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STATE OF WISCONSIN
BEFORE THE VETERINARY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
ESTA L. PARRISH, D.V.M., RESPONDENT.	:	ORDER 0001029

[Division of Enforcement Case #'s 09 VET 058 & 10 VET 053]

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

Esta L. Parrish, D.V.M.
P.O. Box 324
Wilton, WI 54670

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

Wisconsin Veterinary Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
Madison, WI 53708-8935

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. Esta L. Parrish, D.V.M. ("Respondent"), was born on June 4, 1956, and is licensed to practice veterinary medicine in the State of Wisconsin (license # 2275-50). This license was first granted on June 17, 1981.

2. Respondent's most recent address on file with the Wisconsin Veterinary Examining Board is P.O. Box 324, Wilton, WI 54670.

3. At all times relevant to this case, Respondent worked as a veterinarian at her clinic, Esta's Mobile Veterinary Service in Wilton, Wisconsin.

4. Respondent was previously disciplined by the Wisconsin Veterinary Examining Board in May 2008, for failing to maintain adequate patient records. Respondent was reprimanded and ordered to take a continued education course in recordkeeping.

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5. Between October 12, 2004 and March 25, 2009, veterinarian Dr. P, a veterinarian in Tomah, Wisconsin, treated six animals presenting with post-surgical complications arising from procedures performed by the Respondent.

6. On October 12, 2004, Samson, a four month-old male Rottweiler mix dog, presented to Respondent for a neuter, tail dock and declaw surgeries. Respondent used catgut to suture the tail dock surgical incision site. Respondent failed to create any records of these procedures. Immediately after the surgeries, Respondent released the patient to the client. Respondent failed to provide the client with post-operative instructions, an Elizabethan collar (to prevent the patient from chewing on the surgical site) or pain medication.

7. On October 13, 2004, Samson presented to Dr. P's clinic with an open wound and infection on the tail dock surgical site secondary to the use of the catgut suturing material. The patient was treated for infection, prescribed pain medication and issued an Elizabethan collar.

8. Respondent's use of catgut suturing material for a cutaneous closure of the surgical site, failure to provide post-operative instructions to the client, issue an Elizabethan collar, or prescribe pain medication deviated from the standard practice and minimum competence in veterinary medicine.

9. On January 23, 2007, Deago, a male cat, presented to Respondent for neutering and declaw surgeries. Immediately after the surgery, Respondent released the patient to the client, and failed to provide the client with post-operative instructions, pain medication or schedule follow up appointments to monitor the patient's health, post-surgery.

10. On January 25, 2007, Deago presented to Dr. P with excessive bleeding from the surgical sites. Dr. P treated the patient and re-applied the bandages, and provided the client with home care instructions, antibiotics and pain medication.

11. Respondent's failure to provide post-operative instructions to the client, prescribe pain medication and failure to schedule follow up appointments deviated from the standard practice and minimum competence in veterinary medicine.

12. In May 2008, Diesel, a six month-old male Pug dog, exhibited pain symptoms and corneal ulcerations. The owners, who had not previously established a client-patient relationship with the Respondent, telephoned the Respondent reporting Diesel's symptoms. Without first conducting a physical examination of the patient or forming a client-patient

relationship with the owners, Respondent instructed the owners to administer to Diesel one half of 12.5 mg diphenhydramine tablet.

13. Respondent's failure to perform a physical examination of the patient or establish a valid client-patient relationship prior to diagnosing and prescribing medication deviated from the standard practice and minimum competence in veterinary medicine.

14. Approximately two weeks later, Diesel presented to the Respondent for a neutering surgery. Post-surgery, Respondent conducted a physical examination of the patient's corneas. Following this examination, Respondent applied antibiotic ointment and a bottle of 1% miconazole (55% alcohol) spray to directly into the patient's corneas. The miconazole spray contained a manufacturer's warning "Not for use in the eye." Respondent then released the patient to the client with instructions to apply the miconazole spray directly to the patient's eyes.

