to Betty that was within the applicable standard of care. The facts and circumstances, which include by reference Paragraphs 12 through 17, as though fully set forth herein, are as follows:

(a) Respondent failed to adequately surgically repair Betty's fractured bones. Respondent attempted to repair the fracture to the fifth metatarsal (the long bone just below the hock or ankle) by placing a K-wire in the fifth metatarsal. No attempt was made to fix the fractures in the other four metatarsal bones. By failing to address the other fractures and dislocated metatarsal bones, Respondent failed to provide rotational stability to the fifth metatarsal.

(b) Respondent failed to adequately fuse Betty's tarsal/metatarsal joints. In order to properly fuse a joint, a veterinarian should remove all cartilage and other non-boney tissues from the joint, apply a bone-graft or similar product to facilitate new bone growth, and apply devices to provide complete immobility (i.e., prevent any movement from side to side, front to back, rotation, and slippage) for four to eight weeks. Betty had at least three dislocated joints that needed to be treated but Respondent only treated one dislocated joint. Moreover, the one dislocated joint that Respondent did treat was treated improperly. Respondent did not use a bone graft or similar product and used only a small K-wire placed through the fourth metatarsal bone and into the small bones of the tarsus (hock or ankle) and a tongue depressor. These methods failed to ensure complete immobility and Betty's joints continued to be severely dislocated.

(c) Respondent failed to recognize that Betty had fractures in her other metatarsals besides the fifth metatarsal and failed to recognized that Betty had multiple joint dislocations, thus he failed to adequately interpret Betty's pre-operative radiographs. Additionally, there are no notes in the medical records specifically describing which bones were fractured nor are the dislocated joints mentioned in any of the medical records.

(d) Respondent failed to adequately monitor Betty post-surgery. The surgery occurred between 9:30 p.m. and 10:00 p.m. on August 25, 2013. Betty was not checked again until approximately 2:30 a.m. on August 26, 2013. At that time, her respiratory rate had become elevated but there are no notes in the medical records indicating that this was considered. Betty was not checked again until approximately 7:00 a.m.

(e) The post-operative radiographs show that a very large area of the patient was included in the radiographs, rather than focusing on the surgical site. The images are inadequate to fully assess the extent of the injuries and the effectiveness of the surgery. Additionally, there are no notes in the medical records describing the results of the post-operative radiographs.

SECOND CAUSE FOR DISCIPLINE

(Record Keeping Violations)

19. Respondent is subject to disciplinary action under Code section 4883, subdivision (o), in conjunction with California Code of Regulations, title 16, section 2032.3, on the grounds of violating regulations regarding record keeping. The facts and circumstances are as follows:

(a) Respondent failed to document treatment information and failed to adequately record the strength, dose, and frequency of all medications administered to Betty in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(8) and subdivision (a)(12). Prior to surgery, the medical records state that at 6:00 p.m. on August 25, 2013, an intravenous "MLK [drip] @3ml/hr" was started. This is a common abbreviation for a mixture of three different injectable pain medications, i.e., morphine, lidocaine, and ketamine. However, the concentration of medications is not listed. At 9:30 p.m. on August 25, 2013, the medical records state that the intravenous drip was increased to 30ml/hr. However, there are no notes to indicate how long that rate was maintained.

(b) Respondent failed to properly document the surgical procedure in violation of California Code of Regulations, title 16, section 2032.3, subdivision (a)(9). The medical records indicate that Respondent made a "cranio-plantar incision." This is a confusing term given that "cranial" means "towards the head" (and while not typically used when referring to extremities) would refer to the top of the foot while "plantar" refers to the bottom of the foot. The standard approach for a surgery such as the one at issue would be from the front. The medical records also indicate that Respondent "curated[1] [sic] [the] tarsal and metatarsal bones" but they do not indicate which bone or bones Respondent is referring to. There were multiple dislocated joints and fractures and the medical records do not indicate which surfaces were curetted.

