CVBC File No. 21-065(b)
Citation Authorized: June 15, 2023
Citation Issued: November 27, 2023

IN THE MATTER OF THE *VETERINARIANS ACT*, S.B.C. 2010, c. 15

and

IN THE MATTER OF

THE COLLEGE OF VETERINARIANS OF BRITISH COLUMBIA and a

hearing before a DISCIPLINE PANEL

of the COLLEGE DISCIPLINE COMMITTEE

and

DR. RAJAN SALHOTRA

Decision on a Citation

Panel:	Carol Baird Ellan K.C., Chair Dr. Amy Cheung Dr. Teresa Cook
Counsel for the Respondent	Clea Parfitt
Counsel for the College	Elizabeth Allan
Hearing Dates	May 1, 2, 29, June 6, 2024
Decision Date	November 21, 2024
Amended Decision Date	November 25, 2024

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[1] This Decision has been amended from the original to address the requirements of CVBC Bylaw 298(a) [name removed in paragraph 103]; and Sections 61(6)(b)(ii) and 68(1)(a) of the *Act.* Section 61(6)(b)(ii) directs that the Respondent be provided with notice of his right to appeal the Decision to the BC Supreme Court. This right is set out in Section 64 of the *Act* and the Panel hereby notifies the Respondent accordingly. Section 68(1)(a) requires a panel to "direct the registrar to notify the public" of the information set out in Section 68(2), arising from the Decision. The Panel hereby directs the Registrar accordingly.

A. Overview

[2] The registrant, Dr. Rajan Salhotra, is the Respondent named in a Citation issued November 7, 2023, by the College of Veterinarians of British Columbia ("CVBC" or the "College") alleging the following:

> On or about June 29, 2021, during the care and treatment of … a nine-year-old French bulldog, you breached section 61(1)(a) and/or (b) of the Act[1] by failing to sufficiently document in the medical records:
>
> a. Treatment and/or monitoring between the hours of approximately 12:00 a.m. and 5:00 a.m.; and/or
>
> b. your communication(s) with [the dog's] owner(s) regarding his death,
>
> as failing to do so was contrary to section 38 of Schedule "D" – Accreditation Standards, Section 4 – Medical Records and/or section 245(2)(b)(ii) of Part 4 of the CVBC Bylaws, section 2(b) of the CVBC Professional Practice Standard: Medical Record Keeping and/or section(s) 2(g)(ii), (v), (vii) and/or (viii) of the CVBC Professional Practice Standard: Companion Animal Medical Records.

[3] The Citation proceeded to a hearing before the Panel on the dates specified above. Following the hearing dates, counsel exchanged written submissions, the last of which were received on September 25, 2024.

[1] *Veterinarians Act*, S.B.C. 2010, c. 15

[4] For the reasons that follow, the Panel has decided that the allegations contained in the Citation have been proven.

[5] Section 298(a) of Part 5 of the CVBC Bylaws[2] states as follows:

> 298. For the purposes of section 61(6) of the Act, the discipline panel's written decision must:
>
> (a) be written in a manner that protects the privacy of third parties and is suitable for public disclosure in full;
>
> …
>
> (d) not include the names of a Complainant or any witnesses, except when they have appeared at an open hearing in an official capacity;
>
> (e) not include other possible personal identifiers or health care information of a Complainant, an animal or a third party, except where necessary to adequately explain the reasons for the decision…

[6] To comply with the above section, the animal's name has been removed from the wording of the Citation above, and the animal, the Complainant, the Respondent, and all other witnesses or persons involved will be referred to generically in these reasons.

B. Legal Framework

[7] Pursuant to by CVBC Bylaw Section 282,[3] a panel is authorized to hear a complaint contained in a citation in the place of the CVBC Discipline Committee. The Discipline Committee's mandate in relation to hearing a complaint at this stage is set out in Section 61(1) of the *Veterinarians Act*[4]:

> **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;

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[2] https://www.cvbc.ca/wp-content/uploads/2022/01/Bylaws_Part-5_Complaints-and-Discipline.pdf

[3] https://www.cvbc.ca/wp-content/uploads/2022/01/Bylaws_Part-5_Complaints-and-Discipline.pdf

[4] *Veterinarians Act*, S.B.C. 2010, c. 15 (referred to as "the *Act*"), https://www.cvbc.ca/wp-content/uploads/2020/03/Veterinarians-Act.pdf

> (ii) the respondent has not complied with a standard, limit or condition imposed under this Act;
> (iii) the respondent has not complied with a term, condition or requirement imposed under section 3 (4) (c) of the *Labour Mobility Act*;
> (iv) the respondent has committed professional misconduct or conduct unbecoming a registrant;
> (v) the respondent has incompetently practised veterinary medicine;
> (vi) the respondent suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs the respondent's ability to practise veterinary medicine.

[8] The Citation here, as set out in Part A above, alleges breaches of "section 61(1)(a)[5] and/or (b)" of the *Act*, and also specifies certain standards and bylaws that are alleged to have been breached. The College confirmed in its submissions that it is pursuing findings only under subsections 61(1)(b)(i) and (ii), and not (iii), (v) or (vi) [nor presumably (a)] of the *Act*.

[9] As noted above, Sections 61(1)(b)(i) and (ii) provide that the panel acting as the discipline committee pursuant to Bylaw Section 282 may determine if the Respondent has not complied with "[the] Act, a regulation or a bylaw," or "a standard, limit or condition imposed under [the] Act".

[10] In relation to the formation of bylaws and standards, Section 4 of the *Act* creates a Council to "govern, control or administer the affairs of the college in accordance with [the] Act, the regulations and the bylaws." The Council is empowered by Divisions 2 and 3 of the *Act* to fulfill its various duties "by bylaw". "Bylaw" is defined in Section 1 of the *Act* as "a bylaw of the college made under this Act."

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[5] Section 61(1)(a) provides that the discipline committee may "dismiss the matter," which does not appear to be a provision that can be "breached."

[11] Section 8 of the *Act* assigns the following "general" bylaw-making powers to the Council:

> 8 (1) In addition to the bylaws that must be made under sections 5 to 7, the council may make other bylaws, consistent with this Act, that the council considers necessary or advisable.
>
> (2) Without limiting subsection (1), the council may make bylaws, consistent with this Act, respecting any of the matters described in sections 9 to 25.

[12] Section 17 of the *Act* provides as follows:

> 17. The council may by bylaw do any of the following:
>
> (a) establish standards for the practice of veterinary medicine by registrants;
>
> (b) establish standards of professional ethics and professional conduct for registrants…

[13] Under Part 4 of the College's Bylaws[6], entitled, "Ethics and Standards," Section 199 defines "standards of practice" as "the standards set out in Divisions 4.3 to 4.7" of that Part. The term, "standards of practice," is not found anywhere else in the *Act* or Bylaws.

[14] Division 4.2 of Part 4 creates a Code of Ethics, which includes the following section:

> 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.
>
> (2) A registrant must be familiar with and adhere to procedures and rules as may be approved by the council.

[15] The first of the specific provisions the Respondent is alleged by the Citation to have contravened is section 38 of Schedule "D" – Accreditation Standards, Section 4 – Medical Records. This provision is found in Part 3 of the CVBC Bylaws, which is entitled, "Accreditation and Naming".

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[6] https://www.cvbc.ca/resources/legislation-standards-policies/

[16] The preamble to Schedule D provides as follows:

> The overall purpose of these accreditation standards is to ensure that every veterinarian has, maintains and uses facilities, equipment and supplies which are capable of delivering veterinary care, commensurate with the scope of their practice, at a level equal to the generally accepted accreditation standards as determined by their peers, for veterinary medicine in British Columbia.
>
> The objectives of these accreditation standards are to serve the following interests:
>
> 1. Protection of the public by ensuring public safety;
> 2. Consideration of public expectations;
> 3. Protection of patients by ensuring patient welfare including comfort and safety;
> 4. Definition of clear, uniform, reasonable and defensible standards
> 5. Provision of reasonable flexibility in the means of meeting standards; and
> 6. Susceptibility to effective enforcement.

[17] Section 4 of Schedule D contains a series of conditions of accreditation relating to medical records, starting with Section 21, which requires that a "facility's medical records must conform to the requirements for medical records in the Bylaws."

[18] Section 38 of Section 4 reads as follows:

> 38. Medical records must contain a summary of pertinent verbal communications or written communications with the owner.

[19] The second alleged breach contained in the Citation is of section 245(2)(b)(ii) of Part 4 of the CVBC Bylaws [Ethics and Standards][7], which reads as follows: "(2) A registrant must: … (b) ensure that medical information in the medical record is … (ii) accurate, complete, appropriately detailed, comprehensible…"

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[7] https://www.cvbc.ca/wp-content/uploads/2023/11/Part-4-Ethics-and-Standards-Nov-2023-version-1.pdf

[20] The third specified provision in the Citation is section 2(b) of the CVBC Professional Practice Standard: Medical Record Keeping, which provides that, "A veterinarian meets the Professional Practice Standard: Medical Records when he/she: … 2. Ensures records: … b. provide an accurate, complete and up-to-date profile of the animal(s) to enable continuity of care."

[21] And finally, the fourth allegation is a breach of section(s) 2(g)(ii), (v), (vii) and/or (viii) of the CVBC Professional Practice Standard: Companion Animal Medical Records: "2. Specific requirements: g. For each physical and behavioural assessment: … ii. Physical examination findings or behavioural assessments, including both normal and abnormal findings… v. A written treatment plan that provides the level of detail necessary for a colleague to understand the direction of the case at the time of writing… (vii) The date and (approximate) time of each client communication, the name of the person communicated with, and a summary of the exchange… (viii) Any additional pertinent information."

[22] The College must prove the allegations on a balance of probabilities, based on clear, convincing and cogent evidence[8]. More will be said about the legal standard in Part E.

C. Evidence

1. Medical Records

[23] The medical records pertaining to the time the animal spent at the Clinic on the date in question are set out in Appendix A.

[24] The Respondent's portion of the notes start with "6/21/2021 RKS 03S SHIFT 12:00 Midnight to 6:00 AM" and end with the following paragraph:

> Shift Medical Notes" has been created on CID at the beginning or earlier in the shift, however the contents of the notes have been uploaded at the end of the shift.

[8] *F.H. v. McDougall*, [2008] 3 S.C.R. 41; *Chaudhry* Decision, CVBC File No. 20-105(b), August 28, 2024

> Therefore, uploaded information represents all changes in the patient's health status and client communication happened until end of shift.

2. The Complainant

[25] The Complainant testified on the hearing that her partner had owned the subject animal, a male French Bulldog, for nine years. The Complainant sometimes assumed the animal's primary care, having resided with her partner and the animal since 2020. The clinic at which the Respondent worked ("the Clinic") was not their regular veterinarian clinic, although the animal had been there before.

[26] On June 21, 2021, during a hot weather spell, the Complainant and her partner noticed the dog had laboured breathing and took him to the Clinic sometime after 10:00 p.m. The partner took the dog into the clinic and when he came out, he advised the Complainant that the dog was staying overnight. He related to her that the vet said he did not believe it was heatstroke but that there was something else wrong with his breathing, and the vet was concerned that he might collapse. The partner advised that he was asked to pay $1500 in advance to leave the dog overnight.

[27] Based on what the partner told her, the Complainant expected that they would receive a call after the vet had stabilized the dog's breathing, and expected that he would be monitored in the meantime. Her partner received a call at 5:00 a.m. He told the Complainant that the caller advised him that the dog's breathing was still not stable, the caregivers were doing the best they could, and that the owners were more than welcome to come and visit any time. From what her partner told her, the Complainant did not understand that the situation was dire, and she assumed the dog was still being monitored. She said she had understood that the overnight stay was precautionary, and believed after the call that nothing had changed in that respect.

[28] They went to the Clinic, arriving by about 5:30 a.m. The man at the reception desk led them through a short hallway into the back. As they were following him, he turned back to the Complainant and said, "your dog passed," or "your dog died." She responded, "I am sorry,

what?" She did not recall him saying anything more before they reached a back room, where she saw the dog on a table, lying on his back, with his legs in the air. He was not moving, and had tubes down his throat.

[29] The Complainant saw the Respondent nearby at a computer. She and her partner were in shock and asked what had happened. The Complainant recalled that the Respondent said he didn't know, it could have been many reasons. He said they had run some tests and did not have the results yet, but would know more when they did. The Complainant believed the Respondent had suggested it could have been heatstroke and that for several reasons, that did not make sense to her: Her partner had led her to believe they had ruled out heatstroke, the clinic was air-conditioned, and the temperature was cooler that morning.

[30] The Complainant said that she and her partner kept asking the Respondent what could have happened, but she did not feel that he was speaking clearly or being responsive to their questions. He pointed to a computer and said some tests had showed that the dog was elevated in three areas, but she felt he was unable to explain what that meant, and this seemed inconsistent with his prior statement that they did not have the results of the tests. She recalled that he had pointed to a garbage bag on the ground and said it could have been heatstroke, and "many animals died last night." The Complainant concluded that there was another deceased dog in the garbage bag.

[31] The man from reception then came back with the Clinic Owner on the phone, though the Complainant and her partner had not asked that another vet be called. The Complainant took the call, and the Clinic Owner said things like, "calm down"; "these things happen"; "dogs are not like cars; you can't just replace the battery"; and they did not know what happened. The Clinic Owner spoke for a time to the Respondent, and then again to the Complainant. He said he would get the Respondent to send them the test results and that he, the Clinic Owner, was going to go over them. All of this caused the Complainant to question the Respondent's credentials.

