NORTH CAROLINA VETERINARY MEDICAL BOARD

February 28, 2018

Janine M. Oliver, DVM
Benessere Animal Hospital
1052 Grecade Street
Greensboro, NC 27408

Letter of Caution
Board Rule 21 NCAC 66.0601(j)

Re: Complaint No. 2017037-7
Ms. Arlene Laing

Dear Dr. Oliver:

I write as attorney for the N.C. Veterinary Medical Board to explain the decision of the Board, through its Committee on Investigations No. 7, on the complaint against you by Ms. Arlene Laing of High Point.

The decision, as explained below, is to issue you a letter of caution pursuant to Board Rule 21 NCAC 66.0601(j).

Board Investigative Procedure

Complaints within the jurisdiction of the Veterinary Medical Board are investigated pursuant to the Veterinary Practice Act [North Carolina General Statute § 90-179 *et seq.*] and the Board Administrative Rules [21 NCAC 66.0101 *et seq.*]. Board Rule 21 NCAC 66.0601, copy enclosed, governs the investigation. This complaint was assigned to the Board's Committee on Investigations No. 7, which reviewed all relevant materials in this file to determine whether there is probable cause that you violated the Veterinary Practice Act and/or Board Rules on the issues presented.

1611 JONES FRANKLIN ROAD, SUITE 106
RALEIGH, NORTH CAROLINA 27606
919-854-5601 ~ FAX 919-854-5606

Summary of Complaint – Received 8/11/2017

Arlene Laing's complaint (received 8/11/17) alleges that your errors in the surgery and treatment of her 3.5 year-old female Pit-Bull mix, Angel, led to the dog's death on 3/7/17 following spay surgery at Benessere Animal Hospital ("Benessere") in Greensboro.

On 3/1/17 Ms. Laing took Angel to High Point Veterinary Hospital for vaccinations. A blood test conducted there by Dr. Regina Watters showed that the dog was positive for heartworms and tapeworms. When Ms. Laing said that she wanted Angel spayed, Dr. Watters recommended deferring spay surgery until two weeks after the dog received her vaccinations. She also advised Ms. Laing to give Angel Drontal, a deworming medication, before giving her Heartguard.

On 3/1 Ms. Laing called your facility, Benessere, to obtain an appointment for a second opinion before giving Angel Heartguard. She presented Angel to Benessere that same day. Blood work revealed that Angel was in the early stages of heartworm infestation. You recommended she begin ProHeart 6 treatment for six months. Ms. Laing advised you that Angel was in heat and she wanted to have her spayed. You said that you could spay Angel on 3/7 for $120.00. Ms. Laing questioned the scheduling of the surgery because Dr. Watters told her that two weeks needed to pass following Angel's receiving the vaccinations that morning. You told Ms. Laing that it was not necessary to wait two weeks.

Ms. Laing administered the Drontal to Angel on 3/2.

Ms. Laing did not receive any instructions about the surgery at the 3/1 visit. A few days prior to 3/7, the receptionist at Benessere called to confirm the spay appointment. No instructions for the spaying procedure were given to Ms. Laing during the call with the receptionist other than to not give Angel any food after midnight the night before the surgery.

On 3/7 Ms. Laing's father presented Angel to Benessere for spaying and was given paperwork to sign. Neither he nor Ms. Laing was made aware of the importance of pre-operative blood work prior to giving an animal anesthesia. Her father reported to her that he was forced to sign the paperwork without any information as to what he was signing.

That afternoon, Ms. Laing was informed that Angel had died. She and her brother went to Benessere. When they spoke with you, they recorded that conversation. Ms. Laing requested the notes that were made prior to and following the procedure. You declined to give her the paperwork claiming you "didn't have enough time to finish" all of it. You did show her the form that was signed by her father and a veterinary assistant. She reiterates that neither her father nor she was advised of the importance of blood work being performed prior to a spay procedure.

You suggested to Ms. Laing that it would be pointless to sue you because she would spend more on attorneys' fees than the amount she could recover. You did not charge her for the spaying procedure.

Ms. Laing took Angel's body to Rollins Animal Disease Diagnostic Laboratory in Raleigh ("Rollins") for a necropsy. The necropsy report showed that Angel suffered severe blood loss from a clot at her uterine stump. The medical device used at the stump was "too loose," which in turn caused the dog to hemorrhage into her abdomen. A toxicology analysis of Angel's blood performed at the Pennsylvania School of Veterinary Medicine did not show any poison in her blood.

Ms. Laing reiterates her complaints that you failed to inform her or her father of the importance of pre-operative bloodwork, and that Angel died following the spay surgery.

Ms. Laing included with her letter medical records for Angel from Benessere and from High Point Veterinary Hospital; and the necropsy report from Rollins dated 4/17/17.

