SUMMARY OF DECISION OF PROFESSIONAL CONDUCT COMMITTEE
RE DR. SIETSE VAN ZWOL

The Professional Conduct Committee of the Nova Scotia Veterinary Medical Association met on June 21, 2016 to consider a Settlement Proposal recommended by the Complaints Committee.

The Settlement Proposal contained agreed facts, the allegations referred by the Complaints Committee, admissions from Dr. Van Zwol and an agreed upon disposition. These are summarized as follows.

A complaint was filed by the owner of a dog who brought the dog to Dr. Van Zwol's office for treatment. The owner advised that the dog was acting normally on the morning she brought him to Dr. Van Zwol, but she found a pool of blood mixed in with urine in an area where the dog was known to spend time.

The owner indicates the dog jumped into her car and walked unassisted into Dr. Van Zwol's hospital. She informed Dr. Van Zwol that she suspected the dog was bleeding from the mouth. Dr. Van Zwol examined the dog's mouth and gave him an injection. The owner says Dr. Van Zwol conducted no further examination.

The owner indicates she advised Dr. Van Zwol of her concern that the dog may have some internal bleeding and she insisted her dog stay at the hospital for an x-ray. When the owner returned later that afternoon, Dr. Van Zwol was not present. A staff member informed the owner that the dog's x-ray had not revealed any problems. The staff member further indicated that the dog would need exploratory surgery to determine the cause of additional bleeding. The owner agreed to leave the dog at the hospital overnight.

When the owner called the hospital later that day, the staff member informed her that the dog was doing fine. The next morning, the owner received a call that her dog had bled to death. There had been no communication from Dr. VanZwol or the hospital.

In his response to the complaint, Dr. Van Zwol says he examined the dog and found subnormal temperature and several other issues. He provided a different version of events from that provided by the owner. He indicates he gave the owner a very guarded prognosis and that he told the owner that the dog would have to stay at the hospital for diagnosis and treatment.

Dr. Van Zwol says the owner left the hospital with the dog, returning later for an x-ray. Following the x-ray, he says the owner left and the dog was left in the treatment area. He indicates his staff member checked on the dog at 10:00 p.m. and indicated that there was no change in the dog's condition at that time. He advises the dog was found dead the next morning.

The medical record maintained by Dr. Van Zwol was sparse, questioning the source of blood, and noting that an x-ray was taken. The dog was noted to be “ok” at 4:30 p.m. and was eating and drinking, although the dog urinated blood. Dr. Van Zwol made no written entries on the chart after 4:30 p.m. The medical record also does not reveal the dog’s temperature or other vital parameters such as heart rate, respiration, mucus membrane color and capillary refill time. The record does not note any diagnosis or treatment plan. The record does not note any blood testing or x-ray findings.

Following receipt of a complaint from the owner, the Complaints Committee met separately with the owner and Dr. Van Zwol. The owner provided information consistent with her complaint. During the Committee’s meeting with Dr. Van Zwol, he provided additional and inconsistent information from that in his written response and he also spoke disparagingly toward the owner of the dog. He later wrote to the Committee to apologize for his “poor choice of words”.

In order to determine whether the care provided to the dog was an isolated incident, the Complaints Committee ordered an audit of Dr. Van Zwol’s records. The audit revealed significant deficiencies in record keeping and overall quality of care. In response to the audit, Dr. Van Zwol acknowledged his medical records have at times lacked detail and he indicated that both himself and staff have recognized these deficiencies and have begun to remedy them.

Allegations

The Complaints Committee referred the following allegations of professional misconduct and incompetence to the Professional Conduct Committee:

A. Dr. VanZwol failed to provide competent care to the dog on May 14, 2014, in that he:

   i. Failed to appropriately assess, diagnose, and treat the dog;
   ii. Left the dog unattended when near death;

B. Dr. VanZwol failed to provide timely and accurate communication to the family, with respect to the dog’s condition, prognosis and/or cause of death;

C. Dr. VanZwol failed to offer or recommend a post-mortem;

D. Dr. VanZwol failed to maintain appropriate medical records with respect to his care of the dog on May 14, 2014;

E. Dr. VanZwol provided inconsistent, inaccurate and/or unprofessional comments to the Complaints Committee in the course of responding to the complaint;

F. The records of Dr. VanZwol and the clinic which he owns, that were subject to the audit conducted on June 11, 2015, are deficient in that they consistently lacked information pertaining to physical examinations, diagnostic and treatment plans, laboratory and x-ray results, hospitalization, surgical procedures and patient follow-up, and failed to identify the author of the entries on the records.

Admissions and Disposition

Dr. Van Zwol admitted the above allegations and agreed they constitute professional misconduct and incompetence.

Through a Settlement Agreement reached between the Professional Conduct Committee and Dr. Van Zwol, the parties agree to the following:

(1) Dr. VanZwol will serve a period of suspension of his licence of two months commencing at a date to be agreed upon with the Registrar of the Association, which must commence no later than July 1, 2016.

(2) In addition to the suspension, Dr. VanZwol is reprimanded for his professional misconduct with respect to:

a. his failure to provide timely and accurate communication with respect to the dog's condition, prognosis, and cause of death;
b. his inconsistent, inaccurate and unprofessional comments he made to the Complaints Committee in the course of responding to this complaint;
c. his inadequate record keeping.

(3) Dr. VanZwol must complete the online record-keeping program through the College of Veterinarians of Ontario no later than July 30, 2016. He shall provide proof of successful completion to the Registrar, failing which his licence will remain suspended until such proof is provided.

(4) Following the two month suspension and successful completion of the record keeping course, Dr. VanZwol will be subject to re-audits by the Association 60 days after returning to practice followed by two additional audits at six month intervals. Thereafter, an audit will be conducted by the Association annually, for such time as Dr. VanZwol holds a general practice licence. The costs of these audits will be borne by Dr. VanZwol. Failure to pay these costs will result in an immediate suspension of Dr. VanZwol's licence. These audits will review Dr. Van Zwol's personal medical recording keeping, and, to the extent the charts include records from other veterinarians, will also review that record keeping to ensure Dr. Van Zwol is appropriately exercising his supervisory role in his practice to ensure that record keeping by his Associates meet acceptable standards. The records to be reviewed will include records from both the small animal practice and the large animal practice.

In addition, Dr. Van Zwol was ordered to pay an amount of costs to the Nova Scotia Veterinary Medical Association as part of reimbursement for the costs of the investigation and conclusion of this matter.

In accepting the Settlement Agreement, the Professional Conduct Committee indicated that it was satisfied that the public was protected; the conduct of Dr. Van Zwol and its causes can be successfully remedied; and settlement is in the best interest of the public and the veterinary medical profession.

In accepting the Settlement Agreement, the Committee agreed that the conduct of Dr. Van Zwol represented a serious breach of the standards of practice. As a result, it was important that the decision reflect the denunciation of Dr. Van Zwol's conduct by the Committee. It was also important that the decision provide a general deterrent to other members of the profession, and specific deterrence to Dr. Van Zwol. In determining that a serious disposition was needed, the Committee was influenced as well by Dr. Van Zwol's previous history where he had been reprimanded on six separate occasions between 1992 and 2009.

The Committee was satisfied that the disposition upholds the protection of the public in that Dr. Van Zwol is required to correct his record-keeping deficiencies and to have re-audits of his practice at defined intervals by the Association.