THIRD CAUSE FOR DISCIPLINE

(Anesthesia Violations)

20. Respondent is subject to disciplinary action under Code section 4883, subdivision (o), in conjunction with California Code of Regulations, title 16, section 2032.4, subdivision (b)(1) and subdivision (b)(2) on the grounds of violating regulations regarding anesthesia. The facts and circumstances are as follows:

(a) Betty's surgery was performed between 9:30 p.m. and 10:00 p.m. on August 25, 2013 and she was sedated by anesthesia throughout the procedure. Respondent failed to perform, or failed to cause to be performed, a physical exam of Betty within 12 hours of anesthesia. A physical exam was performed at approximately 10:30 p.m. on August 24, 2013 by another veterinarian. Respondent administered anesthesia and performed the surgery at 9:30 p.m. on August 25, 2013, and another physical exam was not performed again until approximately 6:30 p.m. on August 26, 2013. Respondent also failed to adequately observe Betty, or failed to cause Betty to be adequately observed, following general anesthesia.

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[1] A "curette" is a surgical instrument that has a scoop, ring, or loop at the tip and is used in performing curettage, which in turn is a surgical scraping or cleaning by means of a curette. This practice is generally used to remove cartilage from surfaces in a joint that is going to be fused.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Veterinary Medical Board issue a decision:

1. Revoking or suspending Veterinary License No. VET 13678, issued to Balpal S. Sandhu;

2. Assessing a fine against Balpal S. Sandhu not in excess of $5,000 for any of the causes specified in Business and Professions Code section 4883;

3. Ordering Balpal S. Sandhu to pay the Veterinary Medical Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

4. Taking such other and further action as deemed necessary and proper.

DATED: May 4, 2015

ANNEMARIE DEL MUGNAIO
Executive Officer
Veterinary Medical Board
Department of Consumer Affairs
State of California
Complainant

LA2015500613
51767718.doc

EXHIBIT 4

Veterinary Medical Board

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • VETERINARY MEDICAL BOARD
1747 North Market Blvd., Suite 230, Sacramento, CA 95834-2987
P (916) 515-5220 | Toll-Free (866) 229-0170 | www.vmb.ca.gov

COST CERTIFICATION
CASE # 4602025000207
Balpal S. Sandhu, DVM

I, Ashley Sanchez, declare that I am an Enforcement Manager at the California Veterinary Medical Board, and, in that capacity, certify pursuant to the provisions of the Business and Professions Code Section 4808 and the California Code of Regulations Title 16, Section 2003, Petition for Reinstatement or Modification of Penalty No. 4602025000207 to be filed against Balpal Sandhu, DVM, who was formally licensed by this agency as a Veterinarian, and who held license number VET 13678.

In my capacity as manager, I review and approve payments for costs incurred by the Board while enforcing the laws and regulations under its jurisdiction. I have reviewed the records of the agency and the following costs have been incurred by the agency in connection with the investigation of the Accusation and Petition to Revoke Probation Decision and Order No. 4602016000085.

1.	**Cost Recovery**	**$ 47,512.11**
	Fine	**$ 5,000.00**
	TOTAL COSTS	**$ 52,512.011**

I certify pursuant to the provisions of Section 4808 of the Business and Professions Code of the State of California and Title 16, Section 2003 of the California Code of Regulations that, to the best of my knowledge, the foregoing statement of costs incurred by the California Veterinary Medical Board is true and correct and that the amounts set forth therein do not exceed the actual and reasonable costs of investigation in the Accusation and Petition to Revoke Probation Decision and Order No. 4602016000085.

Dated: February 7, 2025 SIGNATURE ON FILE

Ashley Sanchez, Enforcement Manager
VETERINARY MEDICAL BOARD

EXHIBIT 5

CLEAR FORM

VMB Veterinary Medical Board

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY · GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS · VETERINARY MEDICAL BOARD
1747 North Market Blvd., Suite 230, Sacramento, CA 95834-2978
P (916) 515-5220 | Toll-Free (866) 229-0170 | www.vmb.ca.gov

PETITION FOR REINSTATEMENT OR MODIFICATION OF PENALTY

INSTRUCTIONS: **Please type or print neatly**. All blanks must be completed; if not applicable enter N/A. If more space is needed attach additional sheets. Attached to this application should be a "Narrative Statement" and two original verified recommendations from a veterinarian licensed by the Board who has personal knowledge of activities since the disciplinary action was imposed.

