SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BEFORE THE STATE BOARD OF VETERINARY MEDICAL EXAMINERS

IN THE MATTER OF: **MICHAEL TERENCE SAUER,** License No.: VET.3127 Respondent. Case Nos.: 2021-43; 2021-100; 2022-26; 2022-69	**FINAL ORDER**

This matter came before the South Carolina State Board of Veterinary Medical Examiners ("Board") for hearing on September 5, 2024 to consider the Memorandum of Agreement and Stipulation of Facts ("MOA") signed by the above-named respondent ("Respondent") on August 30, 2024. In the MOA, Respondent waived the authorization and filing of a Formal Complaint as well as formal hearing procedures and elected to dispose of the matter pursuant to S.C. Code Ann. § 1-23-320(F) (2005, as amended).

A quorum of the Board was present. The hearing was held pursuant to S.C. Code Ann. §§ 40-1-90, 40-69-90 (2011), and the provisions of the S.C. Administrative Procedures Act, S.C. Code Ann. § 1-23-10 *et seq.* (1976, as amended), to determine what sanctions, if any, were appropriate.

The State was represented by Robert Elam, Assistant Disciplinary Counsel. Respondent appeared and was represented by J. Todd Rutherford, Esquire.

After consideration, the Board voted to accept the MOA, with the sanctions specified in this Order.

WITNESSES

The following witnesses testified on behalf of the State:

1. Tracy Adams ("Investigator"), an employee of the South Carolina Department of Labor, Licensing and Regulation, formerly of the Office of Investigations and Enforcement.

2. Rebecca Payne.

Respondent appeared and testified on his own behalf.

FINDINGS OF FACT

Based upon the preponderance of evidence on the whole record, the Board finds the facts of the case to be as follows:

1. Michael Terence Sauer ("Respondent") is a veterinarian who is duly licensed by the State Board of Veterinary Medical Examiners ("the Board") to practice veterinary medicine in South Carolina. Respondent's license was first issued on June 21, 2012, and Respondent was so licensed at all times relevant to the matters asserted in these cases. The Board has personal jurisdiction over Respondent and jurisdiction over the subject matter in these cases pursuant to South Carolina Code Ann. § 40-69-115 (1976, as amended).

2. At all times relevant to the matters in these cases, Respondent practiced veterinary medicine as sole proprietor at Paws and Claws Animal Clinic ("PCAC") in Lexington, South Carolina.

3. On or about August 29, 2022, in the instant cases numbered 2022-26 and 2022-69, the Board issued an Order of Temporary Suspension temporarily suspending Respondent's South Carolina license to practice veterinary medicine. Respondent remains under that suspension.

Case No. 2021-43

4. On or about May 17, 2021, about 1:15 p.m., Momo, a five-year-old neutered male domestic longhair cat, was mauled by two pit bulls. A neighbor ("Neighbor") drove the pit bulls off with an axe handle and alerted Momo's owner ("Owner 1"). Momo was panting and unable to stand up and was carried into Owner 1's house. Owner 1 called PCAC and, as soon as family arrived to provide transportation, brought the cat to the clinic by 3:11 p.m. Respondent shaved Momo to better reveal the wounds, x-rayed the cat, and hooked up to an IV for pain control. The x-rays revealed no free air or fluids. Respondent reported to Owner 1 that Momo was in shock and should be maintained on fluids and pain control overnight. With Owner 1's consent, Respondent kept Momo overnight at PCAC, where a monitoring system allowed Respondent to monitor the patient from home.

5. The next day, May 18, 2021, Owner 1 contacted PCAC and avers she learned Momo was doing well and could be released that afternoon. Lacking transportation, Owner 1 sent an acquaintance ("Owner's Acquaintance") to PCAC to retrieve Momo. Owner's Acquaintance avers when staff brought Momo out to her car in the afternoon, a staff member opined that Momo should not be released yet, and she hoped the cat would make it through the night. Owner's Acquaintance avers she walked back into the clinic to ask what was meant by that, only to be met with denials that any such thing was said. Owner's Acquaintance further avers she asked for any discharge instructions but simply received a small bag with three pills. When Owner's Acquaintance relayed the staffer's warning to Owner 1, Owner 1 avers she telephoned Respondent to gauge whether he had such concerns and to see if he had any discharge instructions. Owner 1 avers she was reassured by Respondent that Momo was fine and could walk if he wanted but did need rest. Owner's Acquaintance listened in on this telephone

conversation and avers Respondent sounded rushed but said that Momo was fine.

