PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Veterinary Medical Examiners (Board) initiated disciplinary action against Todd Murphy, D.V.M. (Respondent) for multiple alleged standard of care violations. Staff requested revocation of Respondent’s veterinary medical license. The Administrative Law Judge (ALJ) finds that Staff proved the violations, but recommends lesser sanctions than license revocation.

I. PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The hearing convened on October 19, 2010, before Administrative Law Judge (ALJ) Hunter Burkhalter, at the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. The Staff was represented by Staff Attorney Laura Moriaty. Respondent did not appear and was not represented at the hearing.

Staff offered competent evidence establishing jurisdiction and that appropriate notice of the hearing was provided to Respondent. Staff moved for a default. In accordance with the rules of the State Office of Administrative Hearings (SOAH), the default is granted and the allegations in the notice of hearing are deemed true.
II. DISCUSSION

Pursuant to TEX. OCC. CODE §§ 801.401 and 801.402(6) and (16), the Board is authorized to take disciplinary action against a holder of a license to practice veterinary medicine, including revoking or suspending the license if, among other things, the license holder violates the Board’s rules of professional conduct, or “commits gross malpractice or a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.”

Pursuant to 1 TEX. ADMIN. CODE § 155.501, Staff moved for, and the ALJ granted, a default in this case. Accordingly, the factual allegations listed in Staff’s notice of hearing are deemed admitted, as set forth in the proposed Findings of Fact, below. Having deemed those facts as true, the ALJ finds that Staff has proven violations of TEX. OCC. CODE § 801.402(6) and (16) by Respondent, thereby warranting the imposition of sanctions against him. This does not, however, resolve all outstanding issues in the case. Rather, additional analysis must be undertaken to determine whether the sanction sought by Staff, license revocation, is warranted.

When determining the appropriate sanction, SOAH is required to “use the schedule of sanctions adopted by board rule.” The schedule of sanctions that has been adopted by the Board is found at 22 TEX. ADMIN. CODE § 575.25. Pursuant to the schedule, license revocation may be imposed only if Respondent is found to have committed a Class A violation. However, license revocation is only one of several possible “maximum penalties” that can be assessed for a Class A violation. The range of possible penalties also includes:

(B) a penalty not exceeding $5,000 for each violation per day;
(C) continuing education in a specified field related to the practice of veterinary medicine that the board deems relevant to the violation(s). The total number of hours mandated are in addition to the number of hours required to renew the veterinary license;
(D) quarterly reporting certifying compliance with board orders; and/or
(E) Licensee sit for, and pass, the SBE.

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1 TEX. OCC. CODE § 801.407(c).
2 22 TEX. ADMIN. CODE § 575.25(a)(3).
3 22 TEX. ADMIN. CODE § 575.25(a)(3).
For the purposes of this case, there are two possible Class A violations which Respondent allegedly committed:

-- gross malpractice with a pattern of acts indicating consistent malpractice, negligence, or incompetence in the practice of veterinary medicine;\(^4\) and

-- engaging in veterinary practices which are violative of the Rules of Professional Conduct.\(^5\)

Staff failed to prove the first type of Class A violation listed above (\(i.e.,\) that Respondent committed gross malpractice with a pattern of acts indicating consistent malpractice, negligence, or incompetence in the practice of veterinary medicine). Staff alleged, and in the proposed Findings of Fact the ALJ finds, that Respondent’s actions constituted “a pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.” Thus, pursuant to TEX. OCC. CODE § 801.402(16), Respondent is subject to disciplinary action by the Board. Under the Board’s schedule of penalties, however, the ALJ must find that Respondent’s “pattern of acts that indicate consistent malpractice, negligence, or incompetence in the practice of veterinary medicine” was committed in combination with “gross malpractice.”\(^6\) Staff neither alleged nor proved that Respondent committed gross malpractice.

Staff did prove, however, that Respondent committed the second possible type of Class A violation (\(i.e.,\) that Respondent engaged in veterinary practices which are violative of the Rules of Professional Conduct). The Board’s rules of professional conduct are found at 22 TEX. ADMIN. CODE ch. 573. One of those rules, 22 TEX. ADMIN. CODE § 573.22, provides:

\(^4\) 22 TEX. ADMIN. CODE § 575.25(a)(1)(B).
\(^5\) 22 TEX. ADMIN. CODE § 575.25(a)(1)(H).
\(^6\) 22 TEX. ADMIN. CODE § 575.25(a)(1)(H). Note that in order to be subject to sanction under the statute (TEX. OCC. CODE § 801.402(16)), Staff must prove “gross negligence or a pattern of acts indicating consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.” In order to be a Class A violation, however, the rule (22 TEX. ADMIN. CODE § 575.25(a)(1)(H)) requires Staff to prove “gross negligence with a pattern of acts indicating consistent malpractice, negligence, or incompetence in the practice of veterinary medicine.” (Emphases added.)
Veterinarians shall exercise the same degree of humane care, skill, and diligence in treating patients as are ordinarily used in the same or similar circumstances by average members of the veterinary medical profession in good standing in the locality or community in which they practice, or in similar communities.