[32] The Clinic Owner or the Respondent told her they wouldn't know anything without an autopsy. The Complainant and her partner decided not to put their dog through that. After they got home, they received a call from the Clinic Owner, who advised that the dog may have had a pre-existing condition of the larynx or thorax that led to his death. The Complainant remained confused that a vet who had not treated their dog was advising what he thought had happened, when the Respondent said they could not determine that. She felt they had a lack of information about what had happened between the call they received at 5:00 a.m., inviting them to visit their dog, and their arrival to find him dead at 5:30 a.m. She also felt their questions about the steps taken during his stay, and why they were taken, were left unanswered.

[33] The Complainant received a copy of the Clinic's medical records and saw the notations that the animal died at 5:45 a.m. and the owner was called at 5:50 a.m. She believed these were false because they had arrived before 5:45 a.m. and the dog was already deceased. She disagreed that they received a call at 5:50 a.m. She reiterated that they received a call at 5:00 a.m., and that her partner was not told on the phone that the dog had died.

[34] The Complainant filed a complaint with the College because she and her partner were upset by the lack of information, and the way they had learned of their dog's death. She described it as the most traumatizing thing she had ever gone through – a memory she could still not erase several years later. She had expected better from the Clinic and felt that they had extended "zero compassion," as if it was just their car that had broken – an object. She said she hoped this was a one-off. She filed a complaint to help ensure that it did not happen to someone else because no one deserves to be treated as if the loss of their pet means nothing.

[35] In cross-examination, the Complainant confirmed that in her complaint she took issue with the Respondent's competency in handling an emergency and alleged unprofessional conduct in relation to the dog's death, but she was now taking issue with how they learned about his death. She agreed that the Citation addresses only whether the Respondent's records meet the required standard, and said she did not know anything about that. She said she had attended the hearing in the belief that the issue with record-keeping ties in with her not

understanding the series of events while the dog was in the Respondent's care, and that if there was something wrong with his care, that may tie in with why it was not explained to her.

[36] The Complainant agreed that she had not reviewed the records despite having the opportunity to do so at her own vet's office, and explained that she did not expect to be able to decipher them. She needed a vet to explain what happened leading up to her dog's death. She did not ask her vet to walk her though the records, as they were reluctant to comment. She held the Respondent responsible for not explaining to them in layman's terms what had led to the death. She noted that the Respondent seemed unable to do that at the time, and he was the only one present during the relevant time. She confirmed that the dog's breathing had been laboured for a couple of days. She did not recall him being more lethargic than usual. She agreed that being a French Bulldog, he tended to breathe noisily and pant a lot.

[37] The Complainant acknowledged that another vet did the intake for the dog. She was unaware that he had noted the dog's prognosis as "guarded to poor." If that vet conveyed to her partner that he was concerned about the outcome, her partner had not related that to her, other than to say there was a possibility he could collapse, and that it might be something other than heatstroke. She understood they were going to do some testing and had indicated it could be something more serious, but she did not understand it could be fatal.

[38] The Complainant agreed that she had included in her complaint that the first vet had exhibited a lack of compassion, but that she had no basis for saying that, as he had interacted with her partner. She said her partner had participated with her in compiling the complaint. She was unaware that the first vet had placed the dog in an oxygen chamber and did not know if he told her partner he was going to do that. She did not know that they had sent bloodwork out as well as doing some at the clinic. She was aware that X-rays were included in the fee. She did not know if her partner had arranged to call the clinic about the results, and believed only that he was expecting a call from them. She agreed they had not called the clinic between 11:00 p.m. and 5:00 a.m.

[39] The Complainant admitted she and her partner were both upset after they learned that their dog had died, but denied that they were angry until later when the Respondent was not answering their questions. She admitted he would have been able to tell she was frustrated. She agreed she was louder than normal, and kept asking questions, but denied she was rude or disrespectful. She agreed that the Respondent may have felt intimidated, and he was stumbling over his words. She assumed that was why the Clinic Owner was called. She denied it was a "scene," as they were in a room with the Respondent and perhaps a staff member, and she remained respectful and polite. She disagreed that the Clinic Owner appeared to be trying to calm her down. He was saying they should not be taking the dog's death out on the clinic, which further upset her. She remained upset, shocked and frustrated. Her partner was crying and saying nothing. She asked if they could have the tubes removed and go into a room alone with their dog, which they were permitted to do.

[40] The Complainant did not recall having trouble understanding the Respondent beyond the fact that he was mumbling. She confirmed that he had said he could not explain the death until the tests came back, and after that he told her about some blood results.

[41] The Complainant said that the way the receptionist had delivered the information about their dog's death had shocked and upset her, but she did not know if the Respondent had directed him to do it that way. She agreed she did not know how long before they arrived the dog had died. She understood that he was alive 30 minutes earlier when the clinic had called her partner, because if they had told him the dog had died, he would have been visibly upset, and he would have told her.

[42] The Complainant acknowledged that the Respondent would likely have been dealing with an emergency situation with the dog before they arrived, but she did not accept that would make him reluctant or unable to talk with them about what had happened.

[43] The Complainant confirmed that the complaint against the Respondent did not proceed for eight months after she filed it. She did not follow up because she had given birth at the end

of 2021. She confirmed that she had complained about the Respondent and the two other vets, and she understood that the complaints against the other two had not proceeded.

3. The Respondent

[44] In his testimony, the Respondent confirmed the credentials and experience he had received in India, practicing there as a veterinarian for more than 30 years. He emigrated to Canada in 2020 and became licenced by December of that year, working at the Clinic after that. He worked eight-hour shifts. On the dates in question, June 28 and 29, 2021, his shift was 10:00 p.m. to 6:00 a.m. He took over the care of the subject animal at midnight when the first vet left, leaving him as the only vet on duty.

[45] When he took over, the Respondent read the records pertaining to the dog, then checked on him, and everything looked stable. He understood from the records that the first vet had examined the dog, put him in the oxygen chamber and then intubated him. He also knew that he had done some blood tests and sent an X-ray out for interpretation.

[46] The Respondent was aware that the first vet had identified some differential diagnoses – brachycephalic syndrome, renal insufficiency, possibly a tumor, or something else. That vet had given the dog some medication: an antibiotic, Baytril, for a possible respiratory infection, and Butorphanol, for anxiety. The dog's pulse oximetry was 60, which was very low, and the first vet had brought it back up with oxygen and oxygenation. The dog was on IV fluids, and the Respondent said he was closely checking those and his mucous membranes. The Respondent said the dog was stable throughout the time when he checked him.

[47] The Respondent said he did not notice a change in the dog's condition until he suddenly became unconscious at 5:00 a.m. He did not remember what happened after that, other than that he was busy with CPR and administering medication, Atropine and Epinephrine. He believed it was routine procedure for someone to call the client. He worked on the dog for some time, but was unsuccessful in reviving him.

[48] The Respondent confirmed his records reflected a time of death of 5:45 a.m. It was after that, he said, according to the notes, that he called the owner and informed him that, despite his efforts, he was not able to revive the dog.

[49] The Respondent said that the passage of time since the incident had affected his memory, and he did not remember much more about it. He met with the owners when they came in, and the Complainant asked him the cause of death. He said she was not able to understand, and he recommended an autopsy, but they declined.

[50] The Respondent said he generally made notes at the end of a shift. He identified the medical records pertaining to the animal, and indicated that his notes began with the notation, SHIFT 12:00 to 6:00 with his initials, and ended with the notes, "pronounced dead 5:45 a.m.", "called the client at 5:50 a.m.", and "autopsy was recommended-declined." The Respondent said that the portion marked "Shift Medical Notes" (set out above at paragraph 23) was entered by the software system used by the clinic, called "Avimark".

[51] The Respondent said he made his notes based on an "average" of his observations; for instance, the animal had not defecated during the shift, and this was noted after the fact. He identified the care plan, which contained specific notations pertaining to items like temperature and heart rate, which he confirmed were averages of readings he had taken during the shift.

[52] In cross-examination, the Respondent stated that he learned that the animal had been admitted overnight to the hospital when he started his shift. He understood that the animal was in respiratory distress. The first vet told him about the treatment he had provided, and said that the dog was stable. The Respondent estimated that this conversation was about 5 minutes long. He took over the dog's care and was the only veterinarian present during his shift. He reviewed the dog's records after the first vet left.

[53] The Respondent's duties consisted of checking the dog's respiration, mucous membranes, IV fluids, and heart rate. He had other animals to check on, but he did not remember how many or how their conditions compared. He was led through the notes on the

dog's file from the night before, and agreed that the condition was noted as "guarded to poor," which he confirmed was better than "grave".

[54] The Respondent confirmed that he had made cumulative notes of the results of his checks at the end of his shift, and could not say how many times he had checked each item. He said it was his general practice to check regularly, and that he would average out the results, for instance noting 120 as the heartbeat, when it may have varied between 118 and 122. He agreed that he had not recorded breaths per minute, only that the dog was panting. He explained that he had noticed that the dog was anxious, so checked on him, but found him stable and therefore did not count his breaths.

[55] There was a notation that the dog had urinated during the shift, but the Respondent could not remember when, or whether he had gone outside or urinated in the cage. He said the dog had moved from guarded to poor after being stabilized. He had administered fluids at 28 millilitres per hour, slightly higher than the 27 ml that the first vet had done. He recalled that the fluid intake had increased to 28 ml by the time the first vet left, although there was no note to that effect. That vet had said to add medications as needed, but the animal remained stable, so none were required.

[56] The Respondent did not remember how many times he had checked on the animal, only that he had done so regularly. He agreed with an estimate of once per hour, and agreed that a dog in respiratory distress with a guarded prognosis would need to be checked more frequently than a healthier animal.

[57] The Respondent believed the report from the radiologist in response to the X-rays arrived after the animal died. He agreed the email showed a delivery time of 2:03 a.m. but believed he had not seen it until later in the morning. He understood that the other vet had sent it out before he went home, and he did not know whether there might have been any delay between the time stamp and the Clinic receiving the report. The staff would generally receive the email and bring it to the veterinarian's attention, and the Respondent said he relied on the staff, while he focused on the animal's treatment. He identified a printout from the

Idexx[9] report, showing the bloodwork that had been done in the clinic. He did not know how the time stamp on that report corresponded to when the information became available, or would be added to the dog's record. He was not aware of whether the other vet had those results before he left.

[58] The Respondent agreed he had made the note, "Yes - at 5 a.m. [animal name] get unconscious," but he did not remember if the owner had been contacted at that time. He said the general practice was for staff to call owners, but he did not recall if he had asked the staff to do that. As he recalled, he was focused on CPR after that time.

[59] The Respondent said initially that he had noticed the dog was unconscious when he went to see how he was, to check his mucous membranes, heartrate and IV fluids, "doing his rounds". He was then asked if he knew how long the dog had been unconscious, and stated that he was nearby, so he was able to start CPR immediately when the dog became unconscious. The question was repeated, and he provided the same answer, that he started CPR immediately when the dog became unconscious. He said he had looked over at him and noticed he was not doing well, so he took him from the cage and started CPR, bagging, and medication. The precise exchange was recorded this way in the transcript[10]:

> Q. Okay. And so when you noticed that [dog's name] was unconscious, was this during your approximately hourly visit to [dog's name] cage to assess him?
>
> A So it was not regular, I don't remember at this time, but I was visiting many time to know how is his condition and checking regularly his mucous membrane, like, checking the fluids are running, and auscultating the heart also with the stethoscope.
>
> Q Right. And so you noticed [dog's name] was unconscious when you went to do that, right?
>
> A Yes.

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[9] https://www.idexx.com/en/

[10] Transcript, May 2, 2024, pp. 257 - 261

Q Right. It's not that [dog's name], you know, barked or fell over or something that brought your attention to it, it's just that you noticed it on your rounds?

A I don' What is -- to be made clear, what is the question again?

Q I just want to be clear that you noticed it during your rounds, right?

A Yes.

Q Yes, okay. And so you don't know how long [dog's name] was unconscious before you noticed him being unconscious?

A So I was nearby, so that's why I -- so when he went unconscious I immediately started CPR.

Q And that wasn't quite my question. My question was confirming that you don't know how long [dog's name] was unconscious before you noticed it?

A No. I was nearby, so I was -- when he went unconscious I started immediately CPR.

Q Okay. So you did notice it immediately that he was unconscious?

A Yes.

Q And so what brought that to your attention?

A So then I checked, then I started CPR when he was unconscious, around about what I remember.

Q Again, I'm not sure that's responsive to the question. I want to know what brought it to your attention, if you noticed it immediately? Was it a noise, was it –

A I looked over him and notice he's not at this time doing good, and I took from the cage and then started doing CPR, and I put -- intubated him and started my bagging and his emergency medication.

Q And I'm going to ask you lots of questions about that, but I'm trying to drill down on what brought it to your attention, because first I understood you to say you noticed it as you were making your rounds and now I understand you to say that you noticed it immediately. And so I'm wondering if, you know, you saw [dog's name] fall over or if [dog's name] made a noise or if he yelped or -- you say that you saw his -- you saw him stop breathing and get unconscious, so was it just a fluke that you were looking in the cage and saw him not breathing, or was there something that brought it to your attention?

A I was nearby my rounds. I -- when I saw [dog's name] is not doing good, he's lying down, then I immediately took him from the cage and started CPR.

Q Okay. So you were doing your rounds, you saw him in the cage and that he wasn't breathing, and then that's when you took him out and started doing CPR?

A Yes.

Q Okay. So then it's back to my original question of you agree with me that you don't know how long [dog's name] was unconscious before you took him from the cage?

A I don't remember, but I -- immediately -- I was checking regularly, so I took him immediately and started CPR.

Q Okay. Can you say a period of time from when you last observed him to when you started CPR? Do you think it was an hour?

A No, I was continuously -- he was in front of me when I was sitting, but I don't remember exactly -- I cannot tell you exact amount of time at this time.

