THE STATE OF NEW HAMPSHIRE

SUPREME COURT

No. 2017-0729

Appeal of Sandra Brown, DVM

APPEAL PURSUANT TO RULE 10 FROM A JUDGMENT OF THE NEW HAMPSHIRE BOARD OF VETERINARY MEDICINE

BRIEF FOR THE NEW HAMPSHIRE BOARD OF VETERINARY MEDICINE

THE STATE OF NEW HAMPSHIRE

Gordon MacDonald
Attorney General

Thomas Broderick
Assistant Attorney General
Civil Bureau
33 Capitol Street
Concord, N.H. 03301-6397
(603) 271-4097
(15 minutes)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

ISSUES PRESENTED

1. Whether the Board of Veterinary Medicine may determine that violations of the Controlled Drug Act, RSA 318-B, admitted by a licensee, constitute unprofessional conduct which amounts to misconduct within the meaning of RSA 332-B:14, II(c).

2. Whether the Board erred in imposing disciplinary sanctions on Dr. Brown under RSA 332-B:14, II(d), (g), (l), and (n).

STATEMENT OF THE CASE AND STATEMENT OF FACTS

September 28, 2015 Order

Three years ago, the Board of Veterinary Medicine ("Board") held a hearing to resolve earlier allegations concerning Dr. Brown. CR 17–29.[1] The allegations at issue in the 2015 hearing included allegations of "negligent medical care, a lack of candor with clients, disorganization of medical records and improper management of medications and equipment." CR 17. In its order dated September 28, 2015, the Board found that Dr. Brown's medical and surgical records were often incomplete. *See, e.g.* CR 18, 19, 21. The Board also found that her veterinary office was improperly equipped. *See, e.g.* CR 18, 26, 27. The Board further found that Dr. Brown had failed to properly discuss medical issues with clients, including discussions concerning errors she or her staff had made. *See, e.g.* CR 19, 20, 21, 24–25. The Board also found that Dr. Brown had out of date medications and that she was improperly storing drugs. *See, e.g.* CR 25.

The Board concluded that Dr. Brown had committed professional misconduct within the meaning of RSA 332-B:14, II (d). CR 26. As a result, the Board required Dr. Brown to participate in certain continuing education courses. CR 28. The Board also ordered that:

> Dr. Brown's practice will be subject to board inspections, which may be announced or unannounced, for a period of four (4) years from the date of this order. A NHBVM board member or its representative will carry out hospital inspections of Dr. Brown's hospital facility during business hours . . . . Records will be examined as well as a review of hospital surgical and medical practices, including management practices.

CR 28. Dr. Brown did not appeal the Board's 2015 order.

---

[1] "CR" refers to the Certified Record. "AB" refers to Appellant's Brief. Though the transcript was included in the certified record and thus also has a Certified Record page number, "TR" refers to the original pagination of the transcript of the hearing dated January 25–26, 2017.

May 27, 2016 Inspection

On May 27, 2016, two Board members, Dr. Bob Brust and Dr. David Stowe, inspected Dr. Brown's facilities. TR 13; CR 31–34. When they arrived, both Dr. Brust and Dr. Stowe noticed a bottle of euthanasia solution left out on the counter. TR 15–16, 34. Dr. Stowe was concerned because it was an unsecured controlled substance that should have been locked up. TR 16.

Dr. Stowe and Dr. Brust found many expired medications, both in Dr. Brown's practice and in her mobile van. TR 15; CR 31, 32, 34. In the practice area, Dr. Stowe found a container of dextrose solution that had expired in April of 2010, over six years before the inspection. TR 16–17; CR 34, 36. Dr. Stowe also noted that Dr. Brown had been reusing the bottle of dextrose, which he found troubling because dextrose is considered a single use product. Dr. Stowe later explained in his testimony before the Board that dextroseis "a rich environment for bacteria to live . . . . when we pierce even with a sterile needle, the potential for inoculating the bottle with bacteria and the bacteria can just go to town in a sugar solution." TR 17.

Dr. Stowe also found an entire drawer of expired medications in Dr. Brown's practice area. TR 19. According to Dr. Stowe, when he asked Dr. Brown about this, she explained that "drugs were expensive and some of her clients couldn't afford the cost of the care and so she would use the expired drugs and not charge the clients." TR 19. Dr. Stowe testified that it is never appropriate to use expired drugs with patients and explained the concerns with using expired drugs:

> I mean it just, the standard of care is we don't use expired drugs. I mean it's one of the things the Pharmacy Board looks for when they come into our practice and it's something that's drilled into our heads early in our careers. So, and, again this had been an issue with the original investigation of Dr. Brown and I was surprised to see the number of outdated drugs I discovered there.

TR 18. He further explained that "we don't know what happens when [various drugs] expire, whether they're more potent, less potent, toxic or what, so there's no, no way to predict." TR 20.

Dr. Stowe further noticed some issues with Dr. Brown's controlled substances cabinet. TR 17–18. The way the hasp was attached to the cabinet, someone could easily remove the lock with a Phillip's head screwdriver, tamper with the drugs, and replace the lock without anyone knowing. TR 17–18; CR 31. Dr. Stowe spoke about this concern with Dr. Brown. TR 18.

Dr. Stowe and Dr. Brust also inspected Dr. Brown's van, which she used as her mobile unit for farm calls and house calls. Both Dr. Stowe and Dr. Brust found numerous outdated medications in the van. TR 20; CR 32–34.

Dr. Stowe also reviewed a patient record during the inspection which caused him concern. TR 21. The record indicated that when Dr. Brown had seen a cat previously, a murmur was documented, but there was no indication in the record that she had discussed the murmur with the owner. TR 22. Then, on the most recent exam, Dr. Brown did not make any notation of whether she heard the murmur. Dr. Stowe asked Dr. Brown about this and why she did not discuss the murmur with the client, and "she just sort of said it was a mild murmur. She thought it was maybe physiological from the year before . . . ." TR 22; CR 31. Dr. Stowe later explained in his testimony to the Board that in his opinion it would be a breach of the standard of care not to discuss the murmur with the client. TR 23. Dr. Stowe stated that if a discussion with the client is not documented in the patient record, "then we have to assume you didn't have that conversation." TR 23.

September 9, 2016 Inspection

On September 9, 2016, Dr. Stowe again inspected Dr. Brown's facilities, this time accompanied by Todd Flanagan, an investigator with the Administrative Prosecutions Unit of the Attorney General's Office. TR 24; CR 102–38.

