NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Garcia, this is notice that the Discipline Committee ordered a ban on publication of the names and any information that could disclose the identity of Ms. A and patients referred to orally or in the exhibits filed at the hearing, as well as a ban on publication or broadcasting of the names of Ms. A's relatives who are witnesses, which could disclose the identity of Ms. A under subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

> Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:
>
> Every person who contravenes an order made under … section 45 … is guilty of an offence and on conviction is liable,
> (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Garcia, 2017 ONCPSD 6**

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act, 1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. YELIAN GARCIA

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MS. D. DOHERTY
DR. W. KING
MS. D. GIAMPIETRI
DR. E. STANTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. B. DAVIES
MS. R. AINSWORTH

COUNSEL FOR DR. GARCIA:

MR. M. SAMMON
MR. I. MACLEOD

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Dates:	**July 18 to 21 and August 4 to 5, 2016**
Decision Date:	**February 15, 2017**
Release of Reasons Date:	**February 15, 2017**

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 18 to 21 and August 4 to 5, 2016. At the conclusion of the hearing, the Committee reserved its decision

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Garcia committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and,
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Garcia is incompetent, as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Garcia admitted the first allegation in the Notice of Hearing that, he failed to maintain the standard of practice of the profession. Dr. Garcia denied the second allegation in the Notice of Hearing, that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The allegation of incompetence was withdrawn by the College.

1. Allegation of Failing to Maintain the Standard of Practice

Agreed Statements of Facts

The following Agreed Statement of Facts regarding Clinical Issues was filed as an exhibit and presented to the Committee:

PART I – THE FACTS:

Background

1. Dr. Yelian Garcia ("Dr. Garcia") is a family physician who practised medicine in the Greater Toronto Area at all relevant times.

2. After graduating from medical school and completing a residency program through McMaster University, Dr. Garcia practised under a restricted certificate of registration between August 18, 2011 and January 12, 2012. During this time, he practised family medicine under the supervision of Dr. John Fitzsimons at Wellington Medical Centre in Aurora, and under the supervision of a second physician at Oak Ridges Medical and Urgent Care Centre in Richmond Hill.

3. In January 2012, Dr. Garcia obtained his certificate of registration authorizing independent practice. Although he was no longer under supervision, Dr. Garcia continued to provide family medicine and walk-in services at Wellington Medical Centre and urgent care services at Oak Ridges Urgent Care Centre. He also began providing urgent care and walk-in services at One Care Medical Clinic in Scarborough and Woodbridge Urgent Care Centre in Woodbridge, as well as providing medical care to patients at three long-term/residential care facilities.

4. According to Dr. Garcia, he was seeing on average 10 to 13 patients per hour at the Wellington Medical Centre in 2012. Because of this, Dr. Garcia would chart pertinent information during patient encounters and complete 50 to 70% of his charts at the end of the day. Dr. Garcia tried to be as efficient as possible while ensuring an evidence-based practice. He conducted some patient examinations and assessments very quickly in 2012.

5. There was a Pharmasave pharmacy located in the same premises as the Wellington Medical

Centre in Aurora. George Gunovski was a pharmacist and co-owner of the pharmacy. In the summer of 2012, Mr. Gunovski expressed concern about Dr. Garcia's narcotic prescribing practices to both Dr. Garcia and Dr. Fitzsimons.

6. In the late summer and fall of 2012, Dr. Fitzsimons reviewed the charts for most of the approximately dozen patients to whom Dr. Garcia was prescribing narcotics or opioids at the Wellington Medical Centre. Dr. Fitzsimons also met with several of these patients, along with Dr. Garcia. Dr. Fitzsimons conducted an assessment of each patient's pain and the appropriateness of the narcotics prescriptions given by Dr. Garcia. Following this process, several patients seen together by Dr. Fitzsimons and Dr. Garcia were referred to a pain clinic, specialist or detoxification program.

7. In May 2013, Dr. Fitzsimons contacted the College of Physicians and Surgeons of Ontario (the "College") to report his concerns about the medical care provided by Dr. Garcia.

8. Following receipt of this information, the College began an investigation under s. 75(1)(a) of the Health Professions Procedural Code into Dr. Garcia's practice.

The College's Investigation

9. As part of its investigation, the College retained Dr. Howard Burke in December 2013 to provide an opinion regarding Dr. Garcia's standard of practice. Dr. Burke is a family doctor who graduated from the University of Toronto medical school in 1988. In addition to maintaining a family practice, Dr. Burke holds an active staff appointment at Lakeridge Health in Bowmanville.

10. The College obtained medical records with respect to 36 patients of Dr. Garcia from four of Dr. Garcia's practice locations in 2013. Dr. Burke reviewed these records and also conducted interviews of Dr. Garcia and Dr. Fitzsimons in connection with his preparation of several reports in 2013 and 2014. Dr. Burke also delivered an addendum report to the College on July 15, 2016 following his review of additional records that were provided to him.

11. In his reports, Dr. Burke concluded that Dr. Garcia provided very fine medical care to some

patients and that Dr. Garcia failed to maintain the standard of practice of the profession in his care of other patients.

12. Dr. Garcia acknowledged during the College investigation that he should slow down in terms of the manner in which he assessed and communicated with patients. Dr. Garcia also stated that his practice had changed since 2012 and early 2013, and that he had tried to slow down his patient interactions and communicate more effectively with patients.

13. Dr. Garcia acknowledged during the College investigation that he was "duped" by a couple of patients who were engaged in drug-seeking behaviour and that he was too trusting of patients who were seeking narcotics for pain medication. At that time, Dr. Garcia also stated that he had learned to be less trusting of patients and that he no longer had patients with chronic pain in his family practice.

14. The following paragraphs provide a brief description of patient encounters reviewed by Dr. Burke as well as Dr. Burke's conclusions:

a) **Patient B**: Patient B was a patient of Dr. Garcia's at the Wellington Medical Centre in 2012. Patient B's first appointment was on a date in the summer of 2012. The chart indicates that patient B was seeking a new family doctor. He complained of chronic pain following an accident. As Dr. Garcia noted in patient B's chart, they discussed opioid contracts and opioid prescriptions during patient B's first appointment. The opioid contract signed by patient B with Dr. Garcia required him to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. At their first appointment, Dr. Garcia renewed the patient's existing prescriptions, including prescriptions for fentanyl patches at a dose of 100 mcg/hr and Dilaudid 4 mg. There is no record in the chart of Dr. Garcia conducting a physical examination of patient B and there are no notes of Dr. Garcia taking a history of the patient's pain or the effectiveness of past treatments. Over the next two months, Dr. Garcia renewed patient B's prescriptions for fentanyl and Dilaudid two more times. The prescriptions were renewed early without a notation in the chart to explain why. In September 2012, Dr.

Fitzsimons met with patient B along with Dr. Garcia and patient B was referred to an addiction centre. Dr. Burke concluded that Dr. Garcia fell mildly below the standard of care in the care of this patient.

b) **Patient C**: Patient C was seen by Dr. Garcia and other physicians at the Wellington Medical Centre in 2011 and 2012. Patient C's chart reflects that he reported chronic pain from multiple surgeries. Dr. Garcia's clinical notes describe a discussion with patient C regarding an opioid contract and opioid addiction. The opioid contract signed by patient C with Dr. Garcia required him to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. Patient C's prescription history included the following:

- On a date in January 2012, patient C was already on Dilaudid and mirtazapine and was being seen at a pain clinic. At this appointment, Dr. Garcia prescribed patient C Hydromorph Contin 3 mg and Dilaudid 4 mg. There are no notes in the chart of Dr. Garcia conducting a physical examination during this appointment.
- In April 2012, Dr. Garcia increased patient C's dose of Dilaudid to 6 mg, and switched him from Hydromorph Contin to fentanyl patches at a dose of 25 mcg/hr.
- Between April and June 2012, the dose of the fentanyl patch was increased by Dr. Garcia from 25 mcg/hr to 75 mcg/hr.
- On August 24, 2012, Dr. Garcia increased patient C's dose of Dilaudid to 8 mg.

On August 29, 2012, the patient saw another physician at Wellington Medical Centre because Dr. Garcia was away. Patient C requested an early renewal of his fentanyl prescription, claiming he was going away for work and would run out while he was away. This physician prescribed one additional fentanyl patch for patient C. In September 2012, Dr. Fitzsimons met with patient C along with Dr. Garcia – patient C was referred back to his anesthetist for pain management and was discharged as a patient. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care in the care of this patient. With respect

to his review of the chart for this patient, Dr. Burke also expressed concern that Dr. Garcia was exposing his general patients to harm by not obtaining an adequate history or doing a proper physical examination of a patient who complains of "chronic pain."

c) **Patient D**: Patient D was a patient of Dr. Garcia's at the Wellington Medical Centre. She first saw Dr. Garcia on in the summer of 2012. According to Patient D's chart, at that time she was already taking fentanyl and Dilaudid for pain resulting from a motor vehicle accident. In the summer of 2012, Dr. Garcia provided patient D with a prescription for 15 days' worth of Dilaudid and fentanyl patches. Dr. Garcia had the following additional encounters with patient D:

- Dr. Garcia saw patient D again in the summer of 2012. According to his notes of that visit, he and patient D discussed an opioid contract and proper prescription practices, and Dr. Garcia recorded a social history. The opioid contract signed by patient D with Dr. Garcia required her to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. On that appointment in the summer of 2012, Dr. Garcia gave patient D a prescription for 2-3 weeks' worth of Dilaudid and fentanyl patches. There is no explanation in the chart why he renewed the prescription for Dilaudid and fentanyl early.
- Patient D was seen again in the summer of 2012, two weeks after the previous appointment. Dr. Garcia prescribed her 10 fentanyl patches at a dose of 75 mcg/hr and 40 Dilaudid 4 mg. There is no explanation in the chart regarding early prescription renewals.

There is no record in patient D's chart of the type of pain she was experiencing or of any physical examination being conducted by Dr. Garcia. In October 2012, Dr. Fitzsimons met with patient D along with Dr. Garcia and suggested she attend a detoxification centre. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care in this case.

d) **Patient F**: Patient F was a patient of Dr. Garcia's at the Wellington Medical Centre. The

chart indicates that she first met with Dr. Garcia on a date in the summer of 2012, seeking a new family doctor. At that time, she was taking Dilaudid for chronic pain. Dr. Garcia provided her with a prescription for 4 weeks' worth of Dilaudid 8 mg on a date in the summer of 2012. Dr. Garcia did not record the cause of patient F's pain and did not record conducting any physical examination. Dr. Garcia made a note that he discussed "opioid contract and proper prescribing practices" with patient F during the appointment. The opioid contract signed by patient F with Dr. Garcia required her to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. Dr. Garcia saw patient F a second time in the summer of 2012. The chart indicates that Dr. Garcia provided a renewal of her Dilaudid prescription on that day. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care in this case.

e) **Patient H**: Patient H was a patient of Dr. Garcia's at the Wellington Medical Centre. The chart indicates that he first met with Dr. Garcia in the summer of 2012, looking for a new physician. At this appointment, Dr. Garcia prescribed patient H 10 fentanyl patches at a dose of 75 mcg/hr and 3 weeks' worth of Dilaudid 8 mg. Dr. Garcia did not record the source of patient H's pain and did not record conducting any physical examination. According to Dr. Garcia's notes, this patient was to follow up for "further interviewing/records review and physical." In September 2012, patient H was seen by Dr. Fitzsimons along with Dr. Garcia. Dr. Fitzsimons took a detailed history from patient H, including a history of methadone and suboxone therapies. Dr. Fitzsimons advised patient H to seek treatment at a pain clinic. Dr. Burke concluded that Dr. Garcia fell mildly below the standard of care in the care of this patient.

f) **Patient I**: Patient I was a patient of Dr. Garcia's at the Wellington Medical Centre in 2012. The chart indicates the following appointments with and prescriptions from Dr. Garcia:

- Patient I was first seen by Dr. Garcia in the late spring of 2012. Dr. Garcia's notes of that appointment indicate that he was "too busy today for meet and greet". The notes also indicate that Dr. Garcia discussed "opioids contracts" with Patient I. The opioid

contract signed by patient I with Dr. Garcia required him to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes.

- Patient I was seen again in the late spring of 2012. On that date, Dr. Garcia took a social and medical history. A physical examination was booked for a later time and Dr. Garcia prescribed Patient I 224 tablets of Percocet.
- On a date in July of 2012, Dr. Garcia's notes indicate there were "no red flags" and "no drug seeking" behaviour. Dr. Garcia switched Patient I from Oxycontin to OxyNeo, and prescribed him 100 tablets of Oxyneo 80 mg.
- On a subsequent date in July of 2012 , Dr. Garcia prescribed Patient I 224 Percocet tablets, 100 tablets of Oxy-Neo and 30 tablets of Dilaudid 8 mg for break-through pain.
- On a date in July of 2012, Dr. Garcia prescribed Patient I a further 100 tablets of OxyNeo and 30 additional Dilaudid 8 mg.
- Patient I returned on a date in August of 2012 complaining that neither the Dilaudid nor the OxyNeo were working well.
- On a date in August of 2012, a note was placed on Patient I's chart, which states "Narcotics watch – speak to pharmacist before renewing medications."
- On a date in August of 2012, Dr. Garcia renewed patient I's prescription for OxyNeo despite making a note in the chart that reads, "see Ms. A bit early for oxyneo … must await before refill". The pharmacist spoke to Dr. Garcia about filling this prescription. Dr. Garcia approved the early release of 84 tablets of OxyNeo.

Dr. Garcia did not include a detailed description of the source of patient I's pain and he did not record conducting a physical examination in the chart. Dr. Garcia renewed prescriptions for patient I early, with no explanation in the chart for the early renewals. In September 2012, Dr. Fitzsimons met with patient I along with Dr. Garcia. During that meeting, patient I advised that he had been on both methadone and suboxone in the past in an attempt to treat addiction to narcotics and opioids. On that date, patient A was referred to a pain clinic and no

further prescriptions were given. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care with respect to this patient.

g) **Patient J**: Patient J first saw Dr. Garcia at the Wellington Medical Centre on a date in July of 2012. The chart indicates that he complained of chronic pain from a hockey injury and a ladder accident. The notes of the appointment indicate that patient J had a "long complicated pain history". Dr. Garcia took a social and medical history. There are a few brief notes in the chart about the social history. The notes also indicate that Dr. Garcia discussed opioid contracts and proper prescribing practices with patient J. The opioid contract signed by patient J with Dr. Garcia required him to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. The chart indicates the following prescriptions given to patient J:

- On a date in July of 2012, Dr. Garcia prescribed patient J 27 days' worth of fentanyl patches at a dose of 50 mcg/hr and 3 weeks' worth of Dilaudid 8 mg.
- On a date in August of 2012, Dr. Garcia renewed patient J's prescription for both fentanyl and Dilaudid. There is no note to explain the early renewal of fentanyl: Dr. Garcia had prescribed patient J 27 days' worth of fentanyl 19 days earlier.

Dr. Garcia did not record details of the nature of patient J's pain and he did not record conducting any physical examination. In September 2012, Dr. Fitzsimons met with patient J along with Dr. Garcia. Dr. Fitzsimons took a detailed history of patient J's pain and medication use and determined that patient J had missed an appointment at a pain clinic. Dr. Fitzsimons discussed with patient J concerns that he was misusing opioids and referred him back to the pain clinic. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care with respect to this patient. With respect to his review of the chart for this patient, Dr. Burke also expressed concern that Dr. Garcia's general patient population was put at risk based on Dr. Garcia's repeated inability to detect the misuse of opioid medication.

h) **Patient K:** Patient K first saw Dr. Garcia at the Wellington Medical Centre on a date in

December of 2011. The chart indicates that patient K complained of chronic pain from multiple surgeries. Dr. Garcia started patient K on a trial of tramadol. Between late 2011 and a date in October 2013, patient K was prescribed tramadol (Ralivia), gabapentin, Percocet and Dilaudid to control his pain. Patient K received early renewals of certain pain medications from Dr. Garcia during that time without explanations documented in the chart. Dr. Garcia recorded that he discussed, among other things, an opioid contract with patient K and patient K's past use of opioids. There is no signed opioid contract in the patient record. Dr. Burke concluded that Dr. Garcia fell mildly below the standard of care with respect to this patient.

i) **Patient L**: Patient L first saw Dr. Garcia at the Wellington Medical Centre on a date in June of 2012 and complained of chronic pain. According to Dr. Garcia's notes in the chart, he discussed an opioid contract with patient L. The opioid contract signed by patient L with Dr. Garcia required him to fill all prescriptions for narcotics and opioids at the Pharmasave pharmacy located in the same premises as the Wellington Medical Centre for monitoring purposes. Dr. Garcia did not record a detailed description of the source of patient L's pain, but did note that patient L was involved in a motor vehicle accident. There are no notes in the chart of a physical examination being performed to assess patient L's pain. The chart indicates the following patient encounters and prescriptions given to patient L:

- At the first appointment in June of 2012, Dr. Garcia prescribed patient L 60 tablets of Dilaudid 4 mg and 10 fentanyl patches at a dose of 50 mcg/hr.
- On a date in June of 2012, patient L returned to see Dr. Garcia asking for a refill of his Dilaudid prescription. Patient L said he had been recently arrested, showed Dr. Garcia his arrest records, and stated the police confiscated his medication. Dr. Garcia renewed the prescription of 60 tablets of Dilaudid but told patient L this sort of situation would not be accommodated again.
- On a date in June 2012, patient L returned to Dr. Garcia a third time requesting a 2-month renewal of his prescriptions. Patient L said that he was going to work in another city for 2 months. Dr. Garcia asked for a fax of the work order and discussed

an opioid contract with patient L.