Q And so when it says "Client communications: Yes at 5:00 A.M. [dog's name] get unconscious", you'll agree with me that you don't actually know at what time that phone call took place or what was said?

A I was doing CPR. I was not involved in call.

Q Yes. And I think that answered my question. You weren't involved in the call because you were doing other things, and so I'm just confirming that notation in the record, you don't actually know at what time the call took place and what was said, right?

A Yes.

Q Okay. And so CPR started –

A From the record I am seeing, it is 5:00 A.M.

Q Yes. And that's what [the Complainant] says. She says she received a call at 5:00 A.M., or her husband did and she was in bed with him. So it says "CPR started". At what time did you start CPR?

A Immediately I started CPR. I took him out of the cage and hooked intubation and started bagging and giving emergency drugs, so –

Q So, like, 5:01 A.M

A It is done exactly immediately, yes.

[60] The Respondent identified the notes he had made in relation to the treatment after the dog became unconscious. Respondent's counsel objected, pointing out that the Citation refers

only to records between midnight and 5:00 a.m. The Panel allowed the question, and the Respondent confirmed the steps reflected in the later records.

[61] One of these notations reads, "IV Fluid LRS 40ml/lb (dog) and 20ml/lb (cat) started" and the Respondent was asked why he had noted the dosage this way. He said he knew it was not a cat, but that, "we do cat like this and dog like this." He agreed that it was a standard generic or "boilerplate" reference to the recommended dosages, but he also confirmed that he had typed all of those words into the record. He explained the reference to the cat dosage as follows: "I wrote standard doses I would give to an animal..."

[62] The Respondent believed that he had conducted CPR for the whole period until 5:45 a.m. when the animal died. He recalled that he had administered epinephrine when he started CPR, and at 10-minute intervals after that. He did not remember the dosage, but believed he had done that twice during the time frame.

[63] The Respondent confirmed that his shift ended at 6:00 a.m. and he typed out his records after that. In response to the notation that the owner was called at 5:50 a.m. the Respondent did not remember if it was him that did that. The notation about declining the autopsy related to the conversation he had with the owners in the clinic after they learned of the animal's death. He was not clear on when in relation to these notes they had arrived at the clinic.

[64] In relation to making notes of observations collectively after the fact, the Respondent said it was not difficult for him to remember readings that were in the standard range and not changing significantly while the animal was stable.

[65] The Respondent did not remember if the owners had attended at 5:30 a.m. as indicated by the Complainant. In relation to her assertion that he was unable to provide her with information she expected from him, he said she was frustrated, and he found it difficult to speak with her. He stressed to her that the dog's temperature was normal, in response to a question she asked about heatstroke, and that was why he recommended an autopsy. He noted that there was nothing in his notes about heatstroke, and that it would not apply, given

that the temperature was normal. He denied that he would have suggested that as a cause of death.

[66] The Respondent recalled talking about the possible causes, such as kidney insufficiency, brachycephalic syndrome, or a tumour. He did not recall whether he had pointed to a bag on the floor and said other dogs had suffered from heatstroke that night, but did not think he had done that. He said tried to explain to the Complainant about the three areas in which the blood work was elevated, but she was frustrated and not able to understand him. He relied on his notes to confirm that the owners were called at 5:50 a.m., but had no independent recollection of the call. He did not remember where he was when they arrived. He agreed his notes did not reflect that they had attended the Clinic that morning or that the blood work had been discussed, or that they were upset about the death.

[67] The Respondent agreed that the Clinic Owner had talked with the Complainant on the telephone while he was present. He did not remember why the Clinic Owner had been called. He did not remember if he had talked with the Clinic Owner or how the conversation ended, or anything about what happened after that call.

[68] The Respondent confirmed that medical records are important because they help with patient care; form a log to show how the patient's status is changing in order to continue with medication and care of the patient; and document what is happening with the animal. He agreed that these factors applied even if an animal has died.

[69] The Respondent stated that his understanding of the College records requirements was to keep records properly and if the status of the patient changed, "we have [to] provide that". He said he became aware of the College's accreditation standards, bylaws, and professional practice standards when he was accredited in December 2020, and remained aware of them at the time of this incident. He had reviewed them at some point in 2024, but it had been "a long time." He did not take a course; he reviewed them on his own time, but he could not say when. He had not reviewed them before the hearing.

[70] In relation to the standards, the Respondent agreed that Section 38 of Schedule D of the Accreditation Standards, requiring a record of "pertinent verbal communication" with an owner would include discussing blood work with them. He stated, "since I successfully talk about autopsy, I recorded that." He agreed that discussing possible causes of death would be a pertinent verbal communication, "if possible causes are known."

[71] In relation to section 245(2) of the Bylaws, requiring "accurate, complete, appropriately detailed, comprehensible" medical information in a medical record, the Respondent understood that to mean that relevant and accurate information must be presented in the record. He disagreed that including average records of temperature did not meet that standard, stating, "I followed standard that you written [sic] and you record at the end of the shift." He added, "we only record changes and we give details at the end of shift." He believed that recording an average temperature would be sufficient for continuing care, if it was not varying much during the shift. He said he would not have changed anything about his record-keeping.

[72] In re-examination, the Respondent explained that he did not consider his conversation with the owner to be pertinent because she did not understand the information he provided her.

[73] The Panel asked the Respondent a few questions for clarification, in response to which he confirmed that when he took over the care of the animal, the animal was no longer intubated, had recovered from or was recovering from the anaesthetic that had been administered to him, and was stable. He did not believe he had any obligation to record or make notes about the anaesthetic recovery beyond observing that he was stable throughout the shift. He confirmed that if there had been any significant change, he would first stabilize the animal and then record the incident. He may have made hand notes during the shift to assist him in later updating the file, but if he did, he had not retained them.

4. The Clinic Owner

[74] The Clinic Owner testified on May 29, 2024. He confirmed that he is the owner of the Clinic and has been a registrant of the College since 1995. He described his experience in

starting up and opening over 20 such animal clinics, and his familiarity with the record-keeping practices in this and other clinics.

[75] He testified that there would normally be two doctors on shift until midnight and one from midnight until 6:00 a.m., unless one stayed longer because it was busy. The Clinic Owner was not present during the treatment of the animal in question but had reviewed the medical records. He understood that the dog had been admitted in respiratory distress, and had been stabilized before the Respondent took over his care.

[76] The Clinic Owner described the configuration of the Clinic, with a set of cages in an area at the front, where the on-duty veterinarian could observe them while sitting at a computer and working. He concluded from the medical record that the dog was stable until the morning when he took a turn and stopped breathing.

[77] In relation to monitoring and maintaining a record in relation to an animal that is stable, the Clinic Owner stated as follows:

> Like, some animal, they're critical. For example, some dogs diabetic, ketoacidosis, some other heart issue, in that case they bring the chart, they make the chart, then they attach the chart to it. And those cases, they are stable. They check them periodically, then they accumulate, the end of the shift they write the record, you know, basically based on the temperature, the heart rate, the animal is stable. That's the common practice. Not only [the Clinic].[11]

[78] On the incident date, the Clinic Owner received a call from the Clinic advising him that a client was really upset because their dog had passed away. He understood that they were not talking to the Respondent at that time, but later did so, and he also talked to them at that time. They said the dog was fine before and wanted to know how it happened. the Clinic Owner told them the dog was really sick when he came in, and he took a bad turn, and that it would be best to do autopsy. He believed they had settled down after he talked to them.

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[11] Transcript, May 29, 2024, p. 338, ll. 21 – 30, p. 339 ll. 1 - 4

[79] In cross-examination, the Clinic Owner confirmed that the practice was to check on a stable animal every hour or so. He said this practice was not written down specifically for this clinic, as the veterinarians are expected to follow College standards. Although he did not read them in full regularly, he said he read any new bylaws that came to him, and he was very familiar with the standards from his years of practice and experience. He said he understood the bylaw record-keeping requirements required a doctor "to keep the records so the next doctor, when he saw the record, he should understand what happened with this dog, you know. And that's the standard of keeping record. And then whatever the -- whatever exam is done, you have to document that." Later, in relation to published standards, he said, "the bylaw is whatever the procedure you did, whatever the exam you did, whatever medicines you gave, you have to document that."

[80] The Clinic Owner distinguished between when a veterinarian did a physical exam, which required him to touch the animal, and a situation where the animal was stable and could be monitored without touching him; for instance, to check his breathing, the colour of his tongue, or his eyes. In some cases where dogs were nervous it was better to monitor them for stability without taking them from the cage. He confirmed that temperature could not be monitored from outside the cage, that someone had to hold the animal and take it rectally, but respiration and pulse could be taken without removing the animal. In relation to how those observations would be recorded, he said, "if the animal is stable, sometimes you just make notes on your paper, and you can make an —end of the day you can make in your chart, you know."[12]

[81] As to whether a veterinarian might record an average of values he had observed during the shift, the Clinic Owner stated:

> You can do that. It's up to the doctor, the way he -- if he see, you know, the temperature's almost same, he can put the record. If he see the animal is under stress or animal is in emergency or he's not stable, then they make a chart.[13]

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[12] Transcript, May 29, 2024, p. 360, ll. 10 - 13
[13] Transcript, May 29, 2024, p. 361, ll. 17 - 21

[82] The Clinic Owner observed that monitoring heart rate was not important in a case of respiratory stress, as it could go up and down if you got the animal out of the cage, for instance, so it was not as important for the next veterinarian as monitoring respiration.

[83] The Clinic Owner was asked a question about his discussions with the Respondent about this Citation, and he responded at some length, outlining what he believed to be unfair treatment by the College of Indo-Canadian veterinarians, and a double standard between them and "native" veterinarians, by which he meant Canadian veterinarians who were "close" or "inside circles" with the College.[14]

D. Ruling re Calling Witness

[84] After the Clinic Owner finished testifying, on May 29, 2024, Respondent's counsel sought to call a College employee as a witness. Counsel had previously indicated that she expected the employee to testify as part of the College's case, as she had been included on the College's witness list. The College's intention was to have her identify documentation it intended to produce, but these materials were ultimately included in the Common Book of Documents, and the College therefore did not call her.

[85] When the hearing was adjourned on May 29, 2024, the matter was set to continue on June 6, 2024, pending submissions by counsel on the application to call the College employee. After receiving and reviewing the submissions, the Panel provided an indication by email on June 5, 2024, that its ruling would be that the Respondent was not permitted to call the College employee, and that written reasons would follow. This section of the decision provides the reasons for that ruling.

[14] Transcript, May 29, 2024, p. 347 to 377

1. History of the Proceedings

[86] It is necessary to set out a considerable amount of the background to the application made by the Respondent on May 29, 2024, in order to put the ruling into context. Here, we have relied largely upon the facts contained in the chronological summary provided by the College in its written Response submission filed on June 4, 2024, and accompanying Affidavit, with edits for neutrality and ease of reference.[15]

[87] The first pre-hearing conference ("PHC") was held on January 12, 2024, where the following directions were made:

a. the hearing dates were adjourned, by consent, to May 1 and 2, 2024[16];
b. the Respondent was to provide his position on a virtual hearing on or before January 25, 2024;
c. the College was to provide disclosure on or before February 2, 2024;
d. the College was to provide its witness list and summary of anticipated evidence on or before March 15, 2024;
e. the Respondent was to provide his witness list and summary of anticipated evidence on or before March 22, 2024[17];
f. the College would deliver a proposed common book of documents on April 5, 2024; and
g. the Respondent would provide a response to the College's proposed common book of documents on April 12, 2024.

[88] The Respondent did not provide his position on a hearing by videoconference on January 25, 2024. The Panel ultimately directed on March 19, 2024, that it proceed by video.

[89] The College provided initial disclosure on February 2, 2024, and its list of witnesses and summaries of anticipated evidence on March 15, 2024. The witness list included the College

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[15]RESPONSE OF THE COLLEGE TO THE APPLICATION OF THE RESPONDENT TO CALL AN ADVERSE WITNESS, June 4, 2024 and Affidavit #3 of J. McShane dated June 5, 2024.

[16] Meaning that the 15-day deadline for a prehearing conference provided in Bylaw Section 283 would be April 16, 2024.

[17] The Respondent requested staggered dates specifically so that he could review and consider the College's witness list before committing to his witnesses.

employee, or another named employee of the College, "if necessary" to speak to business records if not entered as an exhibit by consent.

[90] Respondent's counsel indicated to counsel for the College that she would not provide the Respondent's disclosure, list of witnesses and summaries of anticipated evidence on March 20 and 22, 2024 as directed, because she would be on vacation for the rest of the week. She proposed to provide it on March 26, 2024. These communications were not provided to the Panel but were the subject of an affidavit that accompanied the College's Response.

[91] The Respondent did not provide any documents as part of his disclosure, and provided his list of witnesses and summaries of anticipated evidence to the College on March 25, 2024. These included only the Respondent and the Clinic Owner.

[92] The second PHC was held on March 28, 2024. The College expressed concerns about the sufficiency of the witness list and summary of anticipated evidence, as well as relevancy of the evidence of the Clinic Owner. Counsel for the Respondent stated it was "unimaginable" that something could derail the hearing then set for May 1 and 2, 2024.

[93] The Respondent's counsel was invited by the Panel to review Bylaw 289, consider the summaries of anticipated evidence as provided, and provide by April 3, 2024, any additional information she intended to present at the hearing.

[94] At the end of the PHC, without prior notice to the College, Respondent's counsel raised concerns that a Panel member had a conflict with the clinic at issue, apparently based on information learned from the Respondent at some prior time. The Panel directed that the Respondent bring forward any preliminary issues with the Citation, disqualification/recusal, documents, particulars, adjournment or otherwise, in writing on or before April 3, 2024, if they were going to be raised. The Respondent did not provide any further witnesses or summaries of anticipated evidence by April 3, 2024.

