GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
BOARD OF VETERINARY MEDICINE

IN THE MATTER OF	:
	:
DARBY THORNBURGH, DVM	:
	:
License No. VET000000321	:
	:
Respondent	:

FINAL ORDER

Jurisdiction

This matter comes before the District of Columbia Board of Veterinary Medicine (Board) pursuant to D.C. Official Code § 3-1201.01 *et seq.* (2016 Repl.), otherwise known as the Health Occupations Revision Act (HORA). The HORA, D.C. Official Code § 3-1202.21(b), authorizes the Board to regulate practice of veterinary medicine in the District of Columbia.

Background

On or about October 13, 2016, Marina Kozak filed a complaint with the Board regarding the treatment of her dog, Barney, by the Respondent and his practice, Petworth Animal Hospital (PAH). According to the complaint, on September 28, 2016 at approximately 5:00 PM, Barney was being cared for by the dog day care service when a car door accidentally closed on and injured his tail. The day care driver, Hermes Yanes, tried to contact Ms. Kozak but she was not reachable by phone until 6:30 PM. Mr. Yanes took Barney to PAH to get care for his injured tail. According to the complaint, Barney was admitted and kept at PAH, which closed for business at 6:00 PM and would not be open again until Friday, September 30, 2016, since the

practice was closed on Thursdays. When Ms. Kozak was informed of Barney's injury, she tried to reach PAH to get information but was unable to reach anyone after hours. Despite the fact that the practice was normally closed on Thursdays, Ms. Kozak drove to PAH at 7:00 AM the next morning in the hope of finding information about her dog. She waited for over four hours until the Respondent arrived at PAH at 12:00 PM. When Ms. Kozak was able to collect Barney, she noted that he seemed to be in pain and struggled to stand or walk. She also saw that his tail was not bandaged and was covered in dried blood. When Ms. Kozak and Barney walked out into the street, Barney stopped and urinated for a long time, causing her to believe that he was not given an opportunity or space to void. Ms. Kozak then took Barney to Dupont Veterinary Clinic, where Barney normally received care. Barney's tail was then amputated due to extensive injury to the affected portion. Ms. Kozak's complaint went on to state that when she contacted PAH to obtain Barney's medical record, she was told that no medical record was created because no care was provided.

In accordance with § 4101.4 of Title 17 of the District of Columbia Municipal Regulations (DCMR), the Board issued an Order to Answer (OTA), requiring the Respondent's response to the complaint. Respondent provided his answers through his attorney, Larry Williams. The response to the OTA states that Mr. Yanes and Ms. Ana Garcia brought Barney to PAH. Both indicated that they were not the owner of the dog but did not provide the owner's contact information. Respondent stated that he told Mr. Yanes that he would make a surgical repair on Barney's tail the following morning. The answer also states:

> "The dog was given a Penn G injection of 3cc and a dose of Metacam for an approximately 45 pound dog. Respondent informed Mr. Yanes that he would have to leave a deposit of $150.00 and sign a permission slip for anesthesia on behalf of the owner.

> "Barney was taken down stairs to a cage with blankets. He was given food and water and noted that all bleeding had stopped and the dog seemed to be comfortable."

In addition to the OTA, the Board also requested a subpoena of Barney's record at PAH. An investigator for the Department of Health (DC Health) obtained the record, which consisted of one page of a "Patient Record" containing hand-written information that was partially illegible. Accordingly, the Board requested that DC Health investigator conduct an interview of the Respondent and obtain a confirmed reading of the Patient Record. During this interview, Respondent confirmed that the Patient Record concerned Barney, that the dog's temperature was 102.2, and that he was given Metacam (a non-steroidal anti-inflammatory drug) and 3cc of Pen-G (an antibiotic). However, there was no entry with regard to Barney's weight. Additionally, there was a small stamp on the right side of the document containing the following information:

"ANESTHESIA RELEASE

> "I understand that the doctors and staff will use all reasonable precaution against injury, escape, or death of my pet. I understand that all anesthesia involves some minimal risk to my pet and I will not hold the doctor and staff responsible under any circumstances. I understand that I assume all risks.
> "09-28-16 Hermes Yanes
> "Date Signature of Owner or Guardian"

