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STATE OF WISCONSIN
BEFORE THE VETERINARY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
ROXANNE E. RYGIEWICZ, D.V.M., RESPONDENT.	:	ORDER 0000329

[Division of Enforcement Case # 07 VET 006, 07 VET 050, and 09 VET 039]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Roxanne E. Rygiewicz, D.V.M.
431 Main Street
Montello, WI 53949

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Veterinary Examining Board
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Wisconsin Veterinary Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Roxanne E. Rygiewicz, D.V.M., (D.O.B.: July 2, 1969) is duly licensed as a veterinarian in the state of Wisconsin (license # 4406-50). This license was first granted on September 8, 1995.

2. Respondent's last address reported to the Department of Regulation and Licensing is 431 Main Street, Montello, Wisconsin 53949.

3. At all times relevant to this action, Respondent was working as a veterinarian at the River Valley Veterinary Service in Montello, Wisconsin.

Allegations relating to Case # 07 VET 006

4. On January 16, 2007, an approximately 8-month old kitten ("Ebony") owned by Estelle Funk was presented to the Respondent for scheduled spay and front declaw procedures.

5. The Respondent delegated responsibility for anesthetic monitoring on Ebony to Karen Ackerson, who was not and is not a certified veterinary technician. Ms. Ackerson is a surgical technician and has experience working in hospital operating rooms and at veterinary clinics. She was also responsible for administering Ebony's pre-medications, starting isoflurane and placing the endotracheal tube.

6. The Respondent then began the procedures. During the spay procedure, Ms. Ackerson checked Ebony's heart rate/rhythm every four minutes and visually checked her respirations on a more frequent basis. She did not document the heart and respiration rates.

7. As the Respondent was closing the spay incision, Ms. Ackerson advised the Respondent that Ebony's respirations had become slow and shallow. Ms. Ackerson turned off the isoflurane and began ventilating Ebony.

8. The Respondent closed the incision and administered 0.3 ml of epinephrine and 0.3 ml of atropine. She then attempted to place a left cephalic catheter, but was unsuccessful so she placed a catheter in the right cephalic area to administer Normosol R. The Respondent initiated chest compressions and ventilations continued. A faint regular rhythm returned after approximately five minutes. The Respondent slowed the ventilations to see if Ebony would spontaneously breathe, however she arrested again and the Respondent was unable to restart her heart with chest compressions and epinephrine.

9. Approximately 45 minutes after Ebony's change in respiration, her core temperature fell to 94, and Respondent pronounced her dead. Ebony's owner requested that a necropsy be performed. The Respondent performed the necropsy and concluded that Ebony had a drug reaction which caused her respiratory arrest and subsequent death.

10. The Respondent submitted the kidney, heart, and liver sections to the College of Veterinary Medicine in Urbana, Illinois. The pathology report revealed "marked renal and hepatic congestion." The pathologist concluded that the cause of death was not apparent from the gross or histological examination and that the absence of inflammation indicated cardiovascular collapse (shock) which can occur terminally from multiple causes.

11. Respondent's conduct in providing care and treatment to Ebony failed to meet the minimum standards of acceptable veterinary practice and evidence a lack of knowledge or the ability to apply professional principles and skills in the following manner:

a. The Respondent improperly delegated anesthetic monitoring to Ms. Ackerson who was not a certified veterinary technician.

b. The Respondent failed to adequately monitor Ebony's heart rate and respirations during the surgical procedure.

c. The Respondent failed to employ a proper resuscitation technique in that she failed to address Ebony's respiratory arrest prior to closing the incision and she placed an IV catheter to start Normosol R before she started chest compressions.

Allegations relating to Case # 07 VET 050

12. On December 11, 2006, an 8 year-old golden retriever ("Ally") owned by Gregory Riesen was presented to the Respondent with a complaint of lethargy and anorexia of one week's duration. The dog's temperature was 102.4 and her weight was 11 pounds less than it had been in May of 2006. Examination revealed that the dog did not have any vaginal discharge. The Respondent performed a chemistry screen and complete blood count. The white blood cell count was 22,600. She diagnosed the dog with pyometra and mammary masses in the left #4 and #5 glands. The Respondent recommended spay and tumor removal procedures.

13. On December 12, 2006, the golden retriever was presented to the Respondent for the scheduled spay procedure and removal of two mammary glands. On that date, the Respondent noted that the golden retriever had a foul smelling vaginal discharge. The Respondent delegated responsibility for anesthetic monitoring during the procedures to Karen Ackerson, who was not and is not a certified veterinary technician. Ms. Ackerson administered acepromazine, atropine and butorphanol pre-operatively and diazepam and ketamine intra-operatively.

