

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

IN THE MATTER OF:

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SCOTT K. ANDERSEN, DVM  
LICENSE NO. 2484

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DOCKET NO. 24-72B

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**CONSENT AGREEMENT AND ORDER**

This Consent Agreement and Order (“Consent Agreement”), dated this 6th day of November 2025, is between the State Board of Veterinary Medical Examiners (“SBVME” or “Board”) and Scott Andersen, DVM (“Dr. Andersen”), License No. 2484. This Consent Agreement resolves a case arising from a complaint filed with the SBVME on January 18, 2024 (assigned Docket No. 24-72B), alleging that Dr. Andersen did not satisfy 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 October 8, 2025, Dr. Andersen, 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. Andersen 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 the state, which includes filing disciplinary actions against veterinarians charged with failing to comply with 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 instead of or in addition to suspending or revoking a veterinarian's license, respectively. Agric. § 2-310.1. When setting the amount of a civil penalty, the Board shall consider the severity of the violation, the violator's good faith, any history of prior violations, and the Board's established 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 while presented by legal counsel, Scott Andersen, DVM, License Number 2484, 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 he did not satisfy COMAR 15.14.01.07A (Professional Judgment and Practice) and COMAR 15.14.01.10 (Record Keeping) as described below:

1. Dr. Andersen is a veterinarian licensed to practice in Maryland since 1982.
2. At the time of the events described herein, Dr. Andersen was the owner and responsible veterinarian at Waugh Chapel Animal Hospital ("WCAH" or "Hospital") (License No. 02-053), located at 2638 Brandermill Blvd, Gambrills, MD 21054.
3. Dr. Andersen's history of discipline with the Board includes two Consent Agreements and Orders. In Docket No. 11-43, Dr. Andersen was found to have violated the Board's professional judgment and practice standards by incorrectly interpreting radiographs and inappropriately prescribing a steroid for a patient. Under the agreement, Dr. Anderson paid a \$1,000 civil penalty, completed six hours of continuing education in internal medicine, and served six months of probation.
4. In the second case, Docket No. 12-67B, the Board found that Dr. Andersen failed to satisfy its record-keeping standards by not documenting a medication dispensed and administered to a patient. For this violation, Dr. Andersen paid a \$300 civil penalty, completed 12 hours of continuing education in internal medicine, canine reproduction, and pharmacology, and served one year of probation.
5. The case currently before the Board involves care provided to Ernie, a six-year-old Golden Retriever, owned by Kelly Ross ("Ms. Ross") and her husband, Jeff Ross ("Mr. Ross") (collectively, "the Owners").

6. On March 22, 2023, the Owners took Ernie to Dog and Cats Veterinary Referral of Bowie (“DCVR”) (License No. 16-00221) for an evaluation of lameness. Ernie had a history of idiopathic pleural effusion and inflammatory bowel disease (“IBD”). Euan Murray, DVM (“Dr. Murray”) (License No. V-08602) was Ernie’s attending veterinarian. Dr. Murray examined Ernie and diagnosed him with a torn left cranial cruciate ligament (“CCL”).

7. Later that day, the Owners called Ernie’s primary veterinary practice, Bowie Towne Veterinary Hospital (“BTVH”) (License No.16-044), and spoke to John Seddon, VMD (“Dr. Seddon”) (License No. 3030), BTVH’s owner and responsible veterinarian, about Ernie’s torn CCL. Based on Ernie’s medical history, Dr. Seddon believed that CCL surgery was too risky.

8. On April 3, 2023, the Owners took Ernie to WCAH for a second opinion on possible CCL surgery. Dr. Andersen was Ernie’s attending veterinarian. Dr. Andersen examined Ernie and performed x-rays, which revealed no significant findings. Based on his physical examination, Dr. Andersen confirmed that Ernie had a ruptured CCL and recommended surgery. The Owners scheduled Ernie’s CCL repair surgery for April 24, 2023.

9. On April 24, 2023, the Owners returned to WCAH with Ernie for CCL surgery to be performed by Dr. Andersen. At drop-off, a WCAH staff member noticed that Ernie’s stomach was distended. An X-ray was taken and revealed fluid in Ernie’s chest. The Owners explained to Dr. Andersen that Ernie had a history of idiopathic pleural effusion and had been treated with various medications, including prednisone. Additionally, they reported that Ernie had been having fluid drained from his chest approximately every 8 weeks.