During this inspection, Dr. Stowe again found many outdated drugs throughout the clinic and in the mobile van, some that had expired that year and others that expired years ago. TR 26; CR 102–06. In the clinic's refrigerator, he found other outdated chemical reagents and outdated drugs. TR 27; CR 102, 107. Dr. Stowe found more expired drugs in the pharmacy area of Dr. Brown's practice. TR 29; CR 102–03, 109. Dr. Stowe also found several bottles where the expiration date was crossed off and a new one was written in. TR 29–30. He found another bottle without a label, with just "TRAM" written on it and no expiration date, with pieces of pills which he assumed were Tramadol. TR 31–32; CR 103, 112. Dr. Stowe was concerned because if a drug is repackaged, both the new expiration date and the new lot number must be on the bottle. TR 30.

Dr. Stowe again found a drawer full of expired medication in Dr. Brown's clinic, and Dr. Brown again indicated that she would use those expired drugs for clients who could not afford drugs that were in-date. TR 30; *see also* CR 103.

Dr. Stowe found other issues of concern during the inspection. First, he and Mr. Flanagan noticed a pill vial for a dog named Cutie with Tramadol in it, a schedule IV controlled substance, left out on the counter. TR 32; CR 103. Dr. Stowe later testified that a controlled substance should never be left out unsecured overnight. TR 32–33. Second, Dr. Brown's controlled substances cabinet still appeared inadequate. TR 33. The only change from the last visit was that someone had placed tape over the screws, apparently as an attempt to secure the screws. TR 33.

Dr. Stowe again inspected Dr. Brown's mobile van. TR 34. At around ten in the morning, Dr. Stowe noted that the temperature was over 80 degrees Fahrenheit. TR 35; CR 103. Dr. Stowe had looked up the storage temperatures that most drugs can tolerate and later testified, "I believe it was 58 to 84 maybe. But again, it was only ten o'clock in the morning and the temperature wasn't going down." TR 35. Dr. Stowe also found many more expired medications in the van. TR 35, 36–37; CR 114. Of particular note was a bottle of dextrose that had expired in May of 2014, but had been marked as having been first pierced in August of 2016. TR 36; CR 104, 138.

When Dr. Stowe reviewed the medical records, he found several issues of concern. TR 37; CR 104. Dr. Stowe first reviewed the records of a cat named Mittens. TR 37; CR 39–45. Dr. Brown had dispensed Tramadol to the owners of the cat, with instructions to "Give ¼ tablet once weekly or as needed one 1 hour before grooming to enable grooming or as needed for pain." TR 37; CR 39. Dr. Stowe was concerned that Dr. Brown had dispensed ten tablets, which would last forty weeks, but veterinarians are limited by law to prescribing for no more than seven days at a time. TR 37; CR 109. When Dr. Stowe asked Dr. Brown if she was aware of this law, she indicated she was but said it would have been inconvenient for the customer to bring the cat back to her. TR 38; CR 104.

Dr. Stowe reviewed the records of several other animals. TR 38; CR 47–56. Dr. Stowe stated that some of the records did not reflect that Dr. Brown had completed a pre-surgical examination on the animal. TR 39, 41; CR 54, 59–68. Dr. Stowe stated that in his opinion, Dr. Brown's pre-surgical notes did not meet the standard of care. TR 40. Dr. Stowe was also concerned with Dr. Brown's anesthesia monitoring. TR 40. He explained that "typically you're checking vitals every five or ten minutes, so for a two hour [surgery], you should have at least

twelve [monitoring records]." TR 40. Dr. Stowe also expressed concern that Dr. Brown had not documented that she had discussed possible side effects of a medication with the owner, and stated that in his opinion it is a breach of the standard of care not to document such a discussion. TR 43–44; CR 81, 104–05.

October 18, 2016 Pharmacy Board Inspection

On October 18, 2016, two inspectors with the New Hampshire Board of Pharmacy, Bob Elder and James Queenan, inspected Dr. Brown's practice and mobile van. TR 140; CR 140–146. They inspected Dr. Brown's pharmacy area and took a look in the back of the treatment area where her refrigerator for medication was. TR 144. Food was still being stored in the clinic refrigerator. TR 162. Mr. Elder testified at the Board hearing that that practice is not safe because food can provide a good medium for mold growth that could affect medication in the refrigerator or, conversely, medication could contaminate the food. TR 162–63.

Mr. Elder also noticed that Dr. Brown's controlled substances cabinet was poorly constructed and the door could easily be pried off; he recommended buying a sturdier door or installing a lock on a sturdy drawer in her clinic. TR 145; CR 146. He also found four vials of Tramadol that had not been properly labeled. He explained at the hearing that:

> It's very important that you have the lot number and the expiration date, along with the drug name and strength on each vial. The purpose for this is to ensure that in case of a recall, you would be able to trace to that vial, find the lot number and take appropriate action. Simply storing a handwritten or hand-scrawled name of a drug and its strength on an amber vial does not constitute proper labeling . . . .

TR 146–47.

With regards to Dr. Brown's mobile van, Mr. Elder noted that she had added a thermometer, but there were no temperature logbooks to put the recordings to use. TR 160. He later explained at the Board hearing why this was a concern:

> Q: So if the medications are stored and it falls below the temperature that they're allowed to be stored at, are those medications still safe to use?
> A: I would say not, and it really depends on how long that drug was stored below, but it's clearly a matter of if you fall below what is acceptable or exceeds the acceptable temperature, you're already putting that drug at risk.

TR 161.

Mr. Elder and Mr. Queenan discovered several other concerning issues during the inspection. TR 163. For instance, multi-dose vials, once opened, need to be used within 28 days, but Mr. Elder found vials in the treatment room that had been punctured but not labeled with the puncture date. TR 163. Mr. Elder explained at the hearing that "[o]nce you go beyond the 28 days, with re-entry into the vial, back and forth, the risk of contamination goes up logarithmically." TR 163.

December 22, 2016 Inspection

Dr. Stowe and Mr. Flanagan returned to Dr. Brown's practice on December 22, 2016, for another inspection. TR 44; CR 148–50, 180–82. Dr. Stowe again found many outdated drugs in Dr. Brown's mobile van. TR 46; CR 148. In addition, the temperature in the van was 48 degrees Fahrenheit, which was below normal for drug storage. TR 46; CR 149. Dr. Stowe found several drugs in the van that were labelled for storage between 59 degrees and 86 degrees Fahrenheit. TR 46; CR 149.

Dr. Brown also still had numerous expired drugs in the practice area. TR 49; CR 148. Dr. Stowe found outdated IV fluids, other drugs, and chemistry reagents in Dr. Brown's prep area. TR 48; CR 148. Dr. Stowe also found numerous expired drugs in the pharmacy area and in Dr. Brown's refrigerator. TR 50–51; CR 156, 161. Dr. Stowe again found food stored in the refrigerator with the drugs. TR 51.