14. During the procedures, the dog was placed on a human over-the-counter heating pad which the Respondent had purchased ten years previously. Intra-operatively, the Respondent failed to monitor the temperature of the heating pad and the dog sustained a burn to her skin on her back. The uterus and two mammary glands were removed during surgery without further complication. The Respondent noted intra-operatively that the uterus was enlarged and full of red-brown pus. She did not administer any antibiotics intra-operatively.

15. Following surgery, the Respondent placed the golden retriever in a kennel to finish waking up. The Respondent discharged the dog home with the owner at approximately 5:30 p.m. that day. At the time of discharge, the dog was still sleepy and unable to walk due to the sedative medication but the Respondent felt that the dog would be able to recover from the butorphanol at home. The Respondent and the owner carried the dog to the owner's vehicle. No pain medications or antibiotics were dispensed at that time.

16. On December 15, 2006, Mr. Riesen presented the golden retriever to the Respondent for a re-check. Physical examination revealed that the mammary incision was warm which the Respondent felt was due to irritation from too much activity. She dispensed an antibiotic and pain medication on that date.

17. On December 18, 2006, the golden retriever was presented to the Respondent again with dehiscence at the mammary incision. She recommended incision repair which was scheduled for the following day. The golden retriever remained at Respondent's clinic overnight.

18. On December 19, 2006, the Respondent performed the incision repair surgery. She was not aware of the previous burn which the golden retriever sustained on her back and used the same heating pad for the second surgery, causing another burn to the same area.

19. On December 22, 2006, the Respondent saw the golden retriever for re-check at which time she noted that there was seroma drainage from the incision, but did not note the presence of the burn on the golden retriever's back. She dispensed the antibiotic cephalexin.

20. On December 26, 2006, the golden retriever was presented to the Respondent with a complaint from the owner that the dog was not drinking. The Respondent felt the dog was slightly dehydrated. Examination showed that the burn on the dog's back was slightly larger but was healing well. She recommended continuing cephalexin.

21. On January 2, 2007, the Respondent saw the golden retriever for re-check at which time she noted the burn area to be healing well with a new area of hair coming off. She recommended to the owner that he put echinacea powder and extra virgin olive oil on the burn area to assist with healing and to continue the cephalexin.

22. On January 8, 2007, the Respondent saw the golden retriever for re-check at which time she cut off part of the burn scab which was healing well. The edge was pale pink and Respondent noted that the rest of the scab should come off in a week.

23. On May 8, 2007, the golden retriever was seen by Respondent for re-check. At that time, the central deep area of burn on the golden retriever's back had skin but did not have any hair. The Respondent noted that that area may not grow any hair.

24. Respondent's conduct in providing care and treatment to the golden retriever failed to meet the minimum standards of acceptable veterinary practice and evidence a lack of knowledge or the ability to apply professional principles and skills in the following manner:

a. The Respondent improperly delegated anesthetic monitoring to Ms. Ackerson who was not a certified veterinary technician on December 12 and 19, 2006.

b. The Respondent failed to adequately monitor the temperature of the heating pad intra-operatively which resulted in burn injuries on December 12 and 19, 2006.

c. The Respondent failed to administer antibiotics intra-operatively on December 12, 2006.

d. The Respondent failed to dispense either pain medications or antibiotics before discharging the golden retriever home on December 12, 2006.

e. The Respondent discharged the dog home on December 12, 2006 while the dog was unable to walk due to the sedative medication.

Allegations relating to Case # 09 VET 039

25. On July 15, 2009, a four year-old pit bull mix ("Justice") owned by Rosie Tremaine was presented to the Respondent for a scheduled neuter procedure. The Respondent's records reveal that the procedure began at 8:51 a.m. and was uneventful. She used an open technique with double ligation of spermatic cords. The tunics were left open with stumps tucked inside before closing of the scrotum with one cruciate of 2.0 Premilene. The procedure was completed by 8:57 a.m. During lunch, the Respondent and her staff left the office while the dog was left alone in a kennel. When they returned, the dog was howling and whining.

26. The dog was discharged to home that afternoon.

27. Later that same day, the owner called the Respondent's office and spoke to Kimberly Mallmann who was a certified veterinary technician. The owner advised that there was seeping blood from the dog's scrotum and blood was present on the blanket where he had been laying. Ms. Mallmann advised her to ice the scrotum for 15-20 minutes and to keep the dog quiet as he possibly loosened a clot in moving around. The owner was also advised that if he was still bleeding/seeping in an hour that she should bring the dog in to be examined.

28. Approximately three hours later, the bleeding began again. The owner attempted to ice the area but the bleeding continued. She attempted to call the Respondent's office and obtained an emergency number off the answering machine. She called the emergency number but it was no longer in service. The owner also tried to contact the Respondent by calling her cell phone but was unsuccessful as the Respondent had left her cell phone in her office.