Your Response – Received 9/11/2017

You responded to the complaint by letter received 9/11/17.

Angel presented to you on 3/1/17 for blood work for heartworms. Angel had not been on heartworm, intestinal parasite or flea/tick prevention in the two years following her arrival in North Carolina, nor was she current on vaccinations until she went to High Point Veterinary Hospital before presenting at Benessere. You discussed with Ms. Laing at some length the risks of pregnancy, heartworm disease and surgery.

In your experience, dogs with stages of heartworm similar to Angel's who are spayed prior to being given adulticide do better with surgery and anesthesia. Waiting until after treatment was completed and until the dog was fully recovered from heartworm infection would have been ideal but would have postponed the spay surgery for seven to eight months, during which time she would have been vulnerable to unwanted pregnancy and increased stress on her cardiovascular system. Therefore, you recommended having Angel spayed as soon as possible.

You believed that Dr. Watters' recommendation of waiting two weeks to spay following vaccinations was due to Angel's immune system rather than surgical risks. In your opinion, so long as there was no reaction to the vaccinations, spaying her soon was the best option.

Because Ms. Laing declined staging of the heartworms, you were estimating that Angel was in stage 1 or 2 given that she did not present with symptoms of stages 3 or 4. Her vital signs were in normal range; she did not have a heart murmur; and her bronchovesicular sounds were not concerning. You explained staging to Ms. Laing and gave her literature on its importance.

Ms. Laing's father presented Angel on 3/7. He signed the surgical and anesthetic release as an agent of his daughter. You and Ms. Laing had previously had a long discussion about the importance of pre-operative lab work and radiographs, which she declined. For this reason, and the fact that she arranged for the surgery, you did not have any misgivings with her father consenting to the surgery as her agent. Angel's surgery was "uneventful and her vital signs were stable throughout." She was awake and looking around before your staff took her to recovery.

You then proceeded into another surgery. At about 1:00 p.m. your assistant informed you that Angel "was resting comfortably and had even stood up and eaten a small amount" of food. About 15 minutes later, the same assistant told you that Angel had collapsed. You told your assistant what to do for Angel while you finished your current surgery and removed that patient from anesthesia. Angel was in full cardiac arrest and you performed CPR. She was intubated and given epinephrine and CPR was performed for approximately 25 minutes, but you were unable to resuscitate her.

When you informed Ms. Laing about Angel's death, she was verbally abusive and used foul language. You were distraught over Angel's death as well. You offered to perform the necropsy, or in the alternative transport her body to Rollins, but Ms. Laing accused you of trying to hide what happened. Ms. Laing's brother apologized for her behavior, and you told him to

keep the body cold and provided him with directions to Rollins. You never heard further from them about Angel until you received Ms. Laing's complaint letter from the Board.

You perform soft tissue surgeries, including spays, on dogs on a daily basis. In Angel's case, you used Miller's knots and there was no bleeding when you dropped the pedicle and closed Angel. You believe you did your best and hate the fact that a loose ligature was found during the necropsy.

You enclosed a copy of Benessere medical records for Angel.

Ms. Laing's Reply – Received 10/2/2017

Following review of your response, Ms. Laing submitted a reply (received 10/2/17).

Ms. Laing restates many of the allegations in her complaint letter. She reiterates that she was not informed of the importance of pre-operative blood work. She denies that you gave her a brochure on heartworms.

Ms. Laing insists that Angel was a healthy dog when she presented for surgery on 3/7. She asked you for Angel's paperwork on the afternoon of 3/7 when she came to pick up Angel's body, but you said you were too busy. She acknowledged receiving it eventually. Ms. Laing asserts that she did not curse at you.

Ms. Laing questions your anesthesia protocol and whether her dog was adequately monitored.

Your Second Response – Received 10/16/2017

You responded to Ms. Laing's reply by letter received 10/16/17.

You do not dispute the Rollins' pathologist's findings. You explained to Ms. Laing how to go about making sure a necropsy was done so she could get answers to how Angel died. You waived your fee for services to Ms. Laing not out of guilt but because you did not want her to have to pay in her anguished state. You could have contacted your insurer but you felt that

would cause more pain, which is why you attempted to talk with her despite her behavior towards you on 3/7 and why you chose not to charge her.

Rollins' Necropsy Report – 4/17/2017

Test Level Result; Gross Exam Small Companion

A 3.5 year old spayed female Red Nose Pit Bull dog weighing 26.5 kg was presented for necropsy. The necropsy was started at approximately 1:45 pm on 3/9/17. . . . . The right ventrical of the heart contained 25 worms. One heartworm was in the caudal vena cava near the right adrenal gland. . . . At least 450 ml of blood were in the abdominal cavity. 160 ml of that blood was clotted. . . . There was a 4 cm long mid ventral abdominal incision that was well closed in 3 layers. Mild hemorrhage was in the tissue adjacent to the incision. Each ovarian pedicle was well ligated with 2 tight sutures. A blood clot was adhered to the tip/end of the uterine stump. The uterine stump was double ligated. One ligature was tight and secure but the second ligature was close to the end of the stump and mildly loose.