The interview with the Respondent confirms that Barney was dropped off by Ms. Garcia and Mr. Yanes, both of whom indicated that they were not the owner. Further, Respondent confirmed that, although PAH was normally closed on Thursdays, he came to the office on Thursday, September 29, 2016, in part to perform the necessary surgical repair on Barney's tail. Responding to the investigator's inquiry regarding consent for surgery, Respondent stated that the "Anesthesia Release" served as consent to both anesthesia and surgery.

To the question concerning care of the dog during the night between 7:15 PM on September 28 to 12:00 PM the next day, Respondent indicated that there was no overnight staff. Barney was left by himself and was taken for a bathroom break shortly before kenneling at 7:15 PM.

To the question concerning the dosage of Pen-G in relation to the dog's weight, Respondent stated that he did not weigh Barney and simply estimated his weight. The investigator informed the Respondent that his estimate was off by about 23 pounds and asked Respondent if the Metacam dosage would be the same for such a weight disparity. Respondent answered that the dosage would differ by about ½ cc. He also demonstrated the difference to the investigator using an empty syringe.

Respondent also stated that he did not clean or bandage Barney's wound because he was protesting being handled. This was also the reason that Barney was not weighed. Additionally, Respondent described the cage as being padded with newspaper and two towels, blankets, or similar things. He also indicated that if Barney needed to relieve himself, he would need to do so in the cage. Respondent also stated that he did not put an E-Collar on Barney since the dog appeared calm in the cage.

When asked by the DC Health investigator, Respondent indicated that he believed he provided adequate care for Barney since he was placed in a safe cage, given pain medication, and the initiation of antibiotic therapy prior to the actual surgical repair. A peer reviewer provided her expert opinion in a report on February 25, 2019, based on the whole record, including the Order to Answer, the Consent Order, the Respondent's Answer to the Complaint of Marina Kozak, the Board's investigative report, and other relevant documents.

On December 11, 2019, the Board issued a Notice of Intent to Take Disciplinary Action (NOI) against the Respondent. The NOI charged the Respondent as follows:

Charge I **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to fulfill the duties within the veterinarian-client-patient relationship and specifically with regards to medical recordkeeping. Medical records subsequently obtained by the Department of Health were neither complete nor legible.

Charge II **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent did not try to obtain prior medical records before proceeding with Barney's treatment in advance of anticipated anesthesia and surgery. Respondent scheduled Barney for surgery that required anesthesia and there is no documentation that Respondent had or requested previous lab work and past medical and surgical information.

Charge III **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to obtain and document owner consent or informed consent. The standard of care required Respondent to obtain informed consent from the owner and document it in the medical record, but Respondent failed to do so.

Charge IV **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to offer a referral to a facility that was open and offered full services and staff. The standard of care for a veterinarian is to offer a referral or provide information for 24 hours daily care for an emergency after hours.

Charge V **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to monitor or provide patient care for the duration of the seventeen hours while Barney waited for treatment for his injury. The absence of patient care for the duration of seventeen hours does not satisfy the standard of care.

Charge VI **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to accurately administer a non-steroidal anti-inflammatory drug (NSAID) and did so without proper consent. The record notes that Barney was never weighed and his weight for medication doses was based on a substantially inaccurate guess. The standard of care requires accurate administration of the NSAID.

Charge VII **You failed to conform to standard of acceptable conduct and prevailing practice within a health profession, for which the Board may take the proposed action under D.C. Official Code § 3-1205.14(a)(26).**

Respondent failed to have adequate staffing during business hours, as the standard of care would require, to allow for safe restraint required to treat the patient.