29. On July 15, 2009 at approximately 9:55 p.m., Ms. Tremaine presented the dog to Steven Hines, D.V.M., at the Adams Marquette Veterinary Service in Oxford, Wisconsin. At that time, the dog was hemorrhaging from the incision in the scrotum which was severely swollen. Dr. Hines observed that there was only one stitch in the scrotum itself. He performed surgery to stop the bleeding.

30. Respondent's conduct in providing care and treatment to the pit bull mix failed to meet the minimum standards of acceptable veterinary practice and evidence a lack of knowledge or the ability to apply professional principles and skills in the following manner:

a. The Respondent left the dog unattended at the office while she and staff left for lunch during which time the dog was still recovering from surgery and the anesthesia.

b. The Respondent improperly delegated responsibility of a veterinarian to Ms. Mallmann who recommended treatment for the pit bull mix over the phone post-discharge.

CONCLUSIONS OF LAW

1. The Wisconsin Veterinary Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 453.07(2), and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. Respondent's conduct as set out in paragraphs 4 – 10, 12 – 23, and 25 - 29 above, constitutes a violation of Wis. Admin. Code §§ VE 7.06(1), 7.02 (1)(b) and 7.02(4)(a) and she is therefore subject to discipline pursuant to Wis. Stat. § 453.07(1)(f).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Respondent, Roxanne E. Rygiewicz, D.V.M., is REPRIMANDED in each of the above cases for the described conduct.

IT IS FURTHER ORDERED that:

2. Respondent shall, within twelve (12) months from the date of this Order, obtain and successfully complete the following four (4) hours of continuing education through the University of Illinois College of Veterinary Medicine: "Assessment, Triage, & Monitoring ER Patient; Cardiopulmonary, Cerebral Resuscitation – Current Guidelines"; "Feline Respiratory Distress"; and "Feline Shock". Respondent will also complete the following courses at the Central States Veterinary Conference in Kansas City in August of 2010: "Assessment of Post Surgical Pain" (1 hour) ; "Using Local Anesthesia for Surgical Analgesia" (1 hour); "Wet Lab: Anesthetic Complications and Monitoring Workshop" (3 ½ hours); and Acute Abdomen (Part 3): Post-Operative Management Monitoring" (1 hour). Respondent will also read a CE article titled "Canine Pyometra: an Update on Pathogenesis and Treatment" available at www.vetlearn.com and either complete and pass the test included or provide a written summary for review by the case advisor to demonstrate understanding of the principles discussed. The course(s) attended in satisfaction of this requirement may not be used to satisfy the statutory continuing education requirements for licensure.

3. Respondent shall be responsible for obtaining the course(s) required under this Order, for providing adequate course descriptions to the Department Monitor, and for obtaining pre-approval of the courses from the Wisconsin Veterinary Examining Board, or its designee, prior to commencement of the programs. All costs of the educational programs shall be the responsibility of the Respondent.

4. Within thirty (30) days following completion of the course(s) identified in paragraph 2 above, Respondent shall file with the Department Monitor certifications from the sponsoring organization(s) verifying his attendance at the required courses.

5. Respondent shall participate in a monitoring program with the following components:

a. Commencing on September 1, 2010 and concluding no later than September 1, 2011, Respondent shall participate in a monitoring program under the direction of a veterinarian pre-approved by the Board. This program shall involve a review of surgical files from the Respondent's practice to determine if such practice meets the minimum standards of the veterinary profession with regard to anesthetic monitoring, post-operative monitoring, cardiopulmonary resuscitation (as needed), intra- and post-operative pain relief and the treatment of canine pyometra (as needed).

b. The Monitoring Veterinarian shall, during the period of monitoring, review 10 surgical medical records created by the Respondent following her completion of the courses described in paragraph 2 above. Respondent shall make any recommended changes or additions to her surgical practice in order to meet the minimum standards of the veterinary profession with regard to the above referenced areas. The Monitoring Veterinarian shall review a minimum of five (5) additional records over the following 30 days to determine if the Respondent is in compliance.

c. All costs of the Monitoring program and the Monitoring Veterinarian shall be the sole responsibility of the Respondent. All bills submitted to Respondent shall be paid to the submitting party no later than 30 days after mailing.

6. Respondent shall, within 180 days of the date of this Order pay costs of this proceeding in the amount of ONE THOUSAND SEVEN HUNDRED ($1,700.00) dollars. Payment shall be made to the Wisconsin Department of Regulation and Licensing, and mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

7. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs or fails to comply with the ordered continuing education as set forth above, the Respondent's license (# 4406-50) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

8. This Order is effective on the date of its signing.

Wisconsin Veterinary Examining Board

By: Matthinah Greer DVM
A Member of the Board

8/4/10
Date