TYPE OF PETITION [Reference Business and Professions Code section 4887]

☑ Reinstatement of Revoked/Surrendered License or Registration ☐ Modification of Probation ☐ Termination of Probation

NOTE: A Petition for Modification and/or Termination of Probation can be filed together. If you are requesting Modification, you must specify in your "Narrative Statement" the term(s) and condition(s) of your probation that you want reduced or modified and provide an explanation. Please check all boxes above that apply.

PERSONAL INFORMATION

NAME: First	Middle	Last
Balpal		Sandhu

Other name(s) licensed under, if any:

HOME ADDRESS: Number & Street [redacted] City [redacted] State Zip [redacted]

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL NUMBER
( )	( )	[redacted]

E-mail address:	CA License or Registration Number
[redacted]	13678

Are you licensed by any other state(s) or country(ies) (please include license number(s), issue date(s), and status of license(s)):

ATTORNEY INFORMATION (If Applicable)

Will you be represented by an attorney? ☐ No ☑ Yes (If "Yes," please provide the following information)

NAME: Bonnie L. Lutz

ADDRESS: 2 Park Plaza, Ste. 1250 Irvine , CA 92614

PHONE: (949) 868-2600

DISCIPLINARY INFORMATION

Provide a brief explanation in your "Narrative Statement" as to the cause for the disciplinary action (e.g., negligence or incompetence, self use of drugs or alcohol, extreme departures from sanitary conditions, conviction of a crime, etc.)

Have you ever had your license revoked, suspended, voluntarily surrendered, denied, or placed on probation in any other state or country? ☑ No ☐ Yes

(If Yes, give a brief cause for administrative action or license denial in your "Narrative Statement" section, including dates and discipline ordered (e.g., 5 years probation.)

VETERINARIAN/REGISTERED TECHNICIAN BACKGROUND

Total number of years in veterinary practice: 24

CONTINUING EDUCATION (List continuing education completed since the date of the disciplinary action)

WVC Annual Conference [02.18-23, 2023] 44 Hours [see attached]
Abdominal Ultrasound Training [05.31.2023] 8 Hours [see attached]
Developing your Emotional Intelligence [June 21-22, 2023] 10 Hours [see attached]
Veterinary Medicine: Multi-Modal Pain Management for Companion Animals [09.27.2023] 18 Hours
Veterinary General Soft Tissue Surgery [10.04.2023] 8 Hours [see attached]
Veterinary Pan Management Workshop [10.1.2023-11.19.2023] 12 Hours [see attached]
Medical Records the Roadmap to Quality Care [06.12.2024] 10 Hours [see attached]

CURRENT OCCUPATION OTHER THAN VETERINARIAN OR REGISTERED VET TECHNICIAN
(Answer only if currently not practicing as a Veterinarian or Registered Vet Technician)

List employer, address, e-mail address, phone number, job title, and duties:

Dr. Sandhu Animal Hospital, Inc
1055 W. Columbia #110
Lancaster, CA 93534

EMPLOYMENT HISTORY (list for the past 5 years only)

Provide the employer's name, address, phone number, job title and dates of employment:

Dr. Sandhu Animal Hospital, Inc 1055 W. Columbia #110 Lancaster, CA 93534

President

01/01/2009 - Current

REHABILITATION

Describe any rehabilitative or corrective measures you have taken since your license/registration was disciplined. List dates, nature of programs or courses, and current status. You may include any community service or volunteer work.

See attached.

CURRENT COMPLIANCE

Since the effective date of your last Veterinary Medical Board disciplinary action have you:

1. Been placed on criminal probation or parole?	☐ Yes	☑ No
2. Been charged in any pending criminal action by any state, local or federal agency or court?	☐ Yes	☑ No
3. Been convicted of any criminal offense? (A conviction includes a no contest plea; disregard traffic offenses with a $100 fine or less.)	☐ Yes	☑ No
4. Been charged or disciplined by any other veterinary board?	☐ Yes	☑ No
5. Surrendered your license to any other veterinary board?	☐ Yes	☑ No
6. Had your licensee manager's premise permit disciplined?	☐ Yes	☑ No
7. Had any civil malpractice claims filed against you of $10,000 or more?	☐ Yes	☑ No
8. Become addicted to the use of narcotics or controlled substances?	☐ Yes	☑ No
9. Become addicted to or received treatment for the use of alcohol?	☐ Yes	☑ No
10. Been hospitalized for alcohol or drug problems or for mental illness?	☐ Yes	☑ No

NOTE: If your answer is "Yes" to **any** of the above questions, please explain in the "Narrative Statement."