Dr. Stowe again found the same drawer full of expired medications. TR 49; CR 155. This time, Dr. Stowe also found "a waiver it looks like she developed, to get the client's permission for dispensing expired drugs." TR 49; CR 148, 164. Dr. Stowe testified that having a waiver, in his opinion as a veterinarian, does not allow a veterinarian to dispense expired drugs. TR 49.

Dr. Stowe testified about the records he reviewed during this inspection. TR 52; CR 164–178. Dr. Stowe once again found that some of Dr. Brown's records were deficient in that she failed to document a pre-surgical examination.TR 52; CR 166.

The January 25 and 26, 2017 Disciplinary Hearing

As a result of these inspections, the Board voted to proceed with a disciplinary hearing and sent Dr. Brown a Notice of Hearing dated November 23, 2016. CR 2. The Board held the hearing, as scheduled, on January 25 and 26, 2017. TR 1, 244. At the hearing, the Board heard testimony from Dr. Stowe, Mr. Elder, and Dr. Brown. TR 3; 246.

Both Dr. Stowe and Mr. Elder testified as to the above described events. In addition, Mr. Elder, on direct examination, was asked several questions regarding controlled drugs. TR 158–60, 167–68. When asked about the safety of drugs that are used past their expiration date, Mr. Elder stated: "[T]here are certain drugs that become toxic if you exceed the expiration date. Tetracyclines, certain types of penicillins and a few other antibiotics definitely carry the risk of renal failure if you go past the expiration date." TR 167. Mr. Elder was also asked how quickly a bottle of dextrose must be used once it has been punctured. TR 168. Mr. Elder explained that in a veterinary setting, he would not expect to use it for more than a few days, due to concerns about bacterial growth. TR 167–68. Mr. Elder also explained that a veterinarian may not dispense more than a seven day supply of a controlled substance. TR 158. Finally, Mr. Elder

stated it is never appropriate to reuse prescription vials, because there may be reside from the previous prescription that could contaminate or adulterate whatever was put in the vial. TR 159–160.

Mr. Elder also explained that providers who administer and dispense controlled substances are required to keep a controlled substance log. TR 151. He stated that the logbook must have the date, the patient's name and street address, the amount of the drug dispensed, and the signature of the practitioner who authorized dispensing the drug and perhaps the initials of the technician who counted the tablets. TR 152. When asked if a practitioner is ever allowed to take back a controlled substance from a patient, he stated "No, no, it's against the law." TR 154.

Dr. Brown also testified as to the three inspections by the Board of Veterinary Medicine and the one inspection by the Pharmacy Board inspectors. TR 268. When asked why it took her three warnings to change the lock on her controlled substances cabinet, Dr Brown explained that she had been working 70–90 hours per week and had not had time to make the changes. TR 268–70.

On several occasions, Dr. Brown admitted to having dispensed or administered expired medications. TR 295, 304, 347–49. When asked if it had been her practice to dispense expired medications to clients who could not afford medication, Dr. Brown admitted, "I, I had been doing that." TR 295. On another occasion, Dr. Brown was asked about the bottle of dextrose with the expiration date in May 2014, which had been marked as first pierced on August 22, 2016. TR 303–04. When asked to explain this, the following interaction took place:

> Q: So is [the handwritten date of August 22, 2016] the date that the patient received it or is that the expiration date after you pierced it?
> A: That I believe is the day that the patient received it, and I would have opened it.
> Q: So the patient received an expired medication that had been expired for over two years, correct?

A: Yes, but I did not inject it if I gave that medication. It would have been orally.
Q: So when you orally give something to a patient, is that still considered administering a medication?
A: Yes.
Q: So you administered an expired medication to the patient, correct?
A: Correct.

TR 304. However, when asked about a different bottle of dextrose found on her shelf, expired in 2010, Dr. Brown indicated that she had just not got rid of it and would not have used it on a client. TR 300–01. Dr. Brown was also asked about a medication vial that was found that stated: "No charge due to expiration date." TR 312. Dr. Brown again admitted to dispensing this expired medication. TR 312. When asked about other specific expired drugs found in her practice, Dr. Brown's explanation was that she had simply not got around to throwing out the expired medication, despite some of the medication expiring five or six years prior. TR 299, 300–01.

Dr. Brown also admitted to having dispensed more than a seven day supply of controlled substances. TR 331–32, 363. Dr. Brown was asked to review a prescription for Tramadol, provided to a patient named Chewie:

Q: Could you read what the prescription for that prescription is – or the directions?
A: It says: Give one, one tablet two to three times daily with food as needed for pain.
Q: And how many were dispensed?
A: 40.
Q: And how many, how much is seven days' worth based on those directions?
A: Ahh, it would be, it should be only 21.
Q: Okay. So you gave almost double what was necessary?
A: Correct.

TR 331–32, *see also* TR 362 (later admission that she provided more than a seven day supply of Tramadol). Dr. Brown was then asked to review a prescription for Tramadol, where 10 pills were dispensed, which stated "Give one-fourth tablet once weekly or as needed one hour before

grooming to enable grooming or as needed for pain." TR 332. When asked if the ten pills is much more than what was indicated for one week, Dr. Brown stated, "actually for this cat, I, I think it – there's a slight possibility that they might have used those 10 up in seven days . . . . it may have lasted them more than a week but it's possible that they could have used it up in a week." TR 333–35.

Dr. Brown was also asked several questions about her ability to control and monitor the temperature in her mobile van. TR 305–11. During a pharmacy board inspection in February of 2014, the inspector had written "Obtain a thermometer and monitor temperatures within mobile unit." TR 309; CR 200. However, Dr. Brown admitted that although she bought a thermometer and would periodically check the temperature, she did not do anything else to remedy the situation until December 2016:

> Q: So for almost three years ago now, they told you to be monitoring [temperature] and you didn't do anything to address the situation until December 2016, is that correct, other than purchasing a thermometer?
> A: Correct.

TR 311. When asked if her van was temperature controlled, Dr. Brown answered that it had air conditioning and heating. TR 305. But when asked what temperature controls she had when the van is parked outside her practice, she only answered "we do keep it in a shaded space." TR 306. And when she was asked what keeps the van warm when it is cold outside in the winter, she stated "[r]unning it and not leaving the doors open." TR 306. Dr. Brown stated she only began bringing the medications in from the van to the clinic in December 2016. TR 311.