Staff alleged, and in the proposed Findings of Fact the ALJ finds, that Respondent’s actions violated this standard of care. As such, the ALJ concludes that Respondent’s actions constituted Class A violations.

Having so concluded, the Board’s schedule of sanctions next requires that the following factors be considered in order to determine whether license revocation, as opposed to some lesser sanction, is appropriate:

1. The seriousness of the violation, including the nature, circumstances, extent, and gravity of any prohibited acts, and the potential hazard created to the health, safety, or economic welfare of the public;
2. The economic harm to property or the environment caused by the violation;
3. The history of previous violations;
4. What is necessary to deter future violations; and
5. Any other matters that justice may require.

Each of these factors will be discussed in turn.

a. The seriousness of the violation, including the nature, circumstances, extent, and gravity of any prohibited acts, and the potential hazard created to the health, safety, or economic welfare of the public

The violations demonstrate a degree of sloppiness and inattention to detail on the part of Respondent. They are serious violations in the sense that they endangered the health of several of Respondent’s patients. The violations do not evidence any intentional wrongdoing on Respondent’s part, nor do they evidence a potential hazard to the economic welfare of the public. If the term “the public” is given its common meaning, (i.e., “of or relating to people in general”), then there is no evidence that Respondent’s violations constituted a potential hazard to the health or safety of the public. If, on the other hand, the Board interprets “the public” to

7 22 TEX. ADMIN. CODE § 575.25(a)(2).
8 WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 952 (1988).
include animals, then the violations do suggest that Respondent may be careless in his veterinary practice to an extent that places patients in danger.

b. **The economic harm to property or the environment caused by the violation**

No evidence was provided directly on this point. Logically, the owners of the pets involved incurred extra costs due to Respondent’s actions and inactions. For example, as discussed in the proposed Findings of Fact, some of the pet owners had to visit additional veterinarians or undergo extra vet visits due to Respondent’s subpar care and/or failure to communicate. The amount of such economic harm is unknown. There is no evidence of harm to the environment.

c. **The history of previous violations**

Because no evidence was provided on this factor, the ALJ will assume that Respondent has no previous violations.

d. **What is necessary to deter future violations**

No evidence was presented on this factor.

e. **Any other matters that justice may require**

Staff is seeking license revocation, the most draconian of the sanctions it can impose. The ALJ is not convinced that such strong medicine is warranted. Staff did not present evidence demonstrating that Respondent is beyond reform as a veterinarian. Moreover, this is apparently the first enforcement action against Respondent.

Rather than revocation, the ALJ believes that imposition of a lesser array of penalties is more appropriate. The violations committed by Respondent are of the type that might be avoided in the future if Respondent’s license were temporarily suspended and he were required
to undergo supplemental continuing education. Having concluded that license revocation is not warranted, the ALJ notes that Respondent’s violation – engaging in veterinary practices which are violative of the Rules of Professional Conduct – may also constitute a Class B violation under the Board’s schedule of sanctions.\(^9\) The range of possible penalties for a Class B violation includes a “one to 10-year license suspension with none, all, or part probated.”\(^{10}\) In assessing sanctions for a Class B violation, the Board’s schedule of sanctions requires consideration of essentially the same factors as those listed above for Class A violations. Having considered those factors and the evidence presented by Staff, the ALJ concludes that Respondent’s license should be suspended for one year and he should be required to complete supplemental continuing education.

III. RECOMMENDATION

Based upon the following Findings of Fact and Conclusions of Law and in accordance with 1 TEX. ADMIN. CODE § 155.501, the ALJ grants Staff’s motion for default, deems the facts contained within Board’s Notice of Hearing admitted, and concludes that, on multiple occasions, Respondent engaged in veterinary practices which were in violation of the Board’s Rules of Professional Conduct. The ALJ recommends that Respondent’s veterinary medical license not be revoked. Instead, the ALJ recommends that:

- Respondent’s license be suspended for a period of one year; and

- Respondent be required to complete continuing education in a specified field related to the practice of veterinary medicine that the board deems relevant to the violation(s).

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\(^9\) 22 TEX. ADMIN. CODE § 575.25(b)(1)(B).

