CVBC File Number 24-147

IN THE MATTER OF the *Veterinarians Act,* SBC 2010, c. 15, as amended

The College of Veterinarians of British Columbia
(the "CVBC" or the "College")

and

Dr. Janice Posnikoff
(the "Respondent")

DECISION ON A DISCIPLINE HEARING

Panel	Carol Baird Ellan K.C., Chair Dr. Al Runnells Dr. Amy Cheung
Dr. Janice Posnikoff	Appearing without counsel
Counsel for the College	Natasha John
Hearing Date	July 10, 2025
Date of Decision	September 10, 2025

1. Overview

[1] The Respondent veterinarian is the principal in an equine veterinarian clinic, Okanagan Equine Veterinary Services ("OEVS"). She is facing a Citation issued April 8, 2025, alleging failure to respond to correspondence, and failure to cooperate with the investigation of a complaint (the "Complaint") pertaining to the Respondent's care of an

injured horse (the "Horse") in 2021. The College[1] alleges the investigation remains outstanding due to the Respondent's failure to cooperate and provide information pertaining to the care of the Horse.

[2] While the College is not required to prove that the underlying complaint has merit in order to establish a failure to cooperate, there are some issues arising in this matter in relation to the extent to which the Respondent reasonably believed that certain materials she had provided to CVBC personnel addressed the questions raised by the CVBC Inspector in relation to the Complaint. Those materials included a copy of a decision by the BC Civil Resolution Tribunal ("CRT") which resolved the question of negligence in relation to the Respondent's care of the Horse in the Respondent's favour.

[3] Paragraph 2.a. of the Citation alleges 8 occasions through 2023 and 2024 on which the Respondent failed to respond within specified time parameters to written correspondence from CVBC personnel pertaining to the investigation of the Complaint. Paragraph 2.b., a single allegation of failure to provide requested clarification, has been withdrawn. Paragraph 2.c. is a collective allegation of failure to provide information sought by CVBC personnel in a series of 11 questions posed in a letter dated April 2, 2024 (the "Inspector's Letter").

[4] Paragraph 3 of the Citation alleges that these breaches constitute professional misconduct (contrary to Section 61(1)(b)(iv) of the *Act*); and breaches of Section 52(3) of the *Act*, Sections 207(1) and (3) of the CVBC *Bylaws*, and the CVBC *Professional Standard: Registrant Cooperation during Investigations and Accreditations ("Cooperation Standard")*.

[5] The Panel finds that the Respondent failed to respond to correspondence from the CVBC on numerous occasions and failed to provide the information sought in the Inspector's Letter and follow-up correspondence. The Panel finds that this conduct constitutes breaches of the CVBC *Bylaws* and *Professional Standards*, and professional misconduct. These are the reasons for the Panel's decision.

[6] The *Veterinarians Act* has privacy requirements precluding the publication of witnesses' names other than those who appear publicly in an official capacity, or the Respondent. Accordingly, several individuals and the Horse are referred to generically in this Decision.

[7] The Panel gives notice to the Respondent, pursuant to Section 61(6)(b)(ii) of the *Act* of her right to appeal this decision to the Supreme Court of British Columbia under

[1] The College of Veterinarians of BC will be referred to as the "CVBC" when acting in its neutral capacity as regulator and the "College" when acting in its capacity as a party to the discipline proceeding.

section 64 of the Act. The Panel also directs the College Registrar to publish this decision as required under section 68(1)(a) of the Act.

2. Legislative Context

[8] The following are the applicable provisions of the *Act*, *Bylaws* and *Standards*:

a. Act

Section 52(3)

Investigations
(3) A registrant must cooperate with an investigation, including providing information or records requested by the investigation committee.

Section 61

Action by discipline committee
61 (1) On completion of a discipline hearing, the discipline committee may by order

(a) dismiss the matter, or
(b) make one or more of the following determinations:
(i) the respondent has not complied with this Act, a regulation or a bylaw;
(ii) the respondent has not complied with a standard, limit or condition imposed under this Act;
…
(iv)the respondent has committed professional misconduct or conduct unbecoming a registrant…

b. Bylaws

Section 207

Duty to the college
207(1) A registrant must at all times conduct him or herself in a manner that demonstrates understanding of, respect for and a readiness to be bound by the Act, the regulations and the bylaws.
…
(3)A registrant must respond promptly and appropriately to any communication from the college where a response is requested.

c. Standards

Professional Standard: Registrant Cooperation during Investigations and Accreditations

This Professional Standard sets out the expectations for registrants who are under investigation or inspection:

1. A reply within the time parameters sought in written correspondence with the CVBC, either with a substantive reply or with a request for an extension supported by the reason for the request.

The basis and authority for this Professional Standard is contained in the following statutory and Bylaw provisions:

- *Veterinarians Act* sections 3, 49, 52, 56
- Bylaw section 207 (Part 4)

3. Evidence

a. College

[9] The College's case consisted of an affidavit sworn by the Senior Paralegal of the CVBC, Darcie Light[2], outlining the relevant correspondence contained in the original complaint file. That correspondence spans a period of 16 months and is summarized here.

i. Investigation

[10] The CVBC received the Complaint on March 12, 2023[3], almost two years after the death of the Horse on May 3, 2021. The Respondent had treated the Horse after an injury arising from an impact with a gate on April 23, 2021. In the Complaint, the owners expressed concerns that the Respondent: 1) used honey to treat the wound instead of Biozide ointment; 2) refused to explore the possibility of a nail from the gate being embedded in the wound even after admittedly finding one in it a few days later; and 3) curtailed her care for the Horse too early, after prematurely concluding that the wound was healing.

[11] The Complaint referenced a Small Claims Court action that the Respondent had filed with the Civil Resolution Tribunal ("CRT") to enforce payment of her invoice for the care of the Horse. The Horse owners, a husband and wife, both signed the Complaint, but the Respondent invoiced the husband, and he was the named defendant in the CRT action. References in this Decision to the "Complainant" will therefore generally refer to the husband but may in some cases include both owners.

[12] On May 3, 2023, CVBC legal counsel sent a letter to the Respondent (the "Investigation Letter") by email enclosing the Complaint and requesting copies of medical records, consent forms, estimates, invoices, and the names of those who made entries in the medical record for the Horse. The letter listed four issues arising from the Complaint, and enclosed a Complaint and Investigation Information Sheet (the

[2] Exhibit 3 on the Discipline Hearing ("Light Affidavit")
[3] Exhibit "B" of Light Affidavit

"Information Sheet") and a document checklist. The Respondent was asked to provide her records and response by May 24, 2023.

[13] The Information Sheet included the following paragraphs:

> **What to do if you get a complaint**
> **…**
> Respond. It is your professional obligation and a requirement of the Veterinarians Act and the CVBC Bylaws to respond promptly and respectfully to the CVBC about the complaint...
> …
> **Frequently Asked Questions**
> **…**
> **If I sign a settlement agreement with a client, does that settle/cancel the complaint the client has filed with CVBC too?**
> No. The civil and regulatory processes are separate, and there is no ability for a registrant to "settle a complaint" with the complainant…

[14] The Investigation Letter stated that the Intake Panel of the Investigation Committee had "identified the following four issues requiring [the Respondent's] detailed response":

> 1. You allegedly treated [the Horse's] wound with organic honey, rather than Biozide ointment, and continued this treatment after finding a nail within the wound. This issue raises potential concerns regarding your patient care (pursuant, but not limited to section 204 of Part 4 of the CVBC Bylaws).
>
> 2. You allegedly refused to perform an ultrasound or X-ray to determine if two missing nails may be inside the wound and potentially causing infection, although the complainants had urged/requested you to do so. This issue raises potential concerns regarding your patient care with respect to assessment and diagnosis and informed consent (pursuant, but not limited to sections 204 and 211 of Part 4 of the CVBC Bylaws).
>
> 3. You allegedly laughed and said "my bad" when you located a 4-inch nail within the wound approximately 7 days after the initial injury and after allegedly mocking the complainants about their concern of nails being left inside the wound. This issue raises potential concerns regarding your patient care with respect to assessment and diagnosis and informed consent (pursuant, but not limited to sections 205 and 209 of Part 4 of the CVBC Bylaws).

