

**STATE OF MARYLAND
DEPARTMENT OF AGRICULTURE
BEFORE THE STATE BOARD OF VETERINARY MEDICAL EXAMINERS**

IN THE MATTER OF:

ERIC ALEXANDER, DVM
LICENSE NO. 5837

DOCKET NO. 23-09

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CONSENT AGREEMENT AND ORDER

This Consent Agreement and Order ("Consent Agreement"), dated this 17th day of January 2024, is between the State Board of Veterinary Medical Examiners ("SBVME" or "Board") and Eric Alexander, DVM ("Dr. Alexander"), License No. 5837. This Consent Agreement resolves a case arising from a complaint filed on July 25, 2022, with the SBVME, assigned Docket No. 23-09, alleging that Dr. Alexander did not comply with the Veterinary Practice Act, Md. Code Ann., Agric. §§ 2-301 – 2-316 and related Code of Maryland Regulations ("COMAR") 15.14.01 – 15.14.17, as set forth herein.

On December 11, 2023, Dr. Alexander, having been advised in writing regarding his due process rights and while represented by legal counsel, agreed to resolve this case under the terms and conditions reflected in this Consent Agreement. By signing this Consent Agreement, Dr. Alexander agrees to waive his right to formal proceedings in this case, including the issuance of charges and a hearing. He further agrees to the terms and conditions of this Consent Agreement.

Under Maryland law, the SBVME is the licensing authority responsible for regulating the practice of veterinary medicine in this State, which includes filing disciplinary actions against veterinarians charged with violating the provisions of the Veterinary Practice Act and related COMAR regulations adopted under this law. As part of its authority, the SBVME "may refuse, suspend, or revoke any application or license, and censure or place on probation any licensee ... if the veterinarian ... [f]ails to comply with Board rules and regulations after receiving a license." Md. Code Ann., Agric. § 2-310(8). The Board may also impose a civil penalty of not more than \$5,000 for a first offense or \$10,000 for a second or subsequent offense in

licu of or in addition to suspending or revoking a veterinarian's license, respectively. Agric. § 2-310.1. In setting the amount of a civil penalty, the Board shall consider the severity of the violation, the good faith of the violator, and any history of prior violations, as well as the Board's civil penalty standards. Md. Code Ann., State Gov't. § 10-1001(b); COMAR 15.14.11 (Civil Penalty Standards for Veterinarians).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

By entering and signing this Consent Agreement after having had the opportunity to seek the advice of legal counsel, Eric Alexander, DVM, License Number 5837, agrees to the provisions of this Consent Agreement, acknowledging that the SBVME has sufficient evidence to find as fact, and to conclude as a matter of law that Dr. Alexander did not satisfy COMAR 15.14.01.07 (Professional Judgment and Practice) as described below:

1. Dr. Alexander is a veterinarian licensed to practice in Maryland, where he has been licensed since 2005. Dr. Alexander has no relevant disciplinary history with the Board.
2. At the time of the events described herein, Dr. Alexander was the responsible veterinarian at Alexander Animal Hospital ("AAH" or "Hospital") (License No. 02-080), located at 160 Richie Highway, Severna Park, MD 21146.
3. This case involves care and treatment provided to Molly, an 8-year-old spayed American Bulldog owned by Robert Tuttle ("Mr. Tuttle") and Michelle Tuttle ("Ms. Tuttle") (collectively, "the Tuttles" or "Owners").
4. On June 2, 2022, the Tuttles took Molly to AAH for surgery to remove tumors on the right thigh, left lateral hind leg, and ventral neck. Dr. Alexander was Molly's attending veterinarian on that day. According to AAH's medical records, Dr. Alexander suspected the mass on the right thigh was a mast cell tumor ("MCT").
5. Molly had a history of elevated ALT (324), recorded in June 2020. The Tuttles declined further diagnostics to assess the elevated ALT at that time and Molly was not seen again until October 20, 2021.
6. Molly was known to be an aggressive dog. On the day of surgery (June 2, 2022), Dr. Alexander noted that Molly could not be handled even when muzzled. Dr. Alexander administered a mixture of

acepromazine and Torbugesic intramuscularly ("IM") to Molly. Molly also received an injection of Rimadyl subcutaneously ("SQ").

7. According to Dr. Alexander, despite Molly's pre-sedative, the technicians could not safely obtain blood from her jugular or cephalic veins before surgery. Dr. Alexander stated that he elected to alter Molly's induction plan by giving her a combination of ketamine and midazolam IM. Once Molly was sedated, blood was obtained to run a chemistry panel, and an intravenous ("IV") catheter was placed. While Molly was maintained under gas anesthesia, Dr. Alexander proceeded with the mass removals before receiving blood work results.