10. Concerned about how frequently Ernie’s chest was being drained, Dr. Andersen asked the Owners for permission to perform an ultrasound (“US”). After obtaining consent, a WCAH staff veterinarian, Joshua McHarg, DVM (“Dr. McHarg”) (License No. V-08814), performed the US. Dr. McHarg found what he believed to be a questionable region in the sub-lumbar area with two unidentifiable masses. Ultimately, after further evaluation by specialists, this area was not found to be problematic.

11. According to Ms. Ross, Dr. Andersen returned to the exam room without Ernie after the scans. Ms. Ross recalls Dr. Andersen asking her husband and her whether they wanted to see the images taken and telling them that Ernie “was full of lymphoma and did not have long to live.”
12. The Owners followed Dr. Andersen to the treatment area, where Ernie was lying on the table. They were introduced to Dr. McHarg. Ms. Ross recalls Dr. McHarg pulling up the scan and pointing out the location of concern. According to the Owners, Dr. McHarg diagnosed Ernie with lymphoma.
13. Ms. Ross and her husband were upset and emotional. According to Ms. Ross, Dr. McHarg told them that they “had been lied to by Ernie’s specialist, Ernie would die soon, and it would be best to humanely euthanize him.” The Owners told Dr. McHarg that their children were expecting Ernie to come home after his surgery, and they were not ready to euthanize him. Ms. Ross alleges that Dr. McHarg told them that they were making a mistake and cautioned them that they would not want their children to watch Ernie die from lymphoma.
14. Dr. Andersen provided the Owners with phone numbers for veterinarians who perform at-home euthanasia services. According to the Owners, Dr. Andersen also made disparaging comments about DCVR, where Ernie had been treated by an internal medicine specialist, Nicole Guma, DVM (“Dr. Guma”) (License No. 6130), and “expressed displeasure” with Dr. Guma for draining Ernie’s chest so frequently. Nonetheless, the Owners did not intend to change specialists.
15. The Owners opted to take Ernie home, treating him “like a king” at that time, because they expected that he did not have long to live.
16. Subsequently, Ms. Ross emailed Dr. Guma to inform her that Ernie had been diagnosed with lymphoma. Dr. Guma recommended having Ernie reexamined at DCVR.
17. On April 29, 2023, the Owners took Ernie to Bayside Animal Medical Center (“BAMC”) (License No. 02-041) for a second opinion on the lymphoma diagnosis and Dr. Andersen’s euthanasia recommendation.

18. Rebekah Sims, DVM (“Dr. Sims”) (License No.5022) was Ernie’s attending veterinarian at BAMC. Dr. Sims took Ernie’s medical history, examined him, and performed chest/abdominal radiographs. Dr. Sims’ differential diagnoses included neoplasia, chyle, heart disease, and clotting disorder.
19. Dr. Sims interpreted Ernie’s radiographs as showing pleural effusion and organomegaly (enlarged organs) of the liver or spleen. She recommended taking Ernie to DCVR to have an abdominal ultrasound (“AUS”) performed and the pleural effusion drained. Dr. Sims informed the Owners that while BAMC could perform an AUS on the following Monday, due to Ernie’s elevated respiratory rate, she was concerned that he would not be able to lie on his back for an extended period without having the fluid from his chest. Dr. Sims agreed with Dr. Guma’s recommendation that Ernie begin taking mycophenolate and consider a referral to a teaching hospital because appropriate diagnostics had not led to a definitive diagnosis.
20. On May 8, 2023, the Owners took Ernie to DCVR for a thoracic US to evaluate his pleural effusion and screen for neoplasia. Images were taken and compared to a study from May 2022. Sarah Tibbs, DVM (“Dr. Tibbs”) (License No. 6644), DCVR’s radiologist, interpreted the images as reflecting asymmetric pleural effusion, worse on the left side; however, she did not identify any overt mass lesions.
21. On January 18, 2024, Ms. Ross filed a complaint with the SBVME alleging that the veterinarians at WCAH provided substandard care by misdiagnosing Ernie with lymphoma and unnecessarily recommending euthanasia. As of March 2025, Ms. Ross reported that Ernie is doing well. Ernie has not been diagnosed with lymphoma or any other medical condition and has not needed to have fluid drained from his chest for over two years. Ms. Ross and her family are thankful they did not euthanize Ernie based on Dr. Andersen’s recommendations.
22. The Board opened a case and conducted an investigation.
23. On April 29, 2024, Dr. Andersen submitted a response to SBVME. In it, Dr. Andersen detailed his treatment of Ernie and his interaction with the Rosses. Dr. Andersen was concerned with how frequently DCVR was draining fluid from Ernie’s chest. Dr. Andersen asked Dr. McHarg to perform an US. Dr.