Dr. Brown testified that she kept a controlled substances log for all her controlled substances, maintained by her staff, which she reviews. TR 272. Dr. Brown's Tramadol log did not include the patients' addresses. TR 277; CR 213–14, 162. When discrepancies in her Tramadol log were pointed out to her, Dr. Brown explained that some of her staff were recording

actual inventories incorrectly. TR 274–76, 294; CR 213, 162. At other times, she admitted her inventories did not add up. TR 283–84. Then, when asked why there was an entry stating "donated by Matt, +40," Dr. Brown stated:

> A: That is somebody who had gotten their dead dogs Tramadol, and didn't know what to do with it.
> Q: You're not a drug take-back facility, are you?
> A: I was not aware at that time there is a regulation preventing us from taking back those medications. To me it seemed like that was a better option than having them have it, but now I know better . . . .

TR 278; CR 214; *see also* TR 346 (admission that she has accepted some return drugs). When confronted with the mistakes in her Tramadol log and asked if the Board could trust those numbers, Dr. Brown replied, "We'd have to recount them again." TR 294. She stated that she understood that as a licensee, it was her responsibility to maintain controlled substances, but said it is hard to check up on this periodically when she was working 70 to 90 hours per week. TR 294–95.

At the end of the hearing, a board member asked Dr. Brown questions concerning her records on Tobie, a dog who passed away during surgery and the notes indicated Dr. Brown suspected an error by the anesthesia machine. TR 390; CR 164–78. Dr. Brown stated that it was not the machine that had failed, but had been her error in not making sure a knob on the machine had been turned up. TR 390–91. When asked, Dr. Brown stated she informed the owners that the death had been caused by human error, but this was not reflected in the record. TR 395. A board member pressed her:

> Q: You told the owner, Mr., Mr. . . .
> A: Cretion.
> Q: Cretion, sorry, that it was a human error? You wrote a fairly extensive follow-up note here but didn't include that?
> A: Um, I said the oxygen pressure had elevated.
> Q: Okay.

A: Yeah, I didn't specifically write down human error but I, I told him it was managing the machine.

TR 395–96.

The October 3, 2017 Decision and Order

The Board issued its final Decision and Order on October 3, 2017. AB 36–42; CR 375–381. Based on the evidence and the testimony received during the hearing, the Board concluded that Dr. Brown had committed misconduct within the meaning of RSA 332-B:14, II (c), (d), (g), (l), and (n). AB 40; CR 379.

First, the Board found that Dr. Brown had committed misconduct under RSA 332-B:14, II(c), which states that misconduct includes "[a]ny unprofessional conduct, or dishonorable conduct unworthy of, and affecting the practice of, the profession." AB 40–41; CR 379–80. The Board found that Dr. Brown had violated a provision of New Hampshire's Controlled Drug Act, RSA 318-B:10, II, "by filling prescriptions for schedule IV controlled substances for more than a seven-day supply on multiple occasions." AB 41; CR 380. The Board further concluded that Dr. Brown violated a different provision of the Controlled Drug Act, RSA 318-B:12, I, "by failing to adequately and accurately keep controlled drug records." AB 41; CR 380. The Board found that these violations of the Controlled Drug Act constituted unprofessional conduct under the meaning of RSA 332-B:14, II(c). AB 40; CR 379.

Second, the Board concluded that Dr. Brown had committed misconduct under RSA 332-B:14, II(d) by continually prescribing expired medications. AB 40; CR 379. RSA 332-B:14, II(d) states that misconduct includes "willful acts performed in a manner inconsistent with the health or safety of animals under the care of the licensee." AB 40; CR 379. The Board explained that prescribing expired medications "is dangerous as expired medications can develop increased potency, decreased potency, or become toxic over time." AB 40; CR 379.

Third, the Board found that Dr. Brown had committed misconduct under RSA 332-B:14, II(g) because she "consistently showed a nonchalant attitude towards the multiple investigations and hearings" and "failed to take remedial corrective measure[s] in a timely fashion." AB 41; CR 380. The Board relied on this finding to conclude that Dr. Brown showed "willful or repeated violations of the provisions of [RSA chapter 332-B.]" AB 41; CR 380.

Fourth, the Board found that Dr. Brown had committed misconduct under RSA 332-B:14, II(l), which states that misconduct includes the "failure to keep the veterinary premises and equipment in a safe, clean sanitary condition." AB 41; CR 380. The Board noted that Dr. Brown's mobile unit was "disorganized, contained expired medications, and there were no actions being taken to maintain an appropriate temperature to store the medication properly." AB 41; CR 380.

Fifth, the Board found that Dr. Brown had committed misconduct under RSA 332-B:14, II(n) by exhibiting a pattern of not being forthcoming with clients. AB 41; CR 380. The Board noted that Dr. Brown at times failed to include client communications in the record. AB 41; CR 380. The Board thus found that Dr. Brown had committed misconduct under RSA 332-B:14, II(n) by showing "dishonesty or negligence... in the maintenance of medical records." AB 41; CR 380.

The Board voted to suspend Dr. Brown's license for a period of six months and further limited Dr. Brown's license by ordering that she "be limited to practice veterinary medicine without controlled substances, with the exception of euthanasia solution," until December 31, 2021. AB 41–42; CR 380–81.

Dr. Brown moved for reconsideration on October 13, 2017. CR 382. The Board denied the motion for reconsideration on November 28, 2017. CR 413. Dr. Brown then filed a motion

for rehearing on December 21, 2017. CR 415. Dr. Brown then filed her Notice of Appeal on December 27, 2017. The Board denied the motion for rehearing on February 8, 2018. CR 424. This appeal followed.

SUMMARY OF THE ARGUMENT

The Board properly found that Dr. Brown had committed unprofessional conduct, which constituted misconduct under RSA 329-B:14, II(c). Dr Brown admitted to having dispensed more than a seven day supply of a schedule IV controlled drug, a violation of RSA 318-B:10, II. She also admitted to having many mistakes in her controlled substances log, a violation of RSA 318-B:12, I. The Board members properly relied on their expertise in the veterinary field in determining that these violations constituted unprofessional conduct under RSA 329-B:14, II(c).

Furthermore, the Board did not err in concluding that Dr. Brown had committed misconduct as defined in RSA 329-B:14, II (d), (g), (l), and (n). The Board provided Dr. Brown with a detailed Notice of Hearing two months before the hearing was held, and did not deprive Dr. Brown of her due process rights to adequate notice. Moreover, the Board based its decision, in part, on the testimony of Dr. Stowe and Mr. Elder, both of whom were qualified to provide the relevant testimony. The Board also did not err in disciplining Dr. Brown for failing to include client communications in her medical records, because the Board members had the expertise to determine that this failure constituted a breach in the standard of care. In addition, the Board did not err in citing Dr. Brown for an unclean and disorganized mobile van because the van constituted the "premises" within the meaning of RSA 332-B:14, II(l). Finally, the Board did not err in restricting Dr. Brown's ability to dispense and administer controlled drugs because the Board has the statutory authority to place limitations or restrictions on a license. RSA 332-B:14, III(b).