[95] In her submissions, counsel for the College advised that she wrote to Respondent's counsel on April 2, 2024, to the effect that, if agreement could be reached on medical records

and correspondence being entered by consent, then the College would not call a witness to identify those documents. Respondent's counsel did not respond. College counsel provided Respondent's counsel with a proposed 3-tab book of documents on April 5, 2024, and invited her to consent to its entry.

[96] The Respondent filed an application on April 3, 2024, seeking the recusal of a Panel member, particulars, and further disclosure. That application raised no issues in relation to the Citation. The recusal issue was dealt with in due course by the Discipline Committee Chair, administratively under Section 286(b), by replacing the panel member.

[97] A third PHC proceeded on April 17, 2024, with the remaining two panel members. The Panel confirmed the appointment of Dr. Cook by the Chair, subject to the Respondent's agreement as required by the section. The Respondent sought an adjournment of the hearing scheduled for May 1, 2024. The Panel denied the adjournment at the PHC, and provided the following reasons in its Order:

1. This hearing date was set in January, after a previous adjournment sought by the Respondent and consented to by the College.
2. The Respondent first raised applications for recusal, particulars, and further disclosure orally at the second prehearing conference on March 28, 2024, despite the citation having been issued on November 27, 2023, and issues of disclosure having been canvassed at a prehearing conference on January 12, 2024;
3. The College promptly conceded the conflict issue and Dr. Kumar promptly recused himself in response to the application;
4. While the College's response to the remaining applications was delayed pending a decision under College Bylaw Section 286, the hearing is still two weeks away; and
5. The issues raised in the Respondent's Notice of Motion are relatively straightforward, as is the citation.

[98] The Panel also directed at that third PHC that the Respondent would have until April 22, 2024, to indicate his position regarding the College's proposed Common Book of Documents and Document Agreement, or would be taken to accept them. The Respondent provided no response by April 22, 2024, with the result that the Respondent was deemed to have accepted them, and that the College made the decision not to call its in-house witness. Counsel for the

College advised that the Respondent provided to the College a supplemental summary of anticipated evidence for the Respondent (and no other witnesses) on April 24, 2024, despite the April 3 deadline directed by the Panel on March 28.

[99] The two members of the Panel who had presided pending Dr. Kumar's replacement provided a ruling on the remaining issues raised in the Respondent's April 3 application, on April 24, 2024, directing that the College make some limited further disclosure. The College disclosed additional documents on April 26, 2024, which counsel advises related to the other two registrants involved in the care of the animal.

[100] Also on April 26, 2024, Counsel for the College sent Respondent's counsel a request to start the hearing an hour earlier on May 1, to accommodate the Complainant's schedule. This request was passed on to the Panel on the same date, and the three Panel members responded that day indicating that they were agreeable.

[101] The Respondent filed an application on April 29, 2024, requesting that the Panel reconsider its disclosure decision of April 24, 2024; requesting further disclosure, and again seeking an adjournment of the hearing. The College filed a written response to this application on April 30, 2024.

[102] The Panel provided a ruling dated April 30, 2024, delivered to counsel before the start of the hearing on May 1, 2024, in which it stated:

> [4] With respect to the Respondent's continued applications for disclosure, the Respondent had ample opportunity to make his disclosure applications in a timely way before or at one of the three pretrial hearings. This was a second scheduled hearing date after a consent adjournment in January. The first of these disclosure applications was raised orally at the second pretrial hearing in late March. Directions were provided to the Respondent at that time with respect to the timing for raising further preliminary issues before the hearing.
>
> [5] The Respondent was asked at that time to file his disclosure applications in writing, which he did on April 3, 2024. The Panel provided a ruling on April 24 granting some additional disclosure which, if it has not been fulfilled by the hearing date, may be discussed further at the hearing. The College advises that it provided further disclosure on April 26 and that what was provided was not voluminous. It also provides reasons that the disclosure is not as extensive as the Respondent would like.

> [6] The Panel ruled against the rest of the Respondent's disclosure applications, and although the Respondent has asked the Panel to reconsider it, that ruling stands at this point. The issue of whether the Panel has jurisdiction to reopen the ruling need not be considered at this point because the Panel is not persuaded to do so by the Respondent's April 29 submissions.
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> …
>
> [9] The Panel is not satisfied at this point that proceeding with as much disclosure as has been provided and with as much of the evidence as can be dealt with on the scheduled hearing dates will prejudice the Respondent, given the history and nature of the proceedings. The Panel is concerned that multiple complex disclosure requests, preliminary arguments and repeated adjournments should not be encouraged in these matters, as it will lend to prolix proceedings and undue delay in matters that should be relatively straightforward at the discipline hearing level.
>
> [10] It has already been determined that a portion of the hearing will likely be adjourned to accommodate a Respondent's witness who is out of the country. If the Respondent wishes to renew his disclosure requests after an evidentiary foundation for them is laid before the Panel at the initial hearing, he may be able to do so, subject to the Panel's expressed view that the denied disclosure as it relates to other registrants is privileged, and subject to the College's arguments regarding jurisdiction to reopen.

[103] During her cross-examination of the Complainant on May 1, 2024, Respondent's counsel sought to introduce letters the Complainant had received from the College pertaining to the other two veterinarians involved in the care of the animal, about whom the Complainant had also filed complaints. The Panel made an oral ruling at the hearing that it would not receive evidence or hear about letters involving the other registrants included in the complaint because they are "not potentially relevant" and "too far afield."[18]

[104] After the College closed its case, Respondent's counsel expressed surprise that they had not called the College employee or another College witness as part of their case, and indicated that she wished to have introduced certain documents through them, on cross-examination. The Panel understood that these documents again pertained to the College's investigation or proceedings against the other two registrants, and declined to order the College to produce

[18] Transcript May 1, 2024, p. 117, ll. 5 - 13

them. At that time, counsel said this in relation to the documents she sought to elicit from the College employee:

> It's their record of what happened in the investigation, and the position that the College -- various College entities took along the way about what the College's own essentially policies mean and how they should be applied. So, you know, we will be seeking to enter certain documents as we go along, just as we did this morning in cross-examination. We put some documents to the witness and those went in, and we'll be doing the same thing with [the Respondent] and -- but we -- there are documents that have been disclosed to us have never been sent to us that were not part of the communications that were shared with [the Respondent].
>
> …
>
> If the College is not prepared to agree that the documents are acceptable should we be able to make an argument about their relevance, then I think the proper approach is for us to call [the College employee]. She's the senior paralegal. She, as I understand from other stories, knows everything about the documentation that's occurring on these files and is sort of the keeper of the files in that respect in disciplinary matters, so she's the correct witness to call to get the College's disciplinary record in, a record of its investigation and so on, and we will -- we'll seek to call her, if that's the way it has to go.[19]

[105] At that time, when the Panel resisted the Respondent's request to have the College call the College employee, counsel for the Respondent indicated that she would proceed with her opening and the evidence of the Respondent, and then "tackle the issue of [the College employee] attending."

[106] During the examination-in-chief of the Respondent on May 2, his counsel (again) sought to introduce a letter he had received from the College, containing information about the other two veterinarians. The document at issue was entitled, "Investigation Memorandum," and was written by the College investigator to the Investigative Committee of the College. It pertained to the Clinic Owner and the other involved vet, as well as the Respondent.

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[19] Transcript, May 1, 2024, p. 134, ll. 15 – 25, p. 135, ll. 1 - 3

[107] The Panel provided an oral ruling declining to admit the letter in evidence, indicating that written reasons would follow. After the Respondent finished testifying, there was discussion about setting a date for continuation. In relation to the issue of the College employee attending, Respondent's counsel said:

> I had planned to put in more documents from the investigation process in order to establish -- you know, to provide that information about the College's view about medical records and what -- you know, throughout this process. I have your ruling from today, but I think it would be appropriate actually for us to stand down…
>
> …I had planned to call as an adverse witness someone from the College, probably [the College employee], to speak to that. The investigation documents, I have your ruling, but I think it would be appropriate for that ruling to be provided in writing so that I can review it and ensure that I fully understand how it applies and also ensure that it doesn't contain any misunderstandings of fact that I might like to address.[20]

[108] The hearing was adjourned by consent to May 29, 2024, because the Respondent's witness, the Clinic Owner, was not available, and counsel were asked to also reserve June 6, 2024, as a back-up date because the Respondent's counsel had not yet confirmed the Clinic Owner's availability for the 29th. She indicated on May 2, 2024, that she would send an email "now" to attempt to get confirmation, and counsel were to confirm May 29th by email to the Panel, so that June 6 could be released.

[109] Counsel for the College advised that she wrote to the Respondent on May 14, 2024, stating her understanding that the hearing was set to conclude on May 29, 2024, and that, if the Respondent intended to call evidence in his defence other than the evidence of the Clinic Owner as outlined in the summary of anticipated evidence, he "must apply to do so and [provide] fair notice of that application and a sufficient opportunity to respond so that the hearing may complete on May 29 as reschedule[d] to accommodate your client's witness…"

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[20] Transcript, May 2, 2024, p. 278, ll. 7 – 13, 16 - 24

[110] The Panel issued its Reasons on the May 2 ruling on May 15, 2024, providing in part as follows:

> [1] … During the discipline hearing held May 1 and 2, 2024, the Respondent sought to introduce evidence pertaining to the College's internal investigation of the complaint that had been filed by [the animal's] owners. Specifically, counsel for the Respondent wished to have the Panel consider correspondence from the College to [the Respondent] and two other veterinarians who were investigated in connection with the complaint, which included inquiries and decisions made by individuals on behalf of the College prior to the issuance of the Citation.
>
> [2] The Respondent says these documents are relevant because they demonstrate inconsistencies in the way the College dealt with [the Respondent's] colleagues, and unfairness to [the Respondent] in the process leading up to the issuance of the Citation, both because of those inconsistencies and because the focus of the investigation changed from the care of the animal to the Respondent's record-keeping, at a time and in a manner that impaired the Respondent's ability to answer the allegations.
>
> …
>
> [7] Disclosure of course does not create relevance. The issues to which this aspect of [the Respondent's] evidence was directed at the hearing were decisions by College representatives to proceed or not proceed in a certain fashion, against [the Respondent] or his colleagues, prior to the issuance of the Citation.
>
> [8] The Panel recognizes that because of the way this matter proceeded, the Respondent may not have been able to include all of the now-tendered documents in the document agreement that was to have been signed off on by April 22, 2024. Any of the items he had before the April 17 direction, however, could properly have been included and made the subject of agreement, or if not, the objection could have been raised at that time, rather than simply producing them, without proper notice, during the Respondent's testimony.
>
> [9] Sections 289 and 290 of the CVBC Bylaws, Part 5, contain a comprehensive scheme for prehearing disclosure designed to ensure that evidentiary issues do not arise at the last minute, as this one has. Section 290 permits a Panel to decline to accept evidence that has not been disclosed as required. The Panel's ruling on this point is that, in relation to any of the correspondence the Respondent is now seeking to introduce that he possessed before the additional disclosure order, he has failed to comply with the Bylaw, and the Panel declines to hear the evidence.
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> [10] The Panel is in any event of the view that the materials the Respondent is now seeking to introduce, whether properly disclosed or not, are not relevant or admissible at the discipline hearing, as we will go on to explain.
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> …

> [14] The Panel is of the view that, whenever the evidence may be tendered, correspondence from the College to the other registrants involved in this matter, or internal College correspondence with respect to those registrants, has no apparent relevance to the merits of the allegations against this Respondent.
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> …
>
> [17] The Panel was not referred to the decisions of prior panels that the Respondent says have rejected similar evidence, so it does not have the benefit of those or submissions from the parties pertaining to the Panel's jurisdiction to determine the validity, or fairness, of the process by which a complaint is referred to it. The Panel has concerns that a review of deliberations and decisions of individuals or entities pertaining to the stages of the investigation that preceded the issuance of the Citation may be outside its statutory mandate. The question is whether it is the function of a disciplinary panel to "investigate the investigation."
>
> [18] In any event, given the way in which this issue has arisen within the hearing, without prior orderly notice, the Panel is not equipped to find that the materials the Respondent seeks to introduce during the Respondent's testimony are admissible, or have any relevance to a determination of the Citation on its merits. The CVBC Bylaws do provide the Panel with authority to direct an orderly unfolding of the issues before it. The Panel therefore declines to receive the materials tendered by the Respondent pertaining to other registrants or changes in the focus of the investigation.

[111] The court reporting service circulated a confirmation of the May 29, 2024 hearing date on May 24, 2024. Counsel for the Respondent sent an email at 2:30 p.m. on May 28, 2024, stating that she was unclear whether the hearing was proceeding on May 29, and she had not confirmed that the Clinic Owner was available. She suggested that the matter proceed on June 6 instead. The Panel reviewed the related correspondence and prepared to hear an adjournment application.

[112] The hearing convened on May 29, 2024, as scheduled, without further word from Respondent's counsel, and the Clinic Owner was in fact present. After he testified, Respondent's counsel indicated that she was seeking to call the College employee as an adverse witness, to speak to the business records of the College that she had previously sought to introduce. Counsel indicated she had prepared written submissions in favour of the application, which she was prepared to file that day.

[113] The Panel asked if counsel had considered whether the Respondent might be foreclosed by the Panel's prior rulings, including the May 15 Reasons, from introducing those records. Counsel said she had not reviewed the May 15 ruling until the evening of May 28, 2024, and she would like some time to consider that. She offered to file her written submissions by May 30, 2024. Counsel thereafter filed their submissions on the application prior to the June 6 continuation date.