> 4. You allegedly declared that [the Horse's] wound was healing nicely and that your services were no longer required. However, [the Horse] began hemorrhaging and died just days later, and upon examination of the wound, it was found that there was a large open cavity in which there had been no healing. This issue raises potential concerns regarding your patient care (pursuant, but not limited to section 204 of Part 4 of the CVBC Bylaws).

[15] The above list of issues was followed by this passage:

> Your records and response to the allegations are important to address the above complaint, report back to the Investigation Committee, and ultimately report to the complainant.

[16] On May 31, 2023, a CVBC paralegal sent an email to the Respondent following up on the Investigation Letter, indicating that no response had been received, and seeking a response by June 14, 2023. This email included copies of the Investigation Letter and attachments.

[17] On July 6, 2023, the Respondent responded to the paralegal by email, stating, "My apologies I am only reading this now and seeing the deadline. May I submit my records still?" The paralegal wrote back, "Yes, please submit your records and provide your response at your earliest convenience."

[18] The Respondent provided the medical record for the Horse in an email on July 18, 2023, and indicated in the email that she would be sending copies of "daily videos from this case." She said she would try to upload them "in a couple of days." The medical record includes the body of a statement from the owner to the Respondent outlining the Complainant's belief that the Horse died because a nail was lodged in the wound, and the Respondent had refused to perform an x-ray and failed to use ultrasound to inspect the wound.

[19] The medical records contain an entry dated July 18, 2023, entitled, "Comment,"[4] which reads as follows:

> Comment
>
> On the night of May 2, 2021 [the Horse] had a fatal [hemorrhage] episode.
>
> [Name] found her staggering and bleeding, then collapsed and died. [Name] ("the Associate Veterinarian") was called to examine the horse. She is the sister in law of …[the Complainant] and at the time an employee of OKEVS (Okanagan Equine Veterinary Services)...

[4] Exhibit "E" of Light Affidavit, "Page 1 of 15"

> She examined the horse and reported to Dr. Posnikoff the following day of the death and findings. Her findings were severe hemorrhage and muscle deficients around the femur of the left hind leg. Death was from severe hemorrhage. Report was given orally. No medical record recorded by [the Associate Veterinarian].
>
> Dr. Posnikoff asked [the Associate Veterinarian] if anything could have been done differently and she replied no. She also said that the owner, her brother in law, was informed of this.
>
> It is of Dr. Posnikoff's opinion that [the Horse] was healing but that her late term pregnancy released the hormone relaxin in preparedness for foaling. It may also have been that foaling may have started at the time of her death and too much soft tissue compromise of the left hind leg in combination with the hormone relaxin caused a catastrophic tearing of one of the large blood vessels of the left hind leg as she attempted to lay down.
>
> [The Complainant] has filed a complaint with the College of Veterinarians of BC claiming negligence of Dr. Posnikoff. He has also filed a counter suit with the BC tribunal to OKEVS small claims lawsuit for non payment of his account for services rendered for [the Horse].
>
> Of note is the conflict of interest for [the Associate Veterinarian] who is not only sister in law to [the Complainant] but who has also filed a lawsuit against OKEVS and Janice Posnikoff DVM.

[20] The paralegal provided a return email with links for uploading the videos and asking if the Comment was the Respondent's response to the May 3, 2023 letter or part of the record. The Respondent responded that it was her recounting of the incident and was "formally part of the medical record."

[21] On August 2, 2023, the paralegal sent an email to the Respondent attaching a letter from CVBC Legal Counsel, again including copies of the Investigation Letter and attachments, acknowledging the medical records, and stating, "you… have not provided a response to the issues identified in our letter…" The author requested a response by August 16, 2023, and reminded the Respondent of her obligations under the relevant legislative provisions and the potential consequences of failing to respond.

[22] On October 15, 2023, the Respondent sent an email to the paralegal[5], which she described as her response to the Complaint. It contained links to download videos and documents, including one described as "Complaint response", and another described as "CRT claim response to evidence." The latter was accompanied by a note that read, "The following PDF is my response to evidence in the CRT claim… I feel it answers many of the College's questions."

[5] Exhibit H to Light Affidavit

[23] The paralegal sent a return email on October 16, 2023[6], advising that the links the Respondent had provided would not work for the College, and providing the CVBC link for uploading documents and videos.

[24] On October 23, 2023, the Respondent sent an email indicating that she had attempted an upload, but it looked like "the videos would not load;" that nine files had not uploaded; and that she would try again later but would "need to sort through what did load and did not."[7] The Respondent did not follow up to ensure that all of the videos she intended to send were in fact received by the CVBC. It also does not appear that the documents the CVBC did receive were acknowledged by CVBC personnel.

[25] A SharePoint link provided by College Counsel during the Respondent's testimony, entitled, "2023-10-23 Documents uploaded by Reg,[8]" contained a document entitled, "Complaint response", which addressed the four questions posed in the Investigation Letter; another document entitled, "…CRT argument September 19, 2023;" and a third entitled, "…CRT claim response to evidence." The SharePoint directory also contained some images and videos.

ii. Inspector's Letter

[26] There was no further communication between the parties about the Complaint until April 2, 2024, when a College Inspector sent a letter to the Respondent by email (the "Inspector's Letter").[9] The Inspector apologized for the delay, which she said was "due to a backlog at the College that arose with staff changes during the COVID pandemic."

[27] The Inspector indicated that she had "reviewed the complaint, the medical records, and the Respondent's response to the allegations set forth" in the Investigation Letter. She enclosed photographs and an opinion letter about the Complaint dated June 27, 2023 (the "Opinion Letter"), written by the Associate Veterinarian. The file reflects that the Complainant provided the Opinion Letter to the paralegal on July 14, 2023.

[28] The Inspector's Letter posed the following additional 11 questions for the Respondent to answer, with a requested response date of April 16, 2024:

1. Please review the attached photos and a letter written by [the Associate Veterinarian]. Both were provided to the College by [the Complainant]. Kindly let me know if you have any comments or additional information to provide in response to these attachments.

[6] Exhibit "I" of Light Affidavit
[7] Supra
[8] Exhibit 4 on Discipline Hearing
[9] Exhibit "J" of Light Affidavit

2. Please explain the purpose of administering altrenogest to [the Horse] on April 23, 2021.
3. At any time were you concerned that [the Horse] may have a fracture? Please explain your thoughts on that.
4. You mentioned that [Name] was involved in [the Horse's] care. Kindly provide her contact phone number and/or email address so that I may speak with her about this incident.
5. You have commented on the use of honey to treat [the Horse's] wound. To support this, please provide a couple of peer reviewed evidence-based articles regarding the use of raw unpasteurized honey in the treatment of equine wounds of this nature.
6. Please explain whether at any time you considered performing radiographs or an ultrasound of [the Horse's] wound and surrounding area.
7. Please provide further explanation as to why radiographs or an ultrasound of [the Horse's] wound and surrounding area were not done.
8. Please explain any limitations you have with respect to your expertise, or other circumstances that could prevent you from performing radiographs and/or an ultrasound of this region of the leg.
9. On April 28, 2021, you noted:

   "Muscle laceration further explored by digital palpation, laceration found to extend medial cranial and caudal. Cranial tract approximately 10cm wide and extends all the way to the femur where a large dead space pocket of fluid approx 10cmX10cm cranial and medial to femur could be detected. No apparent fractures of femur. Second muscle tract extending from laceration and extending adjacent to skin and caudal dorsal approx 10cm wide and 15cm long."