15. On June 6, 2008, Diesel presented to Dr. P with bilateral corneal ulceration. Dr. P's examination revealed that the patient's corneas were ulcerated over 75% of the surface with capillary ingrowth around the ulcerations and compromised tear production. Dr. P sedated the patient by administering 0.2 ml of buprenorphine, 0.15 ml of midazolam IM and diagnosed bilateral corneal ulcer involving 75% of each cornea and keratoconjunctivits sicca-dry eye. Dr. P prescribed Optimmune, gentamicin Ophthalmic solution, triple antibiotic Ophthalmic ointment and Metacam for pain.

16. Dr. P re-examined and treated Diesel on seven occasions between June 10 and March 25, 2009. Dr. P's final diagnosis was that the patient was irreversibly, blind with both corneas covered with pigment, the pupils are not visible, and tear production nonfunctional, all secondary to the Respondent's treatment and application and prescription of the miconazole spray.

17. Respondent's application of miconazole spray directly to the patient's eyes and instructions to the client to continue to do the same caused the patient's blindness, deviated from the standard practice and minimum competence in veterinary medicine, and constituted improper and inhumane treatment of a patient.

18. On June 17, 2008, Murray, a 3 year-old male Lhasa Apso mix dog, presented to Respondent for a neutering surgery. During the surgery, an undescended testicle was removed from Murray's abdomen. Immediately after the surgery, the Respondent released the patient to the client while the patient was still under the affects of anesthesia, failed to provide post-operative instructions to the client and failed to provide the patient with post-operative pain relief.

19. At approximately 4 P.M. that same day, Murray presented to Dr. P. with compromised respiration. Dr. P's examination revealed that the patient was unresponsive to stimuli and unable to ambulate. Temperature was 95.5, pulse was 80 beats per minute, respiration was 8 per minute, and his mucous membranes were gray. Dr. P noted that Murray had two incisions, prescrotal and right inguinal.

20. Dr. P warmed Murray with blankets and provided the patient with an intravenous subcutaneous saline. Normal temperature and the patient's ability to ambulate were restored approximately six hours later. The patient was released the next day and prescribed Metacam and amoxicillin.

21. Respondent's release of the patient while under the effects of anesthesia, failure to provide post-operative instructions to the client and failure to provide the patient with post-operative pain relief deviated from the standard practice and minimum competence in veterinary medicine, and constituted improper and inhumane treatment of a patient.

22. On February 24, 2009, Molly, a 2 year-old female domestic short hair cat, presented to Respondent for a routine spaying surgery. Immediately after the surgery, Respondent released the patient to the client while the patient was still under the affects of anesthesia. Respondent failed to prescribe pain medication.

23. A few hours later, Molly became agitated. The client telephoned the Respondent, and the Respondent instructed the client to confine Molly in the bathroom. After two hours of confinement Molly began bleeding from her incision sites. The client attempted to telephone Respondent for assistance, but Respondent was unavailable to attend to the patient's post-surgical complications.

24. On February 25, 2009, Molly presented to Dr. P. The physical examination revealed a heart rate of 180 beats per minute, respirations of 70 per minute and abdomen covered in dry blood. The spay incision had a knot in the buried subcutaneous suture, and was exposed at the caudal end of the incision. Dr. P cleaned and sealed the incision with surgical staples and tissue adhesive.

25. Respondent's release of the patient while under the effects of anesthesia, improper post-operative instructions to the client, failure to be accessible to the patient following a surgical procedure, failure to adequately suture the skin and failure to provide the patient with post-operative pain relief deviated from the standard practice and minimum competence in veterinary medicine, and constituted improper and inhumane treatment of a patient.

26. The Department requested veterinarian records for Molly and Murray. Respondent was unable to produce any records for these patients. In addition to the requested records, the Department also reviewed the Respondent's rabies certificates. The certificates provided by Respondent contained incomplete descriptions of the animal vaccinated, failed to consistently specify the species of the animal and in some instances multiple animals were put on the same certificate.