2. Submissions

[114] The Respondent submitted that the documentary evidence he sought to introduce through the College employee was relevant to arguments he sought to make about the scope of the Citation. Specifically, counsel submitted that the evidence strayed outside the hours specified in the Citation of midnight to 5:00 a.m., and that the Panel would be called upon to interpret the Citation in deciding whether to consider evidence falling outside those hours. The gist of the submission was that the decision-making process followed by the Investigative Committee in relation to the wording of the Citation has relevance to the way in which the Panel should interpret the scope of the Citation.

[115] The second issue to which counsel for the Respondent sought to direct the College employee related to the delay in the investigation of the Respondent. In this respect she sought to have the College employee introduce a document entitled, "Action Log," which related to the progress of the investigation, in addition to the document entitled "Investigation Memorandum" previously referred to (and encompassed in the Panel's prior rulings).

[116] The argument to which these documents were said to relate was that the Respondent was unaware until eight months after the complaint was filed that it was his record-keeping and not his treatment of the animal that was the focus of the misconduct allegations. This delay, he submits, contributed to an inability on his part to recall the incident and provide meaningful comment on his record-keeping. He required the documents reflecting the steps taken or not taken by the Investigative Committee as support for his credibility in relation to his inability to recall.

[117] Counsel for the Respondent also renewed her submissions in relation to the fairness of the way in which the College had proceeded against the Respondent as compared with the other two registrants. She stated, "Here we are suggesting that undue efforts have been made by the College to find an issue against [the Respondent] which is resulting in unreasonable positions being taken in relation to his records, including before this Panel."

[118] Counsel also submitted that the Panel has not specified which documents were the subject of its prior rulings, and that because the Panel's reasons in relation to its May 1 ruling on the disclosure application were not issued until May 2, 2024, and the further College documents were not received by the Respondent before April 26, 2024, it was not possible for the Respondent to provide the College with notice of the documents he would seek to introduce before his May 1, 2024 email to the College.

[119] Counsel for the College opposed the application to call the College employee based on the history of the matter, including the fact that it had been repeatedly indicated to counsel for the Respondent that she needed to file a timely application if she sought to call evidence not previously identified by her in the many prehearing proceedings.

[120] The College stated, "It is not that the College is surprised by the existence of many of these documents identified by the Respondent, but it is the manner in which they are being tendered and the purposes for which they are being tendered that is without notice." The College went on to take the position that the documents were in any event without relevance to the merits of the decision the Panel would be called upon to make. In relation to the Investigative Committee minutes pertaining to the other vet, the College pointed out that the Panel declined to order disclosure of that document in response to the Respondent's application in April on the basis that it was irrelevant and privileged, and nothing had changed to require that assessment to be revisited.

[121] In Reply to the College's submission, the Respondent took issue with a challenge to the application based on procedural considerations, submitting that fairness dictates that the Panel must decide the issue on the merits. The Respondent reiterated that he wanted the records of

the Investigative Committee in order to establish that the Committee interpreted the Respondent's records inconsistently with the way in which it interpreted those of the other vet. He submitted that the Panel could not have decided on the basis of privilege that the IC Minutes were not producible, because the Investigative Memorandum pertaining to all three registrants was provided to the Respondent. He pointed to the "ongoing disagreement" regarding whether Investigative Committee proceedings are subject to deliberative privilege, and decisions of the Human Rights Tribunal in which they were disclosed.

3. Analysis

[122] In relation to the Investigative Memorandum and other correspondence pertaining to the conduct of the investigation, which the Respondent sought to call the College employee to identify, the Panel had already declined to admit that documentation in its rulings on May 1 and 2, 2024, and its written reasons dated May 15, 2024.

[123] The Panel concluded firstly that materials pertaining to the process followed by the Investigative Committee, whether they pertained to the wording of the Citation, the delay in its issuance, or the unfairness of how the Respondent was treated in comparison with his colleagues, all related to issues that were covered by the initial direction to raise (in writing) "preliminary issues with the Citation," for which the Respondent was provided a deadline of April 3, 2024, at the second pre-hearing conference on March 28, 2024.

[124] The Respondent elected not to raise a preliminary objection to the Citation or its foundation at that time. Delay and unfairness were identified as issues by the Respondent as early as the second pre-hearing conference, where timing directions were provided. It is notable that the Respondent complied with none of the dates directed by the Panel in any of the pre-hearing orders. If the neglect of the April 3 deadline had been arguably inadvertent or anomalous, the Respondent's serial requests to come back to the issue of Citation validity may have met with a more receptive audience.

[125] The problem the Panel had with the Respondent's approach in this matter was that it has posed repeated obstacles to the expeditious and fair conduct of the hearing. If there were a

serious challenge to the validity of the Citation, the Panel would have expected to see it raised in the pre-hearing process, in accordance with the deadlines that were set. To challenge the process for unfairness based on extraneous materials, during the hearing on the merits, given the prior rescheduling of the hearing, the passage of those deadlines, and several prior rulings in which the Panel declined to delve into the investigative process, appeared to the Panel to be simply another bid to derail the hearing. If those issues were genuine, the arguments could have been introduced much earlier in the pre-hearing process, before the Panel was convened, reconfigured, called upon to make multiple rulings, and in due course, witnesses were called.

[126] Moreover, Respondent's counsel had indicated in earlier submissions that her reasons for not advancing challenges to the Citation in advance were that she was aware of several CVBC authorities prohibiting her from challenging a citation based on unfairness of the investigative process. Given that backdrop, the late request to call the witness appeared to amount to an attempt to circumvent those rulings and the Panel's numerous prior rejections of evidence which it considered to be irrelevant.

[127] The history of the proceedings as outlined above discloses that the Respondent's counsel's inattention to deadlines imposed by the Panel in this matter has been lamentable. The timing of the application to call this witness, coming at the end of a third hearing date, after two adjournments and numerous deadlines intended to have counsel direct her mind to the orderly conduct of the hearing, suggested that the arguments were an afterthought, or perhaps an attempted end run, rather than a genuine challenge to the validity of the Citation, which counsel made a concerted decision not to raise as a preliminary issue. While two further arguments were raised in the May 30 application, those of delay and scope of the citation, those arguments appear to be tenuous attempts to bolster the application that counsel has made several times, and had rejected.

[128] The Panel acknowledges that, if an unforeseen unfairness argument had arisen within the hearing, of a nature that might undermine the validity of the Citation or the Panel's capacity to adjudicate on the merits, it might be incumbent on a Panel to hear evidence, regardless of what we may consider to have been a lax approach on the part of the Respondent's counsel. As

indicated in the prior rulings, however, the Panel understood the primary foundation for the evidence was an argument that the Respondent was being treated unfairly in comparison with the other veterinarians, in relation to the process that led up to the issuance of the Citation. The Panel reached the conclusion, repeatedly, that the evidence on those points was irrelevant.

[129] In relation to the two new arguments, the Panel has heard evidence about the Respondent's record-keeping outside the specified hours, which it allowed on the basis that it may provide context or assist in assessing the Respondent's approach to medical records. However, no amendment or expansion of the Citation is contemplated or necessary. The Panel is of the view that the intention of the Investigative Committee in relation to the scope of the Citation is therefore not relevant or necessary evidence, and the Respondent will not be prejudiced by declining to hear it.

[130] In relation to the issue of timing pertaining to the focus of the investigation on record-keeping, the Panel sees no basis in the evidence for a rejection of the Respondent's evidence on this point. The additional records the Respondent seeks to adduce through the witness, pertaining to delays in the investigation, are therefore irrelevant and unnecessary. The Panel concludes that the Respondent will not be prejudiced by its exclusion.

E. Preliminary Arguments and Objections to the Allegations

[131] The Respondent commenced his final submissions with the suggestion that because of the severity of the potential penalties available on a finding of non-compliance, veterinarian disciplinary matters merit the "highest standard of justice," such that the Panel should apply a stricter test than the generally applicable civil standard, the balance of probabilities. The Panel is of the view that this argument is not available to the Respondent in light of the Discipline Committee panel decision in *CBVC v. Chaudhry*, issued on August 28, 2024.[21]

[21] Supra, Footnote 2.

[132] *Chaudhry* was delivered after the Respondent's submissions were filed in this matter, and counsel for the College drew it to the Respondent's and the Panel's attention. The Respondent was provided an opportunity to respond to it. He urged the Panel not to follow *Chaudhry*, and reiterated his prior submissions pertaining to the seriousness of the potential consequences. The Panel finds the reasoning in *Chaudhry* persuasive, and agrees with that panel's conclusions that the standard of proof applicable to *Veterinarians Act* discipline proceedings is the balance of probabilities.

[133] The Respondent also submits that a panel acting under the *Veterinarians Act* should adhere to the strict rules of evidence rather than relaxing or departing from those. The Respondent cited no authority for this proposition, which was essentially a bootstraps argument resting on his "highest standard of justice" submission that failed in *Chaudhry*. This aspect of the Respondent's argument is not only without authority, but inconsistent with a large body of cases establishing that rules of evidence may be applied less stringently in administrative proceedings.

[134] The Respondent also submits that section 38 of Schedule D, found in Part 3 of the CVBC Bylaws (Accreditation and Naming), which is particularized in the Citation as one of the provisions contravened by the insufficiency of the Respondent's records, cannot form the foundation of a breach allegation, because it is an accreditation standard under Part 3, and therefore not a disciplinary standard under Part 4. He points to the definition of "standards of practice" in Section 199 of Part 4 (Ethics and Standards) of the Bylaws, which is, "the standards contained in sections 4.3 to 4.7" of that Part. The Respondent's argument, as the Panel understands it, is that because Schedule D does not fall under those sections, it does not create "standards of practice," and therefore cannot form the foundation of a non-compliance allegation. The publication of Schedule D, he says, falls short of adoption as a "standard of practice," or a bylaw, nor does it afford evidence of the standard accepted in the profession. The Respondent says no such evidence has been led and the Panel may not rely either on common industry standards or the experience of the Panel members in identifying the

applicable standards, if they are not properly created and published, or established by evidence.

[135] This Panel rejects this argument for several reasons. Firstly, the definitions found in Section 199 are stated to be "for the purpose of this Part". There is no other reference to the term "standards of practice" in the *Act* or Bylaws, and no provision specifying that disciplinary allegations may pertain only to the contravention of Part 4 of the Bylaws, or "standards of practice." To the contrary, Section 61(1)(b)(ii) of the *Act* directs a panel on a discipline hearing to find whether "the respondent has not complied with a standard, limit or condition imposed *under this Act.*"(Emphasis added). A similar provision in Section 59 enables the investigative committee to investigate such matters.

[136] Additionally, as observed in Part B, Section 8 of the *Act* provides the Council with a general power to make bylaws, separately from those requiring registrant approval. Those general powers include making bylaws under Section 17, which permits the Council, by bylaw, to establish "standards *for* the practice of veterinary medicine" *and* "standards of professional ethics and professional conduct" (emphasis added). Sections 207(1) and (2) in Part 4 of the Bylaws provide that registrants must comply not only with the *Act*, the regulations and the bylaws; but also "procedures and rules as may be *approved by the council*." Moreover, Section 207(2) requires registrants to "be familiar with and adhere to procedures and rules as may be *approved by the council*." (Emphases added).

[137] It is not open to the Panel to question the Council's ability to provide itself the power to create procedures and rules, nor has that argument been articulated here. The *Act* and Bylaw provisions as written afford ample basis on which to find that registrants are required to adhere to all practice guidelines that are published on the CVBC website, provided that those provisions are contained in the *Act*, passed as bylaws, or approved by the Council.

[138] Without delving into the underpinnings of approval for each such provision, and subject to the discussion below about a provision the Respondent argues was not approved by the Council, the Panel relies on the presumption of regularity to conclude that all provisions

published on the website are "standards, limits or conditions imposed *under*" the *Act* and have either been passed as bylaws, where they are published as bylaws, or approved by the Council pursuant to its authority under the Bylaws, where they are published as standards. It may be that the nature of the provision has some bearing on the seriousness with which non-compliance should be viewed, but that is a question for the penalty phase.

[139] The Panel notes that the challenge to the authority of Schedule D of the Bylaws was also raised in the *Chaudhry* case, and rejected by that panel. While the Respondent in his response to *Chaudhry* provided in this matter reiterated his argument about the distinction between "standards" and "bylaws," and relied on Section 17 to suggest that only "standards of practice" could be the subject of disciplinary proceedings, the Panel is of the view that this argument has no merit. The Respondent's submission misstates that Section 17 "says that the College may create 'standards of practice' by bylaw," in an apparent attempt to tie the wording of that Section into the wording of Section 199. A review of the relevant provisions as set out here discloses that the enactment of standards by bylaw is not restricted to bylaws made under Part 4 of the Bylaws, and that limits or conditions that fall short of bylaws, approved by Council pursuant to its authority under Section 207, may also and nevertheless form the basis of non-compliance allegations.

[140] Notably, the preamble to Schedule D, set out at paragraph 12 above, includes as a purpose of the accreditation standards that every veterinarian "…uses facilities, equipment and supplies which are capable of delivering veterinary care, commensurate with the scope of their practice, at a level equal to the generally accepted accreditation standards as determined by their peers, for veterinary medicine in British Columbia." The objectives of the Schedule include "protection of the public by ensuring public safety" and the "definition of clear, uniform, reasonable and defensible standards." Also, as noted above in Part B, Section 21 of Schedule D requires that a "facility's medical records must conform to the requirements for medical records in the Bylaws."

[141] Although the Schedule is directed toward assessing whether a facility or designated registrant should receive accreditation, it might reasonably also be found to include a

presumption that veterinarians will adhere to, and maintain, the standards of facility qualification in conducting their practices. However, the Panel prefers not to make that finding, in light of the discussion of the next issue raised by the Respondent, pertaining to the approval of the Professional Practice Standard: Companion Animal Medical Records.