ARGUMENT

I. STANDARD OF REVIEW

RSA chapter 541 governs this Court's review of decisions of the Board. *See* RSA 332-B:16, VII. The Court's standard of review for appeals pursuant to RSA 541:6 is statutory:

> [T]he burden of proof shall be upon the party seeking to set aside any order or decision of the [Board] to show that the same is clearly unreasonable or unlawful, and all findings of the [Board] upon all questions of fact properly before it shall be deemed to be prima facie lawful and reasonable; and the order or decision appealed from shall not be set aside or vacated except for errors of law, unless the court is satisfied, by a clear preponderance of the evidence before it, that such order is unjust or unreasonable.

RSA 541:13. Thus, this Court reviews the Board's factual findings deferentially and reviews the Board's rulings on issues of law *de novo*. *Appeal of N.H. Dep't of Corrections*, 162 N.H. 750, 753 (2011).

Dr. Brown argues that the Board erred for two reasons. First, Dr. Brown argues that the Board erred in inspecting her practice for controlled drugs and in disciplining her for violations of New Hampshire's Controlled Drug Act. AB 16–26. Second, Dr. Brown argues that for a variety of reasons, including due process concerns, the Board erred in disciplining her under RSA 332-B:14, II(d), (g), (l), and (n). For the reasons discussed below, this Court should affirm the Board's Decision and Order dated October 3, 2017.

II. THE BOARD HAD AUTHORITY TO BOTH INSPECT DR. BROWN'S PRACTICE FOR ANY AND ALL VIOLATIONS AND DISCIPLINE DR. BROWN FOR UNPROFESSIONAL CONDUCT UNDER ITS STATUTE.

A. The Board Has Subject Matter Jurisdiction to Determine that Admitted Violations of the Controlled Drug Act, RSA 318-B, Constitute Unprofessional Conduct Which Amounts to Misconduct under RSA 332-B:14, II(c).

Dr. Brown first erroneously asserts that the Board, in its October 3, 2017 Order, was enforcing the provisions of New Hampshire's Controlled Drug Act ("CDA"), and argues that the

Board lacks authority to enforce the provisions of the CDA . Dr. Brown either misunderstands or misconstrues the Board's Order. The Board did not sanction Dr. Brown under the provisions of the CDA and it did not seek to impose the penalties set forth in RSA 318-B:26. Rather, the Board made clear that it was disciplining Dr. Brown under a provision of the Veterinary Practice Act, RSA 332-B:14, II(c), for unprofessional conduct, due to the violations of the CDA. *See* AB 40 ("Also, Dr. Brown has violated RSA 318-B:12, I and RSA 318-B:10, II with regards to controlled substances, which constitutes unprofessional conduct under RSA 332-B:14, II(c).")(emphasis added), AB 41 ("The violation of these two [provisions of the CDA] constitutes unprofessional conduct under RSA 332-B:14, II(c).")(emphasis added).

This Court has already determined that members of a licensing Board may draw upon their considerable professional expertise in determining whether a licensee acted within the norms of their profession. *See Smith v. New Hampshire Board of Examiners of Psychologists*, 138 N.H. 548 (1994); *see also In the Matter of Bloomfield*, 166 N.H. 475 (2014); *Appeal of Callahan*, No. 2015-0401, 2016 WL 3963452, at *3 (N.H. June 22, 2016).

In *Bloomfield*, the Respondent, a licensed veterinarian, appealed from a decision of the New Hampshire Board of Veterinary Medicine in which it reprimanded him for "unprofessional conduct" because he "failed to respect the opinion of [a dog's] owners" prior to demonstrating a dominance submissive technique and did not examine the dog before that demonstration. *Id.* at 477–79. The Respondent argued, in part, that the term "unprofessional conduct" was vague and violated his due process rights. *Id.* at 478.

This Court disagreed. Relying on *Smith v. New Hampshire Board of Examiners of Psychologists*, 138 N.H. 548 (1994), the Court stated that "the Board had authority to determine whether the [Respondent] had engaged in unprofessional conduct." *Bloomfield*, 166 N.H. at 480.

Since the term "unprofessional conduct" was not defined in the statute or the rules, the Court further explained:

> Unprofessional conduct must relate to conduct that indicates an unfitness to practice the profession. The actions that constitute unfitness to practice are commonly established by the generally accepted practices and procedures within the professional community. Therefore, the Board, six of the seven members of which were veterinarians, may exercise its statutory authority to determine if the respondent's actions constituted "unprofessional conduct" because veterinarians, as professionals, are expected to recognize conduct evincing unfitness to practice the profession.

Id. at 481 (emphasis added) (internal quotations and citations omitted).

Bloomfield establishes that Board members, as professionals in the field they regulate, may draw upon their professional expertise to determine whether a licensee's actions were reasonable or instead constituted unprofessional conduct. *Cf. Chastik v. Anderson*, 83 Ill.2d 502, 509 (Ill. 1981) ("[T]erms such as 'unprofessional conduct' are susceptible to common understanding by the members of the profession. When combined with the legislative purpose of protecting the public... the term 'unprofessional conduct' provides fair notice to licensed professionals...."). As recently as 2016, this Court reiterated that professional licensing boards have the authority to determine what constitutes unprofessional conduct in their profession. *See Appeal of Callahan*, No. 2015-0401, 2016 WL 3963452, at *3 (N.H. June 22, 2016) ("Generally, we defer to the findings of professional board members to recognize unprofessional conduct in their profession.").

Here, all the Board members that were present for the hearing, except one, were members of the veterinary profession. *See, e.g.* RSA 332-B:3, I ("There shall be a board of veterinary medicine consisting of 7 members: 5 veterinarians, the state veterinarian, and one public member."). As such, the Board members were able to rely on their own considerable

professional expertise and experience in determining whether Dr. Brown's actions were reasonable or whether instead, her actions constituted unprofessional conduct.

The Board heard voluminous testimony on whether Dr. Brown had dispensed more than seven days' supply of a schedule IV controlled substances. See, e.g. TR 331–32; 333–35, 362. RSA 318-B:10, II states:

> II. A veterinarian, in good faith, in the course of his professional practice only, and not for use by a human being, may administer and prescribe controlled drugs, and the veterinarian may cause them to be administered to an animal under his care, but only in a quantity not to exceed a 48-hour supply of a schedule II substance or a 7-day supply of schedule III, IV, or V substances.