   With these findings did you consider further surgery, imaging, or a referral of [the Horse] for further care of this wound site? Why or why not?
10. Is it possible to effectively bandage a wound in this location?
11. Please comment on this statement in [the Complaint]:

    "[On April 23, 2021] Both vets agreed that the wound although looked significant, was superficial, in that it was no where near the femoral artery."

[29] The Inspector sent a follow-up email on May 21, 2024[10], extending the response deadline to May 31, advising the Respondent that she need not provide a response to the 4th question, and reminding her of her obligations to cooperate with the investigation. The May 21 letter reflects that the Inspector spoke with the Respondent

[10] Exhibit "K" to Light Affidavit

by telephone on April 26, 2024, when the Respondent advised that she was very busy with foaling season.

[30] On June 24, 2024, CVBC Legal Counsel sent a letter to the Respondent by email through a legal assistant and by regular mail[11], in similar terms to the letter from Legal Counsel sent on August 2, 2023, reminding the Respondent of her duty to cooperate, advising of the potential for consequences including a Citation, and requesting a response by July 8, 2024. This letter included copies of the Inspector's letters of April 2 and May 21, 2024. The Respondent acknowledged receipt on the same day in an email which read simply, "Thank you."[12]

[31] On July 15, 2024, CVBC Legal Counsel sent a letter to the Respondent by registered mail and by email[13] reiterating the request for a "detailed response" to the 11 questions posed by the Inspector (which were reproduced in the July 15 letter and dubbed "Requested Information"), summarizing the record of communication and deadlines for responses from the Respondent since the Inspector's Letter, reiterating the duty to cooperate, and indicating that the matter would be referred to the Investigation Committee if the Respondent did not provide the Requested Information by July 29, 2024. The summary of communications indicated that in the April 26 phone call, the Inspector gave the Respondent an extension to mid-May.

[32] The Respondent acknowledged the July 15, 2024 letter from Legal Counsel in an email the same day[14], confirming she had read it. She requested "more time," being on her own after an associate had left the practice. At that time, the Respondent forwarded a copy of the January 4, 2024 Decision of the CRT (the "CRT Decision")[15] allowing her claim against the Complainant for payment of her invoice and dismissing the Complainant's counterclaim for negligence in the death of the Horse.

[33] On July 17, 2024, a paralegal sent a letter from Legal Counsel by email,[16] in response to the Respondent's July 15 request for more time, extending the deadline for response to August 5, 2024. The Legal Counsel observed that over three months had passed since the questions were posed in the Inspector's Letter, and that the Respondent had not responded to the Investigation Letter until over five months after the initial request for a response.

[11] Exhibit "L" to Light Affidavit
[12] Exhibit "M" to Light Affidavit
[13] Exhibit "N" to Light Affidavit
[14] Exhibit "Q" of Light Affidavit
[15] Exhibit "R" of Light Affidavit
[16] Exhibit "S" of Light Affidavit

[34] On August 14, 2024, the Inspector spoke with the Respondent by telephone (the "Telephone Conversation") and made notes of the conversation. Those notes are as follows.[17]

> **Telephone call to Dr. Posnikoff on August 14, 2024:** Dr. Posnikoff said she had sent the College the findings of the court proceeding on this case as she felt the answers to many of the questions were in there. [The Inspector] advised her that unfortunately she needs to provide the answers again. Dr. Posnikoff explained she is incredibly overwhelmed with work and does not know when she can reply. [The Inspector] suggested she respond in a telephone conversation but she declined due to a previous poor outcome with that route. She will ask her staff to block off some time for her to reply. She would like the College to send a link for videos that she has not yet been able to upload. The horse's pocket was on the other side of the femur which is why she didn't ultrasound and she has video with her hand in it. There is also a video of how much she was bleeding on the first day, she did not ultrasound that day as she was trying to save the horse's life. [The Inspector] explained that we need her to write from her side on the issues. [The Inspector] explained there would be a Failure-to-Respond issue added if she didn't respond. Dr. Posnikoff said she did respond asking for more time. [The Inspector] advised her that there had been a response and the deadline had been extended to Aug 5, 2024 but we still did not receive a reply. Dr. Posnikoff said she did not see that email she would like it resent. She works 7 am to 9 pm on the good days and even longer on the others. Dr. Posnikoff complained that it took about a year for the College to contact her then a response was requested almost immediately. [The Inspector] reminded her that the letter was sent on April 2, 2024 and it is now Aug 14, 2024. Dr. Posnikoff explained it was breeding season. She did not commit over the phone when she will reply as she needs to check with her staff, in addition to her busy practice, she is dealing with another CVBC matter as well as updating her Accreditation. [The Inspector] asked again about a telephone Interview wherein she would send the transcript to Dr. Posnikoff for her clarifications. Dr. Posnikoff did not have a good experience in the past with that so declined. [The Inspector] explained that we need a response this week telling us when she is going to reply. Dr. Posnikoff mentioned that there are too few equine vets and she is so overworked she may have to leave the profession.

[35] The Inspector sent the Respondent an email on August 16, 2024[18] attaching her notes of the Telephone Conversation and asking the Respondent to confirm them by August 23. The paralegal sent the Respondent another copy of her letter of July 17 (extending the deadline to August 5) on August 19.[19]

[17] Exhibit "T" of Light Affidavit
[18] Exhibit "T" of Light Affidavit
[19] Exhibit "U" of Light Affidavit

[36] The Respondent replied to the paralegal on August 25, 2024[20] asking for new links to the photographs included with the Opinion Letter. The Inspector sent an email to the Respondent on August 27, 2024[21], attaching a copy of the Inspector's Letter, instructing how to access the photographs, and confirming that the Respondent no longer needed to respond to question #4.

[37] On September 12, 2024, Legal Counsel sent a letter to the Respondent by registered mail and email, enclosing the Inspector's Letter, reiterating the Respondent's duty to cooperate, and again requesting the information. This letter erroneously specified "August 30, 2024" for a response.[22] That date was corrected by a replacement letter sent on September 13, requesting a response by September 26, 2024.[23] It appears from the materials that the corrected letter was sent by registered mail and received at OEVS by a named person, not the Respondent, on September 23, 2024.[24]

[38] No further correspondence is included in the materials, and Ms. Light confirms in the Affidavit that the College received no communication from the Respondent after August 25, 2025.

[39] The Investigation Committee authorized the Citation on November 7, 2024.[25] It was issued on April 8, 2025, and served on the Respondent on April 15, 2025, along with a Citation on another matter.[26] The Citation on this matter set the discipline hearing date for July 10, 2025, the date on which it proceeded.

b. Respondent

[40] The Respondent elected to proceed without counsel on the hearing date specified in the Citation, and declined an adjournment to obtain counsel. In a preface to her testimony, she stated that she had responded to emails, provided a lot of documents, and tried to explain to the College personnel that their requests were onerous in light of her practice obligations. She hoped to demonstrate at the hearing that she had responded "within reason", that the documentation she had provided included answers to the questions that had been posed to her, and that her conduct did not amount to willful non-compliance or a lack of professionalism.

[41] The Respondent also took the position that the College should exercise its discretion in a case of this nature by extending more sensitivity to registrants, making the point that the inquiries came during foaling season, at a time when the workload

[20] Exhibit "V" of Light Affidavit
[21] Exhibit "W" of Light Affidavit
[22] Exhibit "X" of Light Affidavit
[23] Exhibit "AA" of Light Affidavit
[24] Exhibits "Y" and "Z" of Light Affidavit
[25] Exhibit "A" to Light Affidavit
[26] Exhibit 2 on the Discipline Hearing

was relentless, instead of when the complaint first arose, and that to place expectations on registrants to respond with short deadlines threatened their mental health. She submitted that the College's use of its resources by retaining counsel and a panel for the purpose of pursuing a complaint of this nature was unfair to a practitioner such as herself and did not serve the interests of the public, which should include enhancing and supporting the health of registrants. The Respondent argued that an investigation of the nature involved in this matter created unreasonable pressure by taking a registrant away from work and subjecting them to unfair or unbalanced consequences such as claims on their insurance, legal costs, and potential penalties.