Andersen noted that Dr. McHarg claimed to have found a questionable region in the sub-lumbar area with two unidentifiable masses.

24. Dr. Andersen stated that he presented Dr. McHarg's concerns about possible lymphoma to the Rosses and explained that it could account for the fluid in Ernie's chest. According to his statement, Dr. Andersen gave the Rosses several options, including euthanasia. When the Rosses asked Dr. Andersen what he would do if Ernie were his dog, Dr. Andersen replied that he would put the dog down rather than subjecting him to repeated chest taps. Dr. Andersen advised the owners that he was not willing to perform Ernie's CCL surgery, as he did not think it would be safe while the dog's condition was worsening.

25. According to Dr. Andersen, the Rosses called WCAH on April 27, 2023, following the initial visit, as they were concerned that Ernie's abdomen appeared more distended. Dr. Andersen prescribed a diuretic. That was the last time WCAH saw the Ross family.

26. Following its investigation and review of the case, the Board found that Dr. Andersen did not exercise appropriate professional judgment in his treatment of Ernie. 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."

27. Dr. Andersen did not satisfy this regulation in several ways.

28. First, Dr. Andersen's communications about Dr. McHarg's findings and Dr. Andersen's recommendations for euthanasia were conveyed in an excessively definitive manner, which the Owners interpreted as pressure to euthanize their pet. Dr. Andersen accepted Dr. McHarg's US findings as evidence of masses and conveyed those findings to the Owners as if the findings were certain. In fact, a subsequent evaluation by a board-certified specialist did not support the conclusion that these areas were problematic. A reasonable veterinarian acting under similar circumstances would have provided the Owners with complete and accurate information, along with options for further testing and treatment, allowing the clients to make informed decisions about how to proceed. According to the Owners, Dr. Andersen made them believe that Ernie's cancer diagnosis was definitive and did not discuss or recommend additional options to confirm that diagnosis through referrals and further diagnostics, including fine needle aspiration

(“FNA”). FNA is a quick and minimally invasive test used to diagnose cancer or determine whether a lump or cyst is benign or malignant.

29. In addition, Dr. Andersen’s disparaging comments about the specialists the Owners had used for Ernie’s treatment were unprofessional and could have led the owners to euthanize Ernie without exploring or confirming the suspected cancer diagnosis. Dr. Andersen’s euthanasia recommendation was based, in part, on his concern or professional disagreement about subjecting Ernie to continued test taps, which a board-certified specialist determined were appropriate. As it turned out, not only did Ernie not have cancer, but he also no longer needs to have fluid drained from his chest.

30. The Board also found deficiencies in Dr. Andersen’s record-keeping. COMAR 15.14.01.10A (Record Keeping) requires, for a companion pet animal, that a veterinarian prepare a legibly written record that accurately and thoroughly reflects the treatment provided, including the progress and disposition of the case.

31. Dr. Andersen did not record important information from his physical examination of Ernie on April 3<sup>rd</sup> and April 24<sup>th</sup>, 2024, including the patient’s temperature, heart rate, or respiration. He also did not document the difficulties he and his staff encountered while Ernie’s US was being performed. In a statement to the SBVME, Dr. McHarg indicated that they were unable to position Ernie dorsally recumbent because Ernie became cyanotic due to fluid in the chest, yet this significant fact is not documented.

32. Moreover, Dr. Andersen did not include his differential diagnoses or rule-outs in the record, nor did he document his discussions with the Owners. In his statement to the SBVME, Dr. Andersen claimed to have offered the Owners several options for Ernie’s future care, one of which was euthanasia. However, neither the discussions nor the other options Dr. Andersen allegedly offered are referenced in the records. Even after he reviewed the Owners’ complaint and provided a statement to the Board, Dr. Andersen has not stated what options, other than euthanasia, he offered.