- On a date in August of 2012, patient L asked for an increase in his dose of fentanyl. Dr. Garcia did increase the dose from 50 mcg/hr to 75 mcg/hr, and renewed the Dilaudid prescription.
- Patient L returned to the clinic on a date in September of 2012, but left before being seen. Dr. Garcia's note from the appointment states that patient L "left when heard discussion with other drug seeking patient."

Prior to the appointment in September 2012, Dr. Garcia did not recognize that patient L was drug-seeking. Dr. Garcia failed to properly assess and document the source of patient L's pain and did not record conducting any physical examination. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care in in this case. With respect to his review of the chart for this patient, Dr. Burke also expressed concern that Dr. Garcia's patients were at risk of harm because of his willingness to prescribe narcotics to pain patients without taking a proper and full history and without doing any physical examination.

j) **Patient M**: Patient M was seen by Dr. Garcia at the Wellington Medical Centre on a date in August 2013. According to the chart, patient M was given a typhoid immunization on that day. However, Dr. Garcia made no notes of this appointment in the chart for patient M. No record was kept of the drug identification number or lot number for the vaccine given. Dr. Burke concluded that Dr. Garcia fell slightly below the standard of care in charting in this case.

k) **Patient N**: Patient N was seen by Dr. Garcia at the Wellington Medical Centre on a date in August of 2013. Dr. Garcia's typed note from this visit incorrectly indicated he gave patient N a typhoid shot. Dr. Garcia's handwritten note correctly indicated that he gave patient N an allergy shot on that date. Dr. Burke concluded that Dr. Garcia fell moderately below the standard of care with regard to charting in this case, although he did not appreciate that Dr. Garcia made a handwritten note which correctly indicated that he gave patient N an allergy shot on that date.

PART II - ADMISSION

15. Dr. Garcia admits the facts set out above and admits those facts constitute a failure to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* in respect of 11 patients.

FINDING - Allegation of Failing to Maintain Standard of Practice

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts Regarding Clinical Issues. Having regard to these facts, the Committee accepts Dr. Garcia's admission and finds that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

2. Allegation of Disgraceful, Dishonourable or Unprofessional Conduct

BACKGROUND

The allegation of disgraceful, dishonourable or unprofessional conduct arises out of a personal relationship Dr. Garcia had with Ms. A, during which he prescribed medications and/or provided medical treatment or services for her and sought confidential information about her from a hospital without her consent.

There are three issues to be determined in relation to this allegation:

i) What was the nature of the personal relationship Dr. Garcia had with Ms. A?
ii) If it is found that he is in a close personal and romantic relationship with Ms. A, would the conduct of Dr. Garcia, by prescribing medications and/or providing medical treatment or services to her be reasonably regarded by members as disgraceful, dishonourable or unprofessional?; and
iii) Would the conduct of Dr. Garcia, by seeking confidential information about Ms. A from a hospital and hospital staff without her consent, be reasonably regarded by members as disgraceful, dishonourable or unprofessional?

APPLICABLE LEGISLATION AND LEGAL PRINCIPLES

Burden and Standard of Proof

The College has the burden of proving the allegation of professional misconduct against Dr. Garcia. The standard of proof is on a balance of probabilities (i.e., whether it is more likely than not that the conduct occurred) based on clear, cogent and convincing evidence admitted at the hearing [*F.H. McDougall*, [2008] S.J.C. No. 54 40, 45-49].

FACTS AND EVIDENCE

Summary of the Evidence

The Committee heard the testimony of Ms. A's sisters - Ms. E and Ms. G - and Mr. Dominic Gascon on behalf of the College. Various exhibits were filed, including the Rogers cellular phone records of Dr. Garcia, the Telus cellular phone records of Ms. A, Ontario Drug program records, as well as College Policy Statements #4-12 (Medical Records), #4-07 (Physician Behaviour in the Professional Environment), #8-12 (Prescribing Drugs) and #7-06 (Treating Self and Family Members) contained in an agreed book of documents.

In addition, various notes from Ms. A's medical record at St. Michael's Hospital were filed as exhibits.

Agreed Statement of Facts

The following facts were set out in an Agreed Statement of Facts Regarding Ms. A that was also filed as an exhibit and presented to the Committee:

1. Ms. A was not a patient of Dr. Yelian Garcia at any relevant time.

2. Medical records indicate that Ms. A filled a prescription on July 5, 2013 for an antibiotic, nitrofurantoin, to be taken twice a day for 5 days that was issued by Dr. Garcia. A copy of the "Medication Claims for Ms. A attributed to Dr. Yelian Garcia on the Health Network System for November 1, 2010 to September 9, 2013" is attached at Tab A of the Agreed Statement of Facts Regarding Ms. A.

3. On or about July 26, 2013, Dr. Garcia referred Ms. A to his sister, an obstetrician and gynecologist, for insertion of an intrauterine device ("IUD") for birth control. At that time, Dr. Garcia also provided Ms. A with prescriptions for an IUD, misoprostol and naproxen to facilitate the process. Ms. A filled these prescriptions at a pharmacy in Toronto.

4. In order to prepare an Appointment Requisition with respect to the referral for the IUD insertion, information regarding Ms. A was inputted into the computer system, Healthscreen, at the Wellington Medical Centre. A copy of the Appointment Requisition, which describes Ms. A as a "PERSONAL FRIEND" is attached at Tab B of the Agreed Statement of Facts Regarding Ms. A.

5. Dr. Garcia provided Ms. A's Health Card number to Poornima Balakrishan, a part-time employee at Wellington Medical Centre. In order to create a patient profile in Healthscreen, Ms. Balakrishan needed the health card number and a valid version code. Dr. Garcia did not initially provide Ms. Balakrishan with the version code for Ms. A's health card. Dr. Garcia just had Ms. A's health card number, which he showed her on the screen of his cellular phone. Ms. Balakrishan asked Dr. Garcia for the version code. A few minutes later, Dr. Garcia came back and provided Ms. Balakrishan with the valid version code for Ms. A's health card number. Ms. Balakrishan then created the patient profile in Healthscreen for Ms. A.

6. On or about July 26, 2013, Dr. Garcia created a "Patient Encounter" note in Healthscreen which states:

> Seeking IUD
> Mirena and copper discussed
> OCP currently
> Will send to gyne

7. A copy of the note is attached at Tab C of the Agreed Statement of Facts Regarding Ms. A.

8. Ms. A never attended any medical appointments with Dr. Garcia at the Wellington Medical Centre or anywhere else.

9. Dr. Garcia never billed OHIP for any medical care or treatment in respect of Ms. A.

10. On a date in September 2013, Ms. A was admitted to the inpatient psychiatric unit at St. Michael's Hospital in Toronto.

11. Dr. Garcia learned that Ms. A was taken to a hospital in Toronto shortly thereafter, but did not initially know which hospital Ms. A was at.

12. On or about September 10, 2013, Dr. Garcia asked staff at the Wellington Medical Centre to call hospitals in Toronto to see if they could locate Ms. A.

13. Ms. Balakrishan called the University Health Network to try to locate Ms. A. She was told that they would have to fax a signed Consent to Release Medical Information form before any information would be released. Later that day, Ms. Balakrishan's colleague asked her if she knew any hospitals in downtown Toronto that are not part of the University Health Network. Ms. Balakrishan suggested her colleague try St. Michael's Hospital. Ms. Balakrishan did not call St. Michael's Hospital.

Testimony of Witnesses

Ms. E

Ms. E is the younger sister of Ms. A. She also has an older sister, Ms. G.

Ms. E grew up in a city in Ontario. Subsequently, she moved to an apartment in Toronto in 2013 where she lived with her sister, Ms. A, for approximately six months. She testified that between March and September 2013, she was living at the apartment she shared with Ms. A, with the exception of approximately three weeks when she was travelling abroad.

Ms. E testified that in the spring and summer of 2013, she had a close relationship with Ms. A. She continues to keep in touch with Ms. A by phone and texting.

Ms. E testified that Ms. A had been diagnosed with a bipolar disorder prior to September 2013 and had been hospitalized at least once before Ms. E had moved to Toronto. Ms. E had not been involved in Ms. A's care on that occasion.

However, on September 8th, 2013 Ms. E testified that Ms. A was having a "manic" episode and that she was very frantic and violent towards herself. Ms. E felt that there was a danger to others around Ms. A. She also testified that the apartment was "trashed" and that Ms. A was not herself. She stated that she believed Ms. A was on cocaine at the time.

Ms. E testified that she called the Emergency and that Ms. A was taken by ambulance, and was subsequently admitted, to the hospital.

Ms. E testified that she was driven to the hospital on September 8 by a mutual friend and later that day was joined at the hospital by her older sister Ms. G. She stated that she stayed at the hospital with Ms. A for several hours from early afternoon until late at night.

Ms. E visited Ms. A while she was in the hospital several times but never saw Dr. Garcia at the hospital when she was visiting her sister.

After leaving the hospital on the evening of September 8, Ms. E went back to a mutual friend's apartment in the same building where she shared an apartment with Ms. A, but did not return to her apartment until the next day. Under cross examination, Ms. E testified that at some point on the night of September 8, her sister Ms. G went down to the lobby, accompanied by a friend of Ms. A named Mr. M, to speak to Dr. Garcia. Ms. E acknowledged that the relationship between Ms. A and her sister Ms. G was somewhat "strained" in 2013.

Ms. E testified that, when she re-entered her apartment the day following her sister's admission to hospital, it was a complete disaster. There were items broken as well as writing on the walls. She testified that she, her sister Ms. G and a few of their mutual friends cleaned up the apartment.

Ms. E testified that she knew Dr. Garcia. She testified that before she had met Dr. Garcia for the first time, she believed that he was someone that Ms. A was dating. She testified that she recalled meeting Dr. Garcia on three occasions although she could not recall if she met him on all three occasions before she went to travelling abroad or on just two of those occasions.

The first occasion Ms. E met Dr. Garcia was in the spring or summer of 2013. Ms. E testified that on this occasion, Dr. Garcia came to pick up Ms. A before leaving on a date with her. He had stopped by for about a half an hour and had a quick bite to eat with Ms. A before leaving with Ms. A. During that encounter, Ms. E testified that she observed Ms. A and Dr. Garcia talking and hugging and that Dr. Garcia "pecked" Ms. A on the cheek. Ms. E testified that she engaged in some "small talk" with Dr. Garcia. Ms. E could not recall if Ms. A returned to their apartment that night.

On another occasion, Ms. A had left her phone at home when Ms. A and Dr. Garcia were out together. Ms. A. and Dr. Garcia returned to the apartment to pick up the phone and again, during that encounter, Ms. E engaged in "small talk" with Dr. Garcia. She did not recall seeing any physical contact between Dr. Garcia and Ms. A on that occasion.

The third occasion was a longer encounter which lasted at least a couple of hours and occurred when Ms. A had a "cold". Ms. E and her sister were staying in the apartment for the night. Dr. Garcia stopped by to see how Ms. A was doing as Ms. E described "a normal companion" would do. In addition, on that occasion, Dr. Garcia returned some items that Ms. A had left at his apartment. Ms. E testified that Ms. A and Dr. Garcia sat on the couch while Ms. E sat in a chair and they all watched a movie together. Ms. E testified that she observed Ms. A and Dr. Garcia hugging, kissing and holding on to each other while lying on the couch. Ms. E also testified that Dr. Garcia had fallen asleep with his head on a pillow on Ms. A's lap. Ms. E described Ms. A

and Dr. Garcia interacting “like a couple”. Ms. E testified that Dr. Garcia did not spend the night at their apartment.

Ms. E also testified that Dr. Garcia wrote Ms. A a prescription for an antibiotic and left it on the dining room table.

Under cross examination, Ms. E acknowledged that in two emails that she had sent to the College investigator, Mr. Jake Poranganel, dated February 28 and March 3, 2014, there was no mention of hugging or kissing. Ms. E acknowledged that the first time she suggested to the College that she saw hugging and kissing was on June 26, 2016, during a meeting with College staff in preparation for the hearing.

However, Ms. E confirmed that in the February 28 email, she described Dr. Garcia and Ms. A “cuddling on the couch”. She also confirmed that there was no request in the College investigator’s response to her February 28th email to provide any further information about the incident when she had observed her sister and Dr. Garcia cuddling on the couch.

Ms. G

Ms. G is the older sister of Ms. A. She was living in another city in Ontario prior to moving to Toronto in 2007. She testified that between March and September of 2013, she would see Ms. A once every three weeks for lunch or a coffee but was in contact with her more frequently via text messaging or telephone calls. She described her relationship with Ms. A between March and September 2013 as growing more and more tense as she did not approve of Ms. A’s lifestyle choices and was concerned about Ms. A’s health. She testified that the relationship between Ms. A and her sister Ms. E was good. Ms. G testified that Ms. E was not aware of Ms. A’s lifestyle, which also caused friction in her relationship with Ms. A.

Ms. G testified that Ms. A was diagnosed with bipolar disorder in 2010 and was hospitalized when she was diagnosed. She testified that she was involved in Ms. A’s care in 2010 and it was she who took Ms. A to the Center for Addiction and Mental Health (CAMH) to get help. She

was always in contact with Ms. A's doctors. She testified that Ms. A had a long period of stability until September 2013.

Ms. G testified that she was not involved in Ms. A being taken to hospital in September 2013 and that it was her younger sister Ms E who had informed her that Ms. A was taken to St. Michael's Hospital. She went to the hospital the day Ms. A was admitted. She testified that Ms. A was in hospital for roughly seven to ten days and that she visited her nearly every day. She testified that she had spoken to one of Ms. A's doctors while Ms. A was in hospital, as well as one of the male nurses but could not recall their names. She testified that she asked the doctor to limit who was visiting Ms. A to just family and that specifically, she did not want Dr. Garcia visiting Ms. A.

Ms. G testified that after visiting Ms. A on her first day in the hospital, she went to the apartment where Ms. A and her sister lived to check on her sister Ms. E. On cross examination, Ms. G clarified that when she testified that she went to the apartment where Ms. E and Ms. A lived, she meant her sister's (apartment) building. She testified that she joined Ms. E in "Ms. O's" apartment which was in the same apartment building that her sisters lived in. She testified that her sister was too traumatized to be in her own apartment that evening. She testified during cross examination that she did not enter her sister's apartment that evening.

Ms. G testified that prior to meeting Dr. Garcia. she was aware of Dr. Garcia and believed that he was someone Ms. A was dating. She testified that she first met Dr. Garcia in the foyer of the Ms. A's apartment building on the day Ms. A was admitted to hospital. She testified that while walking through the foyer, she saw a man pacing. She testified that in the back of her mind, she thought it could be Dr. Garcia. She went upstairs to "Ms. O's" apartment to join her sister Ms. E who was with some of Ms. A's friends. About an hour later, another one of Ms. A's friends joined them and indicated that Dr. Garcia was downstairs.

Ms. G testified that she thought that Dr. Garcia might be concerned about Ms. A and she therefore decided go downstairs and let him know that Ms. A was "safe". She testified that she was accompanied by Ms. N, one of Ms. A's friends, when she spoke to Dr. Garcia. She testified that she did not recall Ms. N saying anything to Dr. Garcia and if she spoke it was very limited.

Under cross examination, it was put to Ms. G that she was mistaken as to who accompanied her to the lobby when she spoke with Dr. Garcia and that it was Mr. M, as Ms. E had testified, and not Ms. N, who accompanied her to the lobby. Ms. G disagreed and indicated that it was her sister who was mistaken. When Ms. G introduced herself to Dr. Garcia, she testified that Dr. Garcia looked her "up and down" and "surveyed her body" and noted that there was some similarity with Ms. A. She testified that she "brushed that gross feeling off".