[42] In her testimony, the Respondent admitted that the Horse died in her care, a potential result about which she had warned the owners. She noted that the Complainant was a relative of the Associate Veterinarian, from whom the Respondent had purchased OEVS a month before the incident, and suggested that it was a conflict for the Associate Veterinarian to provide the Opinion Letter.

[43] The Respondent described the Horse's wound as a "severe hind leg injury." The Respondent provided care over a period of about ten days, and the Horse, a pregnant mare, appeared to become stable and seemed to be healing. The Respondent made extensive records, took bloodwork, provided treatments, and took video and photographs of the Horse's progress. The fact that the Horse was about to foal caused the Respondent concern that if it laid down it would be at risk of further damage, and that is what she believed in fact happened, that the Horse had torn her femoral artery when she lay down to foal. She described the death of the Horse and her foal as "very severe and heartbreaking."

[44] The Respondent noted that the Complaint was filed after she had sued the owner in Small Claims Court for payment of her invoice. She observed that the CRT process was completed within a few months, in contrast to the pace of the CVBC proceedings. She believed the CRT Decision should be enough of a response to the College's inquiries, along with the medical records she provided. She noted that there was "quite a bit of correspondence" and that it was "quite a shock" to her that it had come to a discipline hearing.

[45] The last thing the Respondent recalled receiving from the Inspector was a request that she resubmit a video that did not upload properly, which would have shown the Horse's leg so swollen that she could barely walk. The Respondent noted that she had looked in the wound for a foreign object, although the Complainant believed she had missed it and that she did not listen to him or heed his requests. She acknowledged that she was busy and may not have sent the video again before she was served with the Citation.

[46] The Respondent observed that despite being served, she had not been aware that this Citation was proceeding against her, because she received two citations at the same time, and did not realize this was a separate matter. She did not discover that until she attended a prehearing conference in June 2025. She perceived that she was being singled out and pressured by the College.

[47] Dr. Posnikoff described the Light Affidavit as “cherry picking” by including the correspondence that she did not respond to and not including the responses that she had provided. She questioned why the College would move forward with a legal proceeding when she had in fact produced some items and responses, and the matter was still in the “back and forth,” of “normal life.” She received a “lot” of emails and deadlines from the College and questioned whether they had met the onus of proving she was not cooperating and that the expectations on her as a registrant were not unreasonable. She expressed concern that standards with expectations as high as these might cause people not to come into the profession any longer.

[48] The Respondent pointed out that she did not hear from the College until two years after the incident, and then they gave her two weeks to respond. She noted other delays on the part of the College during the investigation, and that the date set for hearing the Citation was then only a few weeks after she was served with the two citations.

[49] In cross-examination by College Counsel, the Respondent acknowledged that there were emails she did not respond to, but said she felt that she worked with the Inspector and provided information that seemed to satisfy her. She acknowledged she had received the Inspector’s Letter posing 11 questions and seeking a response by April 16, 2024, but she was not sure when she had opened and read it. In some cases, she did not open emails from the CVBC until after the deadline. She said she gets a lot of emails in a day and at the relevant time she may have had 15,000 unopened emails and that sometimes it was days before she could look at them. She was not sure if she had even opened the April 2 one.

[50] The Respondent also noted that when she received correspondence like this from the CVBC, it often triggered emotion, and sometimes she would cry when she saw them. In this situation she had worked hard, and the owners refused to pay her, and then came after her in a counterclaim. She described the Complainant as a “big fish”. She was triggered by the Complaint and needed to muster the courage and time to open this kind of email.

[51] The Respondent acknowledged that she had an obligation to respond promptly to requests from the CVBC, which was why she does open their emails, but she lost track of time, working as a veterinarian sometimes 24/7 and prioritizing patient care as a

core value. She did her utmost in practice, sometimes showing up at 2 a.m. and needing to sleep or take a break after that, instead of opening emails on the timeline the CVBC sets out. The response expectations contributed to “massive stress,” but she opens emails as best she can. She suggested expectations should be tailored to the nature of the practice and that an equine veterinarian who responds to emergency calls frequently and promptly may not be capable of providing as prompt a response to CVBC correspondence.

[52] In relation to the Inspector’s Letter the Respondent believed that her correspondence included responses to all the questions, not necessarily within the requested time frame, but she did respond to the questions. She said she spent a whole weekend reviewing the Opinion Letter and the photos and sent a response in September. She observed that the Inspector’s Letter arrived in her heaviest season, and she had heard nothing in the fall when she was less busy.

[53] The Respondent believed she had provided an extensive written response to the Opinion Letter, and the College had not looked hard enough to find it. She believed it was in one of the emails and was included in the CRT materials. She produced the link showing she had uploaded items through the SharePoint file. The link was marked as an exhibit, and provides access to the filed documents. The Respondent pointed out that the documents available through the SharePoint link included her response and had not been provided by the College at the hearing or in the Light Affidavit. She felt like she had provided “a lot of data,” and she was surprised that more was being requested.

[54] The Respondent noted that the CVBC had asked her to respond at her “earliest convenience” in its email of July 7, 2023, after she initially acknowledged the Investigation Letter, and that she had fully complied with the Investigation Letter as of October 2023.

[55] The Respondent acknowledged that the CVBC sent the Inspector’s Letter after that, seeking responses to the 11 further questions. She did not know when she opened that, nor whether she responded to it by the requested deadline. She was very busy at that time with equine emergencies and repeated that she had a backlog of 15,000 unopened emails by December 2024.

[56] The Respondent acknowledged that the Inspector had called her in August 2024 to advise her they were still looking for responses despite having received the CRT materials. She did not remember if she replied to the request for confirmation of the Inspector’s notes of the call. She did not remember opening or seeing the College’s registered letter sent September 13, 2024.

[57] The Respondent said that foaling season varies yearly, beginning roughly in April but sometimes in February or March and lasting until about July, although she had one in September last year, and a mare had stayed at the clinic from September to February before giving birth.

[58] College Counsel pointed out that when she asked on August 25, 2024 for the link for photos to be re-sent, the Respondent demonstrated she understood there were still some questions outstanding. She said she could not remember what her mindset was at that point, but agreed her email stated, “to review and answer the questions.”

c. Civil Resolution Tribunal

[59] The January 4, 2024 decision of the CRT (the “CRT Decision”) is included in the materials filed by the College.[27] The salient features of the CRT Decision and related materials are summarized in this Part. Its potential relevance is discussed in Part 5.

[60] The adjudicator on the CRT viewed the Opinion Letter with caution because of the Associate Veterinarian’s relationship with the Complainant and the fact that she was a “disgruntled ex-employee” of the clinic the Respondent had purchased from her. The adjudicator specifically did not rely on hearsay statements by the Associate Veterinarian about the Horse’s care or remarks by the Respondent that the Complainant reported to her. The adjudicator also noted that the Associate Veterinarian did not review the Respondent’s clinical records.[28] The adjudicator accepted the Associate Veterinarian’s evidence that the apparent cause of death was a burst femoral artery, and observed that no one present had thought to examine the wound to ascertain whether an object had been left in it.

[61] The adjudicator went on to find that the Complainant had not proven negligence on Dr. Posnikoff’s part, specifically addressing the question of whether she should have done an ultrasound or x-rays, and finding that she was not negligent, in that she had not missed the pocket around the femur and was treating it. The adjudicator found that the Opinion Letter did not address how a foreign object would have contributed to erosion of the femoral artery or that a foreign object was the only reason for the wound not healing, nor how an ultrasound would have helped. The adjudicator accepted the Respondent’s submission that a foreign object would not likely be seen on a radiograph due to inflammation, and that an ultrasound would not have been able to image far enough into the wound, and specifically found that it was not proven that the failure to perform either of those tests fell short of the standard of care.