27. Respondent's failure to create and maintain proper medical records deviated from the standard practice and minimum competence in veterinary medicine, compromised patient continuity of care and constituted improper and inhumane treatment of a patient.

28. Respondent's surgical protocols, include:

(a) Anesthetic monitoring and administration of supportive therapy of patients are performed by Respondent while simultaneously doing surgery and/or the delegation of anesthetic monitoring to her unlicensed assistant, DW. Respondent's surgical records fail to record the mucus membrane color, capillary refill time, respiratory rate and heart rate of patients during the surgery.

(b) In low cost situations, using one pack of surgical instruments on three (3) different patients, without sterilizing those instruments after each patient. Respondent's surgical protocols where she has more than three (3) patients per pack of surgical instruments, includes soaking the surgical instruments in chlorhexidine prior to reuse. While a chlorhexidine soak is acceptable for suturing superficial wounds, it is not acceptable for spays and neuters. The surgical instruments should be sterilized by autoclave or gas sterilization prior to each use.

(c) Providing onsite veterinary care to homes and farms. Respondent carries her surgical instruments with her, and has a wooden tray that is used when the patient must lie on its back during the surgical procedure. Respondent's companion animal surgical procedures on location are typically performed in the client's house on a kitchen table.

29. Respondent's surgical protocols deviated from the standard practice and minimum competence in veterinary medicine, and constituted improper and inhumane treatment of a patient.

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30. On September 23, 1020, Skeeter, an eight month-old male grey tabby cat, presented to Respondent for routine rabies vaccinations, Feline Viral Rhinotacheitis, Calicivirus, Panleukopenia and Chlamydia Psittaci vaccinations (FVRCPL) and neutering and declaw surgeries.

31. Respondent delegated the administration of the patient's rabies vaccination to an unlicensed veterinary assistant. Prior to the surgeries, Respondent made no record of Skeeter's temperature, heart rate or his respiratory rate, all of which are necessary preoperative parameters. Respondent both administered the patient's anesthesia and conducted the surgery. The initial dose for anesthesia was .5 cc xylazine with .25 cc ketamine. The Respondent then administered a second dose of .1 cc of xylazine and ketamine. After completing the neuter, the patient experienced compromised respiration. Despite the respiration complications, Respondent then initiated the declaw surgery. When the procedure was complete, Respondent wrapped the patient's paws with gauze and bandaged the paws with a finger from a surgical glove. The patient's paws immediately bled through the gauze.

32. During this procedure, the patient "began to breathe deeply." Respondent released the patient to the client with instructions to keep the patient in a crate or the bathroom floor for approximately twenty four hours. Respondent failed to provide the client any additional post-operative instructions and failed to prescribe pain medication.

33. En route home, the patient manifested respiration complications and began gasping for air. The client transported the patient to the Tomah Veterinary Clinic. Upon arrival, Skeeter was pronounced dead. The patient's corpse was sent to the Wisconsin Veterinary Diagnosis Lab (WVDL) for necropsy. The cause of death was determined to be a combination of general anesthesia and pre-existing diaphragmatic hernia with evidence of mild lung compromise in the form of chronic bronchitis (feline asthma).

34. Respondent's monitoring of anesthesia while simultaneously performing surgery, record keeping, release of the patient while manifesting respiration complications, improper post-operative instructions to the client and failure to prescribed pain medication deviated from the standard practice and minimum competence in veterinary medicine, and constituted improper and inhumane treatment of a patient.

CONCLUSIONS OF LAW

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

2. Respondent's conduct as described above violates Wis. Admin. Code § VE 7.06(1) and (2).

3. Respondent's conduct of delegating anesthetic monitoring and the administration of a rabies vaccination to a non-certified veterinary technician constitutes a violation of Wis. Admin. Code § VE 7.02(4)(a).

4. Respondent's failure to maintain appropriate patient records constitutes a violation of Wis. Admin. Code § VE 7.03 and is actionable under Wis. Admin. Code § VE 7.06(15).