Ms. G stated that Dr. Garcia told her that he had been getting some "weird messages" from Ms. A and that he had called the police. Ms. G testified that she recalled telling Dr. Garcia that Ms. A was "safe" and that he could call the police and let them know not to come. Under cross examination, Ms. G testified that she did not recall telling Dr. Garcia that Ms. A was under medical care. However, Ms. G acknowledged that in an email sent February 26, 2014 to the College investigator, Mr. Jake Poranganel, she told Dr. Garcia that Ms. A was" being looked after and was under medical care".

Ms. G testified that when she told Dr. Garcia that her sister was "safe", they stared blankly at each other and that Dr. Garcia never asked her how Ms. A was or whether he could do anything for the family. She testified that Dr. Garcia just continued to stare out the window and at his phone. At that point, Ms. G asked Dr. Garcia what he had prescribed to Ms. A. In response to a question from College counsel why she had asked Dr. Garcia what he had prescribed to Ms. A, she testified that she wanted to know what was in Ms. A's system because she had been told that Dr. Garcia had prescribed Ms. A at least one item and that someone else had witnessed Dr. Garcia prescribing another item. In addition, she was also told that Dr. Garcia and Ms. A "did drugs together". She testified that it took a long time to get a response from Dr. Garcia and that he continued to look at his phone as he paced and looked out the window. Ms. G testified that she asked Dr. Garcia again what he had prescribed and that he kept pacing and looking out the window and down at his phone. She testified that Dr. Garcia eventually answered that he was aware that Ms. A was taking lithium. Ms. G testified that, at that point, she repeated her question and that Dr. Garcia responded "I gave her an IUD", or "I prescribed an IUD".

Ms. G testified that at this point, Dr. Garcia was fidgeting, staring at his phone and appeared "irritable". She testified that he then told her, "You know, you should know that I'm a doctor. I have better things to do than to come down here". At this point, Ms. G testified that her conversation with Dr. Garcia ended. Ms. G testified that the entire conversation with Dr. Garcia lasted between five and ten minutes and that that she has never seen or spoken to Dr. Garcia since that time.

Ms. G testified that during her conversation with Dr. Garcia, her tone was measured and that she was giving Dr. Garcia a bare minimum of information and that she did not want to tell Dr. Garcia where Ms. A was or how to contact her.

Ms. G described the state of Ms. A's apartment when she entered it. While she could not recall the exact day she went into the apartment, she testified that it was shortly after Ms. A was admitted to hospital. She testified that she was not alone in the apartment and that her sister Ms E and some of Ms. A's friends were with her and that they helped clean up the apartment. She testified that it looked like that there had been a "struggle" in the apartment. It was messy and that there was writing all over the walls and that it upset her. Ms. G testified that in the process of cleaning up the apartment, she found a prescription in the bedroom for Viagra. Using her hands, Ms. G demonstrated the approximate size of the prescription she found in Ms A's bedroom, which was slightly smaller than an 8 x 10 inch piece of paper. The Committee notes this is consistent with the size of the document with the heading "Medications Prescription" (exhibit 5) that Dr. Garcia used to create a fax addressed to the University Health Network.

Ms. G could not recall where in the bedroom she found the prescription. She recalled that the date on the prescription was September 4 or 6 (2013). She also testified that the writing on the prescription was messy but still legible. She testified she saw Dr. Garcia's name on the prescription and it was made out to Ms. A. However, she could not recall whether Dr. Garcia's name was written or typed, but did recall there was a signature, which she did not recognize. In cross examination, it was put to her that the notes of an interview with her by Ms. Breese Davies, Ms. Pam Greenburg and Ruth Ainsworth on July 12, 2016 in preparation for the hearing, she had said, "She thinks she saw his signature on it, she doesn't recall". Ms. G explained that the

interview was a telephone interview and that she was in Vancouver at the time. She was on her way to work and she had not had any coffee. In addition, she testified that she did not have a lot of time to think about her answer. However, she testified that she has been thinking about the events and that when she pictures the prescription, she now sees a signature on it.

Ms. G testified that she showed the prescription to her sister Ms E and to Ms. A's friends who were in the apartment with her and that they only spent a couple of minutes discussing and looking at the prescription. She testified that she kept the prescription and took it home with her. While she could not recall exactly where she put the prescription when she got home, she testified that she likely put it in her desk. Under cross examination, she acknowledged that she never took a picture of the prescription on her I-phone. Ms. G also acknowledged under cross examination that she was trained as a journalist and that in the past, from time-to-time, she used her I-phone to document things by taking photos, but it was not her routine to do so. She testified that she used the I-phone more to record people's voices and that she usually had a photographer assigned to her to take photos.

Ms. G testified that when she was preparing for a move to Vancouver in October of 2013, she tucked the Viagra prescription in one of the books she had put in a plastic bin. She could not recall the name of the book but recalled it being near the top of the bin. She testified that she took that bin to her parents and stored it in a spare bedroom. She testified that in addition to the bin of books that contained the prescription, she had stored another bin of books as well as a few boxes of clothes at her parents. She testified that there were also old clippings from work, documents related to workshops that she had attended as well as a few tax returns. She estimated that she stored over 50 but less than 100 books at her parents.

Ms. G testified that since the time she stored the bin at her parents, she has been unable to find the Viagra prescription. She testified in examination in-chief that she had not moved it at any point in time after she had put it in the bin. Under cross examination, she testified that she first looked for the prescription in Vancouver because she had initially asked her father to look for it but her father could not find it. She testified that when she returned to her parents' home in December 2013 to visit them for Christmas, she also looked for the prescription.

Under cross examination, Ms. G testified that she decided to look for the prescription because Ms. A had visited her parents after she was released from the hospital. Ms. G testified that when she could not find the prescription, it was her belief that Ms. A had destroyed it. Under cross examination, Ms. G acknowledged that in an email to Mr. Poranganel dated February 25, 2014, she wrote, "I am still unable to find the Viagra prescription by Yelian for my sister, but I'm still looking".

Ms. G clarified that while she believed at the time she wrote the email that her sister had destroyed the prescription, she was still hoping that it was at her parent's house and that she was still looking for it any time she was visiting her parents.

Ms. G also acknowledged that in an email dated February 26, 2014 to Mr. Poranganel, she said, "I am still looking for this prescription, as I have since moved and believe I brought it with me". While Ms. G acknowledged that she wrote that, in the email she "believed that [the prescription] was with my parents", she also testified that she was slowly bringing back books from her parents to Vancouver and that she was "looking in everything" and that "I recall thinking it was at my parents', but when that failed, I looked high and low for it everywhere". Ms. G testified that she had done a comprehensive search of every book in December (2013). She subsequently moved to Vancouver. She testified that it was not until afterwards, in the spring of 2014, she was told something that led her to believe that the prescription had been destroyed. However, she provided no further details.

Under cross examination Ms. G acknowledged that she had helped her sister, Ms E, write an email to Mr. Poranganel in March of 2014 and that she never disclosed that to Mr. Poranganel. She testified that her sister had "some of the facts wrong".

Defence counsel put to Ms. G that she never showed the document (Viagra prescription) she described to her sister and that the conversation with her sister in regard to the document never occurred. Ms. G firmly disagreed. Defence counsel also suggested to Ms. G that the prescription

she saw was for an antibiotic (and not for Viagra). Ms. G again firmly disagreed and testified she never saw an antibiotic prescription.

The Committee noted that defence counsel never suggested to Ms. G that she confabulated finding a prescription at her sister's apartment but rather she was mistaken as to what drug was written on the prescription.

Motion Regarding Interpretation of Section 35(9) of the *Mental Health Act*

The Committee heard a motion by the College regarding the interpretation of section 35(9) of the *Mental Health Act*, and for the admission of certain evidence at the hearing.

The Committee delivered its Ruling in writing through Independent Legal Counsel on July 19, 2016, as follows:

> "On a proper interpretation of S.35(9) of the Mental Health Act of Ontario, the panel has decided to allow questions to St. Michael's psychiatric staff about Dr. Garcia's contact with them, and about what he asked for, in regards to Ms. A In the opinion of the panel, such questions by Dr. Garcia do not constitute "information in respect of a patient" within the meaning of S. 35(9), and therefore may be disclosed at the hearing.
>
> Staff responses contained clinical information regarding the patient Ms. A, if any, are not allowed. Any information Dr. Garcia may have imparted to staff about Ms. A's medical or mental health is not allowed.
>
> If a medical record, or part thereof, is to be tendered, all medical information and personal information in respect of Ms. A must be redacted other than the name and date of birth of the patient.
>
> Within this framework we will deal with any specific questions that counsel wish to ask of the staff member."

Reasons for the Committee's ruling are delivered separately. As a result of that ruling the Committee heard evidence in separate *voir dires*, and admitted into evidence redacted inter-professional notes from St. Michael's Hospital, as follows:

Voir Dire #1

A *voir dire* was conducted in regard to the admissibility of an inter-professional note written by Annette Coley RN on a date in 2013.

College counsel tendered a redacted copy of the note (exhibit VDI). College counsel submitted that the redacted portion in the middle of exhibit VD1 related to contact Dr. Garcia and Ms. A had while Dr. Garcia was at the hospital visiting Ms. A. College counsel also indicated there was a reference to Ms. Coley's observation of an interaction between Ms. A and her other friends that was redacted.

Counsel for Dr. Garcia argued that the redacted portion in exhibit VD1 that makes reference to Dr. Robertson should be left in because it contextualizes Dr. Garcia's request to speak with Dr. Robertson and the contact between Dr. Garcia and Dr. Robertson. However, at the same time, defence counsel indicated he recognized the difficulty of leaving the redacted portion in, in that it arguably does include information in respect of the patient. Defence counsel further argues that if the Committee finds that the redacted portion does contain information in respect of Ms. A, the whole document should be excluded, because one cannot parse out the communication at issue from the clinical context.

Furthermore, counsel for Dr. Garcia argues that if the Committee ruled the information in regard to a pass being denied to Ms. A while Dr. Garcia was visiting, it would be prejudicial to Dr. Garcia because the context for Dr. Garcia requesting through a nurse to speak to Dr. Robertson about Ms. A would be absent.

Counsel for Dr. Garcia also argues that there is no particular prejudice in excluding the document, because it does not support the College's theory that Dr. Garcia was inappropriately accessing, or seeking access to, confidential information. However, the College disagrees and submits that if the Committee were to exclude the note and prevent the College from adducing the additional contact between Dr. Garcia and the medical staff, it would, in fact, cause prejudice to the College, in that it does support the College's position.

In addition, College counsel argues that the note speaks to the relationship Dr. Garcia had with Ms. A and also is evidence of a pattern of attempts on Dr. Garcia's part to get information about Ms. A from the health care staff at the hospital. College counsel disagreed with defence counsel's submission that documents or evidence does not generally get redacted. College counsel submits that there is nothing unusual about filing a redacted document when rules of evidence allow some information in the record to go in, and not others.

Counsel for Dr. Garcia in response to a question from a Committee member indicated that he was not "particularly fussed" about the first sentence of the unredacted note dealing with an interaction between Ms. A and her friends going into the record.

The Committee carefully considered the submissions from both counsel on the matter. The Committee considered any information about a pass to be clinical information and therefore "information in respect of a patient" as provided in section 35(9) of the *Mental Health Act.* Therefore, any passages that made reference to a pass would not be allowed. In addition, the Committee determined that the first four lines of Ms. Coley's note were not relevant to these proceedings.

The Committee proposed a modified redacted note, which would include only "Male friend, Yelian Garcia, also visiting after other friends left. And, patient's friend, Mr. Garcia, approached writer at nursing station requesting to speak to MD".

The Committee invited submissions from both counsel as to why it would be prejudicial to receive in evidence only the parts that the Committee was suggesting.

Defence counsel reiterated his position that it would be prejudicial to Dr. Garcia in that it deprives any context of the interaction Dr. Garcia had with the nursing staff when he was visiting Ms. A. Furthermore, without the context it would be unfair for the College to request the Committee to draw an inference against the member in regard to Dr. Garcia attempts to obtain confidential information about a patient. However, defence counsel also acknowledged in reply to a question from the Chair, that he thought leaving in "Male friend, Yelian Garcia visiting" was not particularly prejudicial.

The College submits that the redacted document as proposed by the Committee should be allowed to go in because the fact of the contact (between Dr. Garcia and Ms. A) is relevant and the fact that Dr. Garcia approached nursing staff to speak to the doctor is relevant. However, the College counsel submits that by taking out the context, it precludes the College from adducing evidence vis-à- vis the context. In addition, College counsel submits that if Dr. Garcia wants to put this interaction in context, he can testify and provide whatever context he wants to provide as to why he requested speaking to the doctor.

College counsel requested the Committee not redact the last two sentences "Mr. Garcia's number was taken" and "Patients friend left at 18:15". College counsel submits that they are relevant facts in respect of Dr. Garcia's contact with the nursing staff.

In reply, counsel for Dr. Garcia did not object to the last two sentences as proposed being allowed in if the Committee was inclined to admit the other parts of the redacted note.

The Committee carefully considered the submissions of both parties.

In regard to the sentence, "Male friend Yelian Garcia also visiting after other friends left" the Committee allowed this to go in. This sentence is relevant in that it does speak to the relationship Dr. Garcia had with Ms. A. The Committee does not find that it is prejudicial to Dr. Garcia.

The Committee also allowed in "Pt's friend Mr. Garcia approached writer at nursing station requesting to speak to MD". The Committee was persuaded that it represents, in part, a pattern of attempts on Dr. Garcia's part to get information about Ms. A from the health care staff at the hospital. However, the Committee reserved its decision as to what inference can be drawn, if any, and what weight, if any, it will assign to the sentence after final submissions are made by both parties.

The Committee also allowed the last two sentences "Mr. Garcia's number was taken" and "Patients friend left at 18:15". It is relevant in that it speaks to the fact that Dr. Garcia had an interaction with the nursing staff while he was visiting Ms. A in hospital. The Committee notes that counsel for Dr. Garcia did not object to the last two sentences being allowed in.

Other Inter-professional Notes

Several redacted inter-professional notes from Ms. A's clinical record at the Hospital were entered as exhibits.

Exhibit 4A: A redacted inter-professional note in Ms. A's clinical record written by registered nurse (RN) Annette Coley on a date in 2013 at 18:14, which states:

> "Patient received phone call from friend, Mr. Garcia"

Exhibit 4B: A redacted inter-professional note in Ms. A's clinical record written by Jennifer Baek RN on the subsequent date in 2013 at 12:05 hours, which states:

> "Yelian called the unit this morning, but was told that he is not to have contact with her at this time. No further attempts were made".

Exhibit 4C: A redacted inter-professional note in Ms. A's clinical record written by Jennifer Baek RN on the subsequent date in 2013 at 15:05 hours, which states:

> "Yelian Garcia called but call not transferred to patient. Told him about restrictions in place. He says that he spoke to patient earlier today and wants to know when patient will be discharged. Told him that the writer could not disclose confidential information and to speak to the psychiatrist instead."

Mr. Dominic Gascon

Mr. Dominic Gascon has been a registered nurse for five years and is employed at St. Michael's Hospital. He describes his current position at the hospital as an "operational readiness specialist" who works with the planning department which is involved with the planning and transitioning to a new tower that is being built at St. Michael's Hospital.

Mr. Gascon testified that in 2013 he was working on the psychiatric inpatient unit at St Michael's Hospital. He testified that when he comes on shift, he receives a change of shift verbal report from the previous nurse who was working with the patients that he will be working with. Mr. Gascon testified that he makes notes of his interactions with patients in the inter-professional notes section of the electronic medical chart. He testified that he also reviews the inter-professional notes that are prepared by other people.

Mr. Dominic Gascon testified that Ms. A was his patient. He also testified that he knew someone by the name of Yelian Garcia and that he had been informed about Yelian Garcia when he began working with Ms. A and that he knew him to have some involvement with Ms. A.

While Mr. Gascon testified that he never met Yelian Garcia in person, he did speak to him on the telephone and did make some notes in the patient chart of their conversation. Mr. Gascon wrote a note in Ms. A's chart at 17:39 hrs on the subsequent date in 2013 in which he described a telephone conversation he had with Yelian Garcia. Mr. Gascon testified that the note was written less than an hour after he had the conversation with Yelian Garcia and that the conversation lasted no more than five minutes.

Mr. Gascon testified that Yelian Garcia called him and was asking for information regarding Ms. A. Mr. Gascon testified that Yelian Garcia asked him what all the drama was earlier in the day. While Mr. Gascon acknowledged during cross examination that Yelian Garcia did not elaborate as to what the drama he was referring to was, Mr. Gascon testified that he assumed Yelian Garcia's question was in reference to his earlier attempts that day to either speak to Ms. A or get information about her from another nurse. This assumption was based upon his review of the previous inter-professional notes and also based upon one of the other nurses reporting that Yelian Garcia had called previously but was not provided the information that he was requesting.