6. That night, in the early morning hours, Owner 1 avers Momo woke her up, screaming and wracked with full body contractions, and then expired.

7. On May 19, 2021, Owner's Acquaintance returned to PCAC and requested Momo's medical records. She was refused since she was not Momo's owner. On or about May 21, 2021, Owner 1 requested and received the medical records from PCAC. Owner 1 avers the records were incomplete, consisting of pages "2 and 3 of 3," plus an itemized bill. The provided records show a FAST scan was completed, indicating no free fluid. The records do not indicate that an x-ray was done, or what was seen, despite the itemized bill indicating two radiographs were taken. The records do not contain discharge instructions or notes except "admin onsior [sic] orally" and "per DVM will send home today." Vitals recorded include a temperature of 102.4, apparently at intake based upon the location of the entry in the record, and then the following recitations: "1630: 96.1; 1640: 96.4; 1800: 97.2; 1815 [blank]." There are no recorded temperatures or other vitals for May 18, 2021.

8. Owner 1 filed a Better Business Bureau ("BBB") complaint about Respondent on or about June 15, 2021. With a rebuttal statement to BBB dated June 22, 2021, Respondent's office manager included medical records that differ from the records provided to Owner 1. Most notably, the updated records include vitals and notes on the condition of Momo on the release date of May 18, 2021, and paragraphs detailing interactions with Owner 1, including Respondent's entry that he would have preferred to keep Momo several more days if costs were not a concern for Owner 1.

9. Owner 1 filed a complaint with the South Carolina Department of Labor, Licensing and Regulation ("LLR") on or about May 26, 2021, alleging substandard care of Momo and incomplete medical records. Owner 1 included a detailed timeline, the medical record she had received, and a photograph of Momo after treatment.

10. On or about June 3, 2021, LLR's Investigator Tracy Adams was assigned to investigate the case. She asked Respondent to provide all of PCAC's medical records for Momo. The medical records provided by Respondent to Investigator Adams matched the records provided to BBB. Investigator Adams subsequently collected written statements from Owner 1, Neighbor, and Owner's Acquaintance. Investigator Adams additionally collected written statements and photographs of Momo's wounds from five PCAC staff members. The staff members aver Momo was bright, alert, and responsive upon release, had eaten on the day of release, and had radiographs taken on the day of intake to ensure no bones were broken. The staff members' written statements contain details regarding the treatment of Momo that are not contained in the medical record.

11. On or about August 12, 2021, Investigator Adams interviewed Respondent at his clinic, and Respondent provided one x-ray of Momo for review. When asked about a second x-ray, since there were charges for two on Owner 1's bill, Respondent replied he guessed he owed Owner 1 $75.00 because only one x-ray was taken.

12. On or about November 9, 2021, the owner ("Owner 2") of Tink, a seven-year old spayed female Chihuahua mix, brought Tink to PCAC to check on a left rear toenail, which a PCAC medical record entry provided had been an ongoing issue for the canine. Respondent recommended amputation to remove the nail bed and arranged for Owner 2 to leave Tink at PCAC for surgery. Owner 2 avers that no surgical consent form was provided to her to read or sign, and she alleges no one offered her informed consent as far as the risks of surgery were concerned. Respondent avers he recommended and performed blood work in light of Tink's age to check for signs whether surgery would be unsafe for Tink.

13. Respondent reports he removed P3 of the left rear digit and was closing with sutures and staples when Tink went into cardiac arrest. Isoflurane flow was stopped and Tink was kept on oxygen. Performing cardiopulmonary resuscitation and assisted by veterinary aides, Respondent managed to get Tink breathing on her own, although the breathing was tachypneic. During this time Tink was x-rayed and Respondent determined from the radiographs that Tink had a collapsing trachea.

