

TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS  
AUSTIN, TEXAS

SOAH DOCKET NO. 578-08-2864

TEXAS BOARD OF VETERINARY  
MEDICAL EXAMINERS, Petitioner

v.

MARVIN HARE,  
Respondent

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BEFORE THE

STATE OFFICE OF

ADMINISTRATIVE HEARINGS

**FINAL DECISION AND ORDER**

This matter was heard by the Texas Board of Veterinary Medical Examiners (the Board) in open meeting on the 16<sup>th</sup> day of October, 2008.

The Board finds that after proper and timely notice was given, the above-styled case was heard at the State Office of Administrative Hearings by an Administrative Law Judge on July 7, 2008. Respondent, MARVIN HARE appeared and was not represented by counsel. The Administrative Law Judge (ALJ) filed her proposal for decision on September 5, 2008 containing Findings of Fact and Conclusions of Law, and recommending a formal reprimand, an administrative penalty of \$500.00, and required to complete five hours of additional continuing education in oncology within one year of the date of this Order, and suspended his veterinary license for one year with the suspension fully probated. This proposal for decision was properly served on all parties, who were given an opportunity to file exceptions and replies as part of the administrative record.

The Texas Board of Veterinary Medical Examiners, after review and due consideration of the administrative record, including the Proposal for Decision, by unanimous vote of the members of the Board present at the meeting, adopts the proposal for decision as if fully set out and separately stated herein.

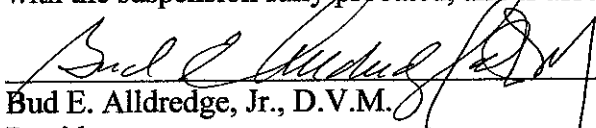
All Findings of Fact and Conclusions of Law contained in the Proposal for Decision are hereby ADOPTED and incorporated by reference in full in this Order.

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TEXAS STATE BOARD OF  
VETERINARY MEDICAL EXAMINERS

**ORDER**

NOW, THEREFORE, it is ORDERED that Respondent MARVIN HARE be formally reprimanded, required to complete five additional hours of continuing education within one year of the date of this Order, Respondent's license be suspended for a one-year period with the suspension fully probated, and is assessed an administrative penalty of \$500.00.

  
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Bud E. Alldredge, Jr., D.V.M.  
President  
Texas Board of Veterinary Medical Examiners

10/25/08  
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Date Entered

TEXAS BOARD OF VETERINARY  
MEDICAL EXAMINERS,  
Petitioner

v.

MARVIN HARE, D.V.M.,  
Respondent

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

### PROPOSAL FOR DECISION

The staff of the Texas Board of Veterinary Medical Examiners (Staff/Board) brought this action to impose disciplinary sanctions against Marvin Hare, D.V.M (Respondent). Staff alleged that Respondent violated the Board's rules of professional conduct by failing to meet the minimum standard of care required for the practice of veterinary medicine. This Proposal for Decision finds that Respondent violated the Board's rules, and the Administrative Law Judge (ALJ) recommends that disciplinary sanctions be imposed against Respondent.

#### I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Because there are no contested issues of notice or jurisdiction in this proceeding, those matters are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing on the merits in this matter convened July 7, 2008, before ALJ Ami L. Larson in the William P. Clements Building, 300 West 15<sup>th</sup> Street, Fourth Floor, Austin, Texas. Staff was represented by Nicole Oria, General Counsel. Respondent appeared *pro se*. The record closed that same day.

#### II. DISCUSSION

##### A. Background

On May 15, 2006, Heidi Lame became concerned because she noticed that a lump, which her ten-year-old dog "Casey" had had for several years, was growing larger and had begun to bleed. That

evening, Ms. Lame took Casey to South Branch Pet and Bird Clinic (South Branch) in Austin, Texas, where she had contact with Respondent, who worked there as a veterinarian. Respondent scheduled Casey for surgery the next day to remove the growth.

On May 16, 2006, Respondent surgically removed the growth from Casey's left shoulder area. Respondent did not do any testing either before or after the surgery to determine the nature of the growth that he removed from Casey.

On August 28, 2006, Ms. Lame took Casey to Lake Austin Boulevard Animal Hospital (Lake Austin) because Casey's growth had returned. At Lake Austin, Dr. Ellen Jefferson examined Casey and performed a fine needle aspirate of the growth tissue. Lab results revealed that Casey had a Grade III malignant mast cell tumor at that time.<sup>1</sup> An ultrasound, blood work and a chemistry panel were also performed to determine the size, exact location, and stage of the tumor, and whether any lymph node contamination had occurred. Dr. Leslie Wilson then removed the tumor and wide margins of surrounding healthy tissue to prevent its re-growth. Following the surgery at Lake Austin, Ms. Lame opted to have Casey undergo chemotherapy treatments.