Mr. Gascon testified that Yelian Garcia expressed frustration about not being given the information he was asking for. Mr. Gascon testified that Yelian Garcia asked him what the care plan was for Ms. A, why she couldn't be discharged, and why people were not letting him come in to speak with Ms. A. Mr. Gascon testified that Yelian Garcia asked him "Can you give me information, one professional colleague to another".

Under cross examination, Mr. Gascon acknowledged that nowhere in his note was there a reference to Yelian Garcia asking what the care plan was or when she was going to be discharged. Mr. Gascon testified that he understood when Yelian Garcia referred to himself as a professional colleague it was in reference to him being a physician. While Mr. Gascon acknowledged in cross examination that the comment in quotation "from one professional colleague to another" may not have been Yelian Garcia's exact words, he testified that they were as close as possible to his exact words.

Mr. Gascon testified during examination in chief that he understood from a shift change report and from reading the inter-professional notes that Yelian Garcia was a physician.

While Mr. Dominic Gascon initially testified that he did not recall Yelian Garcia telling him that he was a physician during the telephone call, he testified later that Yelian Garcia did identify himself as a physician during the telephone call.

In addition, Mr. Dominic Gascon did acknowledge during cross examination that he told Mr. Poranganel during an interview on November 6, 2014 that he could not recall Yelian Garcia saying specifically that he was a physician. However, Mr. Gascon testified that, after refreshing himself by reviewing the information in Ms. A's chart and the notes he made in the chart that he was given to review, he could now recall Yelian Garcia telling him he was a physician during their telephone conversation.

Mr. Gascon testified that he did not provide Yelian Garcia any information about Ms. A.

Mr. Gascon was shown two interprofessional notes written at 12:05 on the subsequent date in 2013 and at 15:05 on the subsequent date in 2013 by Jennifer Baek, who was another registered nurse who worked with Mr. Gascon on the inpatient unit. Mr. Gascon testified that he was aware of and had read the two notes and that it was Jennifer Baek who had provided him the change of shift report on the day the notes were written. The note written at 12:05 states "Yelian called the unit this morning, but was told he is not to have contact with her (Ms. A) at this time. No further attempts were made". The note written at 15:05 states "Yelian Garcia called, but not transferred to patient. Told him of the restrictions in place. He says he spoke to patient earlier today and wants to know when patient will be discharged. Told him that the writer could not disclose confidential information and to speak to the psychiatrist instead".

Mr. Gascon testified that he never spoke to Yelian Garcia after the subsequent date in 2013.

Voir Dire #2

A *voir dire* was conducted in regard to the relevancy of an "Agreed Statement of Facts Regarding Document In Systems of Wellington Medical Centre", which states:

1. On or about September 10, 2013, Dr. Garcia created a document through the Wellington Medical Centre's computer system regarding Ms. A., a copy of which is attached.

2. There is no evidence that the document was ever sent to the University Health Network or anywhere else.

The *voir dire* also addressed the admissibility of the document (a fax) that was attached to the Agreed Statement of Facts. The document that was created by Dr. Garcia addressed to the University Health Network states, "This patient (Ms. A), I believe, has been admitted to one of the downtown hospital psych wards (as per police). May you please be able to verify which facility she is in?"

While the Agreed Statement of Facts provides that there is no evidence that the document was ever sent to the University Health Network, the College asked the Committee to rule on whether the document is relevant. The College position is that if the Committee rules that the document is relevant, the whole package will go in. However, if the Committee rules it is not relevant, the College position is that the Agreed Statement of Facts is not independently relevant and the College would not be seeking to admit it.

Dr. Garcia's position is that the document is not relevant.

The College submits that even if it is not proven that the document was sent, the fact that Dr. Garcia prepared the document is relevant. The College argues that it is relevant because it speaks to Dr. Garcia's state of mind on the date in 2013 in respect to his attempt to get information about which psychiatric facility Ms. A was in and how he was thinking of going about doing that. The College contends that the document in part speaks to the nature of the relationship between Ms. A and Dr. Garcia. In addition, it is a form drafted at his clinic and refers to "this patient" despite the Agreed Statement of Facts specifying that Ms. A never had any appointments at the clinic.

The College further argues that it can be inferred that the document demonstrates that it was Dr. Garcia's intention to hold himself out as a physician with a doctor-patient relationship with Ms. A in seeking confidential information about her and that it supports a pattern of conduct of him attempting to contact or contacting medical professionals in his capacity as a physician.

While the College acknowledges that this is a circumstantial case, it argues that anything that makes a fact more likely is relevant and unless there is some other rule that would preclude its admission, it is admissible.

Counsel for Dr. Garcia submits that the Notice of Hearing establishes relevance. He referred to "Schedule A" of the Notice of Hearing, which includes the following particular: "Dr. Garcia…..sought confidential information about her from a hospital without her (Ms. A) consent". Therefore, defence counsel submits that the allegation is that the member sought confidential information from a hospital. He further argues that it is known that Ms. A was admitted to St. Michael's Hospital and not the University Health Network and therefore the document would not support an inference that Dr. Garcia sought confidential information from St. Michael's Hospital. Defence counsel further submits, if the College's argument is that Dr. Garcia was holding himself out as Ms. A's physician to obtain information and that he was wrong to do so, that would be a prejudicial use of the document given the fact that it is not alleged in the Notice of Hearing that Dr. Garcia ever held himself out as the patient's physician in his interactions with hospital staff at St. Michael's Hospital. Finally, defence counsel submits that since there is no evidence that the document was ever sent to the University Health Network, the document cannot prove the central allegation that is being advanced by the College.

In reply, the College argues that one of the central issues in this case is whether Dr. Garcia sought confidential information about Ms. A from a hospital without her consent and therefore efforts by him to obtain confidential information about Ms. A is the issue. The College further argues that the suggestion that Dr. Garcia used his position as a physician to try and get information is part of the College's case and is part of the allegation. The College submits that the document drafted by Dr. Garcia, where he refers to her as a patient, is relevant to his state of mind at the time. The College argues that the document is relevant, it is not prejudicial and it is part and parcel of a pattern of conduct on Dr. Garcia's part to get his staff to try and get information, trying to get information himself and speaking to staff at the hospital.

The College also responded to the defence position that the document in question cannot prove the central allegation and that the Committee cannot make a finding based upon the document. The College argues that defence position misconstrues the definition of relevance and the rules of admissibility in that a document does not have to prove something conclusively to be admissible. Furthermore, it does not have to be something from which the Committee can on its own draw a particular conclusion. Rather, it has to make a fact in issue more or less likely.

Finally, the College submits that if Dr. Garcia wants to respond and explain why the document was on the system and what he was thinking at the time he created the document, he has the ability to testify and provide an explanation, if he wishes. However, the College submits the fact that Dr. Garcia might or might not want to respond does not change the admissibility of the document.

The Committee carefully considered the submissions of both parties and ruled that the "Agreed Statement of Facts Regarding Document in Systems of Wellington Medical Centre" and the attached copy of the document (Fax) that was created by Dr. Garcia addressed to the University Health Network is admissible.

While the Committee recognizes that by itself the document cannot prove a specific allegation, it is not disputed that it was created by Dr. Garcia. It is not disputed that it was not sent. The issue before the Committee is not whether Dr. Garcia created the document in question, given there is an Agreed Statement of Facts stating that he did. Rather, does the fact Dr. Garcia created the document requesting confidential information, make it more likely than not that Dr. Garcia sought to obtain confidential information of Ms. A without her consent, regardless of whether or not he used his professional status as a physician in an effort to obtain that information.

The Committee finds that the document is relevant in that it not only speaks to the nature of the relationship Dr. Garcia had with Ms. A, but also to the state of mind of Dr. Garcia around the time he was interacting with hospital staff at St. Michael's Hospital. Furthermore, at the time Dr. Garcia created the document he did not know which facility Ms. A was in and therefore he would not have known that Ms. A was not in one of the University Health Network Hospitals.

In the Committee's opinion, simply because Ms. A was not a patient in one of the University Health Network Hospitals and was in St. Michael's Hospital when Dr. Garcia created the document, does not negate the probative value of the document as defence counsel submits it does. And, in the opinion of the Committee, the probative value outweighs the prejudicial effect. It tends to establish that Dr. Garcia was intent on finding out which facility Ms. A was in and made efforts to do so including instructing his office staff to call hospitals to locate her. It would be logical to conclude that when Dr. Garcia created the document, it was his intention to send the document or he would not have created it in the first place. The fact that the document was not sent, in the Committee's opinion, does not diminish its probative value.

What weight the Committee will place on the document was left for Committee determination after hearing the final submissions of both parties.

Credibility and Reliability Assessment

The Committee recognizes the importance of assessing the credibility and reliability of witnesses. The Committee understands that, acting reasonably, it may accept all of what a witness said, some of it, or reject it entirely. The Committee is aware that there are a number of factors relevant to assessing credibility and reliability.

The Committee understands that credibility has to do with the honesty or veracity of a witness. Reliability has to do with the accuracy of a witness' testimony. It relates to the ability of the witness to accurately observe, recall and recount the evidence. *R. v. Sanichar*, 2012 ONCA 117 (CA), at paras. 69 &75 reversed [2013] S.C.J. No. 4, at para. 1

In this case, the factors considered by the Committee included:

- The probability or improbability of a witness' story? Did the evidence make sense? Was it reasonable? Was it probable? Was there a tendency to exaggerate?

- Did the witness have an interest in the outcome of the hearing that may influence his or her evidence?
- Did the evidence of another witness whom the Committee considered more worthy, contradict the witness' testimony?
- Has the witness given a prior inconsistent statement which affects his or her reliability?
- Did the witness have any memory impairment?
- Was the evidence verifiable?
- Was there any inconsistency between his or her oral testimony and the documentary evidence?
- Was there any internal inconsistency in the witness' oral testimony?

While the appearance and demeanour of the witness and the manner in which he or she testified may be also considered by the Committee, the Committee recognizes that demeanor alone is a notoriously unreliable predictor of the veracity of witnesses or the accuracy of the evidence of the witness.

The Committee accepts that when assessing the credibility or reliability of a witness, inconsistencies on minor matters of detail between what the witness said at the hearing and what he or she said on other occasions, are normal and to be expected and do not generally affect the credibility or reliability of the witness. When inconsistencies are on a material point about which an honest witness is unlikely to be mistaken, then that inconsistency may demonstrate carelessness with the truth. The Committee appreciates that an honest witness can still be mistaken and consequently, his or her evidence, while sincerely given, may be unreliable.

Assessment of the Evidence of Ms. E

The Committee found Ms. E to be a credible and reliable witness. She was forthright in her testimony. Her evidence was believable. Her description of the events she observed was detailed, did not appear to be rehearsed and there were no significant inconsistencies in her testimony.

Counsel for Dr. Garcia challenged Ms. E on the fact that she did not mention hugging and kissing in any of her correspondence with College investigators and only mentioned it at a pre hearing meeting with College staff on June 26, 2016. However, Ms. E testified that she did mention "cuddling on the couch" in her correspondence with College investigators. Furthermore, she testified there was no request by the College investigator to provide any further information about the incident.

Ms. E clarified in her testimony that what she meant when she referred to cuddling on the couch in her email to College investigators, including hugging and kissing. Her explanation was reasonable and made sense.

There was a minor discrepancy in her testimony when compared to the testimony of her sister Ms. G's testimony in regard to who accompanied Ms. G on the day she spoke with Dr. Garcia in the lobby of Ms. A's apartment building. This was not felt to be material and did not demonstrate a carelessness with the truth. It was not possible, based upon the evidence before it, for the Committee to determine who actually accompanied Ms. G to the lobby and whether it was Ms. E or Ms. G who was mistaken.

Ms. E's evidence was not exaggerated and there was no evidence that she made up any facts to fit her story. She did not display any animosity towards Dr. Garcia, nor, did Ms. E have any interest in the outcome of the hearing that might have influenced her evidence.

The issue of Ms. G providing assistance to her sister Ms. E in preparing a March 2014 email to the College by way of correcting some facts was raised during Ms. G's cross-examination. In the Committee's opinion, it is highly unlikely that the facts that were referred to were related to Ms. E's testimony of her observations of Dr. Garcia and Ms. A together at her apartment as there was no evidence that Ms. G was present during those occasions

Assessment of the Evidence of Ms. G

The Committee found Ms. G to be a credible witness. With the exception of the uncertainty relating to the whereabouts of the missing Viagra prescription, her testimony was considered to be reliable. She testified in a forthright manner and she was believable. She did not exaggerate. In addition, there was no evidence presented to contradict her testimony in regard to finding the prescription.

Defence counsel submitted that there were inconsistencies as to what she told the College investigator and what her testimony was in regard to what happened to the missing Viagra prescription.

Ms. G explained why she second guessed herself as to where she thought she had put the prescription. She testified that after removing the prescription from Ms. A's apartment, she believed she initially put the prescription in a desk at her home. Later on, on October 2013, when she was preparing to move to Vancouver, she believed that she put the prescription in one of the books in a bin that she left in storage at her parents. When she learned that her sister Ms. A had been at her parent's house after she was discharged, she asked her father to look for the prescription. However, he could not find it. She testified she then looked for the prescription in Vancouver and could not find it. When Ms. G returned to her parents' home in December, she also looked for the prescription but again could not find it. It was at that point she had a belief, but importantly, had not arrived at a firm conclusion that her sister had destroyed the prescription. This would explain why she indicated to a College investigator in February 2014 that she was still trying to locate it and that it may have been in one of the books she had taken to Vancouver as she was gradually bringing to Vancouver the books that she had stored at her parents' home. She testified that it was not until the spring of 2014 that she was told something that led her to believe that the prescription had been destroyed. Her explanation made sense and was believable.

Furthermore, the Committee notes that counsel for Dr. Garcia did not suggest to Ms. G that she fabricated her testimony in regard to finding the prescription in Ms. A's apartment. Rather,

counsel put to Ms. G that the prescription she found was a prescription for antibiotics and not Viagra.

The Committee is aware that blank prescriptions do come in various sizes. The fact that Ms. G indicated with her hands the approximate size of the prescription that she found and it was consistent with the size of document entitled "Medications Prescription" (exhibit # 5) that was created in Dr. Garcia's office, further bolsters the evidence of Ms. G's that she found a prescription for Viagra that was written by Dr. Garcia.

In addition, despite a vigorous cross-examination, Ms. G did not waiver in her testimony that the prescription she found was a prescription for Viagra or that she showed the prescription to her sister Ms. E and her friends. Ms. G acknowledged that she was initially unsure as to whether she saw a signature on the prescription. She testified that the first time she was asked by a College investigator about a signature, she was living in Vancouver and was getting ready to go to work and did not have much time to think about an answer. However, she testified that on further recollection she could "picture" a signature on the prescription. Her explanation was reasonable and believable.

In addition, during cross examination, she did not hesitate to acknowledge that she assisted her sister Ms. E in preparing a March 2014 email to the College by helping her to correct some facts that Ms. E had wrong. When she was unsure of an answer to a question such as the day when she went to clean up Ms. A's apartment, she stated so without hesitation.

In summary, the Committee considered inconsistencies in Ms. G's testimony as minor, which generally can be expected of a witness. The Committee found Ms. G to be a credible witness. While her testimony was uncertain in regard to the whereabouts of the missing Viagra prescription, her testimony as to the existence of the Viagra prescription was both credible and reliable.

Assessment of the Evidence of Dominic Gascon

The Committee found Dominic Gascon to be a credible and reliable witness. He relied on the notes he made in Ms. A's medical record as well as the inter-professional notes written by other nurses. He testified that after reviewing Ms. A's patient record he was able to recall details of the conversation he had with Dr. Garcia that did not appear in his note. He testified in a forthright manner. His testimony was straightforward, made sense and was believable.

However, there were inconsistencies in his testimony as to what he told the College investigator in regard to when he learned that Dr. Garcia was a physician. Regardless of when he learned Dr. Garcia was a physician, the Committee accepted that at some point prior to the end of his conversation with Dr. Garcia, he was aware Dr. Garcia was a physician. If he was not aware Dr. Garcia was a physician or other health professional, there would have been no reason for him to make the chart entry "from one professional to another". When Dr. Garcia described himself as a professional, Mr. Gascon understood that to be in reference to him being a physician. There was no evidence that Dr. Garcia held any other professional designation.

Mr. Gascon's explanation as to how he could recall details of his telephone conversation with Dr. Garcia (that were not included in his inter-professional note in Ms. A's chart) made sense and was believable. The Committee considers it normal and expected that certain events such as reviewing a patient's chart may result in additional details being recalled by a witness. There was no evidence that Mr. Gascon had any vested interest in the outcome of the hearing that may have influenced his evidence, and the Committee did not find any reason by him to fabricate his evidence.

In addition, the fact that Dr. Garcia was the subject of a disciplinary hearing could not have influenced Mr. Gascon in making the entry "from one professional to another", as the entry was made before the Notice of Hearing was issued.