14. Respondent avers he maintained Tink on oxygen approximately three hours and, as the work day was ending, recommended to Owner 2 that Tink be transferred to South Carolina Veterinary Specialists and Emergency Care ("SCVSEC") in Columbia, South Carolina for overnight care and monitoring. Respondent avers he and his office manager personally drove Tink to SCVSEC and kept Tink intubated and on oxygen until they exited their car in the SCVSEC parking lot, at which point the trach tube was removed. Respondent averred Tink was showing signs of discomfort with the trach tube, and Respondent did not want Owner 2 to see her pet with a trach tube. According to Respondent, Tink still had tachypnea at the time.

15. SCVSEC medical records indicate Tink was received at about 3:00 p.m. on November 9, 2021. Tink's breathing was recorded as being labored. The intake veterinarian learned from Owner 2 that at 11:00 a.m. that day Tink had been brought to Respondent and a decision had been made to surgically remove Tink's toe. She further learned Tink ate at 10:00 a.m. that day prior to the toe appointment. Tink was intubated and monitored until about 11:25 p.m., when she was extubated and placed in an oxygen kennel. It was quickly realized she was in a worse state, was unaware of her surroundings, with absent menace, would not stay sternal, and mucous membranes darkened. On or about November 10, 2021, at 12:30 a.m., Tink was re-intubated and constantly monitored with periodic adjustments in treatment. By 7:20 a.m. Tink was weaned off her propofol CRI but remained intubated until she began chewing at the tube. After extubation she was placed back into the oxygen kennel, where she exhibited short, rapid respirations. Noting nystagmus, strabismus, and abnormal vocalizing, the attending SCVSEC veterinarian advised Owner 2 that Tink likely suffered brain damage from oxygen deprivation and would not survive, and at approximately 8:00 a.m. Owner 2 opted to euthanize Tink.

16. In the afternoon of November 10, 2021, Owner 2 filed a complaint with LLR, alleging substandard care of Tink and complaining that Respondent did not adequately communicate with her regarding the details and possible complications of the surgery. Owner 2 further complained Respondent did not x-ray Tink before the surgery and thus missed the

collapsed trachea and did not provide stable medical emergency transportation, noting that records and verbal descriptions to SCVSEC did not reflect that Respondent gave oxygen or intubated Tink. Owner 2 provided that after Respondent learned of Tink's passing, several documents were created by his staff members stating Tink was put on oxygen and intubated.

17. Investigator Tracy Adams was assigned to investigate the case. Upon receipt of medical records on or about December 7, 2021, Investigator Adams noted an absence of medical history in PCAC records regarding the ongoing problems with the toenail that needed amputating. Investigator Adams further noted the absence of a written surgical consent form that would spell out any warnings provided to Owner 2 concerning risks of the proposed surgery.

18. On or about June 26, 2022, Investigator Adams received through Respondent's then-retained attorney a letter spelling out Respondent's position regarding the complaint against him. Respondent denied that his performance was substandard and complained that Owner 2 had failed to provide a complete medical history for Tink. Particularly, Respondent complained that with a collapsing trachea, Tink would have coughed when excited or exercising, but Owner 2 had not divulged this condition to Respondent regarding Tink. Knowing that Tink had breathing issues would have prompted a different anesthetic protocol.

Case No. 2022-26

19. On or about March 10, 2022, Investigator Adams contacted Respondent by e-mail, requesting a written statement for Case No. 2021-43, *supra*, and also requesting an April 6, 2022 meeting time to discuss Case No. 2021-100, *supra*.

20. On or about March 15, 2022, Investigator Adams received an unsigned Word document statement for Case No. 2021-43. Investigator Adams attempted to reach Respondent by telephone, but was not able to make contact. A reply was sent to Respondent's email requesting a signature on the statement in PDF format.

21. On or about March 16, 2022, Investigator Adams received a reply email from Respondent's listed email address. The email identified the sender as the Respondent's receptionist at PCAC. The receptionist stated that Respondent could not make contact at this time.