* * *

Morphological Diagnosis

1. Hemoabdomen, severe
2. Mucous membranes; Pallor, moderate
3. Heart: Dirofilaria immitis: moderate

Comment: The most significant finding was the hemoabdomen indicating that the cause of death was likely exsanguination. There was a blood clot associated with the tip of the uterine stump and this was most likely the site of the internal bleeding. One of the sutures on the uterine stump was mildly loose. This dog also had heartworms in the right ventricle of the heart. Their significance at this time is unknown.

* * *

Diagnosis

1. Exsanguination following ovariohysterectomy (spay surgery)
2. Heartworm Disease

Comment: The most significant finding was the large amount of blood in the abdomen. There was a clot on the uterine stump and one of the ligatures on the uterine stump was mildly loose. This loose ligature likely resulted in the uterine stump hemorrhage and hemoabdomen. This dog was in heat and the veterinary literature indicates that there may be increased risk of hemorrhage at the surgical sites when the dog is in heat.

* * *

Decision of Committee on Investigations No. 7

The members of the Committee on Investigations No. 7 evaluated and discussed the information presented to this complaint file. The Committee finds and decides:

1. With a critical exception, your surgical procedure appears to have been within the standard of care. Each ovarian pedicle was well ligated with two tight sutures. However, although the uterine stump was double ligated, and one ligature was tight, the other ligature, close to the end of the stump, was mildly loose. As noted in the Rollins report, this loose ligature likely resulted in the uterine stump hemorrhage and hemoabdomen. This excessive bleeding apparently caused Angel's death.

2. The Committee finds that your surgical procedure that resulted in a loose ligature on the uterine stump that caused excessive bleeding into the abdomen was not in accord with accepted professional practice and is the basis for this letter of caution to you pursuant to Board Rule 21 NCAC 66.0601(j). That Rule subsection provides:

> (j) If no probable cause is found, but it is determined by the Committee that the conduct of the accused party is not in accord with accepted professional practice or may be the subject of discipline if continued or repeated, the Committee may issue a letter of caution to the accused party

> stating that the conduct, while not the basis for a disciplinary hearing, is not professionally acceptable or may be the basis for a disciplinary hearing if repeated. A record of such letter of caution shall be maintained in the office of the Board.

3. At 1:00 p.m. following the surgery, your assistant in charge of post-operative monitoring informed you that Angel was resting comfortably, had stood up and had eaten a small amount of i/d low fat canned food. The medical record reflects that approximately 15 minutes later, while you were concluding an amputation surgery, Angel was found to be laterally recumbent, panting and tachycardic, and minimally responsive when her name was called. She was pulled from the cage and, based on your instructions, the assistant initiated supportive care, restarted IV fluids at 150 ml/hour and administered 1 ml Naloxone in case this was an atypical response to opioid pain management. The dog's belly was wrapped to support blood pressure and prevent potential internal bleeding. An oxygen mask was placed.

Angel coded at 1:25 p.m. and you initiated CPR. You performed chest compressions and reintubated Angel, administered oxygen at 3 L/minute, and administered manual ventilation with the scavenger bag. You administered 1.33 mg of epinephrine IV and continued CPR. The heartbeat was restarted for 45 seconds but stopped again. You gave epinephrine at a higher dose of 2.65 mg at 1:30 p.m. and gave atropine 1.06 mg IV. You continued chest compressions and ventilations until about 1:50 p.m. The dog's pupils were fixed and dilated from 1:20 p.m. until 1:50 p.m., at which time you were unable to get sinus rhythm, asystole, and there were no independent respirations. You ceased CPR efforts at 1:50 p.m. and called the client and left a message for her to call back

Although there was no error in your CPR efforts, the Committee is concerned that Angel may not have been monitored sufficiently between 1:00 p.m. and 1:15 p.m. Had she been more closely monitored, you might have been able to initiate CPR efforts sooner.

The Committee does not find that had you been able to initiate CPR sooner, Angel would have lived. Such a finding would be speculation. The Committee nevertheless expresses its concern about the timeliness of post-operative monitoring.

The Board has accepted the Committee's findings and decision. The investigation is concluded, and the file is closed.

The Committee on behalf of the Board extends its sympathy to Ms. Laing and her family for their loss of Angel.

If you have any questions about this letter or the decision, please contact Dr. Tod J. Schadler, Executive Director.

Very truly yours,

George G. Hearn
Attorney for the Board

GGH/dbc
Enclosure

cc: Ms. Arlene Laing
Board Members
Tod J. Schadler, DVM, Executive Director ✓

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