FINDINGS - Allegation of Disgraceful, Dishonourable or Unprofessional Conduct

i) What was the nature of the relationship between Dr. Garcia and Ms. A?

Ms. E described three occasions when she observed her sister Ms. A and Dr. Garcia "interacting like a couple" during the spring and summer of 2013. Two of those occasions were in regard to Dr. Garcia going out on "a date" with Ms. A. One of those occasions involved Dr. Garcia having a quick bite to eat with Ms. A in their apartment before going out on a date. On that occasion, Ms. E observed Dr. Garcia and Ms. A hugging and Dr. Garcia giving Ms. A a "peck on the cheek".

The third occasion Ms. E described was when Dr. Garcia, "as would a normal companion", came to their apartment to see Ms. A, who was not feeling well. During that visit, Dr. Garcia and Ms. A were watching a movie together with Ms. E. She described Ms. A and Dr. Garcia cuddling on the couch, kissing and hugging. She also described Dr. Garcia falling asleep with his head on a pillow on Ms. A's lap. She also testified that on that same night, Dr. Garcia had returned some items that Ms. A had left at his apartment. It was also on that occasion that Dr. Garcia wrote a prescription for an antibiotic for Ms. A. In the Committee's opinion, Ms. E's observations supported that Ms. A and Dr. Garcia were having a close personal and romantic relationship.

Ms. G described her interaction in the foyer of Ms. A's apartment building the day Ms. A was taken to hospital. Ms. G testified that Dr. Garcia had been in the lobby for at least an hour before she spoke with him. When she entered the apartment building, she noticed a man "pacing" in the foyer but, at that time, she did not know for certain it was Dr. Garcia. Subsequently, she was informed that it was Dr. Garcia. At that point, she returned to the foyer to speak to Dr. Garcia. She testified that when she spoke with Dr. Garcia, he indicated to her that he had received some "weird" text messages from Ms. A and was concerned enough to call the police. The telephone records of Dr. Garcia did confirm that he called "911". Ms. G described Dr. Garcia as fidgeting, staring at his phone and appearing "irritable". The description provided by Ms. G of what Dr. Garcia had said, his waiting for at least an hour in the apartment foyer, and his mannerism prior

to and when she spoke with him, is consistent with an individual close to Ms. A and demonstrating concern.

There is further evidence in the telephone records (exhibit #2 Tabs A & B) of Dr. Garcia and Ms. A. The Committee notes that there were approximately 119 phone calls made between Dr. Garcia and Ms. A during the period April 20, 2013 and September 30, 2013, the majority of which occurred in the summer of 2013. Several of the calls occurred late in the evening or after midnight. The number, frequency and timing of telephone calls is also supportive of there being a close personal relationship between Dr. Garcia and Ms. A.

The Committee also finds that Dr. Garcia made a significant effort to determine which hospital Ms. A was admitted to. He also visited Ms. A in the hospital.

In determining the relationship that existed between Ms. A and Dr. Garcia, the Committee considered the following:

- the observed cuddling, hugging and kissing between Ms. A and Dr. Garcia;
- the reference to Dr. Garcia and Ms. A going out on "dates" together;
- Dr. Garcia and Ms. A being observed "interacting like a couple";
- the number, frequency and the time of day when there were telephone calls between Dr. Garcia and Ms. A;
- the efforts Dr. Garcia made to locate Ms. A when she was taken to hospital;
- the apparent concern Dr. Garcia displayed for Ms. A including the amount of time he spent in the foyer of Ms. A's apartment the day that she was taken to hospital;
- that Ms. A had been in Dr. Garcia's apartment and had left some items there; and
- that Dr. Garcia visited Ms. A in hospital.

After considering the totality of the evidence, the Committee concludes that Dr. Garcia and Ms. A were in a close personal and romantic relationship at the time Dr. Garcia prescribed medications, an IUD and provided medical services to Ms. A.

The Committee further finds that the relationship that existed between Dr. Garcia and Ms. A would be captured in the definition under the heading "Definitions" in the CPSO policy statement #7-06 Treating Self and Family Members, which states:

> "For the purpose of this policy, "family member " means a physician's spouse… ; or another individual in relation to whom the physician has personal or emotional involvement that may render the physician unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions."

ii) Did Dr. Garcia prescribe medications and/or provide medical services to a family member (Ms. A) contrary to the CPSO policy on treating Self and Family Members?

Dr. Garcia prescribed Nitrofurantoin, an antibiotic, to Ms. A on one occasion that was dispensed at a Shoppers Drug Mart on July 5, 2013. Dr. Garcia also prescribed Naproxen, Misoprostol and Levonorgestel (an IUD), which was dispensed at Shoppers Drug Mart on July 26, 2013. Dr. Garcia also referred Ms. A to his sister who was an Obstetrician and Gynecologist to have the IUD inserted. None of these facts are disputed.

There was also testimony from Ms. G that she found a prescription that indicated that Dr. Garcia prescribed Viagra to Ms. A. However, there is no evidence before the Committee that a Viagra prescription for Ms. A was ever filled at a pharmacy.

Dr. Garcia disputes Ms. G's claim that she found a prescription for Viagra made out to Ms. A in Ms. A's apartment. The Committee accepted the testimony of Ms. G that it was a prescription for Viagra that she had found.

As noted above, the Committee found that the relationship that Dr. Garcia had with Ms. A was captured by the CPSO's Treating Self and Family Members policy definition under the heading "Family member". The policy also states that:

> "Physicians should not treat either themselves or family members, except for a minor condition or in an emergency situation **and** when another qualified healthcare professional is not readily available. [emphasis added]

These conditions were not present when Dr. Garcia chose to prescribe medications and an IUD to Ms. A.

Physicians are advised that if they do not comply with the CPSO policy on treating Self and Family Members, they may be subject to allegations of professional conduct. In addition, the policy reminds physicians that:

> "Physicians must be mindful that treating a family member can create a physician-patient relationship, particularly where the treatment provided is more episodic. This is especially important when an individual receiving treatment is someone with whom the physician is romantically or sexually involved…"

As stated in the College's policy, when a physician treats someone with whom they have a family or a personal/ emotional relationship, there is a risk that the relationship will affect the doctor's ability to provide quality care. In general, physicians should refrain from treating family members or their partners.

Previous Discipline Committees have provided the following reasons for making a finding of professional misconduct in such circumstances:

- The College Policy is clear: care should be provided to family members only for minor conditions or in urgent/emergency situations and only when another physician is not available (*Rai*, para. 93; *Moore*, para. 6);
- Treating family members creates confusion in an individual's mind about whether the member, in providing the incidental medical treatment, is acting in a personal or professional role (*Abouelnasr*, para. 4; *Moore* para. 11);

- When a doctor treats family members, a serious conflict arises as emotional and dependency issues cloud the dynamics of the situation and can lead to difficulties (*Irvine* para. 28);

- There is a risk that the familial or intimate relationship will affect the doctor's ability to provide the patient with proper care. Treating family members raises issues of professional objectivity and cloud a physician's judgment (*Rai*, para. 93; *Moore*, para. 12; *Vasovich*, para. 10);

- It represents a failure to maintain appropriate professional boundaries (*Moore* para. 11);

- Treating family members may impair a good relationship with a patient's family doctor(*Moore* para. 12).

It is this Committee's opinion that the above reasons equally apply when there is a close personal and romantic relationship such as it finds to be in this case.

According to Dr. Garcia's Patient Encounter note dated July 26, 2013, Ms. A was taking an oral contraceptive pill. There is no evidence before the Committee that Dr. Garcia had ever prescribed an oral contraceptive pill to Ms. A. It is reasonable to conclude that there was another treating health care professional involved in Ms. A's care. Furthermore, Ms. A was living in Toronto and there would have been health care professionals readily available, including at a walk in clinic, if her treating healthcare professional was not available.

If Dr. Garcia felt that Ms. A required antibiotic treatment when he visited Ms. A at her apartment on the night she was not feeling well, rather than prescribing the antibiotic himself, he could have advised Ms. A to see either her treating physician, or to attend a walk-in clinic or a hospital emergency ward, where an appropriate clinical assessment could be performed to determine if it was appropriate to prescribe an antibiotic. He chose not to do so.

Dr. Garcia wrote a prescription for Ms. A for Naproxen, Misoprostol and Levonorgestel (an IUD). He also made a referral to his sister to insert the IUD. In this case, there was a "Medical

Consultation- Appointment Requisition" to his sister (exhibit #3 Tab B) dated July 26, 2013, which indicates that Dr. Garcia did prescribe Naproxen and Misoprostol. However, it does not indicate that he also wrote a prescription for the IUD. There is also a "Patient Encounter note" dated July 26, 2013 (exhibit# 3 Tab C) that does not mention the prescription. There is also no record of an assessment, which would include a history and physical examination. There is also no record that Dr. Garcia explained the potential side effects and adverse reactions that Ms. A might experience when taking the medications he prescribed.

The CPSO policy on Prescribing Drugs clearly states "Before prescribing a drug, physicians must have current knowledge of the patient's clinical status. This can only be accomplished through an appropriate clinical assessment of the patient. An assessment must include:

a) An appropriate patient history, including the most complete and accurate list possible of drugs the patient is taking and any previous adverse reactions to drugs. A physician may obtain and/or verify this information by checking previous records and data bases, when available, to obtain prescription and/or other relevant medical information, and if necessary,
b) An appropriate physical examination and/or any other examinations.

In addition, the policy states that "physicians must specifically document the following information regarding the drugs they prescribe in the patient's medical record:

- The date the drug is prescribed;
- The type of prescription (verbal, hand written, electronic);
- The name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for the use of the drug;
- The fact that the drug's material risks, including material side effects, complications or precautions were discussed with the patient;
- Refill information; and
- Other relevant information (e.g. drug cannot be substituted; prescription cannot be adapted; extended or refilled, as applicable).

With the exception of "Seeking IUD; Mirena and copper discussed; OCP currently and will send to gyne", the Patient Encounter is devoid of any other information including a clinical assessment, or any reference to any medications or devices prescribed. Dr. Garcia's referral note to his sister does indicate that he prescribed Naproxen and Misoprostol but does not mention he also wrote a prescription for the IUD. There is no mention in either note of an assessment, the drug strength or quantity or duration of therapy, refill information, a discussion of potential side effects or adverse reactions, the type of prescription, and any other relevant information.

The Prescribing Policy is of assistance in highlighting problems that physicians face if they choose to treat a family member. The policy outlines what is required to provide good quality care when prescribing medications. This would include performing an appropriate clinical assessment as well as appropriately documenting the patient encounter. When physicians choose to treat a family member or an individual with whom they have a close personal and romantic relationship, such as the case with Dr. Garcia, the physician may not feel there is a need to conduct an appropriate clinical assessment of their family or romantic partner prior to prescribing a medication, such as an antibiotic, particularly if it is felt that they are treating a minor condition. In addition, the physician and/or their family member/close personal friend may feel embarrassed or uncomfortable during an appropriate clinical assessment. However, without the supportive information that would be obtained from a clinical assessment, there is a risk that the physician could make an incorrect diagnosis in regard to their family member/close personal friend and as a result, prescribe an inappropriate treatment. This could potentially cause harm to the family member or close personal friend.

The medications and IUD prescribed by Dr. Garcia were dispensed on the same day that he made the referral to his sister to have the IUD inserted. It is therefore reasonable to conclude that Ms. A had not seen Dr. Garcia's sister prior to Dr. Garcia prescribing the medications. It is also an agreed fact that Ms. A never attended any medical appointments with Dr. Garcia at the Wellington Medical Centre or anywhere else. Whether or not Ms. A had seen Dr. Garcia's sister before or after he prescribed the medications and IUD, it would be reasonable to expect that the physician who would be performing the IUD insertion, and not Dr. Garcia, would have been the

appropriate physician to prescribe the medications and IUD to Ms. A. In addition, the physician performing the procedure would be in the best position to perform the appropriate clinical assessment prior to prescribing any medications or an IUD.

Furthermore, according to Dr. Garcia's Patient Encounter note dated July 26, 2013, Ms. A was taking an oral contraceptive pill prior to the referral for an IUD insertion and it can therefore be reasonably concluded that there was another treating health care provider who was involved in Ms. A's reproductive health. There was no evidence that Dr. Garcia had ever prescribed the birth control pill to Ms. A. Considering the close personal and romantic relationship Dr. Garcia had with Ms. A, it was inappropriate for Dr. Garcia to prescribe the IUD and the medications related to the IUD insertion. He should have advised Ms. A to see the treating health care professional who was involved with her reproductive health and who had prescribed the birth control pill to discuss and if appropriate make the referral to a gynecologist for an IUD insertion.

In summary, in the above two instances, Dr. Garcia prescribed medications and an IUD, as well as provided a medical service to Ms. A with whom he had a close personal and romantic relationship, contrary to the Treating Self and Family policy.

It was inappropriate, considering his close personal and romantic relationship with Ms. A, for him to provide an antibiotic prescription when it was not an urgent/emergency situation and when there was another available qualified professional to do so. It was also not appropriate for Dr. Garcia to provide a medical service or prescribe an IUD or medications prior to an IUD insertion for Ms. A.

As Ms. A's romantic partner, Dr. Garcia placed himself in a conflict of interest by providing Ms. A with a prescription and a referral to his sister for insertion of an IUD for birth control. He was not a disinterested party in regard to Ms. A's reproductive health and birth control practices. By blurring the boundary between his relationship with Ms. A and his role as a physician by prescribing a form of long-term birth control, he created a conflict between Ms. A's medical interests and his own interest in the relationship. Furthermore, the prescription of a hormone IUD, a form of long-term birth control, is not treatment of a minor condition or treatment in an

emergency. There was also another treating healthcare professional involved in Ms. A's reproductive health who could have made the referral, if appropriate, to a gynecologist for an IUD insertion. It is also clear from Dr. Garcia's referral letter that there was a gynecologist available.

Furthermore, if Ms. A had been referred to Dr. Garcia's sister who is a gynecologist, she could have performed the appropriate clinical assessment and, if appropriate, provided to Ms. A not only the IUD prescription but also prescribed the medications related to an IUD insertion.

Therefore, after carefully reviewing the "Treating Self and Family Members" policy, and the evidence, the Committee finds that there is sufficient evidence to support the finding that Dr. Garcia breached the CPSO policy "Treating Self and Family Members" and therefore, engaged in disgraceful, dishonourable or unprofessional conduct when he prescribed medications, an IUD and provided a medical service to Ms. A with whom he had a close personal and romantic relationship.

The Committee would like to also address the missing Viagra prescription and its relationship to the above finding. The Committee did accept the evidence of Ms. G that Dr. Garcia wrote a Viagra prescription for Ms. A. While this further supports the Committee's finding of disgraceful, dishonourable and unprofessional conduct, the Committee wishes to point out that the Viagra prescription was not determinative of that finding. Even in the absence of a Viagra prescription, the Committee would have made a finding based the prescriptions for the antibiotic, Naproxen, Misoprostol and Levonorgestel, as well as the medical service Dr. Garcia provided to Ms. A.

iii) Did Dr. Garcia seek to obtain Confidential Information about Ms. A without her Consent?

The Committee carefully considered whether Dr. Garcia sought to obtain confidential information about Ms. A without her consent. In making that determination, the Committee relied on the following evidence:

- On or about September 10, 2013, Dr. Garcia asked staff at the Wellington Medical Centre to call hospitals in Toronto to see if they could locate Ms. A;
- On or about September 10, 2013, Dr. Garcia created a document (Fax) through the Wellington Medical Centre's computer system regarding Ms. A and requesting information about Ms. A from the University Health Network;
- The nurses' inter-professional notes from Ms. A's medical record at St. Michael's Hospital; and
- The testimony of Mr. Gascon.

As a physician , Dr. Garcia would have full knowledge that a patient is required to provide their consent, either directly to the health care provider or by way of a written consent to a third party, before a health care provider can release confidential information about them to a third party. The nurses' notes in Ms. A's patient record indicate that Dr. Garcia visited Ms. A on a date in 2013 and also spoke with Ms. A by telephone on a date in 2013. Therefore, there are at least two occasions prior to the subsequent date in 2013 when Dr. Garcia had an opportunity to obtain Ms. A's consent or request Ms. A to provide her consent to hospital staff to release her confidential information to him. There is no evidence in the nurses' notes that any nurse had received consent, either directly from Ms. A or in writing, to provide confidential information to Dr. Garcia.