33. Overall, the records lacked specificity, making it difficult for a subsequent treating veterinarian or the SBVME to evaluate the progress and disposition of the case. For example, one of the notes in the record

states, “Ruptured ACL, scheduled surgery, stay on meds,” without any detail about the type of surgery Dr. Andersen planned to perform.

Considering the facts and circumstances of the case; the veterinarian’s disciplinary history, which includes one standard of care violation and one record-keeping violation; 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 ORDERED by the State Board of Veterinary Medical Examiners that:

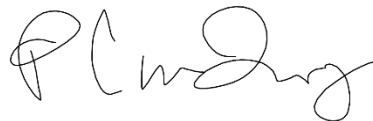
- (a) For not satisfying COMAR 15.14.01.07A (Professional Judgment and Practice) in connection with care provided to Ernie, a six-year-old Golden Retriever owned by Kelly Ross and Jeff Ross, by communicating his potential diagnosis as if it was definitive without discussing or recommending other possible rule-outs or diagnostics, pressuring the clients to euthanize Ernie without discussing additional treatment and diagnostic options, and making disparaging remarks about the care provided by the patient’s specialist, Dr. Andersen is assessed a civil penalty of \$1000 (second offense);
- (b) For not satisfying COMAR 15.14.01.10A (Record Keeping) by not documenting complete physical examination findings (including temperature, pulse, and respiration) for his examination of Ernie, a six-year-old Golden Retriever, owned by Kelly Ross and Jeff Ross, on April 3<sup>rd</sup> and 24<sup>th</sup>, 2023, failing to document that the patient became cyanotic while X-rays were being taken, not documenting client communications, not assessing X-ray findings and recommendations, not including his differential diagnoses and rule outs, and otherwise failing to include relevant specifics in the medical record, Dr. Andersen is assessed a civil penalty of \$1000 (second offense);
- (c) Dr. Andersen shall pay the total civil penalty (\$2000) within ninety (90) days from the date of this Consent Agreement by check payable to the Maryland Department of

Agriculture (“MDA”) with the notation “SBVME – 24-72B” sent to the MDA at 50 Harry S. Truman Parkway, Room 102, Annapolis, MD 21401 – Attn: Nathaniel Boan;

- (d) As an additional condition of this Consent Agreement, Dr. Andersen shall complete six (6) hours of continuing education (“CE”) consisting of the “Efficient Medical Record Keeping for Veterinarians” course offered by VIN/drip.vet or a substantial equivalent pre-approved by the SBVME. To obtain pre-approval for an alternative course, Dr. Andersen shall provide descriptive information about each course proposed to be taken (using a link or attached syllabus) by email to Nathaniel Boan, Executive Director, at [Nathaniel.boan@maryland.gov](mailto:Nathaniel.boan@maryland.gov);
- (e) The CE shall be completed, and verification of completion provided to the Board within ninety (90) days from the date of this Order, with verification sent by email to Nathaniel Boan, Executive Director, at [nathaniel.boan@maryland.gov](mailto: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 was given. This CE may not be counted toward the eighteen (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 6th day of November 2025.

STATE BOARD OF VETERINARY  
MEDICAL EXAMINERS



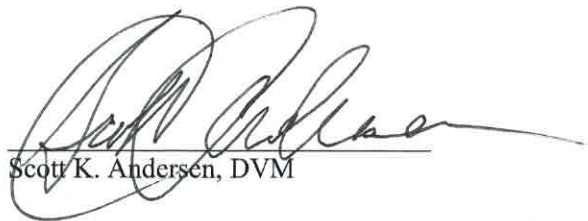
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Patricia Crankshaw-Quimby, CAWA  
Vice-President  
State Board of Veterinary Medical Examiners  
Maryland Department of Agriculture

### CONSENT

I, Scott K. Andersen, 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 ten (10) pages, including this Consent. I sign this Consent Agreement without reservation, as my voluntary act and deed, after having had the opportunity to consult with counsel. I fully understand and comprehend the language, meaning, and terms of this Consent Agreement.

Date: 10/29/2025



Scott K. Andersen, DVM