**BEFORE THE WEST VIRGINIA BOARD OF VETERINARY MEDICINE**

**WEST VIRGINIA BOARD OF VETERINARY MEDICINE,**

**COMPLAINANT,**

**V.** **CASE NO. 0521D**

**SARAH O'DONNELL, DVM, VETERINARIAN LICENSE No. 8813,**

**RESPONDENT.**

## CONSENT AGREEMENT AND ORDER

NOW COME the West Virginia Board of Veterinary Medicine ("Board") and Sarah O'Donnell, DVM ("Respondent") for the purpose of agreeing to disciplinary action which shall be taken against Respondent in the above-referenced matter. As a means of compromise, the Board and Respondent hereby agree to resolve this matter by and through a voluntary agreement and consent to disciplinary action, with consideration given to appropriate safeguards for protection of the public.

WHEREAS, Respondent acknowledges that the Board may file a Statement of Charges alleging that she has violated certain provisions of W. Va. Code §§ 30-10-1 *et seq.* and W. Va. Code R. §§ 26-1-1 *et seq.*, and proceed to a hearing and seek disciplinary action in this matter.

WHEREAS, Respondent hereby waives the filing of a formal Statement of Charges and the parties mutually desire to settle this matter without further prosecution and a formal hearing.

WHEREAS, the Board agrees and acknowledges that this agreement is a compromise of claims disputed by Respondent.

THEREFORE, it is hereby STIPULATED and AGREED between the undersigned parties that this matter be settled and resolved, the parties having reached an understanding concerning the proper disproportion of the matter in controversy, and the Board, approving such an agreement, does hereby FIND and ORDER as follows:

## FINDINGS OF FACT

1. Respondent is a licensee of the Board, holding License No. 8813, and at all times relevant, held an active license with the Board and practiced veterinary medicine in the State of West Virginia.

2. On or about May 20, 2021, the Board received a written complaint and supporting documentation from Dolores M. Eckhart ("Ms. Eckhart") regarding the veterinary care that her dog "Max" received from Respondent.

3. Ms. Eckhart reports in her complaint that on May 11, 2021, she brought Max, a Pug, to Shenandoah Veterinary Hospital to have dental work completed. Ms. Eckhart states that she had never been advised that Max had any medical conditions that would be problematic in surgery. Ms. Eckhart maintains that at approximately 12:45 p.m., she received a telephone call from Respondent, during which Respondent advised that Max had stopped breathing. Ms. Eckhart represents that Respondent questioned whether she would like them to continue assisting Max and she responded yes, but that Respondent failed to advise when Max had stopped breathing and for how long he had been receiving responsive care.

4. Ms. Eckhart states that she and her husband drove to Shenandoah Veterinary Hospital from their home, approximately forty-five minutes away. When they arrived, they learned that Max had survived the dental surgery, but he stopped breathing while being monitored post-surgery. Ms. Eckhart represents that Respondent blamed Max's death on brachycephalic dog

syndrome. Ms. Eckhart states that she had never been advised that Max possibly had this medical condition, but has since learned that if he was suspected to have this syndrome, Respondent should have performed x-rays of his head and throat prior to surgery, as well as should have monitored Max differently. Ms. Eckhart represents that she discovered from Max's medical records that Shenandoah Veterinary Hospital failed to monitor Max's oxygen levels or his pulse. Finally, Ms. Eckhart states that she researched Telazol, the drug used to sedate Max, and learned that the drug was not to be used without Atropine Sulfate, which was not done for Max.

5. On June 8, 2021, the Board received Respondent's response to the complaint and accompanying medical records for Max. Respondent stated that when Ms. Eckhart brought Max in for his dental surgery, it was only his third time being seen at Shenandoah Veterinary Hospital, and that Ms. Eckhart did not provide any records of previous veterinary care for Max, who was six years old at the time. Respondent added that Ms. Eckhart never reported that Max had any respiratory problems, nor were there any physical exam findings of respiratory disease, yet during his recovery from the dental procedure, Max experienced fatal complications.

6. Respondent provided a detailed explanation of the care that Max received prior to his dental surgery, during the procedure, and afterwards. Respondent noted that the technician waited until Max was actively chewing on the endotracheal tube before she removed it following the surgery. Respondent explained that because Atropine has been in short supply due to its heavy use in medical care for people during the Covid 19 pandemic, Shenandoah Veterinary Hospital had been using glycopyrrolate, a similar anticholingeric drug that is an approved substitute in anesthetic regimens. Respondent explained that she reviewed the hospital's patient list, and of the 371 Pug dogs on record as patients, the same anesthetic and monitoring protocol was used on 96 of them.

7. Respondent added that Ms. Eckhart signed the surgical release form the day of Max's procedure, in which she acknowledged and accepted the potential risk that could occur in anesthesia. Respondent asserted that while she routinely discusses anesthetic risk before any surgical or dental procedure, she failed to document such discussion in Max's pre-surgical exam record from April 20, 2021. Respondents admitted that the unusually heavy caseload at the hospital presented time constraints that have prevented Respondent from being as detailed in her record keeping as she "would like to be."

8. Respondent noted that she believed Ms. Eckhart misunderstood the phrasing in Max's medical records that he was "noted 10 min later (after extubation) cyanotic and not breathing." Respondent explained that Ms. Eckhart assumed that the phrasing meant that Max was not being monitored during the 10 minute period, which was not the case. Respondent stated that staff members were continually in and out of the surgical ward and monitoring surgical patients. Respondent maintained that as soon as the surgical ward assistant noticed that Max was no longer sitting up, she examined him, saw that he was not breathing, and immediately alerted other staff members who began resuscitation efforts.