In late July 2007, Casey nonetheless died as a result of the cancerous tumor, which had spread. Ms. Lame spent more than \$5,000.00 on Casey's treatment at Lake Austin.

#### **B. Staff's Allegations**

Staff alleged that Respondent failed to meet the minimum required standard of care for the practice of veterinary medicine when he removed Casey's mass without having it tested before or after the surgery. Additionally, Staff alleged that Respondent failed to meet the standard of care because he did not remove a sufficient margin of healthy tissue surrounding the tumor to decrease the chances of its re-growth.

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<sup>1</sup> Grade III is the most severe grade of malignancy.

### C. Applicable Law

The Board may take various forms of disciplinary action against a person who violates the Board's rules of professional conduct.<sup>2</sup>

The Board's rules of professional conduct require veterinarians to "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."<sup>3</sup>

## III. SUMMARY OF EVIDENCE AND ARGUMENTS PRESENTED<sup>4</sup>

### A. Staff's Evidence

Staff's evidence consists of two exhibits and the testimony of four witnesses, including Respondent.

#### 1. Exhibits

Staff's exhibits include:

- A written report completed by the Board's investigator, Charles Adkins, summarizing his investigation and findings;
- The complaint form and written statement submitted to the Board by Ms. Lame;
- Two handwritten statements by Respondent, addressing the allegations made against him;
- South Branch medical records regarding Casey's treatment;
- Lake Austin medical records regarding Casey's treatment;
- Various lab results regarding Casey's tumor re-growth;
- Letters to the Board's investigator from Drs. Jefferson and Wilson regarding their treatment of Casey and assessing his prior treatment.

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<sup>2</sup> TEX. OCC. CODE ANN. §§ 801.402(6) and 801.401.

<sup>3</sup> 22 TEX. ADMIN. CODE (TAC) § 573.22.

<sup>4</sup> Only the evidence deemed relevant is summarized here.

## 2. Testimony

### a. Respondent

Respondent testified that he has been licensed as a veterinarian for 37 years and currently works as a relief veterinarian in various locations across Texas. He stated that he has remained in compliance with the Board's continuing education requirements but mentioned that he was disciplined once before by the Board for "spaying the wrong cat."

Respondent stated that he had neither met Heidi Lame nor treated Casey prior to May 15, 2006, and that he had only been working at South Branch for approximately two months at that time. Respondent further stated that, on that date, he had contact with Ms. Lame only because her regular veterinarian, Dr. Mekonnen, was not at the clinic when she arrived.

Respondent testified that on May 15, 2006, he was preparing to leave work at South Branch for the day when one of the veterinary technicians told him that one of Dr. Mekonnen's chemotherapy patients had come in for a shot. The vet tech reported that the patient also had a ruptured tumor. According to Respondent, the technician told him that Dr. Mekonnen had left instructions for him to look at the tumor but not to discuss the matter with the client, Ms. Lame. Respondent testified that he directed the technician to put a pressure bandage on the dog and that the tumor would have to be removed. Respondent stated that he spoke to Ms. Lame that evening for only a few minutes. He indicated that he "skimmed" the South Branch records concerning Casey and noted that Casey had been receiving blood tests and Vinchristen chemotherapy injections once each week from Dr. Mekonnen for the preceding two years.

The next day at South Branch, according to Respondent, he observed Dr. Mekonnen looking at Casey. Later that same day, a surgery technician told Respondent that he had a dog ready for surgery. When Respondent asked which dog, the technician told him it was the dog with tumors. The technician further told him that Dr. Mekonnen had left and had asked that Respondent perform the surgery.

Respondent testified that he then removed several tumors from Casey. He acknowledged that he did not conduct any pre-operative testing and did not have the tumors analyzed after he removed them. He explained that it wasn't his case and stated that he "wasn't interested in it." He said that he was invited by Dr. Mekonnen to perform the surgery after Casey was already under anesthesia and he simply did what he had been asked to do – remove the tumors.

Respondent explained that he has removed approximately 100,000 – 200,000 tumors from animals during his career as a veterinary surgeon. With respect to Casey, Respondent stated that he removed approximately three mast cell tumors and two abscesses as well as approximately two inches of the surrounding tissue. After he completed the surgery, Respondent left the masses he had removed from Casey on a blue towel. He testified that he assumed someone would "take care of them later and send them out."

Respondent claimed that once he became aware that a complaint had been made against him, he requested a complete set of the South Branch medical records regarding Casey. He stated, however, that he was allowed to see only a small portion of the records – those he had completed regarding Casey's surgery. Respondent further insisted that the records offered by Staff at the hearing were incomplete and did not reflect Casey's weekly chemotherapy treatments with Dr. Mekonnen.