In accordance with 17 DCMR § 4105.2(c), the NOI was mailed, by certified mail, to Respondent's address of record. However, U.S. Postal Service's record failed to show that it was properly served. Accordingly, it was personally served on the Respondent at his practice (also his address of record) at 4012 Georgia Avenue on February 28, 2020. The District of

Columbia Municipal Regulations provide that the Respondent may request a hearing within twenty (20) days after the service of the notice. 17 DCMR § 4102.4(c)(1). To date the Respondent has not requested a hearing. In accordance with 17 DCMR § 4103.1 the Board may, without a hearing, take the action contemplated in the notice.

Findings of Fact

Based upon the content of the Board's file in this matter, the Board hereby makes the following findings of fact:

1) At all times relevant, the Respondent was and is licensed to practice veterinary medicine in the District of Columbia.
2) Respondent owns and practices at Petworth Animal Hospital (PAH), 4012 Georgia Ave., NW, Washington, DC.
3) Barney is a 68-pound hound mix owned by Ms. Marina Kozak. Ms. Kozak entrusted Barney to a dog day care service. Mr. Hermes Yanes, the day care driver, was caring for Barney when Barney's tail was accidentally closed in a car door. Mr. Yanes and Ms. Ana Garcia, presumably another dog daycare employee, brought Barney to PAH on Wednesday, September 28, 2016 at about 6:00 PM. Both Mr. Yanes and Ms. Garcia informed the Respondent that they were not the dog's owners, but neither of them provided the owner's contact information to the Respondent. PAH normally closes at 6:00 PM and is closed all day on Thursdays.
4) Respondent agreed to receive Barney at PAH.. A patient record was created which consisted of two pages containing some entries of information but many of the entries were not legible. The two pages were nearly duplicate of each other. They begin

with the names: Hermes Yanes, Garcia Ana, and Barney. The first handwritten entry in the notes section indicates: "Tail bitten by another dog vac done by Dupont Circle vet clinic." They also contain stamped entries pertaining to the animal's vital information such as lung, skin, eyes, ears, weight, etc. There was no information in the weight section. Many of the entries, such as eyes, ears, heart sounds, and mucous membranes are shown as "normal." There is some notation seeming to indicate the medication administered and the condition requiring treatment. But the majority of the handwritten entries were either not clearly legible or not legible at all.

5) On the side of the pages was a stamped information reading: "ANESTHESIA RELEASE. I understand that the doctors and staff will use all reasonable precaution against injury, escape, or death of my pet. I understand that all anesthesia involves some minimal risk to my pet and I will not hold the doctor and staff responsible under any circumstances. I understand that I assume all risks. Date: 09-28-16. Signature of Owner or Guardian: Hermes Yanes."
6) The anesthesia release above does not contain any information about the planned treatment or procedure. There is no indication that the anticipated procedure, or the attending risks and benefits, was communicated to Mr. Yanes or Ms. Garcia.
7) Respondent did not weigh Barney, nor did he clean or bandage Barney's wound due to Barney's resistance to being handled. Respondent asserted that Barney was scared and posed resistance. Respondent estimated, "just by looking," that Barney weighed about 45 pounds, which was approximately 33% less than Barney's actual weight.
8) Respondent administered 3cc of antibiotic and a dosage of Metacam (a non-steroidal anti-inflammatory drug (NSAID)) appropriate for a 45-pound dog.

9) Respondent placed Barney into a locked cage padded with newspaper and towels or blankets and then left Barney alone without any caretaker at PAH from 7:15 PM until 12:00 PM the next day. PAH was scheduled to be closed for business on Thursday, so no one would be on the premises to care for the dog until Friday unless the Respondent went to PAH before then.

10) After being put in the cage at 7:15 PM, Barney was not able to leave it and would have had to void in the cage or wait until his release. No E-Collar was put on Barney during his stay overnight at PAH. Barney spent the whole night in the cage without any human caretaker on the premises.

11) The next day, Thursday, September 29, 2016, Respondent went to PAH at 12:00 PM intending to surgically repair Barney's tail. When Respondent arrived at PAH, the dog's owner, Ms. Kozak, was waiting there to retrieve Barney. Respondent returned Barney to Ms. Kozak. Respondent did not provide further treatment to Barney.