COST RECOVERY

Was cost recovery ordered? ○ Yes ◉ No If yes, what is the remaining balance? _____

When is payment anticipated? _____

DECLARATION

Executed on June 12th 20 24, at Lancaster (City), C A (State).

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that all statements and documents attached in support of this petition are true and correct.

Balpal Sandhu
Petitioner (print name)

Signature

The information in this document is being requested by the Veterinary Medical Board (Board) pursuant to Business and Professions Code section 4887. In carrying out its licensing or disciplinary responsibilities, the Board requires this information to make a determination on your petition for reinstatement or modification of penalty. You have a right to access the Board's records containing your personal information as defined in Civil Code section 1798.3. The Custodian of Records is the Executive Officer at the address shown on the first page.

EXHIBIT 6

Balpal Sandhu
[redacted]

May 28, 2024

Veterinary Medical Board
1747 N Market Blvd, Suite 230
Sacramento, CA 95834

Dear Members of the Veterinary Medical Board,

I am writing to address the circumstances that led to the revocation of my veterinary license (CA License Number: 13678) and to demonstrate the steps I have taken towards rehabilitation and ensuring that such issues do not recur in the future.

I acknowledge the serious concerns that led to the revocation of my license, which involved multiple violations, including failure to comply with conditions of my probation. Specifically, failure to submit timely and complete quarterly reports, delayed proof of community service. Additionally, there were deficiencies in my clinical practices, including inadequate pain management, failure to properly notate post operative monitoring, and improper medical recordkeeping. There were also cases that I was not the attending veterinarian for but I was the managing licensee for the premise these cases fell under. I understand the gravity of these violations and the impact they may have had on my clients, their pets, and the trust they placed in my professional care.

Throughout the past year, I've been deeply committed to advancing my knowledge and skills in veterinary medicine through a variety of educational opportunities. Perhaps the most enriching experience of the year was my participation in the WVC Annual Conference from February 18th to 23rd, 2023. Over the course of this event, I immersed myself in a diverse range of topics, accumulating a total of 44 hours of invaluable education. From exploring innovative pain management strategies to delving into the intricacies of leadership development and advanced medical techniques, each session broadened my perspective and deepened my understanding of veterinary medicine. I eagerly absorbed insights on cardiac ultrasound, behavior problem triaging, team leadership, and epidemiological trends in medication use, among many others. In May 2023, I completed an 8-hour "Abdominal Ultrasound Training" course to improve my skills in ultrasound techniques. In June 2023, I recognized the importance of emotional intelligence in my practice and invested 10 hours in "Developing Emotional Intelligence,"

which not only sharpened my clinical skills but also enhanced my ability to empathize with both patients and their human companions. September 2023 saw me engaging in an 18-hour session on "Multimodal Pain Management for Companion Animals," refining my understanding of critical pain management strategies. In October 2023, I dedicated 8 hours to a course on "Veterinary General Soft Tissue Surgery" to hone my surgical expertise. Additionally, from October 1st to November 19th, 2023, I immersed myself in a 12-hour "Veterinary Pain Management Workshop," delving into effective pain management strategies.

These educational endeavors reflect my unwavering dedication to continuous improvement and my commitment to providing the highest standard of care to my patients. I am grateful for the opportunity to grow and evolve as a veterinary professional, and I am eager to apply the knowledge and skills gained from these experiences to better serve the animals entrusted to my care.

I have sought mentorship from respected veterinarians who have guided me in improving my clinical practices. This mentorship has been invaluable in reinforcing proper medical procedures and ethical standards.