At the time he removed Casey's tumors, Respondent did not personally offer any histopathology analysis to Ms. Lame, according to his testimony. He stated that he was told later by Dr. Mekonnen and the South Branch office manager that Ms. Lame had been offered that testing but refused to have it conducted. According to Respondent, based on that information, he later went back and wrote a note in Casey's chart indicating that Ms. Lame had refused testing.<sup>5</sup>

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<sup>5</sup> This notation appears outside the margins of the medical records sheet. Board's Exhibit B, page 25.

**b. Elaine Rose Caplan**

Dr. Caplan testified that she has practiced veterinary medicine for 27 years. After graduating from Texas A&M veterinary school in 1981, she completed an internship and residency in small animal medicine and surgery at the Animal Medical Center in New York City. Additionally, she completed a two-year fellowship in surgical oncology at the University of Illinois. Currently, Dr. Caplan is employed as a veterinarian at Capitol Area Veterinary Specialists and Texas Veterinary Oncology in Austin, Texas. She is also board-certified in veterinary surgery by the American College of Veterinary Surgeons and is recognized by the American Board of Veterinary Practitioners as a dog and cat species specialist. Dr. Caplan testified that she has focused on cancer surgery and has removed thousands of tumors during her career.

Dr. Caplan opined, based on her review of Casey's medical records, that Respondent failed to meet the minimum standard of care for any veterinarian when he performed surgery on Casey. She indicated that, to meet the minimum standard of care, Respondent needed to have a fine needle aspirate performed before he surgically removed Casey's tumors. She acknowledged that, in a case where pre-operative testing was offered to but declined by a client, the surgeon would not breach the standard of care by removing a mass without performing such testing. She added, however, that she would not have agreed to do Casey's surgery without first knowing at least the histopathology results.

Dr. Caplan estimated that the cost of conducting a fine-needle aspirate would be approximately \$50.00 and that a pre-or post-surgical histopathology analysis would range from approximately \$100.00 to \$150.00.

Dr. Caplan explained that malignant and benign tumors can appear alike and one cannot determine the type of mass simply by looking at it. In addition to a fine needle aspirate, a pre-surgical biopsy is also good practice, according to Dr. Caplan. This can help to determine not only what type of tumor is present but also its stage of severity. Additional testing such as abdominal ultrasound may

also be helpful to reveal whether a tumor has spread to other areas of the body. And a chest x-ray for older dogs is recommended to ensure the animal's ability to withstand anesthesia.

Dr. Caplan indicated that she also prefers to do a pre-surgical CAT scan to determine the true dimensions of a tumor since some mast cell tumors have tentacles, which require a larger area of tissue to be removed to prevent re-growth. She testified that it is her practice to remove, if possible, approximately three centimeters around the outer borders and beneath a tumor to minimize the chance that it will grow back.

Dr. Caplan further indicated that, even when a surgeon participates in another doctor's case, the surgeon who performs the surgery is responsible for reviewing the patient's records and ensuring that all necessary testing has been conducted prior to performing the surgery. It is never appropriate, she stated, for any surgeon to just "walk in, do the surgery, and walk out."

Dr. Caplan discussed the importance of the surgeon's obtaining basic information about the nature of a growth before surgically removing it. She noted that this basic information is necessary not only to guide the surgery itself, but also to allow a surgeon to inform the client of the patient's diagnosis and prognosis as well as potential treatment options and risks. Surgeons are responsible for disclosing this information to clients before any surgery so their clients may make informed decisions regarding the care and treatment of their pets.

With respect to post-surgical practice, Dr. Caplan expressed her belief that once a mass has been surgically removed from an animal, it should be preserved for at least six months after the surgery even if a client refuses to have histopathology analysis or other testing conducted.

**c. Charles Adkins**

Mr. Adkins is currently employed by the Board as an investigator and has held that position for more than 13 years. He investigated the complaint he received against Respondent by Ms. Lame in

September 2006. The complaint alleged that Respondent failed to perform any pre- or post-operative diagnostics concerning a tumor that he removed from Casey in May 2006.

As part of his investigation, Mr. Adkins requested and received what he believed to be a complete set of medical records kept by Respondent. He also contacted the complainant, Ms. Lane, as well as Dr. Mekonnen and Respondent.

After Respondent submitted a written statement, Mr. Adkins called him and asked if he wished to provide any additional information since his initial written submission was very brief.<sup>6</sup> Respondent initially declined but later sent another written statement to the Board.<sup>7</sup> Mr. Adkins also reviewed the written statements and medical records of Drs. Jefferson and Wilson, both of whom provided follow-up treatment to Casey approximately three months after Respondent's initial surgery when the tumor had returned.

Upon completing his investigation, Mr. Adkins found that Respondent violated the standard of care by failing to perform the minimum necessary diagnostic procedures on Casey. Additionally, because Respondent's actions caused a potential threat to the public, Mr. Adkins asserted that Respondent's conduct constituted a Class B violation of the Board's rules.

**d. Heidi Lane**

Ms. Lane testified that she is Casey's owner. She stated that she is currently working at St. David's Medical Center and completing her training to become a registered nurse. Ms. Lane first noticed a lump on Casey's shoulder in approximately January 2004. At that time, she took Casey to South Branch for routine vaccinations and pointed out the growth to South Branch staff. Ms. Lane indicated that she was told that it was probably just a lump and nothing to worry about. She continued to observe the lump and noticed that it would come and go and was generally about the size of a grape

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<sup>6</sup> Board's Exhibit B, page 17.

<sup>7</sup> Board's Exhibit B, pages 31-36.

when it was visible. No one at South Branch seemed concerned about Casey's growth or recommended that any testing or treatment be done.

On May 15, 2006, Ms. Lame took Casey to South Branch because she noticed that the lump on Casey's shoulder had grown larger and was red and bleeding. She stated that she called the clinic and was told that the growth would probably need to be removed but that she should bring Casey there that evening to see a veterinarian. Ms. Lame stated that she saw Respondent that day and he told her that the growth was probably a cyst. He further told her about the surgery and explained that a pre-anesthesia panel would need to be performed prior to the surgery, to which Ms. Lame agreed.

The next day, according to Ms. Lame, she did not talk to Respondent until he called her and told her that he had removed a small cyst from Casey. Ms. Lame testified that she asked him if he had reviewed it to determine what it was. Ms. Lame testified that Respondent replied that he had not determined what it was but told her that it seemed like a fibrous mass and that he was going to throw it in the trash. Ms. Lame asserted that no pre- or post-operative testing was ever offered or recommended to her other than the pre-anesthesia panel, which she agreed to have done. She stated that, when Respondent told her he would throw the growth away, she trusted him and assumed it did not need to be tested further. She denied having refused any testing or analysis for Casey. She further stated that, had any testing or analysis been offered or recommended, she would have agreed to have it performed.

According to Ms. Lame, Casey appeared to heal without problems from Respondent's surgery. Approximately three months later, however, she noticed some lumps along Casey's suture line as well as a large growth that was bigger than the one Respondent had previously removed. Ms. Lame also observed that the new larger mass was hot to the touch and that Casey was scratching it, causing it to bleed. Ms. Lame stated that she waited one or two days to see if the growth would heal on its own, but when it did not stop bleeding, she took Casey to Lake Austin for treatment.

There, she saw Dr. Jefferson, who inquired about Casey's growth and symptoms. Dr. Jefferson indicated that, from what Ms. Lame described, it sounded like Casey had a classic mast cell tumor.

She then took a needle aspirate sample and reviewed it before explaining to Ms. Lame what the analysis revealed and what the treatment options for Casey were. Ms. Lame elected to have Casey's malignant tumor surgically removed and to follow the surgery with two different types of ongoing chemotherapy treatments. Ultimately, Casey was euthanized on July 31, 2007, due to complications stemming from the tumor, which had spread. Ms. Lame said she had no idea that Casey's growth was cancerous until it grew back approximately three months after it had first been removed by Respondent. She stated that if she had known earlier that the growth was cancerous, she would have had it removed immediately.

Ms. Lame testified that she spent approximately \$5,000.00 to have Casey treated at Lake Austin after the tumor returned. She also acknowledged that she had been taking Casey to South Branch for approximately three years for routine vaccinations, but denied that Casey had ever received Vinchristen injections or any other chemotherapy treatments prior to his treatment at Lake Austin. She further stated that Dr. Mekonnen was not her regular veterinarian.<sup>8</sup> She explained that she did not have a regular veterinarian at South Branch but rather would see whatever doctor was available when Casey needed routine vaccinations.

Ms. Lame testified that she filed a complaint against Respondent because Dr. Jefferson was able to quickly and easily diagnose Casey's tumor as being malignant. She further expressed her belief that if Respondent had done testing to determine the nature of the growth at the time he removed it; it could have spared Casey unnecessary pain and suffering and may have saved his life.

#### **B. Respondent's Evidence**

Respondent testified on his own behalf and did not offer any exhibits. Respondent testified that his involvement with Casey and Ms. Lame was very minimal and that he never considered Casey to be "his case." He denied having called Ms. Lame either during or after the surgery or ever telling her that Casey's lump was a cyst. If anyone called her, he said, it would have been a surgery technician. He further explained that he never contacted Ms. Lame after the surgery because it wasn't his case.

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<sup>8</sup> Investigator Adkins' written report as well as the medical records from South Branch corroborate Ms. Lame's testimony in this regard. Board's Exhibit B, pages 9 and 18-27.

Respondent posited that, when a doctor invites him to work on a case and he agrees to do so, it is his job, as the incoming doctor, to simply do what is asked of him. It would have been unprofessional conduct, Respondent stated, for him to have taken over the case in that situation, since Casey was Dr. Mekonnen's patient. Respondent further noted that he only spent a total of approximately 15 to 20 minutes on this case and that he did the best he could during the surgery. He testified that he removed the tissue he believed needed to be removed. Respondent acknowledged, however, that a tumor often looks like the tissue surrounding it and it can be difficult to determine where a given tumor begins and ends. It is not unusual, he stated, for a tumor to grow back even after it has been removed. Respondent stated he made a good effort to save Casey even though it was not his case.

### **C. Arguments**

#### **1. Staff**

Staff asserted that the evidence in the record establishes that Respondent failed to meet the required standard of care in this case by removing Casey's tumor without conducting any pre- or post-operative diagnostic testing. Staff argued that Respondent's medical records concerning Casey appear to be substandard. Additionally, Staff noted that there is no evidence, other than Respondent's after-the-fact notation in his records, to indicate that Ms. Lane was ever offered or declined any testing for Casey.

Staff also took issue with Respondent's assertion that the Board's rules of professional conduct prevented him from performing diagnostic testing on Casey since he was not the primary doctor on the case. Staff asserted that Respondent, as the surgeon, was not forbidden but rather was required to make sure the necessary testing had been done pre-surgery, as Dr. Caplan's testimony made clear.

## 2. Respondent

Respondent argued that he did not do anything wrong and is not responsible for Casey's bad outcome. He expressed his belief that Ms. Lame is to blame. Respondent contended that she should have sought a second opinion after she was initially told by South Branch doctors that the growth on Casey was nothing to worry about. Had she done so years ago when she first noticed the growth, Respondent stated, it could have been removed at that time. He further expressed his belief that it was unfair and unrealistic for Ms. Lame to expect him, through one surgery, to be able to correct all the errors made by past veterinarians.

## IV. ANALYSIS AND RECOMMENDATION

### A. Did Respondent's treatment of Casey violate the Board's rules of professional conduct by failing to meet the minimum standard of care?

The preponderance of the evidence establishes that Respondent failed to meet the minimum standard of care for the practice of veterinary medicine. Respondent violated the Board's rules when he failed to perform any pre- or post-operative diagnostic testing of the tissue he surgically removed from Casey on May 16, 2006.

#### 1. Pre-Surgery Standard of Care

Dr. Caplan, a well-qualified veterinarian, who practices veterinary surgery in Austin, offered credible and convincing testimony about the minimum standard of care required before surgery in a case like this. The minimum standard of care requires that a fine needle aspirate study must be conducted before such a surgery. This is true even in a situation where the surgeon is not the primary veterinarian but is merely invited to perform a surgery.

Dr. Caplan's testimony was unequivocal that the minimum standard of care for a growth-removal surgery always requires the surgeon to review the patient's records before the surgery to determine minimally whether a fine needle aspiration has been done. If not, the surgeon must conduct a fine needle aspiration and review the results prior to performing the surgery.

Dr. Caplan's explanations are logical and make perfect sense. Even Respondent acknowledged that it can be difficult to determine the true dimensions of a tumor merely by looking at it. For this reason, at least minimal information about the mass being removed, such as its likely shape, size, and nature must be available to the surgeon before the surgery is performed. Additionally, this basic information is necessary to determine the patient's likely prognosis and allow clients to make informed decisions regarding the appropriate treatment for their pets.

In this case, Respondent did not advise Ms. Lame about Casey's prognosis and treatment options. Had Respondent diagnosed Casey's tumor as malignant at the time he removed it, Ms. Lame could have opted to begin Casey's chemotherapy treatments approximately three months earlier, which may have extended Casey's life. And had Respondent had more specific information about the nature of the tumor before the surgery, he may have been able to remove it in a way that kept it from recurring.

The ALJ finds that Respondent violated the Board's rules by failing to obtain at least the amount of information that would have been revealed by a fine needle aspirate analysis prior to surgically removing Casey's tumor.

## **2. Surgical Standard of Care**

Staff alleged that Respondent failed to meet the standard of care during Casey's surgery by failing to remove a sufficient amount of healthy tissue surrounding the tumors to prevent re-growth. Very little evidence was presented on this point during the hearing. Respondent testified that he removed approximately two inches of healthy tissue surrounding the growths. If true, that would fall within the standard of care for that type of surgery according to Dr. Caplan's testimony. Respondent's surgical notes, however, do not indicate how much, if any, healthy tissue he removed during Casey's surgery. There is simply not enough evidence for the ALJ to make a determination on this issue. Accordingly, the ALJ finds that Staff failed to meet its burden to show that Respondent did not meet the minimum standard of care with respect to his performance of the surgery itself.

### 3. Post-Surgery Standard of Care

Respondent testified that, after he surgically removed Casey's growths, he left them sitting on a blue towel. He stated that he assumed someone else would take care of them later or send them out for testing. In his initial written statement, Respondent stated that the tumor he removed from Casey was kept at South Branch for three days after the surgery and then it was thrown in the trash.<sup>9</sup> He further testified that he wasn't responsible for doing histopathology testing since this wasn't his case. In his subsequent written statement, Respondent noted that, after he removed Casey's tumor, he never saw Casey or Ms. Lame again and that Ms. Lame never called him to talk about the case.

The ALJ finds that Respondent should have recognized the potential for malignancy and the need for further treatment following the surgery. Respondent acknowledged that he neither alerted Ms. Lame to those possibilities nor took any steps to ensure that anyone else would. Instead, he simply removed unidentified growths from Casey, left them on a towel, and walked away, assuming someone else would take care of it.<sup>10</sup>

Ms. Lame, as a layperson, cannot and should not be expected to know what, if any, further testing or treatment was needed. She paid a professionally specialized and trained veterinarian to advise her regarding the proper protocol and possible treatment options and outcomes. It was certainly reasonable for her to rely on Respondent to take the necessary steps to appropriately diagnose and treat Casey. It was equally reasonable for her to assume that if Respondent did not recommend any further testing or treatment, none was needed.

For the above-stated reasons, the ALJ finds that Respondent failed to meet the minimum post-surgical standard of care.

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<sup>9</sup> Board's Exhibit B, page 17.

<sup>10</sup> Additionally, it should be noted that Dr. Caplan testified that she "hopes" that the minimum standard of care would require that any removed mass be kept for at least six months even in a case where a client declined to have histopathology testing conducted. This makes sense. It seems that a growth would need to be maintained for some period of time to allow for later or additional testing. Although it is not clear from the record for how long such tissue need be saved to meet the minimum standard of care, it certainly seems that three days is not long enough.

**4. Did Ms. Lame refuse testing either before or after surgery?**

The standard of care does not require pre- or post-operative testing of a growth where such testing is offered to but declined by a client. In this case, however, the ALJ finds incredible Respondent's assertion that Ms. Lame was offered but refused any testing for Casey at South Branch. No indication of any such offer or refusal is noted anywhere in the South Branch medical records other than in a brief notation made outside the margins of Casey's chart. Moreover, Respondent admitted that he added that notation based solely on third-hand information he received and only after he became aware that Ms. Lame had filed a complaint against him.

The ALJ further notes that Respondent's testimony conflicts with his written statements on this issue. During the hearing, Respondent testified that it was not his responsibility to do histopathology testing on Casey since it was not his case and he "wasn't interested in it." He testified that the sole basis for his later-added notation to Casey's chart indicating that Ms. Lame had refused to authorize testing to identify Casey's tumor was the fact that Dr. Mekonnen and the officer manager gave him that information.

In his initial written statement to the Board, Respondent did not claim to have recommended any testing for Casey. Instead, he simply noted that Ms. Lame had not requested that the tumor be identified after its removal and that the tumor was thrown in the trash three days later.<sup>11</sup> In his subsequent statement to the Board, however, Respondent claimed that Ms. Lame declined histopathology testing twice – once in the exam room and once to the receptionist. In that same statement, he also claimed that he personally offered histopathology testing to Ms. Lame but she declined after Respondent told her how much it would cost.<sup>12</sup>

Conversely, the ALJ finds Ms. Lame's testimonial and written assertions that she never refused any testing option to be highly credible. Bolstering Ms. Lame's credibility in this regard is that she elected to have Casey undergo \$5,000.00 worth of subsequent surgery and cancer treatment.

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<sup>11</sup> Board's Exhibit B, page 17.

<sup>12</sup> Board's Exhibit B, pages 31-32.

Also, she elected this additional treatment three months later when the tumor recurred even though Casey's prognosis was ostensibly worse at that time.<sup>13</sup> It simply defies logic that Ms. Lame would have refused to pay approximately \$150 to identify Casey's growth at the time Respondent removed it but would be willing, three months later, to pay \$5000.00 to have it identified, removed, and post-operatively treated.

Ms. Lame presented herself at the hearing as a bright, sensible, and credible person who cared deeply about her pet. It was clear that Ms. Lame trusted Respondent to provide effective treatment and advise her regarding the best course of action for Casey. And although she was clearly distraught when she determined that Casey had been denied effective treatment by Respondent, she did not appear to be vindictive or to exaggerate her account of what had occurred.

Respondent, at the hearing, came across as cavalier and defensive. He only briefly acknowledged feeling sorry about Casey's plight and focused more on his perception that South Branch was a bad clinic and that Ms. Lame was responsible and should not have relied on the treatment she received there in the first place.

The ALJ finds that Ms. Lame did not refuse any testing offered or recommended to her by Respondent or other personnel at South Branch. Instead, the ALJ finds that the appropriate diagnostic testing was not offered to her by Respondent as required.

#### **B. Appropriate Sanctions**

A license holder who violates the Board's rules of professional conduct is subject to disciplinary action by the Board. That action may include license revocation or suspension, probation, reprimand, administrative penalty, and continuing education.<sup>14</sup>

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<sup>13</sup> The medical records in evidence also corroborate Ms. Lame's testimony that she pointed out the growth on Casey years earlier during a visit to South Branch, but was merely told to keep an eye on it and that no testing or treatment was recommended at that time. Board's Exhibit B, page 19.

<sup>14</sup> TEX. OCC. CODE ANN. §§ 801.401 and 801.402.

The Board has adopted a recommended schedule of sanctions to be imposed against licensees who violate the applicable rules and statutes.<sup>15</sup> According to that schedule, violations are divided into three classes of severity with corresponding penalty ranges for each class.

Mr. Adkins testified that he believed Respondent's conduct equates to a Class B violation. Class B violations encompass "engaging in veterinary practices which are violative of the Rules of Professional Conduct."<sup>16</sup> Violations of the Board's Rules of Professional Conduct may also constitute a more serious Class A violation if the conduct presents imminent peril to the public.<sup>17</sup>

The schedule of sanctions also enumerates factors to be considered in assessing sanctions. Those include: "the seriousness of the violation, including the nature, circumstances, extent and gravity of any prohibited acts; the hazard or potential hazard created to the health, safety, or economic welfare of the public; the economic harm to property or the environment caused by the violation; the history of previous violations; what is necessary to deter future violations; and any other matters that justice may require."<sup>18</sup>

The maximum penalties recommended by the schedule for a Class B violation include a license suspension from one to ten years which may be probated in full or part; an administrative penalty of up to \$5,000.00 per violation per day; additional required continuing education in an area relevant to the violation; and/or quarterly reporting to certify compliance with board orders.<sup>19</sup>

In this case, Staff has requested that Respondent be ordered to pay an administrative penalty in the amount of \$500.00, receive a formal reprimand, and be required to complete five additional hours of continuing education in oncology.

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<sup>15</sup> 22 TEX. ADMIN CODE (TAC) § 575.25.

<sup>16</sup> 22 TAC § 575.25(b)(1)(B).

<sup>17</sup> 22 TAC § 575.25(a)(1)(H).

<sup>18</sup> 22 TAC § 575.25(b)(2).

<sup>19</sup> 22 TAC § 575.25(b)(3).

The ALJ finds that Staff's recommendations are lenient in light of the facts and circumstances of this case. Respondent's violation is quite serious. Had he performed the required pre-operative testing on Casey to determine that the growth was malignant before he removed it, it is likely that Casey would have begun to get appropriate treatment significantly earlier. Had Respondent performed the minimum necessary diagnostics, Casey may also have not needed to undergo an additional painful and expensive surgery. Furthermore, based on Respondent's adamant position that he is not responsible for pre- or post-surgical diagnostic testing when he performs surgery but is not the primary veterinarian, combined with his refusal to accept any responsibility for his unprofessional behavior in this case, the ALJ finds that Respondent poses a potential hazard to the public health, safety and welfare.

Additionally, although Staff did not raise or pursue this issue, Respondent admitted that he was previously disciplined by the Board for spaying the wrong cat. The evidence does not reveal the nature of the discipline previously imposed, but apparently it was not enough to deter him from future violations such as the conduct at issue in this case.

Although Respondent has a 37-year history of veterinary practice, the facts in this case dictate that a more severe penalty be imposed against Respondent than that recommended by Staff. The ALJ recommends that, in addition to the sanctions recommended by Staff, Respondent's license be suspended for a period of at least one year and that the suspension be fully probated contingent on Respondent's compliance with all applicable rules, statutes, and Board orders.

## V. FINDINGS OF FACT

1. Marvin Hare, D.V.M. (Respondent), holds License No. 3087 issued by the Texas Board of Veterinary Medical Examiners (Board) and has been licensed as a veterinarian for 37 years.
2. On May 7, 2008, Staff issued a Complaint Affidavit seeking to impose disciplinary sanctions against Respondent.
3. Respondent notified Staff of his request for an administrative hearing regarding the proposed discipline.