22. Based on reports that PCAC was continuing to see patients with no active licensed veterinarian on site, Investigator Adams and a representative of the South Carolina Department of Health and Environmental Control ("DHEC") performed a surprise visit/audit at PCAC. Respondent was not at the clinic. Investigator Adams avers that no other licensed veterinarian was on the premises at the time of her visit. A licensed veterinary technician was in the clinic seeing a patient, and other staff were unlicensed veterinary aides. Investigator Adams served a subpoena on PCAC for medical records of all patients seen during the time of March 14, 2022, and March 23, 2022, a time span during which Respondent was reportedly not at PCAC. The supplied records tallied a total of 67 doctor appointments and 16 tech appointments, with 11 no-shows. Investigator Adams concluded that unlicensed personnel were being allowed to dispense medications, administer vaccines, provide treatments, and in some cases diagnose

conditions without Respondent or any other licensed veterinarian present at PCAC.

Case No. 2022-69

23. On or about April 7, 2023, Investigator Adams received notice that Respondent had been arrested by RCSD that day and accused of committing the crime of Burglary in the First Degree.

CONCLUSIONS OF LAW

Based upon careful consideration of the facts in this matter, the Board finds and concludes as a matter of law that:

1. The Board has jurisdiction over Respondent and this matter. Upon a finding by the Board that a licensee has committed any of the acts or omissions specified in S.C. Code Ann. §§ 40-1-110 and 40-69-110 (2011) or other conditions specified therein exist, the Board has the authority to revoke or suspend a license or registration certificate, publicly reprimand a licensee, or take any other reasonable action short of revocation or suspension, such as probation, restrictions requiring the person to undertake additional professional training subject to the direction and approval of the Board, psychiatric evaluations, controlled substances restrictions, institutional practice under supervision, and any other actions considered appropriate by the Board. In addition to or instead of such actions affecting the license of a licensee or registration of a registrant, the Board may impose a civil penalty of up to One Thousand Dollars for each violation. S.C. Code Ann. §§ 40-69-120 (2011). In addition to other sanctions, a licensee found in violation of the applicable licensing act may be directed to pay a sum not to exceed the reasonable costs of the investigation and prosecution of the case. S.C. Code Ann. § 40-1-170 (2011).

2. Based on the evidence presented and the expertise of the Board, the Board finds that Respondent's conduct is in violation of the following statutes:

Case No. 2021-43

a. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(1) (1976, as amended) in that Respondent violated this chapter or a regulation promulgated by the Board; specifically, Respondent violated S.C. Code Ann. Regs. 120-8(B) (2011) in that he failed to make and keep adequate and timely written records of a patient's treatment, as described in the facts, *supra*.

b. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(11) (1976, as amended) in that Respondent engaged in unprofessional or unethical conduct in violation of the American Veterinary Medical Association ("AVMA") Code of Professional Ethics or any other standards of professional conduct defined in this chapter or prescribed by regulations of the board. Specifically, Respondent failed to provide complete medical records to Owner 1 when requested to do so. Provision 5.3 provides, "Veterinarians are obligated to

provide copies or summaries of medical records when requested by the client. Veterinarians should secure a written consent to document the provision."

Case No. 2021-100

c. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(11) (1976, as amended) in that Respondent engaged in unprofessional or unethical conduct in violation of the AVMA Code of Professional Ethics or any other standards of professional conduct defined in this chapter or prescribed by regulations of the board. Specifically, Respondent failed to maintain clear and regular communications with a client in that he inadequately discussed Tink's medical history and the risks of surgery with Owner 2 before proceeding with surgery on Tink. Principle 7.a. provides, "The decision to accept or decline treatment and related costs should be *based on adequate discussion* of clinical findings, diagnostic techniques, treatment, likely outcome, ... " (emphasis provided).

d. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(1) (1976, as amended) in that Respondent violated this chapter or a regulation promulgated by the Board; specifically, Respondent violated S.C. Code Ann. Regs. 120-8(B) (2011) in that he failed to make and keep adequate written medical records, as described in the facts, *supra*. Particularly, Respondent failed to obtain Owner 2's surgical consent and did not note what if any aspects of surgical risks were discussed. Also, Respondent's medical records allude to a chronic medical condition that was addressed a year before but there are no records for that PCAC visit, nor is there any medical history for Tink.