\(^{10}\) 22 TEX. ADMIN. CODE § 575.25(b)(3)(A).
IV. FINDINGS OF FACT

1. The Texas Board of Veterinary Medical Examiners (Board) regulates the profession of veterinarians and conducts investigations into allegations or violations of the Act and Board Rules.

2. Todd Murphy (Respondent) holds a license to practice veterinary medicine in the State of Texas, license number 7782.

3. On December 4, 2008, Vonnie Vasquez presented her 13-year-old male dog, Toby, to Respondent for treatment because Toby was experiencing seizures. Respondent took blood from Toby and told Ms. Vasquez that he would perform blood work and report the findings to her within a week.

4. Ms. Vasquez attempted to contact Respondent many times between December 11, 2008 and January 12, 2009, but Respondent did not return her calls.

5. Ms. Vasquez presented Toby to Dr. Robert Hardy on January 7, 2009. Dr. Hardy attempted to contact Respondent to consult with him regarding Toby, but was unsuccessful.

6. Respondent failed to meet the appropriate standard of care by failing to communicate with Mr. Vasquez for over a month while Toby continued to suffer seizures under Respondent’s care.

7. On December 29, 2008, Kenneth Huey presented his one-year-old male domestic shorthair cat, GoGo, to Respondent for surgery. Respondent performed a perineal urethrostomy on GoGo on the same date.

8. After the surgery, GoGo’s surgery site became infected. Mr. Huey attempted to reach Respondent by phone to discuss GoGo’s condition, but Respondent did not return his calls.

9. On January 2, 2009, Mr. Huey presented GoGo to Dr. Nancy Callaway, who treated GoGo for an infection with antibiotics.

10. On January 14, 2009, Mr. Huey presented GoGo to Respondent for suture removal, and Respondent removed some, but not all, of GoGo’s sutures because the suture removal was causing GoGo discomfort.

11. On February 4, 2009, Mr. Huey presented GoGo to Respondent for examination because GoGo was urinating outside of his litterbox. Respondent examined the surgery site and expressed GoGo’s bladder, revealing a free flow of urine. Respondent told Mr. Huey that GoGo was fine and should be treated with Neosporin and aloe vera for local irritation.
12. On February 7, 2009, Mr. Huey presented GoGo to Dr. Callaway, who diagnosed GoGo with an infected urethra. Dr. Callaway attempted to insert a catheter into GoGo, but was unsuccessful because the cat’s urethra was scarred and strictured. Dr. Callaway recommended a second perineal urethrostomy. Dr. Callaway attempted to contact Respondent for consultation, but Respondent did not return her calls.

13. On February 7, 2009, Dr. Catherine Lamkin conducted a second perineal urethrostomy on GoGo and determined that Respondent had made an error in the first surgical procedure by constructing the new opening at the narrower portion of the urethra.

14. Respondent failed to provide the appropriate standard of care to GoGo by conducting a perineal urethrostomy incorrectly, by not responding to phone calls from the client and from other veterinarians treating GoGo, and by failing to diagnose GoGo’s infected, strictured and scarred urethra, as well as GoGo’s need for a second perineal urethrostomy.

15. On April 28, 2009, Duane and Peggy Jarvis presented their one-year-old male mixed breed dog, Levi, to Respondent for treatment because he was experiencing left rear leg lameness. Respondent performed a tibial plateau leveling osteotomy on Levi on the same date.

16. On May 3, 2009, Levi fell on his injured left rear leg. On May 4, 2009, Mr. and Ms. Jarvis presented Levi to Respondent to determine whether the dog had injured himself in the fall. Respondent examined Levi and found no injuries, but did not take radiographs of the dog.

17. On May 9, 2009, Mr. and Ms. Jarvis presented Levi to Dr. Lauri Mendelzon, because Levi was experiencing bloody discharge coming from an open sore at the top of the surgery incision site. Dr. Mendelzon called Respondent, and Respondent refilled Levi’s antibiotics and told Mr. and Ms. Jarvis to keep the area iced.

18. On May 11, 2009, Mr. and Ms. Jarvis presented Levi to Respondent to have his sutures removed. A second sore had opened on the surgery incision site, but Respondent informed Mr. and Ms. Jarvis that this was normal.

19. When Mr. and Ms. Jarvis again presented Levi to Respondent on May 14, 2009 with concerns regarding the two sores, Respondent again told them that this was normal and did not take radiographs.

20. Levi’s condition continued to deteriorate. On May 18 and 19, 2009, Mr. and Ms. Jarvis left phone messages for Respondent, but he did not return their calls.

21. On May 20, 2009, Mr. and Ms. Jarvis presented Levi to Dr. Jensen Young. Dr. Young took radiographs, which revealed a left tibial crest fracture and the appearance of an infection around the screws holding the plate in place, as well as multiple bony fragments surrounding the knee joint.