9. Respondent explained that although she initially believed Max's death was caused by his brachycephalic conformation, no necropsy was performed, and thus, no specific cause of death was determined. Respondent acknowledged that the lack of detail in Max's medical record made documenting Max's standard of care more difficult. Respondent then explained the hospital's medical record keeping procedure, and how Max's records did not follow the procedure precisely.

10. The Board's Complaint Committee reviewed Ms. Eckhart's complaint, Respondent's response thereto, and the medical records and other documents submitted therewith

and found probable cause to believe that Respondent failed to meet the applicable standard of care by failing to adequately monitor the patient following his surgery, by failing to present an anesthesia log in the patient's medical records, and by failing to follow up to date CPR protocols in violation of W. Va. Code § 30-10-19(g)(3) and W. Va. Code R. §§ 26-1-8.1.5, 26-4-5.1.b, 26-4-5.2.a, 26-4-5.3.c, and 26-4-5.8.c.

11. Upon recommendation of the Complaint Committee, and after reviewing the aforementioned complaint, response, and accompanying documents, the Board, by majority vote at its meeting on July 30, 2021, determined there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

## CONCLUSIONS OF LAW

1. Respondent is a licensee of the Board, holding License No. 8813 and is therefore subject to the license requirements and disciplinary rules of the Board.

2. The Board is a state entity created and governed by W. Va. Code §§ 30-10-1 *et seq.*, and is empowered to regulate the practice of veterinary medicine in the State of West Virginia.

3. In order to carry out its regulatory duties, the Board may suspend, revoke, or otherwise discipline an individual's license to practice veterinary medicine under the authority granted to it by W. Va. Code §§ 30-10-5 and 30-10-19 and W. Va. Code R. §§ 26-1-8 and 26-2-1 to 26-2-6.

4. Respondent does not contest that the Board has probable cause to charge her with one or more violations of the Board's governing statutes and rules based upon its investigation and findings in this matter.

5. The conduct described in the above Findings of Fact would, if proven, constitute violations of W. Va. Code § 30-10-19 and W. Va. Code R. §§ 26-1-8 and 26-4-5. Such conduct is therefore grounds for disciplinary action.

## CONSENT OF LICENSEE

I, Sarah O'Donnell, by signing this Consent Agreement and Order, acknowledge the following:

1. After having had the opportunity to consult with an attorney of my choice, I sign this Consent Agreement and Order voluntarily, freely, without compulsion or duress, and understand that my signature has legal consequences.

2. No person or entity has made any promise or given any inducement whatsoever to encourage me to make this settlement other than as set forth in this document.

3. I am aware that I may pursue this matter through appropriate administrative and/or court proceedings. I am aware of my legal rights regarding this matter, but I have chosen to waive those rights intelligently, knowingly, and voluntarily.

4. I waive any defenses including, but not limited to, laches, statute of limitations, and estoppel, that I may have otherwise claimed as a condition of this agreement.

5. I acknowledge that the execution of this document constitutes disciplinary action by the Board and is therefore considered to be public information.

The Respondent, Sarah O'Donnell, by affixing her signature hereto, agrees to the following Order:

## ORDER

Based on the foregoing, the Board does hereby ORDER and DECREE as follows:

1. Respondent is hereby REPRIMANDED for her actions in this matter.

2. Within six (6) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of medical record keeping. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.

3. Within six (6) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of CPR. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.

4. Within three (3) months after taking the above-mentioned medical record keeping continuing education, Respondent shall submit to the Board for its review five (5) patient medical records completed and maintained by her.

5. Within three (3) months from the date of the entry of this Order, Respondent shall reimburse the Board the costs of this proceeding, including but not limited to, the administrative and legal expenses incurred by the Board in the investigation and disposition of this case.

6. Any failure to comply with all provisions in the Consent Agreement and Order may result in additional disciplinary action, up to and including the suspension or revocation of Respondent's license to practice veterinary medicine in the State of West Virginia.

7. This document is a public record as defined in W. Va. Code § 29B-1-2. The Board is bound by law and by this Agreement to report the results of all disciplinary actions, including this matter, for posting in the AAVSB Veterinary Practitioners Disciplinary Database and for posting on the Board's website.

8. This Consent Agreement and Order constitutes the entire agreement between the parties.

In recognition of this Consent Agreement and Order, we hereby affix our signatures.

WEST VIRGINIA BOARD OF VETERINARY MEDICINE

By: John R. Wilson DVM
Dr. John R. Wilson, Board Chairman

Entered: 11-5-2021
Date

REVIEWED AND AGREED TO BY:

Sarah R O'Donnell DVM
Sarah O'Donnell, DVM
Respondent

10/28/2021
Date

This day personally appeared before me, Sarah O'Donnell, whose name is signed to the foregoing document and who is known to me, having acknowledged before me that the statements in the foregoing document are complete, true and correct, to the best of her knowledge, information, and belief, and executed the document voluntarily on the date shown above.

Given under my hand and seal on this the 28th day of October, 2021.

My Commission expires: Sept. 18, 2022

MARY C LEHMAN
Notary Public Official Seal
State of West Virginia
My Comm. Expires Sep 18, 2022
220 Showers Lane Martinsburg WV 25403

Mary C. Lehman
Notary Public