I am fully aware of the importance of adhering to regulatory standards and maintaining the highest level of professionalism in my practice. While I work towards reinstating my license, I am diligently preparing to implement rigorous internal controls and standard operating procedures to ensure compliance once again. This includes plans to adopt specific practices, technologies, or systems aimed at enhancing the accuracy and integrity of medical records and patient care. Additionally, I have helped develop a software system called Veterinary Management Systems (VMS) and a VMS library that is AI-based, similar to Cornerstone. This innovative system is designed to improve the management of veterinary practices, ensuring precise recordkeeping, better patient care, and streamlined operations.

I have been actively involved in community service, dedicating my time and expertise to volunteering at Kennedy Meadows Wild Canine. This experience has strengthened my connection to the community and reinforced my commitment to animal welfare.

On a personal level, I have dedicated myself to introspection and self-improvement, recognizing the importance of addressing any underlying issues that may have contributed to my past conduct. I have embarked on a journey of personal growth and

reflection, striving to cultivate a deeper understanding of myself and my motivations. This process has been instrumental in fostering a holistic approach to my professional responsibilities, as I endeavor to embody integrity, empathy, and accountability in all aspects of my practice. By prioritizing my own well-being and self-awareness, I am better equipped to serve my patients, clients, and the veterinary community with humility and compassion.

I am committed to upholding the highest standards of veterinary medicine and ensuring that the mistakes of the past are not repeated. I have developed a comprehensive plan to continuously monitor and evaluate my practices to ensure ongoing compliance with all relevant regulations and standards.

I respectfully request the Board to consider my application for the reinstatement of my veterinary license. I am eager to demonstrate my renewed dedication to the profession and to provide the highest level of care to my patients.

Thank you for your time and consideration.

Sincerely,

Balpal Sandhu
CA License Number: 13678

EXHIBIT 7

Jane Harris, DVM
[redacted]

May 24th, 2024

My name is Jane Arlene Harris, DVM. I have read and understand the charging document filed against Dr.Balpal Sandhu by the California Veterinary Board.

As a relief veterinarian, I first heard of Dr. Balpal Sandhu while working at his hospital, All Creatures Veterinary Clinic, in Newhall, California. 1 met and worked with some of his administrative staff and other employees but never actually met him in person until I worked at his company's largest hospital, Antelope ValleyVeterinary Center, in Lancaster, California. 1 was immediately surprised by the volume of patients seen and treated at AVVC. I was also impressed by the facility which is very clean and comfortable and has a CT scan, ultrasound,digital x-ray, and in-house laboratory in addition to standard equipment. During the COVID lockdown, clients often waited 4-8 hours to have their pets seen. There are many employees who have worked at AVVC for several years and respect Dr. Sandhu for his knowledge and skill and his treatment of his employees.

Dr Sandhu is providing a vital and valuable service to the Antelope Valley community. Because of the current DVM shortage, it has been difficult to staff the overnight shifts. Before his license revocation, Dr. Sandhu would cover the weekends and overnight himself to ensure that veterinary care was always available. Currently, people are forced to drive to Los Angeles or Bakersfield for emergency care. Unfortunately, the facilities there are also experiencing staff shortages and besides being prohibitively expensive, often will not take in any new patients. Many people have come in the next morning after being denied care at several hospitals in the LA area, often to the pets' detriment.

Dr. Sandhu has always been willing to help seniors, military personnel, and the disabled with their bills to ensure an optimal outcome for their pets. He has also helped the indigent and financially burdened for the sake of their animals.

I personally had end-stage renal failure and was on dialysis for several years. I have had multiple serious health problems secondary to renal failure. When veterinary practice owners in San Diego would not allow me to work because of rumors about my medical status, Dr. Sandhu welcomed me and made accommodations in the office for me. After I suffered a stroke due to a Covid vaccine booster and was unable to drive for a few months, Dr.Sandhu drove all the way to San Diego to pick me up and to take me back home. Because of dialysis, I could only work two days a week which helped cover my living expenses and part of my medical bills. I received a kidney transplant a year ago and can now work four days a week.

Dr. Sandhu is familiar with farm work, breeding Arabian horses, successfully showing them at the national level, and selling them internationally. He is also a small crop farmer, owns a hay

company, and has a working farm with poultry, goats, dairy cattle, and messenger pigeons. He has been an inspiration to many young people from the Lancaster and Palmdale areas. Dr. Sandhu is an example to them of how hard work, diligence, and striving for excellence can lead to a full and successful life.