As expressly stated in Nurse Baek's note of the subsequent date in 2013 at 15:05: "…wants to know when patient will be discharged. Told him (Dr. Garcia) that the writer could not disclose confidential information". This is further evidence that Ms. A had not provided her consent to either Dr. Garcia or the nurse to release her confidential information. In addition, if Ms. A had given Dr. Garcia consent to obtain confidential information during one of their two encounters while she was in hospital, it would make sense that Dr. Garcia would have indicated that during one of his conversations with hospital staff. There is no evidence in the nurses' notes or in Mr. Gascon's testimony that Dr. Garcia ever informed any member of the hospital staff that Ms. A had provided him either verbal or a written consent to release confidential information. The

Committee finds that Ms. A did not provide consent either to Dr. Garcia or the hospital staff to provide confidential information about herself to Dr. Garcia.

Confidential Information

Unlike a member of the general public who may or may not know what constitutes confidential information in regard to a patient within a healthcare facility, Dr. Garcia, as a physician, would have full knowledge as to what constitutes confidential patient information. Despite that knowledge and even after being informed by Nurse Baek on the afternoon of the subsequent date in 2013 that she could not disclose the confidential information about Ms. A that he was seeking, Dr. Garcia persisted in his attempts to obtain that information by calling back later in the day and speaking to another nurse, Mr. Gascon. Not only was Dr. Garcia persistent in his attempts to obtain confidential information, the Committee finds that he used his professional status as a physician in an attempt to persuade or pressure Mr. Gascon to release confidential information about Ms. A.

This is supported by Mr. Gascon's inter-professional note of the subsequent date in 2013 at 17:30 hrs. which states "expressed his frustration on not being given more information as he had requested "from one professional to another". Informed him that the writer could not provide any further information to him…" In addition to what is contained in his note, Mr. Gascon testified that Dr. Garcia asked him what the care plan was for Ms. A, why she couldn't be discharged, and why people were not letting him come in to speak with Ms. A. The Committee notes that the issue of Ms. A's discharge came up during Dr. Garcia's conversation with Nurse Baek earlier in the day and that, at that time, the nurse told him that she could not provide confidential information.

There is further evidence in the fax document (exhibit #5) that Dr. Garcia created that he was prepared to use his professional status and title to obtain confidential information from the University Health Network. The Committee also notes in that document that Dr. Garcia entered intentionally not only misleading, but false information, that Ms. A was his patient. This is

supported by the fact that he chose to write "this patient has I believe been admitted …." rather than writing "a friend of mine has I believe been admitted…"

Finally, rather than calling the Toronto hospitals himself, Dr. Garcia instructed his office staff to call the Toronto hospitals in an effort to locate Ms. A. The Committee concludes that Dr. Garcia made a conscious and calculated decision to have his office staff call the hospital, rather than doing that himself, thinking that the hospital staff would be more likely to release the information he was seeking if the call was coming from staff at a physician's office.

In summary, the Committee is satisfied that Mr. Gascon's evidence as well as the information recorded in the nurses' notes is sufficient and supports the Committee's finding that Dr. Garcia, on more than one occasion, attempted to obtain confidential information about Ms. A that he knew he was not entitled to without her consent, and that he used his professional status as a physician in an attempt to persuade or pressure a nurse to release confidential information about Ms. A.

Adverse inference

College counsel submitted that an adverse inference should be drawn against Dr. Garcia for failing to testify.

The late Justice Sopinka noted in *The Law of Evidence in Canada*, Third Edition, at para. 6.449, that an adverse inference can be drawn in civil cases when,

> "in the absence of an explanation, a party litigant does not testify, or fails to provide affidavit evidence on an application, or fails to call a witness who would have knowledge of the facts and would be assumed to be willing to assist the party. In the same vein, an adverse inference may be drawn against a party who does not call a material witness over whom he or she has exclusive control and does not explain it away. Such failure amounts to an implied admission that the evidence of the absent witness would be contrary to the party's case, or at least would not support it."

The Committee finds that the College established a *prima facie* case. Indeed, this Committee determines that there is clear cogent and convincing evidence, without having to resort to an adverse inference, to find on a balance of probabilities that Dr. Garcia committed an act of professional misconduct in that he engaged in act or omission relevant to the practice of medicine that having regard to all the circumstances would, reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

A member has no right to remain silent in a disciplinary proceeding. In *McIntyre,* the Discipline Committee determined it could draw an adverse inference against the member for her failure to testify. In so doing, it firmly rejected the argument that there would have been unfairness to the member from drawing such an inference. As the Committee stated in *McIntyre:*

> "[T]he onus is, and always remains, entirely on the College to prove the allegations on a balance of probabilities, and based on clear, cogent and convincing evidence. That said, a physician subject to discipline does not enjoy a "right to remain silent" and accordingly, the decision not to testify in his own defence permits the Committee to draw an adverse inference, where that is appropriate (see *College of Physicians and Surgeons v. Rathe, College of Physicians and Surgeons v. Lambert, College of Physicians and Surgeons v. Liberman,* and *College of Physicians and Surgeons v. Golomb).* This does not involve any speculation by the Committee as to the content of the missing testimony, or any reliance upon the substance of that presumed testimony. It is simply a statement of the common sense proposition that if the College's evidence establishes *prima facie* proof of a fact, and the physician chooses not to testify to answer that evidence, it is open to the Committee to draw an adverse inference from her failure to testify.
>
> Dr. McIntyre had relevant evidence that she could have provided to the Committee through her testimony. This Committee found that she engaged in sexual abuse by kissing Ms. Y. The Committee draws the reasonable inference that Dr. McIntyre's own evidence on this point would have been unhelpful to her case and would have assisted the College. Although counsel for Dr. McIntyre submitted that the doctor-patient relationship had

> been terminated sometime in or around October 2010, no evidence was tendered in this regard and Dr. McIntyre did not testify to that effect. The Committee considers that it is appropriate in this case to draw the inference that the evidence of Dr. McIntyre would have been contrary to her termination argument, or at least, not support it. The Committee can draw an adverse inference from the failure of Dr. McIntyre to testify regarding both the sexual touching (the inference being that it did occur as Ms. O stated) and the alleged termination of the doctor-patient relationship in or around October 2010 (the inference being that it did not occur). In any event, it is the Committee's view that the allegations against Dr. McIntyre have been proven to the requisite standard without relying upon any adverse inference being drawn with respect to either of these issues. The findings are even stronger when an adverse inference is drawn."

Similarly, in the case before this Committee, Dr. Garcia had relevant evidence that he could have provided to the Committee through his testimony. This Committee found that Dr. Garcia wrote a prescription for Viagra for Ms. A. Counsel for Dr. Garcia challenged Ms. G who found the Viagra prescription, suggesting that she was mistaken and that the prescription was for an antibiotic, which she denied. The Committee draws the reasonable inference that Dr. Garcia's own evidence on this point would have been unhelpful to his case and would have assisted the College in its case.

There was evidence before the Committee that there was a close personal and romantic relationship between Dr. Garcia and Ms. A. Ms. E in her communication with the College investigator described Ms. A and Dr. Garcia "cuddling on the couch". During Ms. E's testimony, she described Dr. Garcia and Ms. A kissing and hugging while on the couch. There was additional evidence that there was a close personal and romantic relationship between Dr. Garcia and Ms. A.

Therefore, the Committee draws the reasonable inference that Dr. Garcia's own evidence on the nature of the relationship he had with Ms. A would have been unhelpful to his case and would have assisted the case for the College.

There was no evidence in any of the documents admitted in evidence or in Mr. Gascon's testimony that Dr. Garcia had Ms. A's consent to contact hospital staff to obtain confidential information about Ms. A. The Committee can also draw the reasonable inference that Dr. Garcia's own evidence on the issue of consent would have been unhelpful to his case and would have assisted the case for the College.

In any event, it is the Committee's view that the allegation that Dr. Garcia has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would be reasonably regarded by members as disgraceful, dishonourable or unprofessional, is proven to the requisite standard, without relying upon any adverse inference being drawn with respect to the issues outlined above. However, the Committee notes that the findings are even stronger when an adverse inference is drawn.

Summary

The Committee finds that Dr. Garcia prescribed medications on three occasions to Ms. A and on one of those occasions, prescribed an IUD and provided a medical service to Ms. A by referring Ms. A to a gynecologist to perform the IUD insertion.

The policy statement on Treating Self and Family Members clearly states when it is permissible to treat a family member or another individual whom the physician has a personal or emotional involvement. As stated: "Physicians should not treat either themselves or family members, except for a minor condition or in an emergency situation **and** when another qualified healthcare professional is not readily available. [emphasis added]

These conditions were not present on the occasions when Dr. Garcia chose to prescribe medications, an IUD and provide a medical service to Ms. A. Simply put, the Committee finds that Dr. Garcia breached the CPSO policy on Treating Self and Family Members.

The Committee also finds that Dr. Garcia used his professional status as a physician in an attempt to persuade or pressure a nurse to provide confidential information in regard to Ms. A

without her consent, despite the fact that he, as a physician, had full knowledge that he was not entitled to that information.

Therefore, on a balance of probabilities based upon clear, cogent and convincing evidence, the Committee finds that Dr. Garcia has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

MOTION FOR NON- SUIT

Counsel for Dr. Garcia filed a motion for:

(a) A direct verdict/ non-suit dismissing allegation #2 referred to in the Discipline Committee on August 19, 2015 with respect to disgraceful, dishonourable or unprofessional conduct made by the Inquiries, Complaints and Reports Committee of the College; and

(b) Such further and other relief as to the Discipline Committee may seem just.

For this motion to succeed it would require that the College had not established a *prima facie* case. For the reasons noted above, not only has the College established a *prima fascie* case in regard to allegation #2, there was sufficient evidence before this Committee for it to make a finding of disgraceful, dishonourable or unprofessional conduct in regard to allegation #2. Therefore, the motion is denied.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Garcia, this is notice that the Discipline Committee ordered a ban on publication of the names and any information that could disclose the identity of Ms A and patients referred to orally or in the exhibits filed at the hearing, as well as a ban on publication or broadcasting of Ms A's relatives who are witnesses, which could disclose the identity of Ms A under subsection 45(3) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 … is guilty of an offence and on conviction is liable,
>
> (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
>
> (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Garcia, 2018 ONCPSD 35

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act*, *1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. YELIAN GARCIA

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MS D. DOHERTY
DR. W. KING
DR. E. STANTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS B. DAVIES
MS R. AINSWORTH

COUNSEL FOR DR. GARCIA:

MR. M. SAMMON
MR. I. MACLEOD

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Penalty Hearing Date: October 10, 2017 and January 24, 2018
Penalty Decision Date: January 24, 2018
Release of Written Reasons: July 11, 2018

PUBLICATION BAN

REASONS FOR PENALTY DECISION AND COSTS ORDER

On February 15, 2017, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that Dr. Yelian Garcia committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession, and in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

On October 10, 2017, the Committee heard evidence on penalty. On January 24, 2018, the Committee heard a joint submission on penalty and delivered its penalty order with written reasons to follow. On January 24, 2018, the Committee also heard submissions on costs and it reserved its decision on costs, which it now delivers with its reasons for penalty.

Joint Submission on Penalty

On day three of the penalty hearing, the Committee was presented with a joint submission on penalty. The proposed penalty included the following terms and conditions:

1. that Dr. Garcia appear before the Committee to be reprimanded.

2. that the Registrar suspend Dr. Garcia's certificate of registration for a period of eight (8) months, to commence at 12:01 a.m. on February 7, 2018.

3. that the Registrar impose a number of terms, conditions and limitations on Dr. Garcia's certificate of registration, including restricting clinical interactions with no more than a total of forty-eight (48) patients per day, at a rate of no more than six (6) patients per hour within each hour, maintaining a patient log and prescribing log for narcotics and narcotic preparations, controlled drugs, benzodiazepines and other

targeted substances and all other monitored drugs, as defined under the *Narcotics Safety and Awareness Act, 2010,* S.O. 2010 c.22.

4. that Dr. Garcia shall participate in and successfully complete the next available courses in Medical Ethics and Maintaining Boundaries approved by the College.

5. that on resuming practice after the suspension, there will be a twelve-month period of clinical supervision which would include a chart review, direct observation and regular meetings with the clinical supervisor. The clinical supervisor will be required to make regular reports to the College.

6. that approximately twelve (12) months after the completion of the period of supervision as set out above, Dr. Garcia shall undergo an assessment of his practice(s) by a College-appointed assessor(s). The assessor(s) shall report the results of the assessment to the College.

7. that Dr. Garcia shall comply with the College Policy on *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* in respect of his period of suspension.

8. that Dr. Garcia shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and again prior to resuming practice following the suspension of his certificate of registration described above and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location, until the report of the assessment has been provided to the College.

9. that Dr. Garcia shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person

who or institution that may have relevant information, in order for the College to monitor his compliance with the Order.

10. that Dr. Garcia shall be responsible for any and all costs associated with implementing the terms of the Order.

The Committee is aware that a joint submission on penalty must be accepted, unless to do so would bring the administration of justice into disrepute, or would otherwise be contrary to the public interest (see *R. v. Anthony-Cook*, 2016 SCC 43). The Committee carefully considered the terms of the proposed penalty and accepted that it satisfied all of the guiding principles to be considered in the determination of an appropriate penalty. The Committee therefore accepted the joint submission on penalty for the reasons set out below.

EVIDENCE ON PENALTY

Counsel for the College did not call any witnesses but relied on documentary evidence in her submissions regarding penalty.

College counsel sought to introduce in evidence the billing records of Dr. Garcia for the period from January 1, 2012 to December 13, 2013; she submitted that the billing records were relevant and therefore should be admitted in evidence. Counsel for Dr. Garcia took the position that the billing records were not relevant. In addition, counsel for Dr. Garcia submitted that it would be prejudicial to Dr. Garcia if the Committee considers only historical billing data, and does not consider current billing data when determining whether to impose a term on Dr. Garcia's certificate of registration that would restrict the number of patients per hour/day that Dr. Garcia could see. Counsel for Dr. Garcia further submitted that there is no direct link between the specific patient charts or patient concerns and the Committee's findings with respect to Dr. Garcia's professional misconduct in this case.

After careful consideration, the Committee accepted that Dr. Garcia's billing records for the period from January 1, 2012 to December 13, 2013 are relevant and should be admitted in evidence as they contain information regarding factors that may have contributed to the concerns raised about Dr. Garcia's care that he was providing to his patients in 2012-2013. The billing records indicated the number of patients Dr. Garcia was seeing in any given day during the period 2012-2013, when there were issues about his care and the clinical services he provided.

A review of the billing records indicated that the maximum number of patients Dr. Garcia saw in a day was 111 in 2012 and 110 in 2013. Based on the Agreed Statement of Facts, Dr. Garcia was seeing on average 10 to 13 patients per hour in 2012 at the Wellington Clinic, which is one of the clinics where, as Dr. Garcia has admitted, he had a significant number of the clinical issues, which formed the ground for the Committee's finding of professional misconduct. Dr. Garcia also admitted that in 2012 he conducted some patient examinations and assessments very quickly. Dr. Garcia acknowledged during the College investigation that he should have slowed down in terms of the manner in which he assessed and communicated with patients. College counsel also reviewed examples where Dr. Garcia failed to properly record patient encounters.

The Committee noted that Dr. Garcia had previously stated that his practice had changed since 2012 and early 2013, and that he had tried to slow down in order to allow more time for each patient encounter and to communicate more effectively with patients. College counsel submitted that the reason that Dr. Garcia has improved the quality of care he has been providing since 2012-2013 was because he is seeing fewer patients per hour/day.

Counsel for Dr. Garcia presented the following documentary evidence:

1. Dr. Garcia's Undertaking, dated October 2, 2015 (Exhibit # 9);
2. Dr. Garcia's Certificate of the Safe Opioid Prescribing Workshop, dated January 15, 2015 (Exhibit #11);

3. Twenty-eight (28) Letters of Support for Dr. Garcia (Exhibit # 12);
4. Five (5) supervision reports from Dr. Petcho that were prepared between December 20, 2015 and April 18, 2016. Dr. Petcho's clinical supervision of Dr. Garcia's practice involved reviewing patient charts as well as observing Dr. Garcia in his practice. It was Dr. Petcho's opinion that Dr. Garcia maintained a professional demeanor with patients; Dr. Petcho did not have any concerns in terms of patient safety, regarding the clinical skills or judgment of Dr. Garcia (Exhibit # 13).

Withdrawal of Evidence

On October 10, 2017, Counsel for Dr. Garcia called Dr. Chapman as an expert witness. On January 28, 2018, he withdrew the evidence of Dr. Chapman. In addition, counsel for Dr. Garcia withdrew from evidence the following exhibits in relation to Dr. Chapman:

- Dr. Chapman's curriculum vitae (exhibit #14),
- Acknowledgement of Duty signed by Dr. Chapman (exhibit #15),
- Dr. Chapman's June 27, 2016 report of her review of 24 charts of Dr. Garcia (exhibit #16),
- Brief of patients' charts relating to Dr. Chapman's report of June 27, 2016 (exhibit #17),
- Dr. Chapman's September 21, 2017 report of her review of 12 patients' charts of Dr. Garcia (exhibit # 18)
- Brief of patient charts relating to Dr. Chapman's report dated September 21, 2017 (exhibit #19).