[142] The Respondent submits that approval of the Companion Animal Medical Records Standard, which states it was approved by the Council at its January 20, 2018 meeting, is not reflected in the minutes for that meeting of the Council. The published version of the Standard states at the top, "Revised January 2018" and at the bottom of the first page, in a footnote, "Council approved the amended 'Professional Practice Standard: Companion Animal Medical Records' on January 20, 2018. It is available on the CVBC website (www.cvbc.ca) under Resources > Bylaws, Standards & Policies." The Council's minutes for the public portion of each of its meetings are published on the CVBC website[22]. The minutes for January 2018 do not contain a reference to the Medical Records Standard, revised or otherwise.

[143] There is, however, a reference to the Medical Records Standard in the Council minutes from June 17, 2017[23], including the following paragraph:

> Council was presented with a request to consider passing medical records standards, based on perennial problems identified by the Investigation Committee over the years, in identifying substandard record keeping but being met with the defence that the CVBC "has no published standard". While Schedule D of the Bylaws contains requirements for facilities, *these are not legally enforceable against registrants who are not designated registrants*. (Emphasis added.)
>
> Council reviewed the proposed "Professional Practice Standard – Medical Records" and "Companion Animal Medical Records Minimum Standards"… On the understanding that

[22] https://www.cvbc.ca/about/council/

[23] https://www.cvbc.ca/wp-content/uploads/2020/03/June-17-2017.pdf

> applicable Bylaw provisions take precedence over the standards, Council directed that the standards be publicized to the profession…"

[144] The Panel notes that the apparent conclusion of the Council members present at that meeting about the effect of Schedule D is at odds with the above discussion about the status of Schedule D as containing standards potentially enforceable against non-designated registrants. For that reason, the Panel prefers not to rest its decision in relation to this Citation on the enforceability of Section 38 of Schedule D against the Respondent.

[145] The Panel agrees however with the submission of the College, that if Schedule D falls short of status as an enforceable standard applicable to the Respondent, as a publication of the College approved by the Council, Section 38 might nonetheless reasonably be taken to "inform" Section 245 as to the requirement to include pertinent communications with the owner in a patient's medical records, or serve as a yardstick for the level of detail that might reasonably be expected. To the extent that any of them fall short of enforceable standards, the College's published expectations, in the form of its published materials on the website, might nonetheless assist a registrant by defining, or providing particulars, regarding the level of detail he or she should be providing in medical records. For a Panel, if a particular provision or guideline falls short of a foundation for a finding of a non-compliance, it might provide a similar level of assistance to that provided by expert evidence, by establishing a yardstick, or accepted industry standard, against which allegations of non-compliance with enforceable provisions may be measured.

[146] Setting aside the issue of whether Accreditation Standards apply to the Respondent, then, it appears from the applicable Council minutes that the Medical Records Practice Standards were both validly approved and intended to be enforceable against registrants, albeit subject to the precedence of the Bylaws.

[147] Notably, the following statement appears at the outset of the Professional Practice Standards: Companion Animal Medical Records:

> This College publication describes a mandatory *standard of practice*. The Veterinarians Act in section 52 provides that a failure to comply with a standard may be investigated. This practice standard should be read together with "Professional Practice Standard: Medical Record Keeping". (Emphasis added.)

[148] The Panel notes as well that the Citation here reads "and/or" in listing the various provisions it alleges have been breached, and, as pointed out by the College, a finding by the Panel that the Respondent's record-keeping falls short of any of the alleged provisions, in relation to the animal's ongoing treatment or communications with the owners, would require the Panel to find non-compliance.

[149] Finally, the College has cited numerous authorities to the effect that although specific rules are sometimes found in the legislation and regulations pertaining to the manner in which a regulatory body may supervise a profession, more commonly there will be a set of non-legislated rules, procedures and codes of conduct. There is considerable authority for the position taken by the College, favouring "expansive interpretation of a regulator's general authority to establish bylaws, rules, standards and policies that advance the statutory objectives," and, we conclude, considerable latitude for the College to do so.

[150] As indicated, we will nonetheless leave the question of the applicability of Schedule D of the Accreditation Standards to non-designated registrants for another day, or perhaps for public clarification by the Council. Here, we proceed on the basis that the nature of the non-compliance particularized is confined to Section 245(2)(b)(ii) of Part 4 of the CVBC Bylaws, section 2(b) of the CVBC Professional Practice Standard: Medical Record Keeping and/or section(s) 2(g)(ii), (v), (vii) and/or (viii) of the CVBC Professional Practice Standard: Companion Animal Medical Records.

F. Submissions on the Merits

1. College Submissions

[151] Counsel for the College filed submissions in favour of findings that both allegations were proven; specifically, that the Respondent failed to sufficiently document treatment and monitoring of the subject animal, and failed to sufficiently document his communications with the animal's owners regarding its death.

[152] The College relies on the evidence of the Complainant, whom counsel suggests was not answered or challenged in many respects, by the Respondent. The College also challenges the Respondent's explanations of his medical records as vague and unsatisfactory. The College says that the evidence of the Clinic Owner had limited relevance and, in any event, cannot override the College's written records requirements. The College also submits that the Clinic Owner had an apparent predisposition to believe that the College treats South Asian Canadian veterinarians unfairly, and he was consequently less focused or reliable in relation to the narrow issue of the adequacy of the Respondent's records.

[153] The College submits that the Panel needs to consider whether each of the two allegations contained in the Citation, failure to document treatment or failure to document communications with the owner, are established. The College submits that the only issue is whether the medical records were deficient in either respect to the point where they did not meet the requisite standards of the College. The College also submits that, "The Respondent's medical records, and their deficiencies, should be viewed within the context of [the animal's] presentation and prognosis and the fact that [the Clinic] is an emergency hospital facility where [the animal] was admitted to be monitored overnight."

[154] The College relies on the following passages from the *Guide to the Professional Practice Standard: Medical Records*[24]:

> The medical record is the only resource that provides the necessary information to ensure continuity of care, to enable effective collaboration among the veterinary team, and to demonstrate the quality of a veterinarian's practice. Complete and comprehensive medical records are essential to the health and well-being of every patient. (At p. 1)
>
> …
>
> A veterinarian must ensure that records are complete and up-to-date. Records should be created or updated immediately or as soon as possible after contact with the patient or client or new information is received. Timely recording of information minimizes the risk of incomplete records and ensures current information is available to all members of the veterinary team. (At p. 8)

[155] The College observes that the Respondent admitted to taking the animal's temperature more than three times, which according to the Clinic Owner's evidence would have involved taking him out of his cage and enlisting the assistance of another person, yet the Respondent recorded only a single entry of "102" in his notes at the end of the shift. The College also notes that the Respondent agreed that he had taken the animal's heart rate more than three times, recording only "120" at the end of his shift, and had checked his breathing regularly, but recorded only "panting," and not breaths per minute.

[156] The crux of the College's submissions on the issue of the Respondent's notes relating to treatment and monitoring is contained in these paragraphs:

> 127. From the initial entry with the "handover" of [the animal's] care from [the first vet], the Respondent's medical records failed to record the Respondent's treatment and monitoring of [the animal]. It is evident that the Respondent had a conversation about [the animal], while standing in front of [the animal], and that the Respondent's initial

[24] https://www.cvbc.ca/wp-content/uploads/2020/03/Guide-to-the-Medical-Records-Standards.pdf

> exam (which is not recorded in its entirety), was assessed against what [the other vet] recorded and conveyed to the Respondent.
>
> 128. The Respondent described how some entries were "cumulative" over the course of the night. This applied to at least temperature, pulse, respiration, capillary refill time and urination. The Respondent could not say how many times he measured these things to come up with the cumulative value, although it was at least three, and that he maintained the values in his head unless something was noted to be abnormal.
>
> 129. The notion of normal readings being entered as a cumulative value is not acceptable.
>
> 130. As the *Guide to the Professional Practice Standard: Medical Records* sets out, timely recording of information minimizes the risk of incomplete and inaccurate records and ensures current information is available to all members of the veterinary team.
>
> 131. The Respondent's explanation that when, for example, an animal's temperature is not changing, it is not difficult to remember what it was the last time the temperature was taken, even when you are monitoring a number of animals, is not realistic. Furthermore, [the Clinic] is an emergency hospital that treats and monitors emergency cases. Even if a temperature is normal when measured, this value, and the recording of this value in the medical record in a timely manner, is pertinent to continuity of care. Minutia matters in life and death situations.

[157] The College points out that the Respondent agreed that another vet would not be able to tell from his entries that these were "cumulative" values, and goes on:

> 134. The College submits that such a record is demonstrably incomplete, and that averaged values recorded in the manner that they were, are inaccurate.
>
> 135. While the College cannot prove when or how many times the Respondent took [the animal's] temperature or pulse for example, on the Respondent's own evidence it is more likely than not that 102 and 120 respectively were not ever truly accurate values.
>
> 136. The Respondent could not state when the measurements were taken, but he thought that he monitored [the animal] once an hour. If the Respondent had simply noted the time that he conducted the examinations and the results, we would have this information. We would also have a record of when [the animal] was last examined before he became unconscious.

> 137. If the Respondent is making handwritten notes throughout his shift, the College queries why those notes are not being made in the record or at least transposed directly. It is also very concerning that the Respondent would throw out notes rather than just record them in the medical records.

[158] The College also questions why there were no notes reflective of the Respondent's evidence that the animal reacted to his initial examination by looking at him and was not "super playful," and no note or explanation as to the fact that the Respondent administered intravenous fluids at 28 mls per hour, when the other vet's notes said 27 mls.

[159] The College further questions why the Respondent would not have noted each time he examined or checked on the animal that he did not need further medication, noting that the *Professional Practice Standard: Medical Record Keeping* states that a medical record is "a legal document that represents the veterinarian's thought process, decisions, judgment, actions, and interactions with others…each of which has an impact on patient outcomes…[and is] a communication tool which facilitates the continuity of care for animals both within and between veterinary medical-care teams."[25]

[160] The College also questions the adequacy of the Respondent's notes pertaining to the administration of CPR, submitting that the time of 5:00 a.m. did not necessarily reflect the time when the animal became unconscious; that the times at which epinephrine and atropine were administered would have suggested that CPR was discontinued at 5:15 a.m., and that the owners say they arrived at 5:30 a.m., so that the death could not have been at 5:45 a.m. and CPR could not have been conducted for 45 minutes. The College submits as well that the inclusion of the dosage for a cat in the note pertaining to the IV fluids suggests that the Respondent may have inaccurately recorded the dosage he provided, or at least the note was confusing as to what dosage was applied.

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[25] https://www.cvbc.ca/wp-content/uploads/2020/03/Medical-Records-Standard-General.pdf, at p. 2

[161] In relation to the Respondent's communications with the owner, the College points to the Respondent's notes suggesting the clients had been called at 5:00 a.m. and 5:50 a.m., which are inconsistent with the evidence of the Complainant. The College notes that the Respondent was unable to say whether it was him that called the owners the first time. The College submits that the Respondent's own note, which read, "Yes – at 5:00 a.m. [the animal] get unconscious," is inconsistent with the Respondent's evidence that he was engaged in CPR "immediately" at that time. The College notes that the Respondent agreed that the owners had attended at the clinic sometime between those two notes, and before he created his records.

[162] The College urges the Panel to prefer the evidence of the Complainant to that of the Respondent in relation to these communications. The notations of, "Client Communication: Yes at 5:00 AM [Dog name] get unconscious" and "Called the client at 5:50 AM autopsy was recommended-declined," the College submits, reflect two things that the evidence shows did not actually occur as written. The College points to the Complainant's belief that the animal was alive when the first call came and based on that, submits that the owners were not informed he was unconscious. The College submits as well that the Respondent did not make this call, as he indicated he was busy with CPR when it was made. The College says that the evidence of the Complainant about that call, though second hand, should be preferred.

[163] The College submits that the evidence establishes that the owners went immediately to the Clinic, and they were informed by the receptionist that the dog was dead, supporting the Complainant's assertion that there was no call to inform them that he had died. The discussion regarding autopsy took place in person at the Clinic, not on the phone, there was no call at 5:50 a.m., and the Respondent's notes contained no details of the admitted discussion he had with the owners at the Clinic regarding potential causes of death or the Complainant's apparent inability to understand the explanation that the Respondent was providing to her. The problems with communication that the Respondent cited were not excuses for failing to document the conversation, and should themselves have been recorded, it is argued.

2. Respondent Submissions

[164] The Respondent submits that his role in relation to the animal was simply to monitor his condition overnight after he was stabilized by another veterinarian, and to attend to him when he suddenly became unconscious. The Respondent takes issue with the College's decision to proceed to a hearing against him with respect only to allegations in relation to record-keeping, which he submits is unusual and therefore unfair. He also submits that the College delayed its focus on the records and thereby failed to adequately investigate or to provide the Respondent with an adequate opportunity to respond to the case against him. Given the focus on records, the Respondent submits that the Panel must be vigilant not to make findings in relation to his treatment of the animal.

[165] Regarding credibility, the Respondent points out that the delay in focusing on records has hampered his ability to recall that aspect of the matter, and that the extreme emotion experienced by the Complainant in the situation would have coloured her perception of the events and affected the reliability of her evidence.

[166] The Respondent submits that the absence of evidence pertaining to the records provided by the other veterinarians who dealt with the animal, and the College's treatment of them, have hampered his ability to respond.

[167] The Respondent submits that while Bylaw s. 245(2)(b)(ii) requires that registrants ensure that medical information in the medical record is accurate, complete, appropriately detailed, and comprehensible, professional judgment plays a role in what each veterinarian will record in a medical record. The Respondent says that the reference to "appropriately" detailed recordings implies a range of approaches to medical record keeping, and that non-compliance is not demonstrated unless the records are well outside the standard and what competent veterinarians would provide.