Since 1996, I have worked as a relief veterinarian in California and Arizona. 1 have seen several veterinary practices of questionable quality and ethics. AVVC has always been of a high quality.

On reading the charges brought by the Veterinary Board against Dr. Sandhu, I realized that most of his problems stemmed from not keeping accurate records. Although Dr. Sandhu has a phenomenal memory, I don't believe he previously realized the importance of keeping thorough written records. He does now. As a member of the veterinary staff at AVVC, if Dr. Sandhu's license is reinstated, I will do my utmost to make sure that he keeps accurate and thorough records. I remember when I was in school at UC Davis that writing our SOAP's every day was pounded into [us].

Dr. Sandhu's knowledge is expansive and he has the latest tools available for diagnostic work-ups as well as several orthopedic tools. The sheer volume of patients seen at AVVC lends to some inevitable complaints from clients, many of which are spurred by financial reasons.

Dr. Sandhu has integrity and will not tolerate dishonesty, cheating, or injustice among his employees. He is also a good father with five well-mannered and high-achieving kids.
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Sincerely,

Jane A. Harris, DVM

Manohar Deep Singh, DVM
[redacted]

05/29/2024

To whom it may concern:

My name is Dr. Manohar Deep Singh, and I am the owner of San Dimas Animal Hospital. I have known Balpal Sandhu since 2002 when we both began working under the same hospital group. During our time together. We performed numerous orthopedic and soft tissue surgeries. For over 15 years, I have served as the president of the Indus Vet Inc.(Organization of DVMs from South East Asia), a position that has allowed me to closely observe the professional conduct and character of my colleagues, including Dr. Balpal Sandhu.

Throughout the years, Balpal Sandhu has consistently demonstrated integrity and professionalism in all our interactions. His dedication to patient care and his meticulous approach to surgery have always impressed me. He has not only been a skilled surgeon but also a compassionate and reliable colleague.

In recent years, Dr. Sandhu has taken significant steps towards rehabilitation and personal growth. He has participated in various professional development courses and workshops to stay updated with the latest advancements in veterinary medicine. These actions demonstrate his commitment to giving back to society and his sincere efforts towards reformation.

Dr. Sandhu's thoughtful and prudent nature has been evident in many instances. One memorable moment that highlights his character was when he volunteered to cover shifts for a colleague going through a personal crisis, ensuring uninterrupted care for our patients. This act of kindness and responsibility is just one example of his dedication and integrity.

In conclusion, I am confident in Dr. Sandhu's integrity and professional abilities. He has shown significant personal and professional growth, and his dedication to the veterinary field remains unwavering. Should you require any further information, please do not hesitate to contact me at [redacted]

Sincerely,

Manohar Deep Singh DVM

Frank Marco, MBA, VMD, CVA
[redacted]

March 1, 2025

To Whom It May Concern:

My name is Frank Marco I am writing to provide a character reference for Dr. Sandhu, a highly dedicated and compassionate veterinarian whom I have had the privilege of knowing for over 15 years. Throughout this time, I have consistently been impressed by his unwavering commitment to the field of veterinary medicine and his genuine passion for animal care.

I have read and understand the charging document filed against Balpal Sandhu by the Board.

Dr. Sandhu's dedication to his profession extends far beyond the standard requirements. He has devoted countless hours to the study of animal health and disease, always striving to stay abreast of the latest advancements in veterinary medicine. His pursuit of knowledge and his commitment to continuing education demonstrate not only his expertise but also his deep responsibility toward providing the best possible care to his patients.

In addition to his medical acumen, Dr. Sandhu is characterized by his eagerness and devotion to returning to practice. His enthusiasm is evident in every conversation we have had about his plans and goals. It is clear that his desire to contribute positively to the lives of animals and their owners is a driving force in his life.

Conclusion:

I wholeheartedly recommend Dr. Sandhu, confident that his expertise, integrity, and passion for veterinary medicine will make a profound and positive impact wherever he practices. Should you require any further information regarding his character or qualifications, please do not hesitate to contact me at [redacted].