Counsel for Dr. Garcia also withdrew Dr. Garcia's Medical Record Keeping Course Certificate (exhibit #10), which had been relied upon as a mitigating factor.

College counsel agreed with the withdrawal of the evidence noted above. The Committee therefore did not consider this evidence in reaching its decision on the joint submission on penalty presented by the parties.

PENALTY AND REASONS FOR PENALTY

Law and Legal Principles

The Committee's determination on penalty is based, firstly, on the guiding and most important principle of protection of the public. The Committee was also mindful that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member, that it should express the profession's denunciation of the misconduct, that it be proportionate to the misconduct, and that it should serve to uphold the honour and reputation of the profession and maintain the public's confidence in the College's ability to regulate the profession in the public interest. Also, to the extent it is possible, the penalty should serve to rehabilitate the member.

The Committee accepts the general principle that like cases should be treated alike. However, the Committee recognizes that it is not required to impose the "least restrictive" penalty which would be consistent with its objectives (see *CPSO v. McIntyre* (2017)).

While the Committee appreciates that prior decisions of the Discipline Committee may be of assistance in the determination of an appropriate penalty, the Committee is not bound by those decisions as each case before it is unique and the Committee must carefully consider the specific facts of the case before it as well as any relevant mitigating and aggravating factors.

Summary of Committee's Findings

The findings of Dr. Garcia's professional misconduct in the case before this Committee are multifaceted and include:

- Dr. Garcia attempting to obtain confidential information without a patient's consent;
- Dr. Garcia failing to maintain the standard of practice of the profession in relation to prescribing controlled substances; and,
- Dr. Garcia violating an important boundary between a physician and patient by prescribing medications, an IUD, and providing a medical service to an individual with whom Dr. Garcia had a close personal and romantic relationship.

In its determination of the appropriate penalty, the Committee carefully considered its findings, the specific facts of the case before it, and various aggravating and mitigating factors.

Aggravating Factors

Maintaining Confidentiality of a Patient's Personal Health Information

Where a physician is found to have attempted to breach the confidentiality of a patient's medical records without consent, this Committee finds such conduct to be a very serious matter. The privacy of a patient's personal health information is sacrosanct. Patients must trust that their sensitive personal health information is handled in a professional manner. Patients have the right to the expectation that unauthorized individuals, including physicians not in their circle of care, will not attempt to breach that confidentiality. Dr. Garcia attempted to obtain Ms A's confidential personal health information without her consent from allied health personnel, that he knew as a physician, he was not entitled to. Dr. Garcia allowed his curiosity in regard to Ms A's personal health information to compromise his better judgment.

In considering the appropriate penalty, given Dr. Garcia's attempt to breach the privacy of Ms A, the Committee recognizes the importance of maintaining public trust in the profession. It is a physician's duty to preserve patient privacy. Maintaining confidentiality is a fundamental pillar of the profession. Trust is fragile. Dr. Garcia abused that trust. Dr. Garcia was not a physician in the "circle of care" of Ms A. As a physician he would have known that he was not entitled to Ms A's personal health information without her consent. Even though Dr. Garcia's attempt to obtain confidential personal health information was unsuccessful, the fact that he attempted to obtain it undermines the public trust in the profession to a significant degree and therefore must be denounced and met with a significant penalty.

Inappropriate Prescribing

The public and the profession cannot and indeed will not tolerate a physician who fails to maintain the standard of practice of the profession. Dr. Garcia failed to maintain the standard of practice of the profession in his prescribing of controlled substances. The Committee considered the potential physical and emotional harm that can be inflicted on members of our society who become addicted to a controlled substance through the inappropriate prescribing of those substances. The Committee was very concerned with Dr. Garcia's excessive and inappropriate prescribing of controlled substances to his patients.

The opioid crisis has become a significant public health problem in our society. While there may be several factors that play a role in the opioid crisis, physicians who prescribe narcotics inappropriately or prescribe excessive doses of narcotics to patients contribute to that crisis. Dr. Garcia's prescribing of controlled substances was reckless in terms of the amounts prescribed and monitoring undertaken, which put his patients at a significant risk of harm. In addition, the friends and family members of addicted individuals often become unintended victims. Furthermore, when narcotics are prescribed in excessive amounts or inappropriately, there is a risk for diversion to third party individuals who also may be put in harm's way.

Dr. Garcia's prescribing of controlled substances demonstrates a blatant disregard for his patients' safety and wellbeing. When a physician fails to maintain the standard of practice, and as a result, puts patients in harm's way, it calls for a stringent penalty that will demonstrate to the public and to the profession that such professional misconduct will not be tolerated.

Treating Self and Family

Dr. Garcia breached the College policy on Treating Self and Family Members by providing a medical service and prescribing an IUD and drugs for a romantic partner on more than one occasion. The College policy is clear that care should be provided to family members only for minor conditions or in urgent emergency situations and only when another physician is not available.

Neither of these conditions existed when Dr. Garcia prescribed medications, an IUD, and provided a medical service to Ms A.

The Treating Self and Family Members policy is grounded in sound principles. There is the potential for significant adverse consequences, if physicians do not comply with the policy. When a physician treats a close family member or a romantic partner, there is a risk that the relationship will affect the physician's ability to provide proper care. Treating family members raises issues of professional objectivity and may cloud a physician's judgment (see *CPSO v. Rai* (2016), para. 93; *CPSO v. Moore W.H* (2013), para. 12; *CPSO v. Vasovich* (2015), para.10). It also represents a failure to maintain professional boundaries (*Moore* (2013), para. 11). In addition, treating family members may impair a good relationship with a patient's personal family doctor (*Moore W.H.*, para. 12)

Physicians are expected to comply with College policies. Dr. Garcia failed to do so. The Committee considers it to be a very serious matter when physicians do not comply with

College policies that are put in place to protect the public. The penalty must, therefore, be such that the profession, including Dr. Garcia, understands that breaching a College policy is not tolerated.

Mitigating Factors

The Committee was presented with twenty-eight letters of support for Dr. Garcia, of which approximately half were from patients. The remainder were from colleagues and allied health care workers, attesting to Dr. Garcia's professionalism and clinical skills. The Committee did note that two letters were not dated. While the testimonials were impressive, they did not diminish the significance of the findings of professional misconduct made by the Committee, and therefore, the Committee put little weight on the letters of support and did not consider them a significant mitigating factor.

The Committee considered the following factors as mitigating in the circumstances of this case:

- Dr. Garcia admitted to the allegation that he failed to maintain the standard of practice of the profession in regard to his narcotic prescribing, thus saving significant costs for additional hearing days that would have been required to contest that allegation, and sparing witnesses the stress of testifying;
- Dr. Garcia has changed his style of practice since 2012-2013 and has significantly reduced the number of patients per hour he is seeing;
- There are five satisfactory Clinical Supervisor reports from Dr. Petcho regarding Dr. Garcia's practice;
- Dr. Garcia has completed the University of Toronto course on safe opioid prescribing and managing addiction;
- This is Dr. Garcia's first appearance before the Discipline Committee.

REASONS FOR ACCEPTANCE OF THE JOINT SUBMISSION ON PENALTY

Counsel reviewed a number of prior decisions of the Discipline Committee. While there are no previous decisions of the Discipline Committee which are directly comparable to the case before it, the Committee agreed that an eight-month suspension of Dr. Garcia's certificate of registration, in addition to the other terms and conditions set out in the Committee's Order below, is appropriate, in view of the seriousness of the professional misconduct in this case. The Committee is satisfied that this is a proper case for the proposed stringent penalty, which will not only serve to protect the public, but will also serve as a specific deterrent to Dr. Garcia and general deterrent to the profession.

The public reprimand will express the profession's denunciation of Dr. Garcia's professional misconduct.

Dr. Garcia will be required to provide to the College a log of all patients seen and a log of all his patient prescriptions. The required log will ensure that Dr. Garcia appropriately documents in the patient chart all of the medications he prescribes. This condition will provide a clear message to him and to the profession that meticulous records of medications prescribed must be kept to meet the standard of practice of the profession.

The penalty also includes a condition that Dr. Garcia will be supervised by a clinical supervisor approved by the College upon his return to practice following the suspension. The clinical supervision will be for a period of twelve months and will include a direct observation component of Dr. Garcia in his practice. The clinical supervisor will provide ongoing support and monitoring, which will include reviewing Dr. Garcia's prescribing practices in regard to controlled substances. This condition will also serve to emphasize that controlled substances must be prescribed with caution and exercising careful judgment. The clinical supervisor will report regularly to the College. Following the period of clinical supervision, Dr. Garcia will undergo an assessment of his practice to ensure that the standards of practice of the profession are maintained.

Remediation, to the extent possible, is an important goal of any penalty. Dr. Garcia is required to participate and successfully complete individualized instruction in Medical Ethics and Maintaining Boundaries. This should address the issues of Dr. Garcia's boundary violations and his attempts to breach patient confidentiality.

Finally, there is a condition that will restrict the number of patients Dr. Garcia will be permitted to see per day/hour. This condition, which was agreed to by both parties, will address the concern that Dr. Garcia was seeing too many patients a day/hour and will serve to ensure that Dr. Garcia provides appropriate care for each patient and adequately documents patient encounters upon his return to practice after suspension.

The Committee is satisfied that the terms and conditions imposed on Dr. Garcia's certificate of registration will protect the public.

COSTS

Section 53 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, states:

> In an appropriate case, a panel may make an order requiring a member who the panel finds has committed an act of professional misconduct or find to be incompetent to pay all or part of the following costs and expenses:
>
> 1. The College's legal costs and expenses.
> 2. The College's costs and expenses incurred in investigating the matter.
> 3. The College's costs and expenses incurred in conducting the hearing

The Committee is provided significant latitude and discretion in awarding costs. In awarding costs, the Committee must be mindful of the specifics and facts associated with the case before it. While the reasons in previous decisions of the Discipline

Committee may be of assistance in determining costs to be awarded, the Committee is not bound by previous decisions of the Discipline Committee.

The following factors are relevant and may be considered in the determination of the issue of costs:

i. the nature of the misconduct;
ii. any settlement offer made in writing, and the date and terms of the offer;
iii. the member's failure to acknowledge any error or to act reasonably and professionally to avoid a hearing;
iv. the relative success of the parties;
v. the costs of the investigation and hearing;
vi. the nature of the member's defence; and
vii. the impact of the costs order on the member's ability to continue to practise.

The Committee is aware that a cost award is not a penalty. The Committee must balance the concern that the profession ought not to bear the entire cost of a discipline hearing against the concern that members should not be prevented from defending themselves by the threat of a large cost award being made against them.

Both parties agree that the College in this case is entitled to significant costs of the proceeding, but there is disagreement as to the quantum of costs.

The College is seeking $55,000.00 in costs, while Dr. Garcia submits that he only be required to pay $36,000.00.

The College submits that it should be awarded costs for ten hearing days at the *per diem* tariff rate of $5,500.00, which was the *per diem* rate in effect at the conclusion of the hearing. The ten days included: the pre-hearing day to make submissions on the severance motion, the liability hearing days, and the penalty hearing days.

To support its position that the *per diem* tariff rate which was in effect at the conclusion of the hearing should be applied, College counsel relied on the decision in *CPSO v. Redhead*, 2013 CarswellOnt 18632. In that case the *per diem* tariff rate that was in effect at the conclusion of the hearing was applied retrospectively to all the hearing days, despite the decision being released prior to the amendment to the tariff rate coming into effect. Since rules relating to costs are procedural, the Committee in the *Redhead* case was satisfied that any change in tariff rate was presumed to have retrospective effect.

Counsel for Dr. Garcia submitted that the tariff rate that should be applied to each hearing day is the tariff rate that was in effect on that hearing day. Also, counsel for Dr. Garcia submitted that the College was not successful in proving all the allegations, since the allegation of incompetence was withdrawn. It was also submitted that Dr. Garcia had cooperated with the College by narrowing and resolving issues throughout the proceeding.

Furthermore, Counsel for Dr. Garcia submitted that Dr. Garcia should not be responsible for paying costs for a full hearing day, if only a partial day was used. On this basis, counsel for Dr. Garcia maintained that Dr. Garcia should be responsible for costs for only a half day for the Committee to hear argument for the severance motion, a half day for July 19, 2016, a half day for July 20, 2016 and a half day for August 4, 2016. Counsel for Dr. Garcia agrees that Dr. Garcia should pay costs for full days on July 18, 2016 and August 5, 2016.

Counsel for Dr. Garcia submitted that Dr. Garcia should not be responsible for any costs associated with the July 21, 2016 hearing day, as the only business carried on that day was the filing of a redacted version of Exhibit 4D and an Agreed Statement of Facts regarding clinical issues, which resulted in the College withdrawing the allegation of incompetence.

The Committee notes that Dr. Garcia agrees that he should pay costs for three full penalty hearing days: October 10, 2017, October 12, 2017 and January 24, 2017, even though

October 12, 2017 was a very short day where an adjournment was sought. The Committee notes that a full day was scheduled to argue the severance motion on April 14, 2016, as specified in Dr. Pamela Chart's Scheduling Order, dated February 2, 2016.

In determining the matter of costs, the Committee considered the following questions:

1. For the purpose of awarding costs, should any day when a panel convenes count as a full hearing day?
2. If success is a criterion for awarding costs, what are the factors to measure success? Is success determined where all allegations in the Notice of Hearing are proven, or only those that proceed to a contested hearing? In addition, should success be measured by the number of objections, motions, or *voir dires* heard during the course of a hearing which are "won" by each party?
3. What tariff rate should apply in determining costs? Should it be the tariff rate that is in effect on the first day of the hearing, the last day of the hearing or the rate that was in effect on each of the hearing days?

For the purpose of awarding costs should any day when a panel convenes count as a full hearing day?

The Committee is aware that the College's *per diem* tariff rate only partially covers the costs associated with a hearing and it does not cover the costs leading up to the hearing. These include, but are not limited to, the cost of the investigation, the College's legal costs, and the expenses associated with retaining an expert witness, and the expenses associated with bringing a witness from out of town to testify. While the Committee has the authority to award the costs noted above, it notes that in this case the College is only asking that the current *per diem* tariff rate be applied for each hearing day.

The Committee recognizes that hearing days are scheduled based on the estimated number of days that the parties anticipate will be required to complete the hearing.

The Committee understands that, by its nature, the hearing process is inherently complex and that there is a degree of uncertainty as to how a hearing may unfold. While the Committee recognizes that best efforts are made by both counsel to use the entire day, circumstances may arise that are not in control of either party, or are such that it is not always possible to do so.

There is no provision in the Committee's rules for awarding costs based upon partial days used or for calculating the actual number of minutes/hours the hearing is in session during any given hearing day. The Committee is aware that fixed daily costs are incurred when the panel, the court reporter, and counsel have been scheduled for an entire day, whether or not the entire hearing day is utilized. In the past it has been accepted by the parties that where there is an agreed statement of facts and a joint submission on penalty, it is reasonable that costs for one hearing day be ordered at the College's *per diem* tariff rate, even if only a partial day is used for the joint submission. The Committee sees no reason to deviate from the principle that the *per diem* tariff rate is to be applied for each hearing day, notwithstanding that only part of a full hearing day is utilized.

The Committee allows, with sufficient notice, for the release of hearing days in advance of a scheduled hearing to avoid costs being awarded.

The Committee recognizes that it has the discretion to reduce the *per diem* tariff rate if sufficient notice is provided to the Committee that only a half-day is required, as was the case for the August 4, 2016 hearing date.

The Committee does not accept counsel for Dr. Garcia's submission that in awarding costs the Committee should consider what portion of a hearing day was actually utilized. It the view of the Committee that it should not be required to count the minutes and hours that are used during the course of a hearing day in order to calculate costs, given the costs provision that is in effect.

Therefore, after careful consideration, the Committee exercised its discretion to hold Dr. Garcia responsible for the costs associated with nine and one half hearing days in this case.

If success is a criterion for awarding costs, is success measured by whether all allegations in the Notice of Hearing are proven or only those that proceed to a contested hearing? In addition, should success be measured by the number of objections, motions, or *voir dires* heard during the course of a hearing which are "won" by each party?

The Committee carefully considered this issue. In awarding costs the only factor that the Committee will consider regarding the "success" of a party is the party's success in relation to the Committee's findings for those allegations which are contested. Allegations which are withdrawn by the College will not be considered a "success" for the purpose of awarding costs, as the withdrawn allegations do not require hearing time.