[168] For this animal, the Respondent submits, intake, assessment, diagnostics, differentials and principal treatment had all taken place before the Respondent took over. By then, the animal had been stabilized, his oxygen saturation level had returned to 100%, and the harsh

lung sounds the first vet had observed were not present. Although the Respondent observed the animal was "panting," the owner acknowledged that this was normal for him.

[169] In light of his role, the Respondent submits that the state of his medical records are unremarkable, documenting only a stable situation, until 5:00 a.m. His cumulative entries at the end of the shift reflected an accurate assessment of his observations. The readings recorded were within a margin of error and therefore met the requirement that they be accurate, complete, and appropriately detailed. They met the standard of the Clinic, as described by the Clinic Owner, which stands as evidence of a commonly accepted standard in the profession.

[170] The Respondent submits that more detailed notes would not have provided any further answers as to why the dog became unconscious or passed away as it would only have provided more detail about the animal's apparently stable condition. He also argues that timely recording is not instantaneous recording and is not a reasonable expectation in a busy practice.

[171] The Respondent also submits that collaboration between practitioners may supplant, or supplement, written records. He also points to Section 219(1), which requires a newly involved registrant not to comment on the care provided by a previously involved registrant until after they have reviewed, and had a conversation with that registrant, about their medical records. The Respondent submits that the process of having Panel members make a decision about the state of a registrant's records without such a conversation, is an "artificial circumstance" outside the kind of regular practice for which records are created.

[172] The Respondent also points out that in this case, the animal died, so the records were never required to support continuing care.

G. Proof of the Allegations

1. Failure to Sufficiently Document Treatment and/or Monitoring Between Approximately 12:00 a.m. and 5:00 a.m.

[173] The question here is whether the College has proven, as it alleges in paragraph 1 a. of the Citation, that the Respondent's notes pertaining to the results of his reportedly regular checks on the animal between midnight and 5:00 a.m. "failed to sufficiently document … the treatment and/or monitoring" of the animal, and he thereby failed to comply with the *Act*, a regulation, or bylaw; or a standard, limit or condition imposed under the *Act*.

[174] The provisions that the Citation alleges were breached are:

> Section 245(2)(b)(ii) of Part 4 of the CVBC Bylaws [Ethics and Standards): (2) A registrant must: … (b) ensure that medical information in the medical record is … (ii) accurate, complete, appropriately detailed, comprehensible…
>
> Section 2(b) of the CVBC Professional Practice Standard: Medical Record Keeping: A veterinarian meets the Professional Practice Standard: Medical Records when he/she: … 2. Ensures records: … b. provide an accurate, complete and up-to-date profile of the animal(s) to enable continuity of care."
>
> Section(s) 2(g)(ii), (v), and/or (viii) of the CVBC Professional Practice Standard: Companion Animal Medical Records: 2. Specific requirements: g. For each physical and behavioural assessment: … ii. Physical examination findings or behavioural assessments, including both normal and abnormal findings… v. A written treatment plan that provides the level of detail necessary for a colleague to understand the direction of the case at the time of writing… viii. Any additional pertinent information.

[175] The Panel agrees with the College that the Respondent's records of what occurred during the monitoring period do not meet these standards. They are not accurate, complete, appropriately detailed, comprehensible, or up to date. There is no notation of "physical or behavioural assessments" including both normal and abnormal findings, nor a treatment plan describing the direction of the case, even if that direction was simply to maintain (or increase) fluid levels and continue to monitor temperature, pulse and respiration for signs of distress. In fact, no records were made within the period between 12:00 and 5:00 a.m.

[176] Looking at the *Guide to the Professional Practice Standard: Medical Records*[26] referred to by the College in its submissions, which the Panel accepts as evidence of the expectations of the College and veterinary profession in relation to record-keeping, the suggestion is that "records should be created or updated immediately or as soon as possible after contact with the patient or client or new information is received."

[177] While the Panel accepts that contemporaneity cannot always be the standard, particularly when intervention is required, proximity to the relevant events is a reasonable standard to expect, for exactly the reason that the notes in this matter were insufficient. A review of them did not permit an accurate assessment of whether the animal had deteriorated prior to his being discovered unconscious. Although the animal died, if he had survived, the records would not have answered for the next practitioner the questions that arose in relation to the timing of his lapse of consciousness. While continuous observation is not required, regular observation with reasonably contemporaneous records of it must be the standard. That is what the Guide suggests. With or without that published expectation, however, it is also what common sense suggests.

[178] The Respondent was demonstrably aware of the reasoning behind the need for adequate records, which he articulated as the need for another veterinarian to see what had happened with the animal. While he argues that oral communications can supplant records where they are reasonably available, the Panel disagrees that the expectation of communication between providers substitutes for written record-keeping requirements. In addition, the fact that there was no continuity of care issue in light of the death does not remove the need for some reasonable contemporaneity of records while the animal was being monitored over the preceding five-hour period. As already noted, had the CPR efforts been

[26] https://www.cvbc.ca/wp-content/uploads/2020/03/Guide-to-the-Medical-Records-Standards.pdf

successful, the record would not have provided answers as to what observations were last made before the lapse of consciousness, and when they were made.

[179] It must be observed that the Respondent's own evidence about "making rounds" and observing stability is suggestive of available time on his part to make reasonably contemporaneous notes, and not a "busy practice," or any exigencies interfering with his capacity to make records, as argued on his behalf. Moreover, if a practitioner is taking the time to make rounds and check on an animal that has been in respiratory distress, and has a "guarded to poor" prognosis, an objective view of his duties, whatever the specific bylaws or standards disclose, is that he would also take the time to record his findings soon after he makes them.

[180] The simple answer to whether providing single entries reflecting "cumulative average" readings after the event is sufficient is that it was impossible to tell, from the notes, when the animal was last observed to be conscious before the Respondent discovered him. While the Panel accepts the Respondent's assertion that his memory was affected by the passage of time, had there been a chronological or contemporaneous log of his findings, presumably he would have been better equipped to answer that question, and better able to articulate the care he provided to the animal.

[181] Moreover, the Panel found that Respondent's evidence on the question of when the animal became unconscious was telling. He was not prepared to admit that he had not seen him become unconscious, but he was also unable to say when he last saw him conscious. His simultaneous insistence that he found him unconscious on his rounds, "and" started CPR "immediately" upon him becoming unconscious, was not reasonable. This question was put to him several times and his answer was the same each time. He asserted simultaneity, but in the Panel's view his evidence, his notes, and common sense, clearly belied that.

[182] This part of the Respondent's evidence coloured much of the rest of his testimony, in the view of the Panel. A review of the notes the Respondent made after the event, although they do not form part of the timeline contained in the allegation, is of assistance in assessing

the sufficiency of the Respondent's overall approach to notetaking. The standardized wording in the later notes about CPR and medication; particularly the "cat" reference, are suggestive of retroactive reconstruction with the assistance of a template or other resource. His explanation for including the irrelevant dosage pertaining to a cat, which appeared to be a verbatim excerpt from some resource looked up after the fact, was unsatisfactory.

[183] The Panel notes, again, that the time frame after 5:00 a.m. is not the subject of the Citation, but the notes made by the Respondent, the majority of which were made after 5:00, provide context for the state of the notes within the relevant time frame.

[184] Moreover, the timing of the Respondent's entries on the record, coming after the unexpected death and unsuccessful resuscitation of the animal, is also suggestive of self-serving reconstruction, and, with respect, inconsistent with his assertion that he conducted the monitoring that he says he conducted. The Panel acknowledges that the Citation does not allege deficiencies in monitoring or treatment, only in record-keeping, and it is not open to us to conclude that the Respondent was less attentive to the animal than he should have been. The observation here is only that the timing and nature of his notes is better explained by an absence of checks than by his suggestion that "cumulative average" records at the end of an eight-hour shift were his practice.

[185] The Respondent relies on the evidence of the Clinic Owner to support his assertion that this level of record-keeping aligned with the Clinic's standard. the Clinic Owner is not the subject of these proceedings, and the Panel will only say that his evidence displayed a level of disdain for the College that may have coloured his interpretation or acceptance of the published standards. In addition, as submitted by the College, his evidence that such notes were sufficient does not override the standards. The Respondent's evidence about recording cumulative average measurements being standard practice, even with the Clinic Owner's assertion to support it, was not reasonable.

[186] The Panel accepts that the timing of the proceedings caused problems with the Respondent's recollection of the events, and observes that the fact that the Respondent was

foreclosed from bolstering his assertion of memory problems by leading evidence of delay through a College employee did not detract from his assertion in this respect.

[187] The College nonetheless questions why the Respondent may not have retained the handwritten notes he says he made, or may have made, during the period. The Panel understands the Respondent to suggest the delay in the proceedings may have affected his memory as to whether he had taken notes, and as well, his ability to retrieve them. Surely if those notes existed, however, the Respondent would have retrieved and preserved them immediately after experiencing the dramatic death of the animal, and not just at the point where he was advised his record-keeping was under scrutiny.

[188] In addition, had there been any such detailed notes of actual temperature, heart rate, breathing rate and urination, the Panel would expect that those notes would have made their way into the record that was made by the Respondent, albeit after the fact, in a more detailed fashion than occurred here. The suggestion that he may have made hand notes and discarded them simply adds to the issues with the Respondent's credibility.

[189] The Panel finds that the Respondent failed to sufficiently document his treatment and/or monitoring of the animal between the hours of midnight and 5:00 a.m. and thereby failed to comply with Section 245(2)(b)(ii) of Part 4 of the CVBC Bylaws, Section 2(b) of the CVBC Professional Practice Standard: Medical Record Keeping, and Section(s) 2(g)(ii), (v), (vii) and/or (viii) of the CVBC Professional Practice Standard: Companion Animal Medical Records.

2. Failure to Document Communications with the Animal's Owners Regarding His Death

[190] In relation to the issue of communications with the owners, the question posed by the Citation is whether the College has proven that the Respondent failed to sufficiently document in the medical records his communication(s) with [the dog's] owner(s) regarding his death. Setting aside the alleged breach of Section 38 of Schedule D, the Medical Records Standard: Companion Animal Section 2.g.(vii) requires, "For each physical and behavioural assessment:

…The date and (approximate) time of each client communication, the name of the person communicated with, and a summary of the exchange…"

[191] As the Panel previously noted, the requirement in Section 38 of "a summary of pertinent verbal communications" may nonetheless serve as evidence of the College's expectations (and therefore the industry standard), as may the Guide, which states[27]:

> A complete and accurate medical record includes documentation of all communications with the client. This includes face-to-face, telephone, electronic, and other means of communication with owners and/or alternate decision makers. Records should document advice provided, including diagnoses, treatment plans, required tests and interpretation of results, referrals, and discharge directions. They should also document discussions to obtain consent and, in situations when treatment is refused, a notation of the rationale for refusing the recommendation, if provided.

[192] The College submits that the Complainant's evidence as to the content of the first phone call should be preferred over that of the Respondent, even though she was relating what her partner had told her. The Respondent's evidence suggests this call was made, perhaps at his request, at about the time the Respondent realized the animal was unconscious and started CPR efforts.

[193] It seems probable to the Panel that an assistant made that call. The actual contents are not in evidence, nor is there a firsthand account from the call recipient. The Complainant was relating what she surmised from overhearing her partner on the call, and what he related to her after it. The degree to which he either understood what he was being told, or was able, in whatever state he was in, to relate it to the Complainant, is not apparent.

[194] Although the Panel accepts that it can rely on evidence that may not be firsthand, in this situation, the evidence simply did not establish what transpired on that call or who made it.

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[27] https://www.cvbc.ca/wp-content/uploads/2020/03/Guide-to-the-Medical-Records-Standards.pdf

This is an area where, again, the Panel accepts the Respondent's lack of memory. It seems unlikely he made the call, and the evidence does not establish that the Respondent's entry in relation to it was inadequate. It seems unlikely that much about the animal's care or treatment would have been related in that call, and the note, "became unconscious" was arguably sufficient. This would seem consistent with a direction by the Respondent to the receptionist to call the owners as he realized the animal needed CPR.

[195] By all accounts, the owners were invited to come and see their pet, at 5:00 a.m., and went directly to the clinic. It might be assumed from that, that they, or at least the Complainant's partner, understood the situation to be somewhat dire.

[196] The next aspect of the evidence pertaining to communications with the owner is the entry, "Called the client at 5:50 AM autopsy was recommended-declined." The Respondent admits to having made this entry. Based on the evidence of both the Complainant and the Respondent this followed a lengthy interaction at the clinic after the animal had died, in which, by all accounts, the Respondent was not able to explain to the owners why their pet had died, and the Complainant became upset and vocal. She was clearly upset enough that the staff decided to call the Clinic Owner. On her own account, the Respondent seemed intimidated and unable to properly explain what occurred. She took issue with his reference to waiting for tests when in fact some tests had been returned, but the evidence supports a conclusion that this is what happened. The evidence is silent as to the cause of death. It is common ground that the owners declined to request an autopsy.

[197] The question that arises is what level of detail regarding this interaction should have made its way into the notes. The notation made by the Respondent, if he made it, about a 5:50 a.m. call, was admittedly made after 6:00 a.m. There is no suggestion, however, that it was made much later than that, given that the Respondent's shift ended at 6:00 a.m. While the Complainant's evidence was that they called the clinic later that day to advise they did not want an autopsy, it does not appear to be suggested by the College, or the evidence, that the notation about the 5:50 a.m. interaction occurred significantly later in the day.