Dr. Brown admitted to having dispensed more than a seven day supply of a schedule IV drug on at least one occasion. *See* TR 331–32 (Dr. Brown admitting to dispensing forty pills of Tramadol, almost double what was necessary for seven days for the patient), 363. There were sufficient facts for the Board to determine that this had occurred on at least one other occasion. *See, e.g.* TR 333–35 (Dr. Brown stating that dispensing ten Tramadol pills when the prescription read "[g]ive one-fourth tablet once weekly or as needed one hour before grooming to enable grooming or as needed for pain" "may have lasted [the patient] more than a week" but there was a "slight possibility" the pills could have been used in that one week.). Dr. Brown also admitted to understanding the seven day rule laid out in RSA 318-B:10, II. TR 363. The Board was entirely within its authority, given these facts, to determine that in dispensing more than a seven day supply of a schedule IV controlled substance in violation of RSA 318-B:10, II, Dr. Brown committed unprofessional conduct within the meaning of RSA 332-B:14, II(c).

The Board also heard lengthy testimony on whether Dr. Brown properly kept controlled drug records. *See, e.g.* TR 272–77, 294, 346. RSA 318-B:12, I states, in relevant part:

> Practitioners, including . . . veterinarians, . . . shall keep separate records, so as not to breach the confidentiality of patient records, to show the receipt and

> disposition of all controlled drugs . . . .The records shall indicate at least the name, dosage form, strength, and quantity of the controlled drug; the name and address of any person to whom the drug was administered, dispensed, sold or transferred and the date of any and all transactions involved with the controlled drug.

Dr. Brown admitted to not including the client's address in her controlled substances log. TR 277; *see also* CR 213–14, 162 (the controlled substances log). And when confronted with the many mistakes in her Tramadol log, Dr. Brown admitted the Board could not trust those numbers and that she would need to count them again. TR 294. Dr. Brown admitted she knew it was her responsibility, as a licensee, to properly maintain her controlled substances. TR 294–95. Given these facts, the Board was again entirely within its authority to determine that by improperly keeping controlled drug records, in violations of RSA 318-B:12, I, Dr. Brown committed unprofessional conduct within the meaning of RSA 332-B:14, II(c).

B. <u>The Board Has Authority to Inspect for Any and All Violations it May Find During an Inspection</u>.

Dr. Brown next argues that the Board of Veterinary Medicine lacked the authority to inspect Dr. Brown's premises, at least with regard to controlled substances. She argues that the Pharmacy Board alone has the authority to inspect a veterinarian's facilities to look for controlled substances issues. She also appears to argue that the Veterinary Board's inspections were improper. She acknowledges that the inspections were ordered in the September 28, 2015 order but argues that the Board lacked the authority to require future inspections as a sanction.

As a preliminary matter, in its Order dated September 28, 2015, the Board ordered that "Dr. Brown's practice will be subject to board inspections, which may be announced or unannounced, for a period of four (4) years from the date of this order." CR 28. Dr. Brown never appealed this order. Dr. Brown cannot now, roughly three years later, collaterally challenge the Order dated September 28, 2015.

Nevertheless, the Board has specific statutory authority which allows it to inspect any of its licensees' premises. RSA 332-B:15, VII states that during either a formal or informal investigation, "the board may also require a licensee to . . . provide access for inspection of clinic or hospital premises." As such, Dr. Brown cannot plausibly argue that the Board lacked the authority to inspect her facility.

Dr. Brown argues that RSA 318:9-a supplants the Board's authority to inspect, at least with regards to inspections for controlled substances. Dr. Brown is incorrect. At least with regards to controlled substances, the Board of Veterinary Medicine and the Board of Pharmacy have concurrent authority to inspect. RSA 318:9-a states: "The pharmacy board shall provide inspectional services under this chapter and RSA 318-B:25 to the board of medicine, the board of veterinary medicine, the board of podiatry, the board of registration in optometry, the board of dental examiners, and the board of nursing." However, nothing in RSA 318:9-a indicates that the pharmacy board's inspection authority is exclusive. The Board of Veterinary Medicine's inspection authority in RSA 332-B:15, VII was not abrogated by RSA 318:9-a, and nothing in RSA 318:9-a limits the Board of Veterinary Medicine's inspection powers. Thus, the Board had authority to inspect Dr. Brown's premises with regards to controlled substances.

III. THE BOARD DID NOT VIOLATE DR. BROWN'S DUE PROCESS RIGHTS OR OTHERWISE ERR IN DISCIPLINING HER UNDER RSA 332-B:14, II(d), (g), (l), and (n).

Dr. Brown next alleges that the Board violated her due process rights under both the state and federal constitution in several different ways. AB 26–34. First, Dr. Brown alleges that the Board sanctioned her based on violations of the CDA, and she again argues that the Board lacks the authority to enforce the CDA. AB 27–30. Second, Dr. Brown alleges that she did not receive proper notice of the violations of which she was accused. AB 33–34. Third, Dr. Brown

alleges the Board erred in basing its decision, in part, on the testimony of Dr. Stowe, whom she asserts "lacks the knowledge upon which to inspect or cite a practitioner regarding controlled drugs." AB 30. Fourth, Dr. Brown argues that the Board's decision pertaining to her recordkeeping regarding pre-surgical exams was unsupported by the record and was thus unjust or unreasonable. AB 32–33. Fifth, Dr. Brown alleges that the Board erred in basing a part of its sanction on a finding that the van was disorganized and unclean; she argues that the Board had no authority over the van because the van is not part of the "premises." AB 32–33. Sixth, Dr. Brown alleges that the Board erred in sanctioning her for, in part, failing to include client communications in the patient medical record. AB 33. Finally, Dr. Brown appears to argue that the Board did not have the authority to restrict her ability to prescribe and administer controlled substances. AB 8, 14.

The Board first notes that some of these issues were not presented in the Notice of Appeal filed with this Court on December 27, 2017. In particular, Dr. Brown's third and fourth arguments, concerning the testimony of Dr. Stowe and the recordkeeping, cannot reasonably be considered to have been raised in the Notice of Appeal. This Court has stated that "[a]ppellate questions not presented in a notice of appeal are generally considered waived by this court." *Lassonde v. Stanton*, 157 N.H. 582, 587 (2008). Nevertheless, the Board takes each of these arguments in turn.

A. The Board did not Attempt to Enforce the Provisions of the CDA, but Rather Disciplined Dr. Brown for Unprofessional Conduct Under RSA 332-B:14, II(c).

Dr. Brown again alleges that the Board erroneously attempted to enforce the provisions of the CDA in its October 3, 2017 Order. AB 27–30. This time, Dr. Brown alleges that this violated her due process rights, arguing that due process required proper enforcement of

violations of the CDA, which would have entailed criminal charges in front of a state or federal court, of which the Board would later receive notice. AB 30–31.