Similarly, "success" from a costs perspective will not be determined by whether a party is successful in arguing an objection, a motion or an issue in a *voir dire* during the course of a hearing. Motions, objections and *voir dires* are treated by this Committee as part of the "normal course of business" of a hearing.

The role of the Committee is to adjudicate, and not to be distracted by acting as a "score keeper" for each party, keeping track of the "wins" and "losses" and recording the time required for every objection, motion or *voir dire* raised during the course of a hearing. It is not reasonable for the Committee to micromanage a hearing in that fashion.

If the Committee finds that an objection, motion, or issue determined in a *voir dire* is frivolous, then that may be treated differently for costs purposes: the Committee did not find any of these to be frivolous in this case.

The Committee therefore does not accept Dr. Garcia's counsel's submission that a member should not be responsible for costs of the hearing in relation to an issue that could not be resolved in the pre-hearing phase, even if the issue was resolved in the party's favour at the hearing.

The Committee recognizes that negotiating in the pre-hearing phase can be difficult and complex. The Committee understands that not all issues can be resolved in the pre-hearing phase and therefore some issues may be adjudicated before the Committee, as was the case in this matter with the *voir dire* regarding the admissibility of evidence under s. 35(9) of the *Mental Health Act*. In this Panel's view, the inability to resolve issues before the hearing should have no bearing on the award of costs at the hearing, in the absence of a finding that a party was making frivolous motions and objections, or raising frivolous *voir dire* issues.

What tariff rate should apply? Should it be the first day of the hearing, the last day of the hearing, or the rate that was in effect on each of the hearing days?

The Committee accepts the premise that a fixed *per diem* tariff rate based on the rate at the time of each of the hearing days provides a degree of predictability to members for costs that they may be responsible for if the College is successful.

However, it is important to keep in mind that the College has the statutory right to request that the member be responsible for all of the costs associated with the pre-hearing phase, including the College's legal costs and expenses and the College's costs and expenses incurred in investigating the matter. In addition to the College's costs and expenses incurred in conducting the hearing, the Committee recognizes that the College does not seek, and has not sought in this case, reimbursement of all the costs they are legally entitled to. That is taken into account by the Committee in exercising its discretion on the matter of costs.

The Committee reviewed several prior decisions of the Discipline Committee dealing with the issue of what *per diem* tariff rate should be applied.

The Committee notes that there are at least three possible approaches to applying a *per diem t*ariff rate in awarding costs. These include:

- applying the *per diem* tariff rate that was in effect at the beginning of the hearing to all the hearing days as was done in *Deep (Re)* (2008);
- applying the *per diem* tariff rate that was in effect at the end of the hearing to all the hearing days as was the case in the *CPSO v. Redhead* (2013); and
- applying the *per diem* rate that was in effect on each hearing day.

In this case, there was agreement by both parties that the *per diem* tariff rate that was in effect at the time of the penalty hearing be applied to the three penalty hearing days. What is in dispute is what *per diem* tariff rate should be applied to the hearing days during the liability phase and the pre-hearing day for the severance motion.

While College counsel submitted that the *per diem* tariff rate that was in effect at the conclusion of the hearing be applied to all the hearing days, counsel for Dr. Garcia maintained that the *per diem* tariff rate that was in effect at the time of the liability phase and severance motion should be applied to those hearing days.

The Committee considered carefully the submissions of both counsel.

In *CPSO v. Redhead* (2013), the per diem tariff rate that was in effect at the conclusion of the hearing was applied retrospectively. There was also a reduction of costs, because there was divided success. In addition, the College requested costs for nine hearing days, but was only awarded costs for 7.5 days. In *Deep (Re)* (2008), the Committee decided that the *per diem* tariff rate that was in effect at the beginning of the hearing should be applied to all of the hearing days, despite there having been a tariff increase during the period of the hearing.

The Committee carefully considered the specific facts of this case, the submissions of counsel, and the previous cases of this Committee dealing with the issue of costs. The Committee considered that it is fair and reasonable to apply an approach using the *per diem* tariff rate that was in effect at the time of each of the hearing days. The *per diem* tariff rate that was in effect from January 1, 2016 until December 31, 2016 was $5,000.00. The *per diem* tariff rate that was in effect from January 1, 2017 until December 31, 2017 was $5,500.00. Therefore, the Committee exercises its discretion to hold Dr. Garcia responsible for costs for six and a half days at a rate of $5,000.00 *per diem* and costs for three days at the rate of $5,500.00 *per diem*, for a total of $49,000.00.

ORDER AS TO PENALTY

The Committee ordered and directed that:

1. Dr. Garcia appear before the Committee to be reprimanded.
2. the Registrar suspend Dr. Garcia's Certificate of Registration for a period of eight (8) months, to commence at 12:01 a.m. on February 7, 2018.
3. the Registrar to impose the following terms, conditions and limitations on Dr. Garcia's Certificate of Registration:

Restriction

(a) Dr. Garcia shall have clinical interactions with no more than a total of forty-eight (48) patients per day, at a rate of no more than six (6) patients per hour within each hour;

Patient Log

(b) At each of his Practice Locations, Dr. Garcia shall maintain an up-to-date daily log of every patient with whom he has a clinical interaction, which shall include the patient's name, the date, and the hour within which the clinical interaction occurred

("Patient Log"). Dr. Garcia shall maintain the original Patient Log and shall send a copy to the College at the end of every calendar month;

(c) At its sole discretion, the College may require Dr. Garcia to implement other measures to ensure the accuracy of the Patient Log, including but not limited to requiring him to have the Patient Log reviewed and/or approved by a person or persons approved by the College;

Prescribing Log

(d) Dr. Garcia shall keep a log of all prescriptions (the "Prescribing Log") for:

(i) **Narcotic Drugs** (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19, as amended from time to time);

(ii) **Narcotic Preparations** (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19, as amended from time to time);

(iii) **Controlled Drugs** (from Part G of the Food and Drug Regulations under the Food and Drugs Act, S.C., 1985, c. F-27, as amended from time to time);

(iv) **Benzodiazepines and Other Targeted Substances** (from the Benzodiazepines and Other Targeted Substances Regulations made under the Controlled Drugs and Substances Act., S.C., 1996, c. 19, as amended from time to time);
(A current summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule "A" [to this Order]; and the current regulatory lists are attached as Schedule "B" [to this Order])

(v) **All other Monitored Drugs** (as defined under the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22 as noted in Schedule "C" [to this Order]and as amended from time to time);

(e) The Prescribing Log shall be in the form set out at Schedule "D" [to this Order], which will include at least the following information:

(i) the date of the prescription;

(ii) the name of the patient with chart / file number;

(iii) the medication, dose, direction, number of tablets to be dispensed and frequency (if applicable);

(iv) the clinical indication for use;

(v) whether it is a new prescription; and

(vi) physician initials.

(f) Dr. Garcia shall keep a copy of all prescriptions written for all Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines/Other Targeted Substances and all other Monitored Drugs, in the corresponding patient chart.

Instruction in Medical Ethics

(g) At his own expense, Dr. Garcia shall participate in and successfully complete individualized instruction in ethics approved by the College, at the instructor's earliest availability. Dr. Garcia will provide proof of successful completion within three (3) weeks of completing the instruction. The instruction will involve one-on-one sessions with a College-approved instructor, incorporating principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. Garcia as assessed by the instructor. The instructor will report to the College regarding Dr. Garcia's progress and compliance.

Instruction in Maintaining Boundaries

(h) At his own expense, Dr. Garcia shall participate in and successfully complete the next available course on "Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship" offered by Western University, or an equivalent program acceptable to the College, and shall forthwith thereafter provide proof of completion thereof to the College.

Clinical Supervision

(i) Prior to resuming practice following the suspension of his certificate of registration described above in paragraph 2, Dr. Garcia shall retain, at his own expense, a clinical supervisor or supervisors (the "Clinical Supervisor") acceptable to the College, who will sign an undertaking in the form attached as Schedule "E" [to this Order];

(j) For a period of twelve (12) months, commencing as of the date Dr. Garcia resumes practice following the suspension of his certificate of registration described above in paragraph 2, Dr. Garcia may practice only under the supervision of the Clinical Supervisor ("Clinical Supervision"). Clinical Supervision of Dr. Garcia's practice shall contain the following elements:

Chart Review:

i. All charts reviewed shall be independently selected by the Clinical Supervisor without the participation of Dr. Garcia.

Phase 1 of Chart Review

ii. For a minimum of two (2) months, Dr. Garcia and the Clinical Supervisor will meet at least once every week to discuss the Clinical Supervisor's review of the elements set out in (v), below.

iii. After a minimum of two (2) months of *Phase 1 of Chart Review*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the chart review component of supervision be reduced.

Phase 2 of Chart Review

iv. Upon the recommendation of the Clinical Supervisor and approval of the College, the chart review component of clinical supervision will be reduced. Dr. Garcia and the Clinical Supervisor will continue to meet at least once every month to discuss the Clinical Supervisor's review of the elements set out in (v) below.

Elements of Chart Review

v. At each meeting described in (ii) and (iv) above, Dr. Garcia and the Clinical Supervisor will discuss the Clinical Supervisor's review of:

(a) The Prescribing Log;

(b) 20 charts, selected as follows:

- 5 charts selected from Dr. Garcia's clinic practice;
- 5 charts selected from Dr. Garcia's long-term care/retirement home practice; and

- 10 charts of patients to whom Dr. Garcia has prescribed Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs since the Clinical Supervisor's prior review; or
- If there are fewer than 10 patients listed in the Prescribing Log to whom Dr. Garcia has prescribed Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs since the Clinical Supervisor's prior review, then the charts of all patients listed in the Prescribing Log and additional charts selected from both Dr. Garcia's clinic and long-term care/retirement home practices, resulting in a total of 10 charts.

(c) The chart of every patient to whom Dr. Garcia has issued a new prescription for a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug since the Supervisor's prior review.

Direct Observation

Phase 1 of Direct Observation

vi. For a minimum of one (1) month, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once per week;

vii. During *Phase 1 of Direct Observation*, the Clinical Supervisor's observation of Dr. Garcia's practice shall rotate between Dr. Garcia's clinical practice and his long-term care/retirement home practice;

viii. For greater clarity, during *Phase 1 of Direct Observation*, the Clinical Supervisor shall observe Dr. Garcia in practice at least twice in his clinic setting and at least twice in his long-term care/retirement home practice;

ix. After a minimum of one (1) month of *Phase 1 of Direct Observation*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the direct observation component of supervision be reduced;

Phase 2 of Direct Observation

x. Upon the recommendation of the Clinical Supervisor and approval of the College, the direct observation component of Clinical Supervision will be reduced and will take place on the following terms: For a minimum of two (2) months, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once per month in Dr. Garcia's clinic practice and at least once per month in his long-term care/retirement home practice;

xi. After a minimum of two (2) months of *Phase 2 of Direct Observation*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the direct observation component of supervision be reduced;

Phase 3 of Direct Observation

xii. Upon the recommendation of the Clinical Supervisor and approval of the College, the direct observation component of Clinical Supervision will be reduced and will take place on the following terms: For the remainder of the Clinical Supervision, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once every three (3) months in Dr. Garcia's clinic practice and at least once every three (3) months in his long-term care/retirement home practice;

Meetings

xiii. As set out above in (ii) and (iv), Dr. Garcia and the Clinical Supervisor will meet at least once every week, for a minimum of two (2) months, and at least once every month thereafter. In addition to the elements of chart review described above, meetings will include the following:

(a) Prior to meeting with the Clinical Supervisor, Dr. Garcia shall provide the Clinical Supervisor with the audit trail for each patient whose chart is to be reviewed at that meeting, if the chart is maintained in an Electronic Medical Record;

(b) The Clinical Supervisor shall discuss with Dr. Garcia any concerns the Supervisor may have arising from the direct observations or review of charts, Prescribing Log or audit trail;

(c) The Clinical Supervisor shall make recommendations to Dr. Garcia for practice improvements and shall follow up on same;

(d) The Clinical Supervisor shall make recommendations to Dr. Garcia for ongoing professional development and inquire of Dr. Garcia to determine compliance with same;

(e) Dr. Garcia shall review and discuss with the Clinical Supervisor the educational resources and College policies set out below in section (k); and

(f) Any other activities which the Clinical Supervisor deems necessary to Dr. Garcia's Clinical Supervision.

Reporting

xiv. The Clinical Supervisor will keep a log of all patient charts reviewed along with patient identifiers; and

xv. The Clinical Supervisor will provide reports to the College:

(a) At least once every two (2) weeks for the first two (2) months;

(b) If the Clinical Supervisor so recommends and subject to the approval of the College, at least once every month thereafter; or

(c) More frequently if the Clinical Supervisor has concerns about Dr. Garcia's standard of practice or conduct.

(k) Dr. Garcia will review and discuss with his Supervisor the following resources:

i. CPSO Policy "Prescribing Drugs": http://www.cpso.on.ca/Policies-Publications/Policy/Prescribing-Drugs;

ii. 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html;

iii. CMPA advice regarding preventing the misuse of opioids: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/preventing-the-misuse-of-opioids;

iv. the Centre for Effective Practice Management of Chronic Non-Cancer Pain Tool: https://thewellhealth.ca/cncp

v. CPSO Policy "Medical Records": http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Records;

vi. CPSO Policy "Maintaining Appropriate Boundaries": http://www.cpso.on.ca/Policies-Publications/Policy/Maintaining-Appropriate-Boundaries-and-Preventing

(l) Dr. Garcia shall abide by the recommendations of the Clinical Supervisor;

(m) If a Clinical Supervisor who has given an undertaking as set out in Schedule "E" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Garcia shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;

(n) If Dr. Garcia is unable to obtain a Clinical Supervisor in accordance with this Order, he shall cease to practice until such time as he has done so;

(o) Dr. Garcia shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Garcia's compliance with this Order;

(p) Dr. Garcia shall consent to the Clinical Supervisor and/or the College making inquiries of any staff/employees at any of his practice locations in relation to any of the terms of this Order and any aspect of the Clinical Supervision, and shall consent to staff/employees providing information and/or documentation to the Clinical Supervisor and the College, including but not limited to information regarding Dr. Garcia's charting practices;

Assessment

(q) Approximately twelve (12) months after the completion of the period of supervision as set out above, Dr. Garcia shall undergo an assessment of his practice (the "Assessment") by a College-appointed assessor (the "Assessor(s)"). The Assessor(s) shall report the results of the Assessment to the College;

(r) The Assessment shall include both Dr. Garcia's clinic and long-term care/retirement home practices. The Assessment may include chart reviews, direct observation of Dr. Garcia's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Garcia shall abide by all recommendations made by the Assessor(s), and the results of the Assessment will be reported to the College and may form the basis of further action by the College;

(s) Dr. Garcia shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as the College deems necessary or desirable;

Other

(t) Dr. Garcia shall comply with the College Policy on Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation in respect of his period of suspension, a copy of which forms Schedule "F" [to this Order];

(u) Dr. Garcia shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and again prior to resuming practice following the suspension of his certificate of registration described above in paragraph 2, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location, until the report of the Assessment has been provided to the College;

(v) Dr. Garcia shall co-operate unannounced inspections of his Practice Location(s) and patient charts and to any other activity the College deems necessary for the purpose of monitoring and enforcing his compliance with the terms of this Order and shall provide his irrevocable consent to the College to make appropriate enquiries of any person or institution who may have relevant information for the purposes of monitoring and enforcing his compliance with the terms of this Order;

(w) Dr. Garcia shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person who or

institution that may have relevant information, in order for the College to monitor his compliance with this Order;

(x) Dr. Garcia shall be responsible for any and all costs associated with implementing the terms of this Order.

ORDER AS TO COSTS

The Committee orders and directs that Dr. Garcia pay to the College costs in the amount of $49,000.00 within 45 days of the date of this Order.

TEXT of PUBLIC REPRIMAND
Delivered January 24, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. YELIAN GARCIA

Dr. Garcia,

You have demonstrated versatility in your difficulties with the College. You failed to maintain the Standard of Practice in your prescribing of narcotics. Your errors were compounded by poor record keeping, and deficiencies in clinical care. You breached the College Policies by prescribing for your romantic partner on more than one occasion. An emergency situation did not exist, and there were other options for you.

You also attempted to get confidential health information to which you were not entitled. Your cavalier disregard for College Policies in these diverse areas are of concern to this Panel. Standards of Care are present for many reasons, including the monitoring of patients over the long term, and they serve and protect patients. You failed to maintain those Standards.

Your disgraceful actions bring this College into disrepute and reflect poorly on the profession as a whole. This behaviour can't and won't be condoned by the profession and the public at large, who put their trust in physicians. This Panel would like to believe that your problems were due to your youth, inexperience and lack of judgment. And it is our hope, that once you have fulfilled the penalty requirements, that you will be able to practise up to Standards in a clinical and an ethical sense.