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Sincerely,

Dr. Frank Marco

EXHIBIT 8

CE Report

cebroker

Created: Friday, August 18, 2023 3:13 PM

Details

Name	License / Certificate Number	License / Certificate Issue Date	Profession Name
BALPAL SANDHU	13678	6/14/1999	Veterinarian

Range Selected

All

CE Summary

Course	Completed	Provider	Reported by	Subject areas covered	Credits earned
Abdominal Ultrasound Training # 20-760161	5/31/2023	ONCURA PARTNERS HOLDINGS, INC # 50-27577	ONCURA PARTNERS HOLDINGS, INC	• Medical	8 **8**
MEDICAL RECORDS BOOTCAMP (1594-42528) # 20-751841	11/20/2020	ABIGAIL KITCHENS, DVM # 50-29031	ABIGAIL KITCHENS, DVM	• Non-medical	10 **10**

VETERINARY growth partners Elite

CERTIFICATE OF COMPLETION

Developing Your Emotional Intelligence

Date: June 21-22, 2023

Balpal Sandhu

Attendee Name

Attendee Signature: Balpal Sandhu *State(s) and License Number:* CA 13678

This program has been approved for 10 hours of continuing education credit in jurisdictions that recognize RACE approval.

Provider Number: 50-28307
Program Number: 20-900215
Program Category: Non-Medical Programs

Rachel Teichberg

Rachel Teichberg, CVPM, CVBL
Head of Learning & Development

Profit
Dog and Dean of Continuing Education

VetMedTeam
Providing Educational Pathways to Great Careers

Balpal Sandhu, DVM

has completed

Veterinary Medicine: Multi-Modal Pain Management for Companion Animals

on September 27, 2023

This program 742665 is approved by the AAVSB RACE to offer a total of 18.00 CE Credits (18.00 max) being available to any one veterinarian: and/or 18.00 Veterinary Technician CE Credits (18.00 max).

This RACE approval is for the subject matter categories of: Medical using the delivery method of Interactive Distance. This approval is valid in jurisdictions which recognize AAVSB RACE; however, participants are responsible for ascertaining each board's CE requirements. RACE does not "accredit" or "endorse" or "certify" any program or person, nor does RACE approval validate the content of the program.

David Tollon, DVM, MBA, Founder

Pat Lynch, Director of Operations

VetMedTeam, LLC, 2325 SW Dodge Terrace, Port St. Lucie, FL 34953
www.VetMedTeam.com

VETERINARY ONLINE COURSES

Veterinary General Soft Tissue Surgery

CERTIFICATE OF ACHIEVEMENT

This certifies that

Balpal Sandhu

Program Title: General Soft Tissue Surgery
CE Hours: 8.0 Medical Program
(Course #588-41545)
Method of Delivery: Non-Interactive-Distance
Location: Online
PVDR#000588
CE BROKER TRACKING # 20-750205
Florida Veterinary Dentistry

Test name: Veterinary General Soft Tissue Surgery
Score: 100% 40 / 40
Participant:
State: vet 13678
License Number: CA vet 13678

United States 10/4/23

Provider: Brett Beckman,
Veterinary Dentistry, Inc.

BRETT BECKMAN, DVM
FAVD, DAVDC, DAAPM

John Berg

Dr. John Berg, DVM
DACVS

Course meets the requirements for 8 hours of CE in jurisdictions which recognize AAVSB RACE approval.

PAIN MANAGEMENT
WORKSHOP

Veterinary Pain Mangement Workshop

CERTIFICATE OF ATTENDANCE

Awarded To:

Balpal Sandhu

Program Title: Veterinary Pain Management Workshop
CE Hours: 12 (6 hours of Live Session + 6 hours of Non Live Session)
(Course #588-41545)
Method of Delivery: Interactive-Distance/Online
Location: Online
PVDR#000588
CE Broker # 20-841650

License State Information *13678 California*

State Licensee Number DVM

1/23/24

Provider: Brett Beckman, Mark Epstien
Veterinary Dentistry, Inc.

OCT 1st, 2023- NOV 19th, 2023

The workshop meets the requirements for 12 hours of CE in jurisdictions that recognize AAVSB RACE approval.