12) Ms. Kozak then took Barney to Dupont Veterinary Clinic, where Barney normally received care. Barney's tail was then amputated due to extensive injury to the affected portion.

Analysis and Conclusions of Law

D.C. Official Code § 3-1205.14(a)(26) authorizes the Board to take disciplinary action against a licensee who fails to conform to the standards of acceptable conduct and prevailing practice in a health profession, including the practice of veterinary medicine. Like other health professional boards, the Board of Veterinary Medicine has been entrusted with the mandate to protect the public through reviewing and addressing modern health care advances and community needs. See *Davidson v. District of Columbia Board of Medicine*, 562 A.2d 109, 112

(D.C. 1989). Accordingly, the Board's role is to review the current prevailing practice of the profession and determine the current and prevailing standards applicable to the practice of veterinary medicine in the District.

The American Veterinary Medical Association (AVMA) requires that every graduate entering the profession of veterinary medicine swear the Veterinarian's Oath. Through the Oath, graduates must not only swear to protect animal health but also swear to protect animal welfare. The AVMA also sets standards for all veterinarians through the Principles of Veterinary Medical Ethics (Ethical Code), a code of ethical conduct created by the AVMA. Accordingly, the prevailing national standards for the protection of animal health and welfare may be discerned through the Ethical Code adopted by the AVMA.

In addition to the AVMA's national Ethical Code, the Board also requested the expert opinion of a peer reviewer, who performed a review of all the records maintained by the Board. The analysis below is further supported by the peer reviewer's review and conclusions.

The review of Respondent's conduct and practice in this case must begin with the patient record. Section 2811.1 of Title 17 of the District of Columbia Municipal Regulations (DCMR) states, "A veterinarian shall keep on a daily basis a written report of the animals he or she treats. The record shall include pertinent medical data such as dates and type of vaccinations and all relevant medical and surgical procedures." Similarly, the AVMA Principles of Veterinary Medical Ethics states in section V(b), "Veterinary medical records are an integral part of veterinary care. The records must comply with the standards established by state and federal law."

Barney's record failed the required standards by being mostly illegible. Fortunately, the DC Health investigator had the opportunity to obtain Respondent's reading of the patient record,

thus enabling the Board's review of it. The simple fact that the patient record was mostly illegible is a significant professional failure and violation. While Respondent may be able to read and understand the full picture of Barney's condition and care, no other person would be able to do the same. More significantly, if a subsequent veterinarian stepped in to provide continued or ongoing care, the subsequent veterinarian would not have been able to understand what had been done to Barney. Such lack of information may gravely affect the subsequent veterinarian's ability to effectively and safely treat the animal.

Additionally, the patient record does not contain all pertinent information. Most obviously, the record showed no weight or Respondent's estimate of the weight. On this point, Respondent was asked during his interview by DC Health investigator. Respondent explained that he was not able to weigh Barney because the dog protested being handled because he was scared. Respondent asserted that he estimated Barney's weight by sight to be approximately 45 lbs. and administered a dosage of an antibiotic and a non-steroidal anti-inflammatory drug (NSAID) appropriate for the weight. However, none of this information was noted in the patient record, except the dosage of the drugs.

The patient record indicates "repair tail in morning; distal 3 to fourth digit – dangling; after slicing – dog bite." Based on Respondent's response during the investigation, the Board learned that although PAH was normally closed on Thursdays, Respondent planned to return to the office the next day to perform the surgery to remove the part of Barney's tail that was crushed. Also through the investigation, the Board learned that he did not clean or bandage the wound on Barney's tail due to Barney's resistance to being handled. Respondent put Barney in a cage at about 7:15 PM after allowing the dog an opportunity to void. Some newspapers and towels or blankets were placed in the cage for Barney. No e-collar was put on Barney since

Respondent determined that the dog was calm and did not need it. Respondent then left PAH for the night. No personnel or staff members were left on the premises. None of this information, other than the notation above, was entered into the patient record.