[198] Clearly, the timing of the notes in relation to the time of death and the autopsy decision are unclear. The Complainant's estimate of the time they arrived and the Respondent's note of the time of death differ by 15 minutes. If the death was a bit earlier than 5:45 a.m. and the owners had already made their way home by 5:50 a.m., that note could have reflected the later call from the Clinic Owner that the Complainant described. While the Respondent believed it was a call he had made, his recollection of the events was clearly affected by the passage of time. If he did make the call, the note that the autopsy was declined is not inaccurate, given that it was never authorized, and although the owners wanted some time to think about it, they did not elect to have one. A note that they had declined by 5:50 a.m., presumably while at the clinic, is not inconsistent with the evidence that there was a discussion about that, at that time. It does not seem improbable that they said no at that time, and later confirmed that position.

[199] The question that remains, however, is whether that call was made by the Respondent or not, did he sufficiently document the communications he had with the owners while they were at the Clinic. As noted, the standards suggest a record of "pertinent" communications, and "for each physical and behavioural assessment," the details of any exchange with the owners.

[200] Here, the fact of the death may have more relevance. This was not a communication about assessing the animal, or explaining his care to the owners. It was a conversation in which the Complainant was demanding an explanation, and the Respondent was unable to provide it. His inability appears to have been in part due to the fact that the cause was not known, in part due to communication difficulties with the Complainant, and perhaps in part because the Respondent recognized that he was not able to describe to her the moments before the animal became unconscious. That inability is not the subject of the allegations, however.

[201] The question is how much of that interaction with the owners should have been included in the notes. The College points out that the Respondent admitted discussing with the

Complainant alternative potential causes of death, and submits that the notes were not accurate, complete, or appropriately detailed:

> The medical records did not contain a summary of pertinent verbal communications and interactions with the owners which has an impact on patient outcomes. …The summary of the in-person exchange is absent entirely. Even if the Panel accepts that it was erroneously recorded as a phone call rather than an in-person communication, information about the Complainant's questions and the Respondent's response, the substance of the discussion between the Complainant and each of the Respondent and the Clinic Owner (or even the fact that it had occurred), the Complainant's reaction and many other pieces of pertinent information are all absent from the record.

[202] The College's reference to impact on outcomes arises from the Professional Practice Standard: Medical Record Keeping, which defines medical record as "a legal document that represents the veterinarian's thought process, decisions, judgment, actions, and interactions with others [including clients] …each of which has an impact on patient outcomes…"[28]

[203] The Panel is of the view that the records prepared by the Respondent do not comply with the standards established by the College. The two notations pertaining to communications at 5:00 and 5:50 a.m., whether those are accurate, completely fail to document the presence of the owners at the Clinic between those times, and any conversation that the Respondent had with them.

[204] Certainly, at that point, the animal had died, and these were not conversations about advice or treatment plans; however, a clearly dramatic and significant event had occurred within the veterinarian-patient relationship, and clearly one that pertained to outcome. On the Respondent's own evidence, they discussed potential causes of death, testing that had been done and was pending, and the need for an autopsy to determine what had happened. None of that appeared in the file, apart from the 5:50 a.m. entry. At the very least, common sense

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[28] https://www.cvbc.ca/wp-content/uploads/2020/03/Medical-Records-Standard-General.pdf, at p. 2

would dictate some kind of summary of the information the Respondent was trying to get across, even if he believed he was unsuccessful. One would also expect some background of the discussion leading up to the clients' decision not to have an autopsy.

[205] The Panel agrees with the College that the fact that the Respondent believed he was unable to communicate successfully with the owners is not a reason to make no notes of the interaction. Much like the reasoning behind his being too busy to make timely notes of his observations and assessments of the animal while he monitored it, the Respondent's use of an excuse for failing to comply suggests an understanding of the expectation but does not provide a reasonable explanation for failing to adhere to it.

[206] The Panel finds that the Respondent failed to sufficiently document his communication with the owners regarding the animal's death, and thereby failed to comply with Section 2(g)(vii) of the CVBC Professional Practice Standard: Companion Animal Medical Records.

H. Conclusion

[207] For the foregoing reasons, the Panel finds that the Respondent failed to comply with the specified CVBC Bylaws and Standards in relation to his record-keeping on June 29, 2021, pertaining both to his treatment and monitoring of the animal between 12:00 a.m. and 5:00 a.m., and to his communications with the animal's owners regarding his death.

[208] The matter will be set for submissions and and/or a hearing as required, in relation to the appropriate measures under Section 61(2). Counsel will be contacted by the College Executive Assistant to arrange dates, or a case management conference, if necessary.

Carol Baird Ellan
Carol Baird Ellan K.C., Panel Chair

Amy Cheung
Dr. Amy Cheung

Teresa Cook
Dr. Teresa Cook

APPENDIX A

Animal Hospital & Emergency Patient Chart

Printed: 3/25/22 at 5:11p

CLIENT INFORMATION

Name
Address

Phone

PATIENT INFORMATION

Name		**Species**	Canine
Sex	Male, Neutered	**Breed**	Bulldog, French
Deceased	6/29/21	**Age**	D@8y
ID		**Rabies**	
Color	Cream	**Weight**	18.00 lbs
Reminded	(none)	**Codes**	D

(No reminders are due for this patient.)

HEALTH HISTORY SUMMARY

Date	Diagnosis
7/06/21	MEDICAL RECORD SENT BY: email to
10/10/17	MEDICAL RECORD SENT BY: Fax to

MEDICAL HISTORY

Date	By	Code	Description	Qty (Variance)	Photo
7/06/21	**B**	**Z11**	**MEDICAL RECORD SENT BY:**		
email to					
6/29/21	B	PCO001	Private Cremation wt upto 25lbs		
		FNOTE$	By: B, Follow-up notes		
Blood work and Xray sent to owner					
6/29/21	RKS	03S	SHIFT 12:00 Midnight - 6:00 AM		

Age: 8y

PLAN SECTION

NOTES

Presenting complaint
Breathing heavily
-Eating less
-Lethargic

General appearance: LETHARGIC
Mm: Pale-pink
CRT: < 2 sec
Temperature: 102.0 F
Heart: HR 120 b/min
Respiration: Panting
Lungs: Normal
Defecation: No
Urination: Yes
Vomiting: No
Seizures: No

Ate food: No
Fluids done: @ 28 ml/hr

Medication planned at the admission time:
Baytril @ 5 mg/kg IM - bid
Butorphanol 10 mg/ml 0.25 ml IV - as per need
To be done BID

New medication added: none

Medication done: None

Comments: None

Client Communication: Yes at 5:00 AM get unconscious

CPR started
Endotracheal tube 6 mm placed and connected to oxygen supply.
.
Bagging @ 25 breaths/minute.

Placed the patient in right lateral recumbency.
Chest compression @ 100/minute.

Epinephrine 1:1000 (1 mg/ml) @ 0.1 ml/lb IV
Atropine 0.54 mg/ml @ 0.03 ml/lb IV

IV Catheter placed at the right Cephalic vein.
IV Fluid LRS @ 40 ml/lb (dog) 20 ml/lb (cat) started

Pulse absent. No heart beat. No respiration.
Repeated epinephrine and atropine after 10 minutes at above given dose rate.

Despite all CPR efforts could not save
Pronounced dead .5:45 AM
Called the client at 5:50 AM
autopsy was recommended-declined
Note:
" Shift Medical Notes" has been created on CID at the beginning or earlier in the shift, however, the contents of the notes have been uploaded at the end of shift. Therefore, uploaded information represents all changes in the patient's health status and client communication happened until the end of the shift.

6/29/21 NKP I038 Diazepam 5mg/ml

	Items used:		CD010	Diazepam 5mg/ml	1.00
6/29/21		NKP	I040	Butorphanol 10mg/ml	0.25
	Items used:		CD011	Butorphanol 10mg/ml	0.25
6/28/21		NKP	X009	Radiographs	
			IVLSO	Requisition 33926-879118	

Age: 8y

Test	Result	Flag	Normal Range Low	Normal Range High	
ProCyte_Dx 6/29/21 12:09a					
RBC	**4.92**	**L**	**5.65**	**8.87**	**x10^12/L**
HCT	**32.8**	**L**	**37.3**	**61.7**	**%**
HGB	**11.6**	**L**	**13.1**	**20.5**	**g/dL**
MCV	66.7		61.6	73.5	fL
MCH	23.6		21.2	25.9	pg
MCHC	35.4		32.0	37.9	g/dL
RDW	16.4		13.6	21.7	%
%RETIC	1.5				%
RETIC	71.8		10.0	110.0	K/µL
RETIC-HGB	26.1		22.3	29.6	pg
WBC	15.04		5.05	16.76	x10^9/L
%NEU	83.7				%
%LYM	8.7				%
%MONO	7.0				%
%EOS	0.3				%
%BASO	0.3				%
NEU	**12.60**	**H**	**2.95**	**11.64**	**x10^9/L**
LYM	1.31		1.05	5.10	x10^9/L
MONO	1.05		0.16	1.12	x10^9/L
EOS	**0.04**	**L**	**0.06**	**1.23**	**x10^9/L**
BASO	0.04		0.00	0.10	x10^9/L
PLT	**489**	**H**	**148**	**484**	**K/µL**
MPV	10.3		8.7	13.2	fL
PDW	**9.0**	**L**	**9.1**	**19.4**	**fL**
PCT	**0.50**	**H**	**0.14**	**0.46**	**%**

Test	Result	Flag	Normal Range Low	Normal Range High	
Catalyst_One 6/29/21 12:24a					
GLU	5.54		3.89	7.95	mmol/L
SDMA	**18**	**H**	**0**	**14**	**µg/dL**
CREA	83		44	159	µmol/L
UREA	8.2		2.5	9.6	mmol/L
BUN/CREA	24				
PHOS	1.55		0.81	2.20	mmol/L
CA	2.60		1.98	3.00	mmol/L
TP	73		52	82	g/L
ALB	28		22	39	g/L
GLOB	45		25	45	g/L
ALB/GLOB	0.6				
ALT	46		10	125	U/L
ALKP	39		23	212	U/L
GGT	0		0	11	U/L
TBIL	5		0	15	µmol/L
CHOL	5.32		2.84	8.26	mmol/L
AMYL	**341**	**L**	**500**	**1500**	**U/L**

Patient Chart for Client:
Date: 3/25/22, Time: 5:11p Page: 4

Date	By	Code	Description		Qty (Variance)	Photo
LIPA	583		200	1800	U/L	
Na	153		144	160	mmol/L	
K	4.2		3.5	5.8	mmol/L	
Na/K	37					
Cl	117		109	122	mmol/L	
Osm Calc	307				mmol/kg	
TT4	29		13	51	nmol/L	
			Attachments\24512\		~\20210629_000542_6777.pdf	
6/28/21	NKP	H07	In Hospital Medication & Monitoring			
		GT053	Oxygen Therapy			
		SXA 02	IV Catheter			
		IV008	IV Fluids Administration			
		BW05	Blood Work in Hospital with T4			
		EX 01	Examination/Consultation			

Wt.: 18.00 lbs
ASSESSMENT:
Breathing heavily
General appearance: Lethargic
Mucous membrane: Pale-pink
Hydration: Dehydration 4%
Lungs: Harsh lung sounds
Respiration: 45 breaths/min open mouth
Oral Exam: Dental tartar

Age: 8y

PLAN SECTION

NOTES

PRESENTING COMPLAINT:
-Breathing heavy
-Restless
-Eating less

SUBJECTIVE:
As per the client, is breathing heavily and restless since yesterday night.
He is not on any long time medication.

OBJECTIVE:
Wt.: 18.00 lbs
General appearance: Lethargic
Mucous membrane: Pale-pink
CRT: < 2 sec
Hydration: Dehydration 4%
Temperature: 101.4 F
Heart: HR 120 b/min
Lungs: Harsh lung sounds
Respiration: 45 breaths/min open mouth
Oral Exam: Dental tartar
BCS: 3 /5
Eyes: Normal
Ears: Normal
Nose: Normal
Palpation: Abdomen - Normal

Lymph nodes - Normal
Skin and coat: Normal
Musculo-skeletal: Normal
Rest of the Physical Exam nothing clinically significant found.

ASSESSMENT:
Breathing heavily
General appearance: Lethargic
Mucous membrane: Pale-pink
Hydration: Dehydration 4%
Lungs: Harsh lung sounds
Respiration: 45 breaths/min open mouth
Oral Exam: Dental tartar

R/O: Brachycephalic syndrome, Toxicity, Metabolic disease, Infection, Tumor, Open

PROGNOSIS: Guarded to poor

PLAN:
-Oxygen therapy
-Blood work: Hematology and biochemistry
-X-Rays: Thorax and abdomen
-Hospitalization : IVF, meds and monitoring for 24 hours or more

Rule outs, Prognosis and Plan discussed with the client.
Client okayed.
.
IV catheter place at right cephalic vein.
LRS IV @ 27 ml/hr started
.
Medication done:
Baytril @ 5 mg/kg IM - bid
Butorphanol 10 mg/ml 0.25 ml IV - as per need
.
Placed in Oxygen chamber for 20 minutes.
Respiratory distress didn't improve.
Pulse oximetry 60
.
Diazepam 1.0 ml IV
Endotracheal tube 6 mm placed and hooked to Anesthetic machine - Isoflurane 1.5% + Oxygen 2 L/min.
Kept for 45 minutes. Pulse oximetry 100. Isoflurane stopped. Endotracheal tube removed when jaw tone appeared.
.
Blood work done.
Anemia; SDMA elevated R/O Tumor, Kidneys insufficiency, Open .
.
X-Rays done - gas in the stomach - removed with needle
X-Rays sent to Radiologist.

SHIFT DOCTORS can add meds as per need.

Attachments\24512\ \24512 w.jpg

6/13/21 SKB EX 01 Examination/Consultation

\ **Age:** 8y