[27] Light Affidavit, Exhibit R
[28] The Panel observes that the Respondent’s medical records indicate that the Associate Veterinarian also did not make notes in the Horse’s file pertaining to her attendance on the date of the Horse’s death.

4. Submissions

a. College

[62] The College submits that the duty to cooperate with an investigation under Section 52(3) is mandatory. It relies on a finding of another CVBC panel that, "the duty to cooperate constitutes a broad obligation which must be interpreted liberally and in a manner that is consistent with the obligation of the College to protect the public".[29]

[63] The College also submits that the Panel has a wide discretion to determine the proper interpretation of the applicable *Bylaws*, Section 207(1) and (3), in assessing what constitutes breaches of them.[30] The College points out the following passages in the *Cooperation Standard*:

> 1. A reply within the time parameters sought in written correspondence with the CVBC, either with a substantive reply or with a request for an extension supported by the reason for the request.
>
> Cooperation between the College and registrants will minimize the time it takes to investigate the complaint and consequently lower the costs for both the registrant in question and the entire profession....
>
> As a self-regulated profession, we must continually earn the trust of the public whom we serve. Having a robust complaint process, with clear expectations for cooperation, serves to build trust in the profession of veterinary medicine.

[64] The College submits that prior panels have held that non-compliance with published CVBC *Standards* can be a breach of Section 61(1)(b)(ii) of the *Act*.[31] The College also relies on the definition of professional misconduct adopted in *Chaudhry*[32], of a "marked departure" from the standard expected of a competent registrant.

[65] College Counsel points out that a finding in this case may set a standard in relation to registrants' obligations to respond to the CVBC and determine where the line should be drawn in finding that a registrant's behaviour falls below acceptable professional standards.

[66] In reliance on disciplinary cases in other professional regulatory spheres, the College submits that the duty to cooperate relates to the ability of the regulator to

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[29] *CVBC v. Bajwa*, CVBC File No. 23-012 (March 20, 2025) ("Bajwa #1") at para. 61
[30] *Salway v. Association of Professional Engineers and Geoscientists of British Columbia*, 2010 BCCA 94 at para. 32
[31] *CVBC v. Chaudhry*, CVBC File 20-105(b) (August 28, 2024) at paras. 15-23
[32] Supra

discharge their public interest duties, and that the Panel's view of the merits of the investigation is not relevant to the registrant's obligation to respond to requests.[33] It is not necessary for the College to prove a clear refusal or bad faith on the part of the registrant. The issue is whether the registrant acted responsibly and in good faith to respond promptly and completely to investigative inquiries.[34]

[67] As put by a panel of the CVBC Discipline Committee in the case of *Kataria*, the College submits, "the duty to cooperate sets out a clear requirement upon registrants to promptly respond to [C]ollege correspondence and to provide appropriate information" and "[i]t is not an option for a registrant of the College to remain silent or to simply deny the validity of the complaint."[35]

[68] In addition, the College cites authorities for the following propositions: A registrant is not entitled to question or challenge the requests, provide partial responses, or demand an alternative means of inquiry. Inadequate responses, inadvertence, suggestions that the registrant was waiting for more information from the regulator, busyness or health challenges may not afford justifications for prolonged failures to cooperate.[36]

[69] The College points out that in this case, it took 76 days for the Respondent to produce the medical records, which occurred only after the College followed up, and 166 days for her to respond to Investigation Letter, only after two follow-ups. It says that requested responses sought in the Inspector's Letter were never provided despite four written follow-ups. There is no suggestion the Respondent did not receive the correspondence, much of which she admitted, and it does not assist her to say she was too busy or confused to open it. The fact that she may have provided some responses during the relevant time frame does not preclude a finding of non-cooperation if on the whole she was responsible for significant delay,[37] and in any event, there are questions here to which the Respondent provided no response. On the whole, the College says, there were 8 letters from the College that received no response from the Respondent.

[70] The College submits that the Respondent's repeated lack of response and delay constitute breaches of the *Cooperation Standard* and *Bylaw* Section 207, and amount to professional misconduct.

[71] With respect to the relevance of the CRT Decision, the College says it is for the Investigation Committee to determine what information it needs, and the Panel may not

[33] *James v. Real Estate Council of Alberta*, 2004 ABQB 860 at para. 37
[34] *Law Society of Ontario v. Diamond*, 2021 ONCA 255 at para. 61
[35] *The College of Veterinarians of British Columbia re: Dr. Hardeep Kataria*, CVBC File No. 20-064 (May 13, 2025) ("Kataria") at paras. 66 and 77
[36] *College of Massage Therapists of British Columbia v. Gill* (May 13, 2019); *College of Registered Nurses of British Columbia v. Cunningham* (February 6, 2017); *Wise v. LSUC*, 2010 ONSC 1937 at para. 19; *Bajwa #1* at paras. 80 and 101
[37] *Kataria* and *CVBC v. Bajwa*, CVBC File No. 19-084 (April 16, 2025) ("Bajwa No. 2")

look behind the CVBC's decision to continue to seek responses after receiving the CRT materials, nor behind the Investigation Committee's issuance of the Citation. In terms of the subject matter, College Counsel says while the CRT Decision addresses the issue of civil liability premised on negligence, part of the finding was due to insufficient evidence. In addition, this is a separate process, with different standards than negligence in play, and the CVBC has an obligation to investigate the issues further and look in more depth at the medical evidence.

b. Respondent

[72] The Respondent based her closing submission on aspects of fairness, pointing out that the College provided a 19-page closing argument with 118 paragraphs, and that it was the choice of the College to take this matter to this level. She said she had not refused but had pled over and over that there were circumstances affecting her ability to respond and she had done so to the best of her ability. In relation to the College's focus on the 11 questions not being answered the Respondent questioned whether it was in the public interest to focus in such detail, or it would be better to assess the overall level of responsiveness in the context of matters affecting the Respondent's ability to respond.

[73] The Respondent said she had been responding to the best of her ability, had no desire to be unprofessional, and had showed up for an emergency, made professional records, and disclosed those fully to the CVBC. When she tried to raise matters of mental health with CVBC personnel she perceived the response to be, "no one cares if you are overworked or busy, you need to do this, in our time frame, and our way." She noted that the object of the discipline process is to protect the public, which includes registrants, and it would be counterproductive to create these kinds of "incredibly high" expectations in setting standards.

[74] In relation to the relevance of the CRT Decision, the Respondent asserts that it found that negligence was not proven. She said that for the CVBC's purposes, she had turned over everything she had and believed there was only a video left to supply. She believed the CVBC had enough in its materials to make a determination, similarly to the CRT, that she had not provided deficient care for the Horse. She observed that it was frightening to hear the College cite cases in which regulatory bodies ruled that mental health issues are not an excuse. If registrants are to be accountable despite emotional challenges, the process did not serve them. It might become impossible to find new vets, or horse vets, if there is no allowance for human beings doing their best to comply within a professional disciplinary process and if this is to become the standard.

[75] The Respondent noted the one-sided nature of the process in this matter, given that she had not obtained counsel, although she was satisfied that she had presented her side of the issue. The College had the resources to pursue a matter like this through hearing with many professionals involved, and they had the capacity to go back through the materials to ascertain whether they still needed more information. She noted that if the CVBC still wanted more information from her, beyond the video and the documents she had provided, they could have called her, persevered in their inquiries, and behaved in a more supportive fashion. Setting a standard that places the onus on the registrant without considering their practice or personal challenges is a bad precedent. She noted that she was undergoing a facilities inspection at the same time as the investigation process in this matter.