Case No. 2022-26

e. Respondent is in violation of S.C. Code Ann. § 40-1-110(1)(i) (1976, as amended).

f. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(11) (1976, as amended), in that Respondent engaged in unprofessional or unethical conduct in violation of the AVMA Code of Professional Ethics or any other standards of professional conduct defined in this chapter or prescribed by regulations of the board. Principle I states that a veterinarian shall be influenced only by the need to uphold the public trust vested in the veterinary profession. Principle III holds that a veterinarian shall uphold the standards of professionalism. Principle IV.a. holds that veterinarians should obey all laws of the jurisdictions in which they reside and practice veterinary medicine. Principle VI.a. requires that veterinarians shall strive to enhance their image with respect to their colleagues, clients, other health professionals, and the general public.

Case No. 2022-69

g. Respondent is in violation of S.C. Code Ann. § 40-69-110(A)(19) (1976, as amended)

h. Respondent is in violation of S.C. Code Ann. § 40-1-110(1)(i) (1976, as amended).

3. The sanctions below are consistent with the purpose of these proceedings and have been made after weighing the public interest and the need for the continuing service of qualified practitioners against the countervailing concern that society be protected from professional ineptitude and misconduct. The sanctions are designed not to punish Respondent, but to protect the life, health, and welfare of the people at large.

NOW, THEREFORE, IT IS ORDERED, ADJUDGED, AND DECREED that:

1. The Board adopts the MOA.

2. Respondent's license is hereby suspended for two (2) years from the date of the Final Order. This suspension is immediately stayed, and Respondent's license will instead be placed in a probationary status, subject to Respondent's compliance with the terms of this Final Order. If Respondent fails to meet the conditions set forth in this Order, the stay of suspension shall be lifted and Respondent's license shall be immediately administratively suspended pending further order of the Board. Also, the stay of suspension will be lifted, and the suspension enforced, should a relevant substantial complaint be filed against Respondent within the next two (2) years.

3. Respondent is barred from prescribing controlled substances during the two (2) years in which his license is in a probationary status.

4. Respondent may not work more than thirty (30) hours per week during the two (2) years in which his license is in a probationary status.

5. Respondent shall provide proof of having taken thirty (30) hours of continuing education during the two years his license has been suspended.

6. Respondent is assessed the following fines for the statutory violations described in Conclusion of Law 2 above:

Case No. 2021-43

a. Two Hundred Fifty Dollars ($250.00) for the violation described in Conclusion of Law 2a.

b. Two Hundred Fifty Dollars ($250.00) for the violation described in Conclusion of Law 2b.

Case No. 2021-100

c. Two Hundred Fifty Dollars ($250.00) for the violation described in Conclusion of Law 2c.

d. Two Hundred Fifty Dollars ($250.00) for the violation described in Conclusion of Law 2d.

Case No. 2022-26

e. One Thousand Dollars ($1,000.00) for the violation described in Conclusion of Law 2e.

f. One Thousand Dollars ($1,000.00) for the violation described in Conclusion of Law 2f.

Case No. 2022-69

g. One Thousand Dollars ($1,000.00) for the violation described in Conclusion of Law 2g.

h. One Thousand Dollars ($1,000.00) for the violation described in Conclusion of Law 2h.

The total fine of Five Thousand Dollars ($5,000.00) shall be paid in full within ninety (90) days of receipt of this Final Order.

7. Respondent shall remain compliant with all other conditions known to Respondent and the Board.

8. This Order constitutes a final agency decision that is appealable to the South Carolina Administrative Law Court pursuant to S.C. Code Ann. §§ 1-23-380 and 40-1-160.

AND IT IS SO ORDERED.

STATE BOARD OF VETERINARY MEDICAL EXAMINERS

[redacted]

CHRISTINE E. WHITE, DVM
Board Chair

October 17, 2024