Dr. Mark Epstein
DVM, Dipl. ABVP(C/F), CVPP

IVDI International Veterinary Dentistry Institute

BRETT BECKMAN, DVM
FAVD, DAVDC, DAAPM

VetMedTeam
Providing Educational Pathways to Great Careers

Balpal Sandhu, DVM

has completed

Veterinary Medicine: Medical Records the Roadmap to Quality Care

on April 12, 2019

This program 57-35873 is approved by the AAVSB RACE to offer a total of 10.00 CE Credits (10.00 max) being available to any one veterinarian: and/or 10.00 Veterinary Technician CE Credits (10.00 max).

This RACE approval is for the subject matter categories of: Medical using the delivery method of Interactive Distance. This approval is valid in jurisdictions which recognize AAVSB RACE; however, participants are responsible for ascertaining each board's CE requirements. RACE does not "accredit" or "endorse" or "certify" any program or person, nor does RACE approval validate the content of the program.

David Tollon, DVM, MBA, Founder

Pat Lynch, Director of Operations

VetMedTeam, LLC, 2325 SW Dodge Terrace, Port St. Lucie, FL 34953
www.VetMedTeam.com

WVC Annual Conference

Powered by Viticus Group

CERTIFICATE OF ATTENDANCE

Balpal Sandhu, DVM
1055 W Columbia Way
103
Lancaster, CA 93534
United States

95th Annual Conference
February 18-23, 2023

AAVSB-RACE Provider #20-992204
44 CE hours of Veterinary Continuing Education
were presented via lectures and interactive sessions by
WVC in Mandalay Bay Convention Center, Las Vegas, NV

State of Licensure: CA License #(s): 13678

Signature _____ Date 2/23/23

Medical CE Credits: 9.00
Non-Medical CE Credits: 4.00
This course titled WVC 95th Annual Conference (CE Broker Tracking #: 20-992204) has been approved for 44.00 hours of continuing education for veterinarians and 38.00 hours of continuing education for veterinary technicians in jurisdictions that recognize RACE approval. Participants are responsible for ascertaining their state board's continuing education requirements.

Anthony Pease

Anthony Pease, DVM, MS, DACVR
Chief Veterinary Medical Officer
Viticus Group

RACE
REGISTRY OF APPROVED CONTINUING EDUCATION
AMERICAN ASSOCIATION OF VETERINARY STATE BOARDS

2425 E. Oquendo Rd. | Las Vegas, NV 89120 | P: 866.800.7326 | F: 702.739.6420 | E: support@viticusgrouporg | www.viticusgroup.

EXHIBIT 9

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
GENERIC LIVE SCAN FORM

STATE OF CALIFORNIA
BCIA 8016
(Rev. 05/2018)

DEPARTMENT OF JUSTICE

Applicant Submission **REQUEST FOR LIVE SCAN SERVICE** Fingerprint Applicant Submission

AO133
ORI (Code assigned by DOJ)

License/Registration
Authorized Applicant Type

Veterinarian
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Veterinary Medical Board
Agency Authorized to Receive Criminal Record Information

06386
Mail Code (five-digit code assigned by DOJ)

1747 N. Market Blvd, Ste 230
Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

Sacramento
City

CA
State

95834
ZIP Code

9165155220
Contact Telephone Number

Applicant Information:

Sandhu
Last Name

Balpal
First Name

Middle Initial

Suffix

Other Name (AKA or Alias)
Last

First

Suffix

[redacted]
Date of Birth

Sex ☒ Male ☐ Female

[redacted]
Driver's License Number

5'11
Height

192
Weight

Brown
Eye Color

Black
Hair Color

Billing Number
(Agency Billing Number)

India
Place of Birth (State or Country)

[redacted]
Social Security Number

Misc. Number
(Other Identification Number)

Home Address [redacted]
Street Address or P.O. Box

[redacted]
City

CA
State

[redacted]
ZIP Code

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI)

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

JAY
Name of Operator

5/10/24
Date

Manly N More
Transmitting Agency

AMD
LSID

B131SAB729
ATI Number

88.00
Amount Collected/Billed

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency

Applicant must contact their Contributing Agency to verify the accuracy of the form required for their Live Scan submission.