8. While Dr. Alexander was performing Molly's surgery, a technician alerted him that Molly's ALT was greater than 1000 (normal is 0-120 U/l). Dr. Alexander finished Molly's surgery, and the right thigh mass was sent out for histopathology. Due to Molly's elevated ALT, Dr. Alexander switched Molly's post-operative oral medication from Rimadyl to Galliprant. Dr. Alexander told the Board that during Molly's discharge, he informed the Tuttles that Molly might need an abdominal ultrasound and fine needle aspirates of her liver to find the source of her elevated ALT.

9. On June 7, 2022, the Tuttles returned to AAH because Molly was not eating, was drinking excessively, and was leaking urine. Molly had an extensive history of urinary tract infections. Dr. Alexander performed a urinalysis, which was unremarkable, and Molly ate a can of food while she was in the exam room. Dr. Alexander planned to continue Molly on her medications and potentially perform recheck bloodwork and abdominal ultrasound. Molly was discharged.

10. On June 9, 2022, the Tuttles took Molly to AAH due to vomiting and diarrhea. The Tuttles recall that Molly was given an injection of Cerenia during this visit, but they were concerned that her gums looked yellow. The Tuttles wanted Dr. Alexander to examine Molly.

11. Subsequently, Dr. Alexander examined Molly and noted that she was bright, alert, and responsive with pale yellow gums. Dr. Alexander told the Tuttles that the yellow gums were signs of severe liver disease and that Molly needed care at an emergency clinic. According to Dr. Alexander, the Tuttles decided to take Molly home with oral Cerenia.

12. The Tuttles deny that Dr. Alexander recommended emergency care. They allege that he only offered Cerenia to Molly and no other treatment options. The Tuttles maintain that Dr. Alexander told them to “take Molly home and get her to eat.”

13. Later that evening, Molly was not improving, so the Tuttles called AAH. An employee referred Molly to Anne Arundel Veterinary Emergency Clinic (“AAVEC”) (License No. 02-00248) because AAH was closing soon.

14. Once the Tuttles arrived at AAVEC with Molly, she was examined by Stewart McNair, DVM (“Dr. McNair”) (License No. 6164). AAVEC’S medical records reflect that Dr. McNair recommended admitting Molly for supportive care, abdominal ultrasound, and possible FNA if indicated. The Tuttles consented to the plan.

15. Molly’s bloodwork was rechecked. Her ALT was 1541 U/l, and her TBIL was elevated at 13.5 mg/dl. Molly was started on IV fluids, which were administered throughout the night. The following day, on June 10, 2022, Adam Gonzales, DVM (“Dr. Gonzales”) (License No. 5822) performed an abdominal ultrasound on Molly. His report reflects that Dr. Gonzales did not see an obvious cause for Molly’s elevated liver values, so he recommended a liver biopsy.

16. On June 10, 2022, Molly’s histopathology report was finalized, and noted that the growth Dr. Alexander removed from Molly’s right thigh was a grade 2 mast cell tumor.

17. On June 11, 2022, Molly remained hospitalized and continued on IV fluids. The veterinarians also started her on Denamarin, a liver supplement. According to AAVEC’s medical records, Molly’s TBIL was increasing, and she was not eating. Emily Mason Kennedy, DVM (“Dr. Mason”) (License No. 6643) spoke to Ms. Tuttle by telephone and discussed advanced diagnostics such as exploratory surgery. However, the Tuttles declined and elected to take Molly home for hospice care.

18. On June 13, 2022, the Tuttles took Molly to AAH for euthanasia. Dr. Alexander performed the procedure.

19. On July 25, 2022, the Tuttles filed a complaint with the SBVME against Dr. Alexander, alleging errors related to Molly’s care and treatment.

20. The Board opened a case and investigated, which included obtaining and reviewing medical records and obtaining statements from the parties involved.

21. Dr. Alexander submitted a response to the SBVME detailing his interactions with Molly and the Tuttle. Dr. Alexander stated that Molly had a history of elevated ALT that he diagnosed on July 13, 2020 (ALT was 324 U/l). He had offered several options to determine the cause of Molly's elevated ALT at the time of the diagnosis, which is documented in the July 2020 records. Options presented to the owner at that time included: sedation, abdominal ultrasound, and FNA of the liver; hepatoprotective liver supplement ("Hepato") and recheck bloodwork in 3-4 weeks; no treatment and recheck bloodwork in 3-4 weeks; and no-follow up. Ultimately, the Tuttle elected not to pursue any diagnostics at that time.

22. In his response to the Board, Dr. Alexander also noted that Molly's aggressive behavior prevented him from safely obtaining bloodwork before the start of her surgery in 2022.

23. As part of its investigation, the Board requested that an independent expert review the case and offer an opinion regarding the care provided.

24. The expert provided the Board with a report dated July 17, 2023. In the report, the reviewing expert found that Dr. Alexander did not satisfy the standard of care by administering injectable carprofen, an NSAID, to a patient in which hepatocellular enzymes were previously elevated and without pre-anesthetic lab work.