[76] In reply the College observed that the College personnel did not indicate to the Respondent that outside scheduling problems for a registrant were not relevant, and they had extended compassion by providing numerous extensions and concessions to the Respondent. Nonetheless, the College submitted, personal challenges were more relevant to sanctions than to liability in a matter of this type.

[77] In her final submission, the Respondent urged the Panel to find that the CVBC had a duty of due diligence in relation to registrants as well as to the public, and it should be mindful of the pressure it would place on the profession if it set unreasonable standards for cooperation.

5. Analysis

a. Extent of the Duty of Cooperation

[78] The numerous cases cited by the College make it clear that the duty of a registrant to cooperate with a regulator's directions in connection with an investigation is well defined and fairly strict. They place the onus on the registrant to demonstrate compliance and not to challenge the authority of the regulator to make the inquiries it deems necessary to carry out its duty to investigate misconduct. In general, personal challenges will not provide excuses for a lack of diligence in addressing directions. Registrants are expected to prioritize a regulator's inquiries over the exigencies of practice or their personal lives, at least to the extent of making a reasonable and diligent effort to respond.

[79] The duty to cooperate is not absolute and cannot reasonably extend beyond a requirement that a registrant make their best efforts to cooperate within the context of a particular case. The cases do not go as far as negating consideration of personal circumstances. The test for substantial compliance is due diligence. The cases cited by the College establish that the duty to cooperate requires that the licensee be "honest,

open, and helpful."[38] The *Diamond* case distinguished between a good faith effort to cooperate with a regulator and a "'cat and mouse game' that has no place in the relationship between licensee and regulator… [which] stands as the antithesis of good faith dealings or, put another way, of honest, open, and helpful dealings."[39]

[80] *Diamond* also made the point that a [registrant] "cannot be found to have acted in good faith to provide a complete and prompt response when the basis for their delay is their ignorance of their professional obligations or their *negligence in making the efforts they are required to make to provide the requested information promptly*.(Emphasis added.)[40]

[81] The Panel's view is that a CVBC registrant's duties to respond and cooperate require that they organize themselves so that they are reasonably responsive to CVBC communications, and that they prioritize sufficiently to permit them to put other matters aside as reasonably required. It is not only a matter of respect for the regulator's duty to the public interest, which cannot be unreasonably delayed due to a registrant's personal demands or challenges, but in aid of preserving the registrant's own conduct record, reputation, and ultimately, their livelihood.

[82] A response like the one provided here by the Respondent, that the daily demands of practice overtook her ability to provide timely responses to CVBC correspondence, simply means that the Respondent is choosing to prioritize immediate practice demands over the maintenance of her licencing privileges. This would appear to the Panel to be a short-sighted and self-defeating approach.

[83] That is not to say that there can be no inquiry into the reasonableness of the approach of the regulator, in a given case, in an effort to contextualize the registrant's level of cooperation, to determine whether it crossed a line into a breach of professional standards. The defence advanced by the Respondent here is a portmanteau of personal excuses and due diligence. In recognition of the fact that she was unrepresented at the hearing, the Panel is duty bound to go some distance toward an assessment of whether her personal situation, taken with her efforts to comply with the many requests of the College, might in combination negate misconduct, or if not, to properly characterize it on the spectrum of findings available to the Panel.

[84] The available findings are defined by the Citation, which alleges, firstly, in paragraph 2 a., a repeated failure to reply to eight separate CVBC communications, listed by date, by the specified deadlines. The second allegation, 2 c., alleges failure to

[38] *Law Society of Ontario v Diamond*, *supra*, at para 44.
[39] Supra, at para.72
[40] Supra, at para. 48.

provide the information sought in the Inspector's Letter. The Panel will proceed to consider these in turn, in light of the foregoing comments about the duty to cooperate.

b. Failure to Respond to Correspondence by the Specified Deadline

[85] The eight letters referred to in paragraph 2.a. of the Citation are those of May 3, May 31, August 2, 2023 and April 2, May 21, June 24, July 17, and September 26, 2024. It is not disputed that each of these letters had a specified deadline for response that passed without any response by the Respondent.

[86] The Respondent's reasons for overlooking this correspondence are busyness and personal stresses. She points to the volume of emails she receives, and fully acknowledges that she may have completely missed correspondence sent by email from the CVBC. She takes issue with the timing of some of the correspondence in light of the nature of her practice, and points to delays on the part of the CVBC in some phases of the investigation.

[87] Looking at this correspondence in context, the first inquiry, the Investigation Letter, sent by CVBC Legal Counsel, posed the initial four questions, centring on the use of honey to treat the wound, the lack of ultrasound or radiographs, the later discovery of a nail and a remark made by the Respondent, and the apparent absence of healing at the time when the Respondent curtailed her services. It is clear that this letter went unheeded until after the deadline contained in it of May 24, 2023. A follow-up letter of May 31 with a deadline of June 14 likewise received no response until the Respondent's July 6 acknowledgement with a request for extension. The Respondent does not dispute that she completely overlooked the first two letters sent to her by email at her business address.

[88] As noted by the Respondent, her request for more time was met with agreement and a request for a response "at your earliest convenience." The Respondent appears to suggest that this response on the part of the CVBC, taken with its apparent acquiescence in the lack of response to the two prior letters, set a flexible tone for future timelines.

[89] The Respondent sent the medical records on July 18, 2023 and the paralegal responded with the question about the nature of the Comment. The remaining correspondence in this phase of the investigation consisted of a follow-up letter by the College on August 2 with a specified deadline of August 16, which again passed without acknowledgement. Well after that, on October 15, 2023, the Respondent initiated an exchange of emails with the paralegal and then uploaded a number of documents on October 23, 2023, she followed up with an indication that some videos had not gone through and she would need to confirm what had been omitted from the upload. As

noted, the CVBC did not acknowledge the Respondent's materials that she uploaded on October 23, 2023, and no further correspondence was sent to her by the CVBC until the Inspector's Letter on April 2, 2024, setting a deadline of April 16, 2024.

[90] Setting aside the Panel's later comments regarding the delay at this stage of the investigation, this letter and the next deadline of May 31, 2024 in the Inspector's letter of May 21, 2024, again came and went without any response from the Respondent. The third letter, on June 24, 2024, garnered only a "thank you," but no further response by the deadline of July 8. It wasn't until a fourth letter on July 15, 2024 that the Respondent acknowledged the request for further information, requested more time, and sent a copy of the CRT Decision.

[91] In considering this path of correspondence from start to finish, the Respondent's serial inattention to the correspondence from the CVBC over an initial period of five months and a subsequent period of three is nothing short of remarkable, in the Panel's view. While she relies on busyness and stress as reasons for neglecting or overlooking these many letters, in the Panel's view this level of inattention cannot be excused or even explained by her being too busy or distracted due to stress.

[92] The Panel observes that it is the *duty* of a registrant under Bylaw 207(3) and the Cooperation Standard to answer correspondence from the CVBC in a timely way, and while some reasonable leeway might be extended in difficult personal circumstances for a missed deadline or two, this was a clear pattern of ongoing disregard over an extended period, without any demonstrated effort to respond within the timelines provided.

[93] Moreover, if the volume of emails or the exigencies of practice for a registrant are such that CVBC correspondence goes completely unnoticed, as the Respondent appears to be admitting, in the view of the Panel the registrant has failed to implement a responsible, or responsive, communication system; something that, in the view of the Panel, the duties created by the *Bylaw* and *Standard* require her to do. Failure to have in place a system that permits a registrant to adequately receive and respond to CVBC correspondence is simply a lack of professionalism. Similarly to the observation in *Diamond*[41], it amounts to negligence in making the efforts required to respond promptly to the regulator's inquiries.