23. On May 22, 2009, Dr. Young referred Levi to Dr. Laura Peycke, who performed an arthroscopy on the dog’s left stifle and revised the tibial plateau leveling osteotomy.

24. Respondent’s post-operative treatment of Levi did not meet the appropriate standard of care because Respondent failed to take radiographs when appropriate, failed to communicate with the clients, and failed to diagnose Levi’s infection and injury.

25. On May 6, 2009, Rickie and Sharon Krabe presented their 10-year-old female miniature dachshund, Daisy, to Respondent on referral for possible cancer symptoms including coughing and difficulty breathing. Respondent reviewed radiographs taken by Daisy’s primary veterinarian, Dr. Robert Hardy. Respondent stated that an area near Daisy’s lung would need to be biopsied for Respondent to make a diagnosis, and that another suspicious area could be treated with chemotherapy. Respondent performed surgery on Daisy shortly thereafter.

26. When Daisy’s condition did not improve after the operation, Mr. and Ms. Krabe called Respondent several times, but Respondent did not return their calls.

27. On June 3, 2009, Mr. and Ms. Krabe presented Daisy to Respondent for suture removal. Daisy was still experiencing breathing difficulty and coughing. Respondent diagnosed the breathing difficulties as allergies and prescribed Benadryl.

28. On June 6, 2009, Mr. and Ms. Krabe presented Daisy to Dr. Jennifer Martinson for respiratory distress. Dr. Martinson diagnosed pneumonia, and Mr. and Ms. Krabe decided to have Daisy euthanized.

29. Respondent’s failure to diagnose Daisy’s pneumonia and Respondent’s post-operative treatment of Daisy do not represent the appropriate standard of care.

30. The incidents described above show a pattern of acts that indicate consistent malpractice, negligence and incompetence in the practice of veterinary medicine.

31. Respondent has no previous history of violations.

32. On July 20, 2010, staff of the Board (Staff) mailed a Notice of Hearing (NOH) for this matter to Respondent at 1668 Mallory Lane, Brentwood, Tennessee, 37027, by United States Post Office regular mail and by certified mail, return receipt requested. This is the address shown as the last known address of Respondent per the records of the Board.

33. The NOH contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.
34. The NOH contained the following language in at least 12-point boldface type: “[U]pon failure of a party to appear at the hearing, the factual allegations in the Notice will be deemed admitted as true, and the relief sought in the Notice of Hearing may be granted by default.”

35. The NOH set forth that the Board was seeking revocation of Respondent’s license.

36. The hearing on the merits convened on October 19, 2010, at the State Office of Administrative Hearings, William P. Clements Building, 300 West 15th Street, Austin.

37. Respondent did not appear and was not represented at the hearing.

38. Following the admission of evidence establishing proper jurisdiction and notice, Staff moved for a default, which is granted.

V. CONCLUSIONS OF LAW

1. The Texas Board of Veterinary Medical Examiners (Board) has jurisdiction and authority to take disciplinary action against Respondent. TEX. OCC. CODE ch. 801.

2. The State Office of Administrative Hearings (SOAH) has jurisdiction over all matters relating to the conduct of a hearing in this matter, including the preparation of a proposal for decision with findings of fact and conclusions of law. TEX. GOV’T CODE ch. 2003.

3. Notice of the complaint and of the hearing on the merits was provided as required by TEX. OCC. CODE § 801.407 and by TEX. GOV’T CODE §§ 2001.051 and 2001.052.

4. The Board had the burden of proving the case by a preponderance of the evidence.

5. Pursuant to 1 TEX. ADMIN. CODE § 155.501, the failure of Respondent to appear at the hearing on the merits entitled the Board to have the facts in the Notice of Hearing deemed admitted and to the declaration of default by Respondent.

6. Based on the above Findings of Fact, Respondent violated TEX. OCC. CODE § 801.402(16) and 22 TEX. ADMIN. CODE §§ 573.22 and 575.25(H) by engaging in veterinary practices with respect to four different patients which were in violation of the Board’s rules of professional conduct.

7. The Board is authorized to impose sanctions on a license holder who violates TEX. OCC. CODE ch. 801 or rules adopted by the Board. TEX. OCC. CODE §§ 801.401-.402.
8. Based on the above Findings of Fact and Conclusions of Law, the Board should issue an order:

- suspending Respondent’s license be suspended for a period of one year; and

- requiring Respondent to complete continuing education in a specified field related to the practice of veterinary medicine that the board deems relevant to the violation(s).

SIGNED November 12, 2010.

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HUNTER BURKHALTER
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS