



# TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS

BUD E. ALLDREDGE, JR., D.V.M.  
PRESIDENT

DEWEY E. HELMCAAR III, J.D.  
EXECUTIVE DIRECTOR

June 15, 2011

Nettie Dunn

[REDACTED]  
Angleton, TX 77515

Re: Case No. 11-186  
[REDACTED] D.V.M.

Dear Ms. Dunn:

Pursuant to the complaint you filed with this office against [REDACTED], D.V.M., this letter is to advise you that he is entitled to an opportunity to respond to the allegations against him, according to the Administrative Procedure Act, Texas Government Code, Section 2001.054(c), and the provisions of Rules of Procedure governing grievances, hearings and appeals of the Texas Board of Veterinary Medical Examiners. The Board ordinarily offers this opportunity through an informal conference before the Enforcement Committee of the Board. At the conference, you have the right as complainant to be present, and may address the committee.

A date has been set for **June 27, 2011 at 11:00 a.m.**, here in the Board offices at 333 Guadalupe, Suite 3-810, Austin, Texas 78701-3942. The conference will take place before a committee usually made up of two veterinary Board members, a public member of the Board, the Executive Director of the Board, the Director of Enforcement, the Board Investigator who investigated the case (if different from the Director of Enforcement) and the Board's attorney. Hopefully, the conference will correct any misinformation and help resolve the matter. Usually the outcome of the conference is one of three possibilities: (1) continuing the investigation because more information is needed; (2) a finding that a violation of the Act and/or Board rules has occurred; or (3) dismissing the complaint.

You are encouraged to attend. Please contact this office upon receipt of this letter to confirm this conference appointment and advise us of your intentions. If you have any questions, please contact me at (512) 305-7555.

Sincerely yours,

  
Debbie [REDACTED]  
Legal Assistant

Enclosures: Allegations

ALLEGATIONS

1. On January 17, 2011, Nettie Dunn presented her seven year-old male Chihuahua, "Spanky," to ██████████, D.V.M. of ██████████ ("██████████") in Angleton, Texas for skin allergy treatment and to examine a knot located on his abdomen above his left thigh.
2. Dr. ██████████ examined "Spanky" and determined that the knot was likely a benign fatty tumor. ██████████, Dr. ██████████'s veterinary technician, explained to Ms. Dunn that Dr. ██████████ would perform surgery to remove the fatty tumor.
3. Dr. ██████████ performed surgery on "Spanky" to remove the benign fatty tumor, and Ms. ██████████ assisted him in the surgery. Dr. ██████████ did not do any presurgical blood work. The surgery was uneventful, but when Dr. ██████████ completed removing the fatty tumor, he disposed of the tissue in the trash without obtaining a sample of it. According to Ms. ██████████, Dr. ██████████ told her that the tissue was a fatty tumor, and that therefore there was no need to take a sample of it. Dr. ██████████ left gauze with iodine in the removal site to help cauterize the wound. Dr. ██████████ sent "Spanky" home that afternoon with Ms. Dunn's daughter, and prescribed antibiotics for "Spanky."
4. When Ms. Dunn got home from work, she saw that the gauze sticking out of "Spanky's" wound was dripping blood. By 9:30 pm, "Spanky" was bleeding quite a bit, and seemed painful when moved.
5. That same evening, Ms. Dunn brought "Spanky" back to the ██████████. Dr. ██████████ gave "Spanky" a cursory examination without touching him, and told Ms. Dunn to take Spanky back home because "Spanky's" bleeding was not significant.
6. The next morning, on January 18, 2011, Ms. Dunn called to make an appointment for "Spanky" to have his staples removed. She told ██████████, a veterinary technician at ██████████ that "Spanky" was still not feeling good, and would not get up—he was only drinking water when they held the bowl for him and urinated wherever they set him as if he could not hold his bladder. Ms. ██████████ made an appointment for "Spanky" to come back in to ██████████ on January 21, 2011.
7. Over the next day, "Spanky" continued to deteriorate. He was bleeding enough that Ms. Dunn had to change the towels he was laying on every four hours, refused to drink and could not walk.

8. At 4:30 am on January 20, 2011, Ms. Dunn called Dr. [REDACTED] and told him that she did not think "Spanky" would make it much longer. Dr. [REDACTED] told her he would not have anyone to help him until 7:00 am, and asked her to bring "Spanky" in then.