[94] It must be the responsibility of a registrant to implement an information management system that permits them to appropriately recognize and prioritize communications from their regulator, because their very licencing and livelihood may depend upon their ability to respond. As previously observed, the neglect of important

[41] See paragraph 80 above.

communications like this is a very self-defeating and short-sighted approach to the practice of veterinarian medicine, and it is not an answer to say that equine emergencies made her too busy.

[95] Another reason that the Panel rejects the Respondent's assertion of busyness is that she apparently did respond on a few occasions, albeit very late. She ultimately elected to prioritize providing a response, and was able to do so. However, it appears she required the tenor of the communications to reach the level of threatened findings of non-compliance by Legal Counsel before she became responsive. This occurred first in the summer of 2023, and then, alarmingly, again in the spring and summer of 2024, even after she had received those warnings in the prior year's correspondence. The warnings in September 2024 then again went completely unacknowledged.

[96] The Respondent's approach appears to convey an attitude of disregard until legal action was threatened, and says more about her lack of appropriate prioritization than it does about her schedule. It is not open to a registrant to choose the timing of their responses in this fashion. The Panel also observes that the Respondent found the time to provide her materials to the CRT, presumably meeting applicable deadlines in connection with those.

[97] We have no difficulty concluding that the Respondent's failure to adhere to deadlines here was attributable to her failure to appropriately prioritize the CVBC's inquiries, apparently underscored by a lack of concern. There is no suggestion of good faith or due diligence. The ongoing pattern of disregard reflected in the Respondent's approach to CVBC correspondence was disrespectful and in the Panel's view unprofessional.

[98] In fairness to the Respondent, the Panel has gone on to consider whether the CVBC can be said in any way to have contributed to the Respondent's approach, by repeatedly extending deadlines, unnecessarily proliferating the correspondence, or setting a less than diligent pace in its pursuit of the investigation.

[99] The initial delay in the matter was due to the Complainant waiting two years to file the Complaint, and is not something that in the Panel's view would entitle the Respondent to disregard the CVBC's inquiries. There are no applicable timelines under the *Act* and there was no apparent prejudice arising from this particular delay.

[100] The Panel has also considered the delay between the Respondent's provision of materials in October 2023 and the Inspector's letter on April 2, 2024. The Respondent indicates that she believed that the matter was resolved at that point, with the exception of one or two videos that had not been uploaded. Notably, her materials were not acknowledged, and she was not asked to produce additional videos, and she had by

that point fully answered (or at least provided answers) to the four questions in the Investigation Letter.

[101] No doubt the Inspector's Letter surprised the Respondent, whenever she finally saw it. The Panel's view is that while it may indeed have been surprising, it was entirely open to the CVBC to pursue other aspects of the investigation at that point, or raise additional questions, despite the lapse in time, and it is not open to a registrant to be less attentive to correspondence because a second layer of questioning has been added to an investigation, even after a somewhat surprising delay. Similarly to the view expressed in the cited cases that a registrant may not refuse to respond because she differs with the complaint, it was not open to the Respondent to wholly and repeatedly disregard the CVBC's further communications because of any delay on their part that she may have perceived.

[102] As for the extensions of deadlines, these were a courtesy on the part of the CVBC, provided several (or many) times to the Respondent, mainly necessitated by her inattention. While the initial "at your earliest convenience" may have set a somewhat relaxed tone, the timelines were quickly tightened up in view of the lack of response. The occasional absence of a timeline in the correspondence does not justify disregard for earlier or later ones. Finally, providing extensions, as a matter of courtesy and in an effort to complete the investigation, does not in the view of the Panel foreclose the College from pursuing previous missed deadlines as breaches of the *Bylaw* or *Standard*.

[103] If there is any suggestion from the Respondent's observation about the number of communications that the volume of them somehow attenuated her ability to respond, the Panel would expect the opposite. The Respondent should have taken repeated communications and deadlines more seriously, each time, not less.

[104] The Panel's view is that this conduct constitutes a breach of 207(2) of the *Bylaws*. It is also a breach of the *Cooperation Standard* requirement to reply within specified time parameters, but the Panel is of the view that it is sufficient to find proven a single allegation of non-compliance with *Bylaw* Section 207(2), covering the eight instances outlined in paragraph 2.a. of the Citation. With respect to Section 52(3), we consider it to be more applicable to the cooperation issue and will consider it in that context.

c. Failure to Cooperate with Investigation

[105] Paragraph 2.c. of the Citation focuses on the Respondent's response to the Inspector's Letter and the subsequent attempts by the Inspector to obtain answers to the 11 questions she posed in April of 2024. Section 52(3) of the *Act* requires a

registrant to “cooperate with an investigation, including providing information or records requested by the investigation committee.” *Bylaw* Section 207(1) essentially requires a registrant to demonstrate respect for the Professional Standards contained in the applicable provisions.

[106] The *Cooperation Standard* sets out the following expectations of registrants under investigation:

> 2. Provision of information and requested records without modifying, altering or augmenting those records (except that properly dated annotations and additions are permitted where the date of the annotation, modification or addition is clear, and the originally created record is retained).
>
> 3. If requested, attendance at the CVBC for an interview at a mutually agreeable time for the purpose of addressing questions arising during the course of the investigation or accreditation.

[107] The Panel notes that the applicable provisions focus on the registrant’s obligation to provide “information and records”. A question may perhaps arise as to how far the duty extends beyond that, to answering additional layers of questions. Inquiries that go beyond a search for information to attempts to elicit admissions or obtain the registrants’ assistance in proving allegations against them may engage issues of fairness in the conduct of investigations. In this respect, the Panel notes that the *Cooperation Standard* was expressly intended to address an equivocal requirement that a registrant attend for an interview, which the *Standard* now defines as a duty. This may suggest a view that specific investigatory powers should not be inferred too broadly beyond what is provided for in the applicable provisions. While this is perhaps an interesting question for another day, the Panel is of the view that it is not one that arises in this matter, as we will explain in due course.

[108] The Respondent’s position is that she substantially answered the questions posed by the Inspector by providing the materials she uploaded in October 2023, and then the CRT decision in July 2024. Although the Respondent said in October 2023 that she would make efforts to determine what had not been uploaded, the Panel observes that it was also open to the College to confirm for her what more she needed to provide at that point, which it did not do. However, the revival of the investigation in April 2024 was not premised on the Respondent’s failure to respond to the inquiries of 2023. It was a new set of questions arising from the Inspector’s review of the file.

[109] The Panel had some concern about the extent to which that review, and the subsequent pursuit of answers to the Inspector’s questions, took account of the materials the Respondent did provide. That concern arose in part from the fact that the contents of the SharePoint directory were not included in the Light Affidavit and were

only produced by the College while the Respondent was under cross-examination, in the context of her asserting that the College had "cherry-picked" the correspondence it included.

[110] The Panel notes as well that the Respondent also asserted that she believed she had provided a further response to the Opinion Letter that had not been included in the materials, and that the College "had not looked hard enough" for that. The fact of the late production of the SharePoint files made it hard to dismiss this further assertion out of hand. Out of an abundance of fairness, the Panel went on to consider the adequacy of the information provided by the Respondent, as a whole, to address the Inspector's Letter.

[111] The CRT delivered its Decision in January 2024, and the Respondent may have believed at that point, in light of the hiatus in correspondence, that the CVBC matter was at an end because the CRT absolved her of negligence in the care of the Horse, and she had responded to the Investigation Letter.

[112] The CRT Decision did in fact dispense with some aspects of the Complaint, but it was not dispositive of the issue of professional liability or the CVBC's role as a professional regulator, and the Respondent was not entitled to point to it as a full answer. The CVBC has the task of enforcing professional standards, not assessing civil negligence. The Information Sheet the Respondent received at the outset of the investigation distinguished between investigations by the CVBC and litigation between the registrant and the client, and made it clear that the resolution of one did not resolve the other. In addition, both the Inspector's Letter and the Telephone Conversation made it clear that the CVBC did not consider the investigation resolved.