Likewise, the Board learned from Respondent's account provided during the investigation that he was aware[1] that neither Hermes Yanes nor Ana Garcia was the owner of the dog. Mr. Yanes and Ms. Garcia informed the Respondent that they were not Barney's owner; however, they were not able to provide the owner's contact information. Ms. Garcia provided her own address for the patient record. However, there was no notation that Ms. Garcia was not the owner or whether she might be able to act as point of contact for the owner. If Ms. Garcia's statement that she did not have the owner's contact information is accurate, it is questionable how Respondent would be able to return the dog to the owner.

In sum, the patient record the Respondent created for Barney is incomplete in many significant respects.

The government also charges Respondent with failure to conform to the standard of practice by failing to obtain prior medical records in advance of anticipated anesthesia and surgery. On this point, the Board does not believe there is sufficient evidence to reach such a conclusion. While the patient record notes that Dupont Veterinary Clinic provided routine care to Barney, there is no documentation that Respondent obtained or requested previous lab work and past medical and surgical information from them. It is established that Respondent went to his office on Thursday. He stated that he intended to perform a surgery on Barney at that time.

[1] Specifically, Respondent was interviewed along with his wife, who acted as the manager for the practice. Both Respondent and his wife provided verbal accounts and explanation during the interview. It appears that Respondent's wife was the person with personal knowledge of the intake information. Since both Respondent and his wife acted together on behalf of his practice, the analysis deems all information contributed by both as attributable to Respondent as the veterinarian in charge of the practice.

However, the surgery did not occur. Barney's owner, Ms. Kozak, was waiting for him there and took the dog from him soon after he arrived. It is conceivable that Respondent had planned to contact Dupont Veterinary Clinic when he arrived and prior to performing the surgery. However, no inquiry was made to determine whether this was part of Respondent's plan for the surgery. Accordingly, the Board declines to find that Respondent is liable for Charge II.

Further, Respondent is also charged with failure to conform to the standard of veterinary practice by failing to obtain informed consent for the surgery. The AVMA Principles of Veterinary Medical Ethics establishes the standard of acceptable conduct and prevailing practice for informed consent in section II(c), "It is the attending veterinarian's responsibility to inform the client of the expected results and costs, and the related risks of each treatment regime." The standard of care therefore required Respondent to obtain informed consent from the owner and document it in the medical record, but Respondent failed to do so.

The record included an anesthesia release signed by Mr. Yanes. The release simply acknowledges that Mr. Yanes was aware that the use of anesthesia may pose some risks to the animal and was willing to accept them. However, the release did not indicate that a surgery was to be performed, nor what kind of surgery along with what type of risks or benefits. Accordingly, the anesthesia release cannot constitute an informed consent authorizing the surgical procedure Respondent planned to perform on Barney.

There is no evidence in the record that Respondent informed Mr. Yanes or Ms. Garcia of the expected results and costs of the procedure, or of the related risks of treatment. There is no evidence in the record that Respondent obtained consent from Mr. Yanes or Ms. Garcia to administer the NSAID or the antibiotic prior to the Respondent's administration of the medications. Respondent did not contact either Barney's owner or his regular veterinarian, and

therefore did not receive consent from them. Despite the unavailability of the owner, Mr. Yanes was acting in the owner capacity and the veterinarian still had a duty to obtain informed consent from him as the patient's caretaker. Respondent's failure to obtain and document informed consent constituted a failure to conform to the standard of acceptable conduct and prevailing practice within veterinary medicine under D.C. Official Code § 3-1205.14(a)(26).

The government also charged Respondent with failure to offer a referral to a facility that was open and offered full services and staff. The AVMA Principles of Veterinary Medical Ethics establishes the standard of acceptable conduct and prevailing practice for referring a veterinary patient to an available provider after hours or providing information about such a provider in section VII(c) stating, "When veterinarians cannot be available to provide services, they should provide readily accessible information to assist clients in obtaining emergency services, consistent with the needs of the locality." The standard of care for a veterinarian is to offer a referral or provide information for a clinic that is open to provide care when an emergency arises after hours. The standard is further established in section VII(d), which states, "Veterinarians who believe that they haven't the experience or equipment to manage and treat certain emergencies in the best manner, should advise the client that more qualified or specialized services are available elsewhere and offer to expedite referral to those services."