25. The expert noted that Carprofen is an NSAID commonly prescribed by veterinarians to reduce pain and inflammation. However, it is not without risks, as its use has been associated with renal and G.I. toxicity, as well as acute hepatic necrosis. The package insert for Carprofen states that the product's: "... anti-prostaglandin effects may result in clinically significant disease in patients with underlying or pre-existing disease more often than in healthy patients." The insert warns that patients with underlying disease "... may experience exacerbation or decompensation of their ... disease while on NSAID therapy."

26. In addition, according to the expert, general anesthesia has the potential to cause hepatic injury. Increases in ALT and AST have been documented in healthy animals undergoing anesthesia. Concomitant

use of carprofen and gas anesthesia can exacerbate toxicity, posing a significant risk for a patient with a documented history of liver disease like Molly.

27. After considering the evidence gathered during the investigation, the Board concluded that Dr. Alexander provided substandard care to Molly.

28. COMAR 15.14.01.07A (Professional Judgment and Practice) provides that: “[a] veterinarian, when caring for and treating a patient, shall conform to those minimum standards of care and treatment which are customary among veterinarians in this State.”

29. The Board agreed with the expert that Dr. Alexander, acting in accordance with the standard of care, should have exercised greater caution when administering an NSAID and general anesthesia to a patient with known pre-existing liver disease. Dr. Alexander was aware of the risks of prescribing NSAIDs to a patient with liver disease, which is why he used a different NSAID, Galliprant, for post-operative pain control. Due to these risks, preoperative bloodwork would have provided essential information to inform treatment decisions and should have been returned and reviewed by Dr. Alexander before beginning the surgery on June 2, 2022. Dr. Alexander should also have discussed the risks of NSAID and general anesthesia with the owners as part of obtaining informed consent before proceeding with the surgery.

30. The Board could not conclude to a reasonable degree of medical certainty that the use of Carprofen and general anesthesia were the sole cause of the onset of acute liver failure that led to Molly’s death; however, it is likely that they contributed to Molly’s rapid deterioration.

Taking the facts and circumstances into consideration, including the nature of the violation(s), the veterinarian’s lack of disciplinary history, and his acceptance of responsibility and good faith cooperation in resolving this matter, the Board concluded that the most reasonable and appropriate resolution includes the sanctions set forth below.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED by the State Board of Veterinary Medical Examiners, that:

- (a) For not satisfying COMAR 15.14.01.07 (Professional Judgment and Practice) in the care and treatment provided to Molly, an 8-year-old spayed American Bulldog owned by Robert and Michelle Tuttle, by administering an NSAID, namely Carprofen, to a patient with a history of liver disease without waiting for blood work to be returned, and not discussing the risks associated with NSAID use in a patient with Molly's history, Dr. Alexander is assessed a civil penalty of \$1000;
- (b) Dr. Alexander shall pay the civil penalty (\$1000) within sixty (60) days from the date of this Consent Agreement by check payable to the Maryland Department of Agriculture ("MDA") with the notation "SBVME – 23-09" sent to the MDA at 50 Harry S. Truman Parkway, Room 102, Annapolis, MD 21401 – Attn: Nathaniel Boan;
- (c) As an additional requirement of this Consent Agreement, Dr. Alexander shall complete three (3) hours of continuing education ("CE"), pre-approved by the Board, in liver disease diagnosis or treatment;
- (d) The veterinarian or the veterinarian's counsel shall send requests for pre-approval of the proposed CE to Nathaniel Boan, Executive Director, at Nathaniel.boan@maryland.gov and include detailed information about the course proposed, including a link syllabus or other description of the material to be covered;
- (c) The CE shall be completed, and verification of completion provided to the Board within sixty (60) days from the date of this Order, with verification sent by email to Nathaniel Boan, Executive Director, at nathaniel.boan@maryland.gov. Proof from the CE provider shall include the veterinarian's name, the number of hours of CE completed, the topics covered, and the date(s) the CE completed. This CE may be counted toward the 18 credit hours required annually for re-registration of the veterinary license. and
- (f) This Consent Agreement is a public document.

WITNESS the hand of the State Board of Veterinary Medical Examiners, State of Maryland, this
17th day of January 2024.

STATE BOARD OF VETERINARY
MEDICAL EXAMINERS



Elizabeth Callahan, DVM

President

State Board of Veterinary Medical Examiners

Maryland Department of Agriculture

CONSENT

I, Eric Alexander, DVM, acknowledge that I have had an opportunity to consult with counsel before entering into this Consent Agreement. By this Consent, I hereby acknowledge the legal authority and jurisdiction of the Board to issue and enforce this Consent Agreement. To resolve this matter, I agree to accept and submit to the foregoing Consent Agreement, consisting of nine (9) pages, including this Consent. I sign this Consent Agreement without reservation as my voluntary act and deed after having had an opportunity to consult with counsel. I acknowledge that I fully understand and comprehend the language, meaning, and terms of this Consent Agreement.

Date:

1/17/2024


Eric Alexander, DVM