As discussed in more detail above, however, Dr. Brown's argument rests on an improper and erroneous reading of the Board's Order. *See* discussion *supra* 18–22. The Board did not sanction Dr. Brown under the provisions of the CDA and it did not seek to impose the penalties set forth in RSA 318-B:26. Rather, the Board made clear in its Order that it was disciplining Dr. Brown for unprofessional conduct under a provision of the Veterinary Practice Act, RSA 332-B:14, II(c). The Board members are authorized to rely on their own professional expertise and experience to determine whether various admitted violations of the CDA were reasonable or whether instead her actions constituted unprofessional conduct. *See* discussion *supra* 18–22.

B. Dr. Brown Received a Detailed Notice of Hearing Which Provided Her With Proper Notice of the Violations of Which She was Accused.

Dr. Brown next alleges that she did not receive proper notice of the violations of which she was accused. AB 33–34. She asserts that "she was simply provided with broad, generic allegations with regard to alleged violations found by the [Veterinary Board's] inspectors." AB 34. Dr. Brown's assertion is unsupported by the record.

"Due process under our constitutional republic has, as a primary consideration, the notion that no matter how rich, or poor, all our citizens are entitled to fundamental fairness when the government seeks to take action that will deprive them of their property or liberty interests." *Appeal of Plantier*, 126 N.H. 500, 509 (1985). One such protected interest is "the right to engage in one's occupation." *Id.* at 506. Fundamental fairness requires that a licensee be given notice of the charges against him or her, so that the licensee is afforded the opportunity to present a complete defense. *See, e.g., In re Opinion of the Justices*, 160 N.H. 180, 183 (2010); *First N.H.*

Bank v. Town of Windham, 138 N.H. 319, 326 (1984). In determining what constitutes proper notice, this Court has stated:

> For more than a century, the central meaning of procedural due process has been clear: Parties whose rights may be affected are entitled to be heard, and in order that they may enjoy that right, they must first be so notified. The purpose of notice under the Due Process Clause is to apprise the affected individual of, and permit adequate preparation for, an impending hearing. *Id.* **To satisfy due process, the notice must be of such nature as reasonably to convey the required information and must be more than a mere gesture. Due process, however, does not require perfect notice, but only notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections. Thus, our inquiry focuses upon whether notice was fair and reasonable under the particular facts and circumstances of the case.**

In re Blizzard, 163 N.H. 326, 335–36 (2012)(emphasis added)(internal citations and quotations omitted); *see also Appeal of School Administrative Unit #44*, 162 N.H. 79, 87 (2011).

Here, Dr. Brown received a ten page Notice of Hearing. CR 2–11. The Notice of Hearing is dated November 23, 2016, approximately two months before the hearing was held. CR 11. The Notice of Hearing lists, in detail, the various findings from the inspections. CR 5–8. It also gives a detailed list of the specific issues to be determined at the adjudicatory hearing. CR 8–9. This Notice of Hearing provided Dr. Brown with notice "reasonably calculated, under all the circumstances, to apprise [Dr. Brown] of the pendency of the action and afford [her] an opportunity to present [her] objections." *See In re Blizzard*, 163 N.H. at 336. Therefore, Dr. Brown was not deprived of her due process rights to adequate notice.

C. The Board Properly Relied on the Expertise of Dr. Stowe and Mr. Elder in Making its Decision.

Dr. Brown next argues that the Board erred by basing its decision on the testimony of Dr. Stowe, and that this violated due process. AB 30. She states, "Moreover, the testimony of the

[Board] investigator, Dr. Stowe, demonstrates that he lacks the knowledge upon which to inspect or cite a practitioner regarding controlled drugs." AB 30.

The Board first notes that this argument does not appear to have been presented in the Notice of Appeal filed with this Court, and thus this argument should be deemed waived. *See Lassonde v. Stanton*, 157 N.H. 582, 587 (2008).

Nevertheless, as argued above, the Board did not cite Dr. Brown for violations of the CDA, but rather cited Dr. Brown for unprofessional conduct. *See* discussion *supra* 18–22. Dr. Stowe is a licensed veterinarian and has the expertise and experience to testify as to whether these violations of the CDA were reasonable actions for a licensee to take or whether the actions instead constituted unprofessional conduct. *See* TR 9–11 (Dr. Stowe testifying that he has been a veterinarian for almost 30 years, has been on the executive board of the New Hampshire Veterinary Medical Association for about 14 years, and is involved in numerous other veterinary professional associations); *see also In the Matter of Bloomfield*, 166 N.H. 475 (2014). As such, the Board was entitled to base its decision, in part, on the testimony Dr. Stowe.

Moreover, the Board did not solely rely on Dr. Stowe's testimony, but also based its decision in part on the testimony of Bob Elder, an inspector for the Board of Pharmacy. CR 140–197. Mr. Elder testified that he has been a compliance inspector for the Board of Pharmacy for nine years, conducting roughly 300 to 400 inspections per year. TR 140–41. Dr. Brown does not dispute that Mr. Elder had the requisite expertise regarding controlled drugs. AB 24–25. Mr. Elder testified to many of the issues for which the Board ultimately disciplined Dr. Brown. For instance, Mr. Elder specifically testified that it can be dangerous to administer or dispense expired medications: "there are certain drugs that become toxic if you exceed the expiration date. Tetracyclines, certain types of penicillins and a few other antibiotics definitely carry the risk of

renal failure if you go past the expiration date." TR 167. He further testified, for example, as to certain errors in Dr. Brown's Tramadol controlled substances log and opined that had he noticed the deficiencies brought up at the hearing when he was inspecting, "it would have prompted a closer look." TR 153, 158. The Board was entitled to rely on Mr. Elder's expertise in coming to its decision.

D. The Board's Decision Makes Clear it Did Not Discipline Dr. Brown for Failing to Conduct Pre-Surgical Exams Properly on a Couple of Patients.

Dr. Brown next argues that the Board's Decision pertaining to her recordkeeping regarding pre-surgical exams was unsupported by the record. AB 32–33. However, a review of the Board's October 3, 2017 Order reveals that the Board did not discipline Dr. Brown for any recordkeeping errors regarding pre-surgical exams. *See* AB 40–41 (The Order's section entitled "Discussion," where the Board stated its reasoning for imposing discipline).

In addition, the Board again notes that this argument does not appear to have been presented in the Notice of Appeal filed with this Court, and thus this argument should be deemed waived. *See Lassonde v. Stanton*, 157 N.H. 582, 587 (2008).

E. The Board Properly Disciplined Dr. Brown for Failing to Write Client Communications in the Patient Medical Record.

Dr. Brown next argues that the Board improperly disciplined Dr. Brown under RSA 332-B:14, II(n) for failing to write client communications in the patient medical record. AB 33. Dr. Brown argues that because there is no law or rule specifically stating that client communications must appear in the patient medical record, that she cannot be disciplined for failing to do so. AB 33.