5. Respondent's failure to obtain informed consent with clients including discussion of treatment risks and benefits is a violation of Wis. Admin. Code § VE 7.06(23).

ORDER

NOW, THEREFORE, IT IS ORDERED that the Stipulation of the parties is hereby accepted.

IT IS FURTHER ORDERED that:

1. Esta L. Parrish, D.V.M. (license # 2275-50), is hereby REPRIMANDED by the Wisconsin Veterinary Examining Board.

2. Respondent is ordered to immediately cease performing companion animal surgery outside an appropriate veterinary medical facility.

3. **Continuing Education:** Respondent's license to practice veterinary medicine in the State of Wisconsin is LIMITED to require that, within nine (9) months of the date of this Order, Respondent shall locate, and successfully complete a minimum of:

(a) the Wisconsin Veterinary Medical Association records course;

(b) 4 credits of continuing education in intra and post-operative pain relief;

(c) 4 hours of continuing education in appropriate anesthesia for cats and dogs;

(d) 4 credits of continuing education in intra-operative and post-operative anesthetic monitoring; and

(e) 1 credit of continuing education on the proper sterilization of surgical instruments.

The courses attended in satisfaction of this requirement shall **NOT** be used to satisfy the statutory continuing education requirements for licensure. Respondent is responsible for locating the course(s) required under this Order, for providing adequate course descriptions to the Department Monitor, and for obtaining pre-approval of the courses through the Department Monitor, as the board's designee, in paragraph 6 below.

4. **Pre-Approval of Protocols:** Respondent shall within ninety (90) days of the date of this Order, submit written protocols for pre-approval through the Department Monitor, as the board's designee, in paragraph 6 below, regarding her proposed procedures for: (1) post-operative pain relief; (2) anesthesia for common surgeries, including but not limited to, feline and canine spay, castration, dental prophylaxis (with or without extractions), removal of large masses, and orthopedics; and (3) post-operative monitoring.

5. **Limitation and Monitoring:** Respondent's license to practice veterinary medicine in the State of Wisconsin is further **LIMITED** to require that Respondent shall not perform any surgical procedures, including surgeries performed outside of her clinic until Respondent obtains and provides a written report to the Department Monitor in paragraph 6 below, a surgical competency assessment by an independent veterinarian licensed in Wisconsin, who shall observe Respondent's surgical techniques in no less than ten (10) surgeries. This assessment shall report:

(a) the nature of the surgeries;

(b) clinical observations of the Respondent's techniques, practice, performance and protocols in the areas of pre-anesthetic patient evaluation, anesthesia, anesthetic monitoring, surgery, intra-operative and post-operative pain relief and post-operative client instructions;

(c) an opinion of the cleanliness and sanitation of the Respondent's clinic; and

(d) an opinion of whether the Respondent possesses surgical competency in veterinarian practice.

The observing veterinarian shall not be a friend or professional acquaintance of the Respondent and the Respondent shall obtain pre-approval of the observing veterinarian prior to the observation through the Department Monitor, as the board's designee, in paragraph 6 below. The Veterinarian Examining Board retains the full authority to lift the surgery limitation or impose additional limitations as necessary after its review of the competency report outlined above.

6. For the purposes of this Order, the Board's designee is:

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

7. Within thirty (30) days following the successful completion of the obligations identified in paragraphs 2-4 above, Respondent shall file with the Department Monitor above, certifications from the sponsoring organization(s) verifying her attendance at the required courses, a copy of all proposed protocols and a copy of all reports generated by the independent competency evaluation.

8. All costs of educational programs, protocols, and competency reports shall be the responsibility of the Respondent.

9. Respondent shall, within one year from the date of this Order, pay costs of this proceeding in the amount of $2,000.00. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

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

10. 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 comply with the terms as set forth above, the Respondent's license (# 2275-50) may, in the discretion of the Board or its designee, be

SUSPENDED, without further notice or hearing, until Respondent has complied with the terms as set forth above.

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

Wisconsin Veterinary Examining Board

By: Matthias Gredvm JD
A Member of the Board

8/3/11
Date