[113] Notably, as well, the Respondent did not send the CRT Decision to the CVBC until July, well after the Inspector's Letter. While the Respondent may reasonably have expected the Inspector to then consider the extent to which the CRT materials addressed the additional questions, it was not open to her to unilaterally elect to treat those materials as a full answer to those questions, particularly when the Inspector later indicated to her in the Telephone Conversation that they were not.

i. Objective Sufficiency

[114] Setting aside for the moment the issue of whether the Respondent held a genuine subjective belief that she had fully cooperated with the Inspector by the time communications ceased in August 2024, out of an abundance of fairness the Panel has gone on to review the 11 questions to consider whether there was any objective argument that they were all addressed by what the Respondent had already sent.

[115] Without going into each question in depth, there may have been some questions that the Respondent could have considered were substantially answered by the materials she had provided, notably the questions pertaining to the Opinion Letter, the ultrasound and radiographs, the use of honey, and perhaps, the reason for administering altrenogest. However, there were others that were wholly unaddressed. While the Panel might have views on the relevance or importance of some of the questions, they are not open to challenge at this stage any more than they were to the Respondent when they were asked.

[116] Notably, as well, the Respondent did not at any time provide a response identified as a "response" to the Inspector's Letter, like that she had provided to the Investigation Letter. As we have observed, the Respondent provided no direct response at all to the Inspector's Letter. She only provided a late response to the CVBC's follow-up letter(s), requesting "more time" and sending the CRT Decision. There was never a point-by-point response on the part of the Respondent, demonstrating how or where in the materials the questions were answered, or raising a challenge to any of them.

[117] While it was not an argument raised by the Respondent, the Panel also in fairness went on to consider whether a registrant might reasonably decline to respond to challenges raised by an Inspector to answers the registrant has in fact already provided; for instance by seeking peer-reviewed articles. The Panel's view however is that it was not up to the Inspector to justify the questions; the Respondent did not ask her to do so; and, had the Respondent asked her to do so, it would not have negated the Respondent's duty to respond.

[118] As mentioned earlier, there might also be a potential issue as to an Inspector's capacity to essentially require that a registrant submit to "cross-examination," by reiterating already-answered questions in an attempt to obtain admissions, inconsistent answers, or evidence supporting misconduct. Perhaps the Inspector's requests for peer-reviewed articles or comment on the Complainant's statement about the severity of the wound border on that. The Panel finds, however, that it is not necessary to decide that issue in this matter, not just because it wasn't raised, but because as we have observed there are many aspects of the Inspector's Letter that went completely unanswered, and it would not be an answer to challenge parts of it as improper cross-examination while declining to answer others.

[119] The Panel has gone further in this matter than it might in considering the merits of the Inspector's questions posed in the letter of April 3, 2024, and it does not intend by this analysis to place any onus on the CVBC to justify the questions it poses to a Respondent within the context of a particular disciplinary investigation. This situation is unique in that there had been a fairly full inquiry into some aspects of the Complaint by

a separate tribunal before the Inspector became involved in the investigation; the Respondent is unrepresented; and the Panel acknowledges that she expended considerable energy in providing materials for the CRT as well as at one point in responding to the CVBC, during the investigation. From a lay perspective, it may be that the Respondent could have believed her responses were sufficient; however, that would misperceive the nature of her obligation to cooperate.

ii. Subjective Sufficiency

[120] In any event, turning to the mindset of the Respondent, the view of the Panel is that she did not behave consistently with a belief that she had fully cooperated with the investigation. As noted, when she provided the CRT Decision, she did not indicate she intended it as her full response, stating only that it answered "many" of the questions, and requesting more time. In due course, she received at least two further extensions. One of these extensions occurred within the Telephone Conversation, in which the Respondent again conveyed her position that the CRT materials provided responses to *many* of the questions of the College. While the Respondent verbally addressed the aspect of why she did not perform ultrasound in that call, she declined to provide a recorded statement due to a prior bad experience, and the conversation ended without any commitment by the Respondent to complete her response.

[121] In fact, the Inspector told the Respondent they needed her to "write from her side on the issues" and that there would be a failure-to-respond problem, if she did not. The Respondent complained about the timeline in light of the delays she had experienced from the College's side. It was not open to her to do that. The Inspector confirmed that she would like the Respondent to commit to a response timeline "this week," which she failed to do.

[122] It was clear throughout the relevant period that the Inspector wanted the 11 questions answered despite having received the CRT materials. While it may not have been clear to the Respondent whether the Inspector had considered the extent to which those questions were addressed by what the Respondent had already sent, the Respondent did not ask her that. It is doubtful in any event that she could have raised it as a reason not to provide a further response. At best, it is something she should have addressed herself, by explaining, in her response to the Inspector's Letter, which of the questions she believed were addressed by which of the materials she had sent.

[123] After the Telephone Conversation, the Inspector sent a summary of it, asking the Respondent to confirm it. Although the Respondent had stated she was not content to proceed that way, it appears that this was simply extended as a further courtesy in an attempt to pin down some of the Respondent's answers. Again, the Respondent ignored this opportunity and provided no response at all to that letter or to the subsequent

correspondence from the CVBC reiterating the 11 questions, apart from one email on August 25, 2024 asking for the links to the photos accompanying the Opinion Letter.

[124] That email demonstrated an acknowledgement of the need for a fuller response to the Inspector's Letter, and an intention, or a professed intention, to attempt a response, as late as August 25, 2024. It was followed by a further unacknowledged request for the information. All of this conduct was inconsistent with the Respondent's assertion at the hearing that she believed she had fully responded.

[125] The Respondent's approach to the Inspector's attempts to obtain answers to her questions had more of a "cat and mouse" flavour, like that referred to in the *Diamond* case,[42] than that of a good faith, "open, honest and helpful" attempt to provide responses to the questions. The Panel does not accept that the Respondent had a genuine or good faith belief that she had cooperated with the investigation.

[126] The Panel finds that the Respondent did not sufficiently respond to the Inspector's Letter and the subsequent inquiries relating to it, as alleged in paragraph 2.c. of the Citation. This is a breach of Section 52(3) of the *Act*, and of the duty to provide information in the *Cooperation Standard.*

6. Conclusion

[127] In relation to paragraph 2.a. of the Citation, the Panel finds that the Respondent breached Section 207(2) of the Bylaws by failing to respond to the CVBC's correspondence within the investigation. In relation to paragraph 2.c. of the Citation, the Panel finds that the Respondent's failure to provide responses to the Inspector's Letter in the circumstances of this investigation amounted to a failure to cooperate with the investigation pursuant to Section 52(3) of the *Act*.

[128] In *Diamond*, the court stated that a failure to cooperate was "properly stigmatized as professional misconduct if the licensee failed to act responsibly and in good faith to promptly provide the necessary information." That statement is descriptive of the Respondent's attitude in this matter, and in the view of the Panel, the Respondent's failure to cooperate on the whole, as reflected in both paragraphs of the Citation, amounts to professional misconduct under Section 61(1)(b)(iv) of the *Act*.

[129] The Panel acknowledges the Respondent's candid admissions about the challenges she faces with her busy, demanding practice and the need for a disciplinary approach that reflects the effect of discipline proceedings on registrants. The place for these considerations is in the stage of the matter dealing with appropriate measures after the finding of misconduct. The Panel will fully consider the effect of these personal

[42] Supra

obstacles and the availability of measures to assist the Respondent to address them in the next phase of this matter.

[130] The Panel will ask the CVBC Executive Assistant to get in touch with the parties to discuss a schedule and process for submissions on appropriate measures.

Carol Baird Ellan

Carol Baird Ellan K.C.
Chair of the Panel

Al Runnells

Dr. Al Runnells

Amy Cheung

Dr. Amy Cheung