This Court has repeatedly held that members of a licensing Board may draw upon their expertise and professional knowledge to determine the standard of care to which its licensees

will be held. *See, e.g. Appeal of Beyer*, 122 N.H. 934, 940 (1982) ("Like other administrative bodies whose jurisdiction is limited to particular types of cases, the standard of ordinary care is within the competence of the board . . . ."); *Appeal of Boulard*, 165 N.H. 300, 305 (2013) ("An administrative board has expertise and specialized knowledge to evaluate whether a party's conduct was unprofessional . . . . We conclude that the petitioner's violations – failing to have a required medication and adequately trained staff– are not so complex as to be outside the competence of the Board to decide . . . .") (internal quotations and citations omitted); *In the Matter of Bloomfield*, 166 N.H. 475, 486 (2014) (determining that the Board of Veterinary Medicine had the competence to determine standard of care issues.).

Here, Dr. Brown admitted to failing to write various client communications in her patient's medical file. TR 395–96; *see also* AB 39 (finding of fact in the Board Order stating: "At the hearing, Dr. Brown admitted to a medical error which led to the death of Tobi. And, Dr. Brown testified that she told the owners of this fact. However, there is no indication in the medical records that Dr. Brown had made that communication to the client . . . ."). The Board members drew upon their considerable expertise in the field to determine that the standard of care dictates that client communications be included in the medical records. *See* AB 41 (Board Order, stating "While we understand there are no laws requiring client communications be included in the medical records, the Board feels this is a standard of care. If it isn't written in the medical record, how can it be proved to have happened?"). The Board was entirely within its authority, given these facts, to determine that Dr. Brown violated the standard of care by failing to document client communications in the medical records and thus committed misconduct under RSA 332-B:14, II(n).

F. The Board Has Authority to Cite Dr. Brown for a Disorganized and Unclean Mobile Van that Contained Numerous Expired Medications.

Dr. Brown next states that the Board lacked the authority to discipline her under RSA 332-B:14, II(l) for a disorganized and unclean mobile van, arguing that the term "veterinary premises" does not include her mobile van. RSA 332-B:14, II(l) states: "Misconduct sufficient to support disciplinary proceedings under this section shall include: . . . (*l*) Failure to keep the veterinary premises and equipment in a safe, clean, and sanitary condition." (emphasis added). There is no definition of "veterinary premises" in RSA chapter 332-B.

This Court reviews questions of statutory construction by looking to the language of the statute as a whole, and not at any one particular word or phrase. *See, e.g. Costoras v. Noel*, 100 N.H. 81, 83 (1956) ("While there are numerous canons of statutory construction, the principal and overriding one is that the legislative intent of a section of a statute is to be determined from the language as a whole and not from any single word, phrase, or proviso thereof.").

Here, the legislature created the Board with the purpose of "promoting public health, safety, and welfare by safeguarding the people of New Hampshire against incompetent, unscrupulous, and unauthorized persons and from unprofessional or illegal practices by persons licensed to practice veterinary medicine." RSA 332-B:1-a. To promote this purpose, the legislature granted the Board the authority to inspect "clinical or hospital premises." RSA 332-B:15, VII. The legislature also granted the Board the authority to discipline a licensee for misconduct, and defined misconduct, in part, as the "failure to keep the veterinary premises and equipment in a safe, clean, and sanitary condition." RSA 332-B:14, II(l) (emphasis added).

Even if Dr. Brown does not treat any patients in her van, it was apparent from the testimony that she uses the van to store and transport her equipment. *See, e.g.* TR 310–11 (Dr. Brown admitting that she only began bringing medications from the van into the clinic in

December 2016). The Board has the authority under RSA 332-B:14, II(l) to discipline for a "failure to keep . . . veterinary . . . equipment in a safe, clean, and sanitary condition." Finally, it lacks credulity to argue that the clinic's van is not part of a "premises" as used in RSA 332-B:14, II(l) when the business itself is named MWV Mobile Veterinary Clinic. *See, eg.* CR 39 (records from Dr. Brown's veterinary clinic, listing the clinic name as "MWV Mobile Veterinary Clinic.").

G. The Board has Authority to Place Limitations on a License and thus Properly Restricted Dr. Brown's Ability to Prescribe and Administer Controlled Drugs.

Finally, Dr. Brown appears to argue that the Board did not have the authority to restrict her ability to dispense and administer controlled substances. AB 8, 14. Dr. Brown specifically states that the Board "cited no authority for imposing a sanction regarding [a limitation on her ability to dispense and administer controlled substances.]") AB 8.

The record reflects that the Board did cite to the Board's disciplinary action statute, which explicitly makes clear that the Board may place restrictions or limitations on a licensee's ability to practice. The Board's Order stated, in relevant part:

> IT IS FURTHER ORDERED that, after a six-month suspension, the following limitations will be placed on Dr. Brown's license, **pursuant to RSA 332-B:14, III(b).** Dr Brown will be limited to practice veterinary medicine without controlled substances, with the exception of euthanasia solution. She will be unable to dispense or administer controlled drugs until December 31, 2021. . . .

(emphasis added). RSA 332-B:14, III(b) in turn provides that the Board may take disciplinary action "by suspension, **limitation, or restriction of a license.**" (emphasis added). The statute is clear that the Board has the authority to place such restrictions on a license.

CONCLUSION

For the foregoing reasons, the State respectfully requests that this Honorable Court affirm the Board's decision dated October 3, 2017.

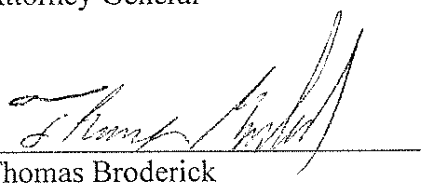
Attorney Thomas Broderick will present oral argument on behalf of the Board.

Respectfully submitted,

THE NEW HAMPSHIRE BOARD OF VETERINARY MEDICINE

By its attorneys,

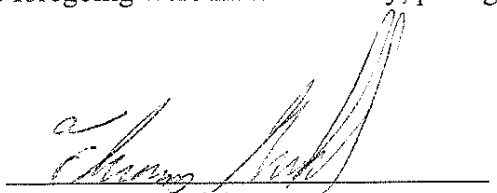
Gordon MacDonald
Attorney General



Thomas Broderick
NH Bar No. 21066
Assistant Attorney General
Civil Bureau
33 Capitol Street
Concord, N.H. 03301-6397
(603) 271-4097

August 24, 2018

I hereby certify that two copies of the foregoing were mailed this day, postage prepaid, to, counsel of record.



Thomas Broderick