Respondent did not refer Barney to appropriate emergency care, as PAH was closed for business shortly after Barney arrived and PAH is not staffed overnight. Barney was left unattended in a cage for seventeen hours, as PAH was not open for business the following day, so Respondent did not arrive until noon. There were 24-hour veterinary clinics available in the D.C. metropolitan area. Respondent did not inform Mr. Yanes or Ms. Garcia of alternative options where Barney could receive emergency treatment or overnight care. When Ms. Kozak

brought Barney to Dupont Veterinary Clinic the next day, his tail ultimately needed to be amputated. As the Respondent was not able to provide emergency treatment on the day the patient arrived, and no one was on the premises to care for the patient overnight, he should have provided information to assist Barney's caretakers in obtaining emergency services for the patient, consistent with the AVMA Principles. Respondent's failure to offer such a referral to an emergency facility constituted a failure to conform to the standard of acceptable conduct and prevailing practice within veterinary medicine under D.C. Official Code § 3-1205.14(a)(26).

The government also charged Respondent with a failure to conform to the prevailing professional standards by failing to monitor or provide patient care for the duration of the seventeen hours while Barney waited for treatment for his injury. The AVMA Principles of Veterinary Medical Ethics establishes the standard of acceptable conduct and prevailing practice for the provision of appropriate patient care. Section VII(a) of the AVMA Principles states, "Once the veterinarian and the client have agreed, and the veterinarian has begun patient care, they may not neglect their patient and must continue to provide professional services related to that injury or illness within the previously agreed limits." Additionally, section VII(b) clarifies that, "In emergencies, veterinarians have an ethical responsibility to provide essential services for animals when necessary to save life or relieve suffering."

At the time when Barney was admitted, he was in pain and some distress or at least discomfort. Respondent stated during his interview with the investigator that he did not weigh Barney or clean and bandage the tail because he resisted being handled. Since Respondent merely guessed Barney's weight and his guess was off by 33%, he only administered the pain medication (Metacam) appropriate for a 45-lb. dog, which would leave Barney insufficiently medicated and possibly in unnecessarily prolonged pain. In addition to the exposed coccygeal

vertebrae both uncleaned and unbandaged, Respondent left Barney in a locked cage without a separate location to void for seventeen hours without any human attendant present to ensure that he would be cared for if his condition deteriorated or his pain worsened. Indeed, seventeen hours is too long to leave a healthy, uninjured dog unattended and without a separate voiding area. The absence of patient care for the duration of seventeen hours does not satisfy the standard of care.

Accordingly, based on the review above, the Board now concludes that Respondent is liable in accordance with Charges I, III, IV, V, and VI.

The government also charged Respondent with failing to maintain adequate staffing during the business hours. The Board declines to find Respondent liable under this charge. When Barney was brought to PAH, Respondent and the office manager were both there. If Respondent should need assistance in restraining or treating the dog, the office manager could conceivably provide such assistance. However, it is clear that on Thursday – the day on which PAH is normally closed and therefore not a business day – Respondent went there alone. It appears that he planned to perform the necessary surgery without any assistance. However, Ms. Kozak took Barney away and Respondent did not actually perform any. Without any actual facts regarding the conduct of the surgery – whether with or without assistance – the Board is unable to conclude that there has been any violation of professional standards. Accordingly, the Board now concludes that Respondent is NOT liable as to Charge VII.

Pursuant to D.C. Official Code § 3-1205.14(c), upon the Board's determination that a licensee has committed any of the acts enumerated in subsection (a), the Board may:

(1) Deny a license to any Respondent;
(2) Revoke or suspend the license of any licensee;
(3) Revoke or suspend the privilege to practice in the District of any person permitted by this subchapter to practice in the District;

(4) Reprimand any licensee or person permitted by this subchapter to practice in the District;
(5) Impose a civil fine not to exceed $5,000 for each violation by any Respondent, licensee, or person permitted by this subchapter to practice in the District;
(6) Require a course of remediation, approved by the board, which may include:
    (A) Therapy or treatment;
    (B) Retraining; and
    (C) Reexamination, in the discretion of and in the manner prescribed by the board, after the completion of the course of remediation;
(7) Require a period of probation; or
(8) Issue a cease and desist order pursuant to § 3-1205.16.

Based on the foregoing findings of fact, the Board hereby concludes as a matter of law that Respondent is liable for the disciplinary action as stated below.

ORDER

Based upon the aforementioned it is hereby

ORDERED that the license of **DARBY THORNBURGH**, **VET000000321**, shall be and is hereby **SUSPENDED**, effective as of the date of service of this Order; and it is further

ORDERED that Respondent shall be and is hereby assessed a **FINE IN THE AMOUNT OF FIVE THOUSAND DOLLARS ($5,000)**, which shall be paid by check or money order made payable to "**D.C. Treasurer**" and shall be submitted to Board of Veterinary Medicine, 899 North Capitol Street, N.E., 2nd Floor, Washington, D.C. 20002; and it is further

ORDERED that the SUSPENSION of the Respondent's veterinary license, **VET000000321**, shall be lifted only after the full remittance of the above-referenced FINE and his COMPLETION OF **TWO (2) HOURS OF CONTINUING EDUCATION IN EACH OF THESE SUBJECTS: a) Record Maintenance; b) ethics; and c) Pharmacology**; and it is further

ORDERED that after the lifting of the **SUSPENSION**, Respondent's veterinary license, **VET000000321**, shall be placed in and subject to **PROBATION** status for a minimum period of **TWO (2) YEARS** from the date the suspension is lifted, during which Respondent shall comply with the following requirements:

a. Respondent shall maintain complete, legible, and accurate patient records, which shall contain the following types of information as applicable:

(i) Patient's name and the date of treatment;

(ii) Records of appropriate physical examination and findings;

(iii) Treatment plan;

(iv) Informed consent document(s) specific to each procedure;

(v) Clinical Findings, diagnosis and treatment rendered;

(vi) List of drugs or vaccine(s) prescribed, administered, dispensed and the quantity;

(vii) Radiographs;

(viii) Patient financial/billing records;

(ix) Name of veterinarian, veterinary technician and/or other auxiliaries providing service(s);

(x) Laboratory test results; and

(xi) Record of an animal or patient voiding, eliminating, or relieving itself where the animal or patient is being boarded;

b. Respondent shall not accept any patient for **medical boarding** unless there is sufficient personnel resource to care for the patient for the duration of the boarding;

c. Respondent shall not accept any animal for **non-medical boarding** for more than twelve (12) hours unless there is personnel resource available to care for the animal for the duration of the boarding; and

d. Respondent shall be subject to **PERIODIC UNANNOUNCED VISITS AND INSPECTIONS** from the DC Health investigator(s) or inspector(s) to review his compliance with the terms specified in this paragraph.

9/17/20
Date

Leanne Lipton, DVM
Acting Chairperson
Board of Veterinary Examiners

Judicial and Administrative Review of Actions of Board

Pursuant to D.C. Official Code § 3-1205.20 (2016 Repl.):

> Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the **District of Columbia Court of Appeals** pursuant to D.C. Official Code § 2-510.

Pursuant to D.C. Court of Appeals Rule 15(a):

> Review of orders and decision of an agency shall be obtained by filing with the clerk of this court a petition for review within thirty (30) days after the notice is given.

This Order is the Final Order of the Board in this disciplinary matter and a public record and, as mandated by federal law, 42 USC § 11101 and 45 CFR § 60, "the National Practitioner Data Bank – Health Integrity and Protection Data Bank," this disciplinary action shall be reported to the U.S. Department of Health and Human Services.

Copies to:

Darby Thornburgh, DVM
4012 Georgia Avenue, NW
Washington, DC 20011

Christopher Sousa, Esquire
Assistant General Attorney
Office of the Attorney General for the District of Columbia
Civil Enforcement Division
441 4th Street, N.W., Suite 630 South
Washington, DC 20001