4. On May 8, 2008, Board Staff (Staff) sent its notice of hearing and complaint to Respondent by certified mail, return receipt requested.
5. The notice of hearing 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.
6. The hearing on the merits was held on July 7, 2008, at the State Office of Administrative Hearings in Austin, Texas. Staff was represented at the hearing by Nicole Oria, General Counsel. Respondent appeared *pro se*. The record closed at the conclusion of the hearing that day.
7. On May 15, 2006, Respondent was working as a veterinarian at South Branch Pet and Bird Clinic (South Branch) in Austin, Texas, where he met with Heidi Lame and Casey, her ten-year-old dog. Ms. Lame showed Respondent a growth on Casey's shoulder and reported her observations that the growth had recently become larger and begun to bleed.
8. On May 16, 2006, Respondent surgically removed the growth from Casey's shoulder.
9. Respondent did not do any diagnostic testing of the growth tissue either before or after he surgically removed it.
10. On August 28, 2006, Ms. Lame took Casey to Lake Austin Boulevard Animal Hospital (Lake Austin) because Casey's growth had returned.
11. At Lake Austin, Casey was examined and lab tests were performed that revealed that Casey's growth was a Grade III malignant mast cell tumor.
12. Casey underwent an additional surgery at Lake Austin to have the tumor removed and was treated with chemotherapy following the surgery.
13. On July 30, 2007, Casey's cancer had spread and he was euthanized.
14. Ms. Lame spent more than \$5,000.00 on treatment for Casey after his tumor recurred following Respondent's surgery on May 16, 2006.
15. Respondent was previously disciplined by the Board for spaying the wrong cat.
16. The minimum standard of care for the practice of veterinary medicine requires that a fine-needle aspirate or other diagnostic testing be performed before surgically removing a growth from an animal unless the client refuses to have such testing done.
17. Respondent did not offer and Ms. Lame did not refuse to have either pre- or post-operative diagnostic testing conducted on Casey when Respondent surgically removed Casey's tumor.

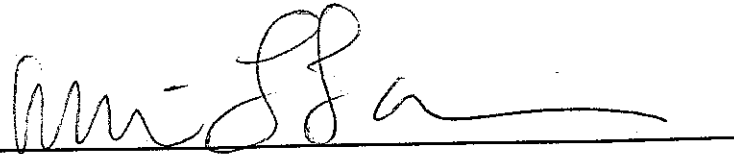
18. A surgeon is responsible for obtaining basic information about the nature of a growth before surgically removing it.
19. Basic information about the nature of a growth is necessary to allow a surgeon to adequately perform the surgery and to advise the client of the various treatment options as well as the associated risks and prognoses.
20. Respondent did not identify or diagnose Casey's tumor either before or after he removed it.
21. Respondent did not inform Ms. Lame regarding Casey's treatment options and prognosis.
22. Respondent threw away the growth he removed from Casey three days after the surgery.
23. Ms. Lame did not know Casey's growth was cancerous until it grew back approximately three months after Respondent initially removed it.
24. The approximate cost of the required pre-operative diagnostic testing for Casey was \$50.00 to \$150.00.
25. Respondent violated the Board's Rules of Professional Conduct by failing to perform any diagnostic testing or analysis of Casey's tumor before or after he surgically removed it on May 16, 2006.
26. Respondent's violation is serious and poses a potential hazard to the public health, safety, and economic welfare of the public.

## VI. CONCLUSIONS OF LAW

1. The Texas Board of Veterinary Medical Examiners (Board) has jurisdiction and authority to take disciplinary action against licensed veterinarians pursuant to TEX. OCC. CODE ANN. (Code) ch. 801.
2. The State Office of Administrative Hearings 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 ANN. ch. 2003.
3. Notice of the complaint and of the hearing on the merits was provided as required by the Administrative Procedure Act, TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.
4. The Board's Rules of Professional Conduct require veterinarians to "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." 22 TEX. ADMIN. CODE (TAC) § 573.22.

5. Based on the above Findings of Fact, Respondent violated the Board's Rules of Professional Conduct.
6. Respondent's conduct constitutes a Class B violation of the Board's rules. 22 TAC § 575.25(b)(1)(B).
7. Based on the above Findings of Fact and Conclusions of Law, Respondent should be formally reprimanded, assessed an administrative penalty of \$500.00, required to complete five hours of additional continuing education in oncology, and his veterinary medical license should be suspended for one year with the suspension fully probated contingent on Respondent's compliance with all applicable rules, statutes, and Board orders.

SIGNED September 5, 2008.



AMI L. LARSON  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS