

**STATE OF CONNECTICUT
CONNECTICUT BOARD OF VETERINARY MEDICINE**

Joseph St. Clair, D.V.M.
License No. 001220
607 East Main Street
Meriden CT 06450

Petition No. 950308-047-006

MEMORANDUM OF DECISION

Procedural Background

The Department of Public Health (the "Department") presented the Connecticut Board of Veterinary Medicine (the "Board") with a Statement of Charges, dated May 27, 1997 (the "Statement"), brought against Joseph St. Clair, D.V.M. ("respondent"). Dept. Ex. 1. On September 26, 1997 respondent received the Statement and a notice of hearing, sent by certified mail, return receipt requested. Dept. Ex. 1. The Board granted respondent's request for a continuance of the hearing originally scheduled for October 8, 1997, setting November 19, 1997 as the new hearing date. Dept. Ex. 1.

On December 27, 1997 respondent filed an answer to the Statement. Resp. Ex. A. On December 30, 1997 respondent filed a motion to exclude certain evidence that had been admitted at the November 19, 1997 hearing when he was unrepresented by counsel. Board Ex. 1. The Department objected to that motion. Board Ex. 2. The Board denied that motion to exclude evidence. Board Ex. 3.

The administrative hearings to adjudicate this case were held on November 19, 1997, January 28, 1998, February 18, 1998, and April 22, 1998. Gareth Bye, Esq., represented the Department at all hearings; respondent represented himself at the November 19, 1997 hearing, and Richard R. Brown, Esq. of Brown, Paindiris & Scott, LLP, represented respondent at the subsequent hearings. Assistant Attorney General Phyllis Hyman was counsel to the Board. Both the Department and respondent presented evidence, including expert testimony, conducted cross-examination of witnesses, and provided legal argument and briefs on all issues.

The Board conducted the hearings in accordance with Connecticut General Statutes Chapter 54 and the Regulations of Connecticut State Agencies 19a-9-1 et seq.

All Board members involved in this decision received copies of the entire record. Moreover, all Board members involved in this decision attest that they have either heard the case or read the record in its entirety. This decision is based entirely on the record and the Board's specialized professional knowledge in evaluating the evidence.

Allegations and Answer

In Paragraph 1 of the Statement, the Department alleged that respondent is, and has been at all times referenced in the Statement, the holder of Connecticut veterinary medicine license number 001220. Dept. Ex. 1. Respondent admitted this allegation. Resp. Ex. A.

In Paragraph 2 of the Statement, the Department alleged that, on or about November 29, 1994, respondent provided care and treatment, including a hernia operation, to Jumper, an approximately nine year old male terrier mix dog, owned by Leonard Sobieski. Dept. Ex. 1. Respondent also admitted this allegation. Resp. Ex. A.

In Paragraph 3 of the Statement, the Department alleged that, in providing such care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally (a) failed to refer Jumper to a specialist after encountering complications during the hernia operation; (b) failed to sufficiently investigate (i) Jumper's post-surgical swelling in the vicinity of the surgical site and/or (ii) the cause of constant post-surgical hemorrhaging near Jumper's surgical site; (c) failed to monitor the surgical site and/or the site of constant hemorrhage after a pneumocystogram ruled out a bladder prolapse; (d) failed to treat timely and/or refer Jumper to a specialist to address the cause of the long-standing hemorrhage, a bleeding vessel; and/or (e) failed to treat properly the resulting hemorrhagic shock. Dept. Ex. 1. Respondent denied this allegation. Resp. Ex. A.

In Paragraph 4 of the Statement, the Department alleged that the above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes 20-202(2). Dept. Ex. 1. Respondent also denied this allegation. Resp. Ex. A.

The Department requested that the Board, as authorized in 20-202, revoke or take any other action as authorized in 19a-17 against respondent's veterinary license, as the Board deems appropriate and consistent with law. Dept. Ex. 1.

Findings of Fact

1. Alan Feldman, D.V.M., testified as the Department's expert witness; Hurbert S. Freiman, D.V.M., testified as respondent's expert witness.
2. Respondent is, and has been at all times referenced in the Statement, the holder of Connecticut veterinary medicine license 001220. Dept. Ex. 1; and Resp. Ex. A.
3. Respondent operates the Meriden Animal Hospital (the "clinic"). Tr. 4/22/98, p. 62; and Dept. Ex. 5 and 6.
4. At all times relevant to the Statement, Jumper was an approximately nine to ten year old male terrier mix dog ("Jumper") owned by Leonard Sobieski and Linda Grant ("Jumper's owners" or the "owners"). Dept. Ex. 1; Resp. Ex. 1; and Tr. 11/19/97, p. 52.
5. Respondent had treated Jumper all of the animal's life, except for his puppy shots. Tr. 11/19/97, p. 40; and Tr. 1/28/98, p. 7.
6. Respondent described Jumper's owners as "good owners." Tr. 4/22/98, pp. 111 and 169.
7. In August 1993 respondent noted that Jumper had a hernia, and he advised the owners that they should correct that situation. In December 1993, respondent neutered Jumper successfully and without complications. Dept. Ex. 6; Tr. 1/28/98, pp. 8-11; and Tr. 4/22/98, pp. 67, 69-70, and 72.
8. On August 18, 1994 respondent treated Jumper for a prolapsed bladder. Dept. Ex. 6; and Tr. 1/28/98, pp. 28-29.
9. Jumper's owners brought him to respondent's clinic on October 14, 1994 because of a flea problem. At that time they spoke with a substitute veterinarian, who advised them that Jumper's hernia situation was serious and he needed an operation. Dept. Ex. 6; Tr. 11/19/97, p. 41; and Tr. 1/28/98, pp. 11-12.
10. Mr. Sobieski called respondent the following week to make an appointment for Jumper's hernia operation. Mr. Sobieski got an appointment for the week of Thanksgiving, but he decided to postpone it another week because of the holiday. Tr. 11/19/97, pp. 44-45; and Tr. 1/28/98, pp. 12-13.
11. On or about November 29, 1994, Jumper's owners took Jumper to respondent's clinic for a perineal hernia operation scheduled for the next day. Dept. Ex. 1 and 6; Resp. Ex. A; Tr. 11/19/97, p. 45; and Tr. 1/28/98, pp. 34-35.

12. Respondent performed the perineal hernia operation, kept Jumper at the clinic for a few days, and sent Jumper home on December 2nd. Dept. Ex. 6; and Tr. 11/19/97, pp. 45-46.
13. Jumper's perineal hernia operation was one of the more difficult ones respondent has performed because it was a large hernia of long-standing duration and because he had to find tissues that were strong enough to hold the suture material. Dept. Ex. 5 and 13; and Tr. 4/22/98, p. 76.
14. Respondent did not give the owners any written instructions about Jumper's post-operative care. Respondent suggested that Mr. Sobieski give Jumper a fiber-type product to assist him in passing stool and Mr. Sobieski did so. Tr. 11/19/97, pp. 46-48; and Tr. 1/28/98, p. 36.
15. Viewing Jumper from behind, the surgical site was below and to the right of the tail on the back of the right thigh. The incision was approximately five to six inches long. Tr. 11/19/97, p. 51.
16. Jumper did not bleed on December 2nd, 3rd, or 4th, although there was some oozing. The wound site was undressed and naked to the eye. The first bleeding the owners were aware of occurred on December 5th. Tr. 11/19/97, pp. 48-50; and Tr. 1/28/98, pp. 16-17, 35-37, and 71.
17. On the morning of December 5th, there was a large pool of blood where Jumper was sleeping. Mr. Sobieski brought him back to respondent's clinic that morning. Tr. 11/19/97, pp. 50-53; and Tr. 1/28/98, pp. 17-18, 33 and 37-38.
18. Mr. Sobieski waited in respondent's waiting room for approximately ten minutes. When Jumper stood up to go with the attendant, there was a pool of blood on the floor. Respondent's attendant said she would take care of it. Tr. 11/19/97, p. 53; and Tr. 1/28/98, p. 38.
19. Respondent was not at the clinic, so Mr. Sobieski left for work. He called respondent's clinic later that day and was told that Jumper would be kept overnight for observation and that he would be checked for a possible prolapsed bladder. Tr. 11/19/97, p. 54.
20. Respondent observed swelling around the surgical site and performed a pneumocystogram to check for a prolapsed bladder, which he suspected was causing some swelling near the surgical site. The pneumocystogram ruled out the presence of a prolapsed bladder. Dept. Ex. 5, 6 and 13; Tr. 1/28/98, pp. 99-100; and Tr. 4/22/98, pp. 81 and 136.

21. Respondent suspected that an infection might have been responsible for the swelling so he administered an antibiotic. Dept. Ex. 6 and 13; and Tr. 4/22/98, pp. 109-110, and 136.
22. Respondent's records do not describe the size or location of the swelling on Jumper except to say that the surgery area was very "swollen.". Dept. Ex. 5, Ex. 6; and Tr. 4/22/98, pp. 30-31.
23. Dr. Feldman testified, and the Board finds, that, given Jumper's symptoms and swelling and the negative pneumocystogram, respondent should have pursued further investigation and diagnostic testing because the swelling would interfere with the healing process. Tr. 1/28/98, pp. 100 and 102.
24. Dr. Feldman testified, and the Board finds, that the minimal standard of care in a case like this one would have required a determination of the type of material in the swelling so that a proper treatment plan could be designed for the patient. Tr. 2/18/98, pp. 75, 89, and 100.
25. Dr. Feldman opined, and the Board finds, that respondent did not sufficiently investigate Jumper's post-surgical swelling in the vicinity of the surgical site. Tr. 1/28/98, pp. 98-103.
27. Mr. Sobieski talked with respondent about Jumper's bleeding prior to Jumper coming home on December 7th. Respondent told Mr. Sobieski that minor residual bleeding was to be expected and was desirable. Tr. 11/19/97, p. 55; and Tr. 1/28/98, p. 32.
28. Jumper returned home on December 7th. Dept. Ex. 6; and Tr. 1/28/98, pp. 72-73.
29. Jumper bled at home the night of December 7th, resulting in a blood stain on his bed comparable to the one that was there on the morning of December 5th. Mr. Sobieski called respondent the next day to inform him of this bleeding. Respondent assured Mr. Sobieski that some residual bleeding was expected and not a cause of worry. Without seeing the dog, respondent concluded that the dog was oozing a serosanguineous discharge. Tr. 11/19/97, pp. 56-58; and Tr. 1/28/98, pp. 19-20, and 43; Tr. 4/22/98, p. 168.
30. During the time frame of December 7th to the 8th, Jumper's owners watched Jumper more closely. They noticed blood oozing from Jumper's hind quarters, from a dime-sized hole between the surgical site and the tail, but not from the surgical site itself. Ms. Grant noticed swelling around the wound site. Also, Jumper looked weak, and was wobbly in his walk. Nonetheless, because of respondent's statement that bleeding was to be expected, Mr. Sobieski did not bring Jumper back to see respondent or any other veterinarian. Tr. 11/19/97, pp. 59-61; and Tr. 1/28/98, pp. 41-44.

31. Without seeing Jumper after his discharge on December 7th, respondent decided that the fluid the owners were complaining about was not blood, but serosanguineous fluid discharge. Tr. 4/22/98, pp. 168-170.
32. Jumper's owners became increasingly alarmed because the bleeding episodes continued and the bleeding got heavier as time passed. On the evening of December 9th, Ms. Grant called respondent at home. He was not there, but he returned the call. Ms. Grant explained the continual bleeding and was reassured that there was no need for concern. Respondent did not recommend that Jumper be seen by him or by another veterinarian. Tr. 11/19/97, pp. 61-62; and Tr. 1/28/98, pp. 44-46.
33. On Monday, December 12th, Ms. Grant's children called her at work to report that Jumper was wobbling, falling to the ground, and blue -- in a semi-conscious state. Ms. Grant returned home immediately and took Jumper to respondent's clinic. Jumper was in hemorrhagic shock and unconscious. Dept. Ex. 5 and 13; Tr. 11/19/97, p. 62; and Tr. 1/28/98, pp. 21-22, 47-48, and 77.
34. Although respondent repeatedly denied seeing Jumper bleed at any time from December 5th through 12th, respondent admitted that Jumper must have bled at some points from December 7th to the 12th. Tr. 11/19/97, p. 22 and Tr. 4/22/98, p. 189.
35. Dr. Feldman opined, and the Board finds, that respondent failed to investigate sufficiently the cause of constant post-surgical hemorrhaging near Jumper's surgical site. In so concluding, the Board interprets "constant" to mean continual or continually reoccurring or persistent, rather than continuous or uninterrupted. Tr. 1/28/98, pp. 103-104; and Tr. 2/18/98, p. 113.
36. At the clinic on December 12th, respondent gave Jumper an emergency blood transfusion that amounted to almost one half the dog's entire blood volume. Respondent described Jumper at that time in this way: "I thought he was dead, I mean, I couldn't feel his heart. He was barely -- I didn't even see him -- no, I detected a heart beat, he wasn't breathing and he was white. . . . [H]e must have bled out internally because of the color of his gums and he was in hemorrhagic shock." Dept. Ex. 13; Tr. 1/28/98, pp. 48-57; and Tr. 4/22/98, pp. 90, 92, and 183.
37. Respondent did not operate on Jumper at that time because he thought it was too risky. Tr. 4/22/98, p. 93.
38. Jumper revived. Respondent applied a pressure bandage to the surgical wound site and sent Jumper home. Respondent did not recommend nor refer Jumper's owners to another veterinarian. Dept. Ex. 5 and 13; Tr. 11/19/97, pp. 67-69; Tr. 1/28/98, pp. 53, 56-58, and 78-79; and Tr. 4/22/98, pp. 90-92, 95-96.

39. Until this time, respondent had never applied any bandages to Jumper and had left the surgical wound bare. Dept. Ex. 5, 6 and 13; Tr. 11/19/97, p. 58; Tr. 1/28/98, p. 42; and Tr. 2/18/98, p. 87.
40. Although respondent denied seeing Jumper bleed on December 12th, Jumper's owners testified and the Board finds that Jumper started bleeding again after the blood transfusion on December 12th. Tr. 1/28/98, pp. 22, and 56-57.
41. When respondent let Jumper go home on December 12th, respondent admitted that he did not know the source of Jumper's hemorrhage. Nonetheless, on that date, respondent only bandaged Jumper and did not attempt to find the the source of the bleeding or refer Jumper to a specialist. Tr. 4/22/98, pp. 186-188.
42. Dr. Feldman opined, and the Board finds, that Respondent failed to treat properly Jumper's hemorrhagic shock because, although he restored Jumper's consciousness via a massive blood transfusion on December 12th, he let the dog return home. Tr. 2/18/98, pp. 186-188.
43. Respondent reexamined Jumper the morning of December 13th. He changed Jumper's bloody bandages and sent him home again. Ms. Grant and respondent both testified that, when respondent later that day removed the pressure bandage he had applied earlier that morning, Jumper was bleeding. Tr. 11/19/97, pp. 69-70; Tr. 1/28/98, pp. 59-60; and Tr. 4/22/98, pp. 97-100.
44. Respondent then recommended that the owners take Jumper to Dr. Lau and the Cheshire Veterinary Hospital ("Cheshire") for further care. Tr. 11/19/97, pp. 70-71; and Tr. 1/28/98, pp. 61-62, and 79-80.
45. Respondent called Dr. Lau to discuss Jumper's condition. Tr. 2/18/98, pp. 132-133; and Tr. 4/22/98, p. 102.
46. Dr. Amy Anderson saw Jumper when he arrived at Cheshire on December 13th. Upon Jumper's arrival, Dr. Anderson put some sterile gauze into the hole in the right thigh, put more gauze over the top, and sutured the bandage on. She also did a hematocrit. Dept. Ex. 7; Tr. 11/19/97, p. 72; and Tr. 2/18/98, pp. 129, 134-135.
47. Within several hours of arriving at Cheshire, Jumper began to bleed profusely. Dr. Anderson obtained the owners' permission to perform surgery and tied the hemorrhaging blood vessels inside Jumper (in the vicinity of the dime-sized hole), thereby stopping the bleeding. She removed a "hand-sized" blood clot from Jumper. Dept. Ex. 7; Tr. 11/19/97, pp. 72-73; Tr. 1/28/98, pp. 68-69; and Tr. 2/18/98, pp. 134-142, and 151.

48. Three days after Dr. Anderson's surgery, Jumper began to suffer seizures and his owners euthanized him. Tr. 11/19/97, pp. 75-76; and Tr. 1/28/98, pp. 69-70.

Discussion and Conclusions of Law

Section 20-202(2) of the Connecticut General Statutes provides, in relevant part, that the Board "may take any of the actions set forth in section 19a-17 . . . [upon] (2) proof that the holder of such license or certificate has become unfit or incompetent or has been guilty of cruelty, unskillfulness or negligence towards animals and birds. . . ."

The Board finds that the Department bears the burden of proof in this matter by a preponderance of the evidence. Steadman v. Securities and Exchange Commission, 450 U.S. 91, 101 S. Ct. 999, reh'g denied, 451 U.S. 933 (1981); Swiller v. Commissioner of Public Health & Addiction Services, 15 Conn. L. Rptr. No. 16, 532 (January 29, 1996). The Board relied on its members' training and experience when making its findings of fact and conclusions of law. Pet v. Department of Health Services, 228 Conn. 651, 667 (1994).

Paragraph 3(a) of the Statement

The Department admitted that it did not sustain its burden of proof as to the allegation contained in Paragraph 3(a) of the Statement and, therefore, the Department withdrew that charge. Department's June 15, 1998 Post-Hearing Brief, p. 1. Thus, the Board does not address that charge further.

Paragraph 3(b)(i) of the Statement

In Paragraph 3(b)(i) of the Statement, the Department alleged that, in providing care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally failed to investigate sufficiently Jumper's post-surgical swelling in the vicinity of the surgical site. The Board concludes that the Department met its burden of proof as to this charge.

The standard of care requires a veterinarian to be constantly aware of post-operative complications and, if they exist, to take appropriate action. The Board recognizes that respondent investigated certain potential causes of Jumper's post-surgical swelling in the vicinity of the surgical site by checking for infection and performing a pneumocystogram.

While those actions were appropriate, they were not enough and, thus, respondent's conduct fell below the standard of care.

The Board is skeptical of respondent's claim that he did "hundreds" or even one hundred of this type of hernia surgery. This particular type of hernia surgery is not common. The respondent's own expert witness testified that he had done only 15 to 20 perineal hernia surgeries in his over twenty-five years of practice. Tr. 4/22/98, p. 56. This surgery invades a highly vascular part of the body. As respondent acknowledged, swelling in the vicinity of the surgical site could have been caused by any number of factors, including a blood clot, a prolapsed bladder, and hemorrhage. Given the owners' reports of bleeding and swelling, which the Board believes were made and one of which respondent acknowledged receiving, respondent should have suspected and ruled out that there was, in fact, hemorrhage occurring. Respondent did not do so in this case, thereby failing to investigate sufficiently Jumper's post-surgical swelling in the vicinity of the surgical site.

The Board disagrees with both experts' opinions that going into the surgical site again could have caused more harm than good; because hemorrhage was a possible cause of the swelling, and given the owners' reports of bleeding, respondent should have gone back in to find the source of the bleeding. Given the nature of the surgery he performed, respondent was not aggressive enough in his investigation and, therefore, he was negligent and/or unskillful in his failure to investigate sufficiently the post-surgical swelling in the vicinity of the surgical site.

Paragraph 3(b)(ii) of the Statement

The Department alleged in Paragraph 3(b)(ii) of the Statement that, in providing care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally failed to investigate sufficiently the cause of constant post-surgical hemorrhaging near Jumper's surgical site. The Board concludes that the Department met its burden as to this charge. In so concluding, the Board interprets "constant" to mean continual or continually reoccurring or persistent, rather than continuous or uninterrupted. Tr. 2/18/98, p. 113.

The Board finds credible the owners' testimony that Jumper bled on the floor of respondent's waiting room on December 5th. Respondent admitted that he received a telephone call from Jumper's owner on December 7 and the Board finds credible the

owners' testimony that Jumper bled continually for four days between December 8 and December 11. Otherwise, Jumper would not have arrived at the clinic on December 12th in the condition he was in (hemorrhagic shock), needing a transfusion. Respondent's records provide scant information about Jumper's condition and respondent's treatment and examination of the animal. The standard of care in veterinary medicine during the time period in question included addressing owners' complaints or concerns in a timely fashion. Respondent did not do so in this case. Respondent's investigation deviated from the accepted standard of care.

Paragraph 3(c) of the Statement

In Paragraph 3(c) of the Statement, the Department alleged that, in providing care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally failed to monitor the surgical site and/or the site of constant hemorrhage after a pneumocystogram ruled out a bladder prolapse. The Department stated in its Brief that the operative time frame for this allegation is the eight-day period from December 5 through December 13, 1994.

The Board concludes that the Department did not sustain its burden of proof as to this allegation. In so concluding, the Board differentiates between the "surgical site" or "the site of constant hemorrhage" and the "patient." The Board also interprets "constant" to mean continual or continually reoccurring or persistent, rather than continuous or uninterrupted. Tr. 2/18/98, p. 113. Respondent saw Jumper when his owners brought him in and performed a pneumocystogram. Given the owners' complaints of bleeding, another way to monitor would have been to do a blood count, which could indicate the quantity of blood the dog had lost. The Board cannot say, however, that respondent's failure to do a blood count is dispositive. Based on the entire record in this case, the Department did not sustain its burden of proof as to this charge.

Paragraph 3(d) of the Statement

The Department alleged in Paragraph 3(d) of the Statement that, in providing care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally failed to treat and/or refer Jumper to a specialist to address the cause of the long-standing hemorrhage, a bleeding vessel. The Board interprets this allegation as addressed to the

time period prior to Jumper having been brought in to the clinic in a hemorrhagic shock on December 12th.

As discussed above with respect to Paragraph 3(b) of the Statement, the Department carried its burden of showing that respondent did not conduct timely treatment and investigation before the dog ended up in a coma. Respondent failed to treat Jumper timely, prior to the coma, and/or failed to refer Jumper to a specialist in a timely manner. By not bringing Jumper back to the clinic or referring him elsewhere when the owners were describing ongoing bleeding from December 7th through December 12th, respondent deviated from the standard of care. Pet owners are not trained in what to look for and cannot recognize when an animal is in need of medical attention. Thus, respondent's actions fell below the standard of care applicable in such circumstances.

Paragraph 3(e) of the Statement

Finally, in Paragraph 3(e) of the Statement, the Department alleged that, in providing care and treatment to Jumper, respondent negligently, unskillfully and/or intentionally failed to treat properly the resulting hemorrhagic shock. The Board interprets this allegation as addressed to the time period after Jumper was brought in comatose to respondent's clinic on December 12, 1994.

On December 12, 1994 respondent gave Jumper two units of blood, almost one half his blood volume, and he applied a pressure bandage to the surgical site for the first time. This was inadequate. The amount of the blood transfusion should have alerted respondent to the need to go back in to find the source of the bleeding as soon as possible. Giving the dog two units of blood was not enough; respondent needed to find the source of the bleeding. There was no rational reason to delay exploratory surgery at that point, and it was improper to send Jumper home without having located the source of the bleeding and without having stopped it. If respondent felt uncomfortable doing the exploratory surgery, he should have referred Jumper to a specialist immediately. His failure to do so deviated from the standard of care.

Order

Pursuant to the authority vested in it by Connecticut General Statutes 19a-17 and 20-202, the Board makes the following order in the case against Joseph St. Clair, D.V.M., veterinary license number 001220:

1. Respondent shall pay a civil penalty of one thousand dollars (\$1,000.00) by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Number on the face of the check, and it shall be payable within thirty (30) days of the effective date of this Decision.
2. Respondent's license shall be placed on probation for a period of one (1) year, under the following terms and conditions:
 - a. During the probationary period, respondent shall attend and successfully complete ten (10) hours of continuing education in soft tissue surgical procedures, some of which shall include post-operative complications, pre-approved by the Board.
 - b. During the probationary period, respondent shall spend one (1) day as an observer in the surgical suite of a major veterinary teaching hospital or institution, pre-approved by the Board. Respondent shall thereafter report back to the Board on his observations and impressions of that experience.
 - c. Upon respondent's completion of the continuing education ordered in subparagraphs (a) and (b), above, respondent shall provide the Department with proof, to the Department's satisfaction, of the successful completion of such continuing education.

3. All correspondence and reports shall be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

4. Respondent shall pay all costs necessary to comply with this Order.

5. Any alleged violation of this Order shall result in the following procedures: at the Department's discretion:

- a. Provided that there has been no prior written modification of this Order, the Department shall notify respondent in writing, by first-class mail, that the term(s) of this Decision have been violated.
- b. Said notification shall include the act(s) or omission(s) which violate the terms of this Order.
- c. Respondent shall be allowed fifteen (15) days from the date of the mailing of the notification required in subparagraph (a), above, to demonstrate to the Department's satisfaction that he has complied with the terms of this Order or that he has cured the violation in question.
- d. If, by the required date, respondent does not demonstrate, to the Department's satisfaction, compliance with the requirement or cure the violation, he shall be entitled to a hearing before the Board, which shall make a final determination of the disciplinary action to be taken.

- e. The evidence at such hearing shall be limited to the alleged violation(s) of this Order.

**CONNECTICUT BOARD OF
VETERINARY MEDICINE**

4/21/99
Date

Jordan R. Dann
By: Jordan R. Dann, D.V.M.
Its Chairperson



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

April 23, 2003

Joseph St.Clair, DVM
26 Rockwood Drive
Southington, CT 06489

Re: Memorandum of Decision
Petition No. 950308-047-006
License No. 001220
DOB: [REDACTED]

Dear Dr. St.Clair:

Please accept this letter as notice that you have satisfied the terms of your license probation, effective April 21, 2000.

Notice will be sent to the Department's Licensure and Registration section to remove all restrictions from your license related to the above-referenced Memorandum of Decision.

Please be certain to retain this letter as documented proof that you have completed your license probation.

Thank you for your cooperation during this process.

Very truly yours,

Bonnie Pinkerton, RNC
Division of Health Systems Regulation

cc: J. Filippone



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