9. At 7:00 am on January 20, 2011, Ms. Dunn again presented "Spanky" at [REDACTED]. When Ms. Dunn brought "Spanky" in, Dr. [REDACTED] stated, "You know he is full of cancer," and commented that the surgery "was a lot for an old dog to go through." Both statements surprised Ms. Dunn because she had previously been informed that the tumor removed was benign, and had not been told that her dog's seven year age made the surgery risky.

10. Ms. [REDACTED] was the veterinary technician on duty when Ms. Dunn presented "Spanky" to Dr. [REDACTED] on January 20, 2011. She also observed that the dog did not appear well, although neither Ms. [REDACTED] nor Ms. [REDACTED] saw blood coming from "Spanky's" suture site.

11. Dr. [REDACTED] told Ms. [REDACTED] to place "Spanky" in a cage for observation. When Ms. [REDACTED] suggested that "Spanky" be administered fluids, Dr. [REDACTED] stated that "Spanky" was only there for observation. "Spanky" died by 10:00 am that morning. Dr. [REDACTED] did not offer a necropsy.

12. Based on paragraphs 1 through 11 above, Dr. [REDACTED] has violated Rule of Professional Conduct 573.22, Professional Standard of Humane Treatment, by failing to send the tumor tissue he removed from "Spanky" for testing to determine whether it was cancerous, and by failing to treat "Spanky" on January 20, 2011.

13. Both Ms. [REDACTED] and Ms. [REDACTED] noted that Dr. [REDACTED] health has been declining, and that he no longer has the energy to perform examinations or treatment for most animals that are presented to [REDACTED]—he only examines the animals that are seriously ill. For routine ailments, Ms. [REDACTED] and Ms. [REDACTED] both examine and treat the animals without input from Dr. [REDACTED]. Both Dr. [REDACTED] and Ms. [REDACTED] confirmed that Ms. [REDACTED] conducts post-operative suturing and surgically removes ear hematomas despite the fact that she is neither a registered veterinary technician nor licensed to practice veterinary medicine. Dr. [REDACTED] stated that he understood he only needed to be present on the premises, and did not need to examine each animal presented to [REDACTED].

14. Based on paragraph 13 above, Dr. [REDACTED] has violated Rule of Professional Conduct 573.10, Supervision of Non-Licensed Employees, by allowing his veterinary technicians to diagnose patients, perform surgery and post-operative suturing on patients, and otherwise treat patients without appropriate supervision.

15. Dr. [REDACTED] patient records for "Spanky" are incomplete: he failed to record a weight or temperature for "Spanky" on January 17, 2011, the date of surgery, and failed to make any record at all of his examinations and/or treatment of "Spanky" on the evening of January 17, 2011 and on January 20, 2011.

16. Based on paragraph 15 above, Dr. [REDACTED] has violated Rule of Professional Conduct 573.52, Patient Record Keeping, by failing to record the required information including dates of visits, weight, temperature, and other details necessary to substantiate the examination, diagnosis, and treatment provided, and/or surgical procedure performed.

17. When Board Investigator Dennis [REDACTED] interviewed Dr. [REDACTED] regarding this investigation on June 10, 2011, Dr. [REDACTED] admitted to Investigator [REDACTED] that he has self-administered Lasix, Amoxicillin and Methocarbamol.

18. Based on paragraph 17, Dr. [REDACTED] has violated Rule of Professional Conduct 573.60, Prohibition Against Treatment of Humans, which prohibits veterinarians from providing care and treatment to humans, including dispensing prescription drugs for personal use by a human.

19. Based on the preceding paragraphs, Dr. [REDACTED] has violated Section 801.402 of the Veterinary Licensing Act, Occupations Code, which prohibits practices which violate Board Rules of Professional Conduct and subjects a veterinarian to disciplinary action under Section 801.401.

20. When Board Investigator Dennis [REDACTED] interviewed Dr. [REDACTED] regarding this investigation on June 10, 2011, Investigator [REDACTED] observed that Dr. [REDACTED] appeared to be under the influence because he could not walk correctly, shuffling his feet as he walked, was brief in his answers to questions, and appeared confused. Dr. [REDACTED] admitted taking numerous prescription medications, several of which had side effects of sleepiness and dizziness.

21. Based on paragraphs 13 and 20 above, evidence indicates that Dr. [REDACTED] may be "chronically or habitually intoxicated, chemically dependent, or addicted to drugs" under Section 801.402 (3) of the Veterinary Licensing Act and is subject to discipline under Section 801.401 of the Act. Further, Dr. [REDACTED] license may be temporarily suspended under Section 801.409 of the Act.