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DISCIPLINE COMMITTEE
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**
which is Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. YELIAN GARCIA

PANEL MEMBERS:

DR. R. SHEPPARD
DR. P. BERGER
MR. M. KANJI
DR. Y. VERBEETEN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS RUTH AINSWORTH

COUNSEL FOR DR. GARCIA:

MR. STEPHEN DARROCH

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS KIMBERLY POTTER

Hearing Date: **January 24, 2020**
Decision Date: January 24, 2020
Release of Reasons Date: March 16, 2020

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 January 24, 2020. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

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

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, *1991* ("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; and

2. under paragraph 1(1)30 of O. Reg. 856/93 in that he failed to respond appropriately or within a reasonable time to a written inquiry from the College.

RESPONSE TO THE ALLEGATIONS

Dr. Garcia entered a plea of no contest to the first allegation in the Notice of Hearing, that he engaged in professional misconduct in that he engaged in an act or omission that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, under paragraph 1(1)33 of O. Reg. 856/93.

Counsel for the College withdrew the second allegation in the Notice of Hearing, that Dr. Garcia failed to respond appropriately or within a reasonable time to a written inquiry from the College under paragraph 1(1)30 of O. Reg. 856/93.

THE FACTS

The following facts were set out in a Statement of Uncontested Facts and Plea of No Contest which was filed as an exhibit and presented to the Committee:

PART I – FACTS

1. Dr. Yelian Garcia ("Dr. Garcia") is a 38-year-old former family physician. He received his certificate authorizing independent practice in 2012 and practiced in the Greater Toronto Area. Dr. Garcia resigned his membership on December 5, 2018.

Background

2. On February 15, 2017, in a previous discipline hearing, the Discipline Committee of the College of Physicians and Surgeons of Ontario ("the College") found that Dr. Garcia had committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct. A penalty hearing was scheduled to commence October 10, 2017.

3. In preparation for his penalty hearing, Dr. Garcia retained an expert to provide an opinion regarding his current standard of practice.

4. On September 9, 2017, the expert requested the charts of 12 patients in order to complete her report. She identified these patients by name, based on a list of

patients provided to her by counsel for Dr. Garcia. One of the patients whose chart the expert requested was Patient A. Patient A was a resident at a long-term care facility where Dr. Garcia worked.

5. Counsel for Dr. Garcia responded to the expert by email, also on September 9, 2017, indicating that the chart of Patient A was not readily available as she had left the retirement home. He invited the expert to select a replacement chart, but did not receive a response.

Alteration of Patient Charts

6. On September 10, 2017, Dr. Garcia attended the long-term care facility, despite not being scheduled to work that day. He arrived at 8 am and was let into the nursing office, where the patient charts were located.

7. Dr. Garcia requested that a nurse, Nurse X, bring him Patient A's chart from storage. He also requested blank progress notes. Nurse X brought these to him.

8. Dr. Garcia proceeded to alter Patient A's chart, removing original chart entries and writing new progress notes for these dates. He removed and re-wrote notes for at least 16 encounters, dating back two years.

9. The altered progress notes were fabricated. For example:

- The text of the altered notes was different from the original notes. The altered notes were more extensive and included objective physical findings that were not present in the original notes. This information was not present anywhere else in the chart;
- For at least one encounter, Dr. Garcia created a chart entry for an entirely new date, for which no original entry existed. No encounter had, in fact,

taken place on this date;

- Dr. Garcia also destroyed at least one original entry without creating a replacement note.

10. Dr. Garcia tore up the original chart entries and disposed of them in the trash can. After Dr. Garcia left the office on September 10, Nurse X retrieved the torn-up original notes from the trash and taped them back together.

11. On the same day, Dr. Garcia also created a fabricated encounter note for another patient, Patient B. This patient was not one of the patients whose chart had been requested by Dr. Garcia's expert.

12. Patient B had fallen on September 4 and September 10, 2017 and was on 72-hour post-fall monitoring. Dr. Garcia documented having seen this patient on September 10, which was not true. His chart entry for the patient described the patient's blood pressure as "stable per staff" and that she was "steady with walker". This was not accurate, as her blood pressure was low and she was not steady (having fallen that day).

Provision of Altered Charts to Expert and Tendering Expert Testimony at Penalty Hearing

13. On September 12, 2017, counsel for Dr. Garcia emailed the expert to advise that Dr. Garcia had been able to obtain the chart for Patient A (which he had previously indicated was unavailable).

14. Dr. Garcia provided Patient A's falsified chart to his expert through his legal counsel. He did not inform the expert that he had altered the chart before sending it to her. On the basis of this falsified chart, the expert prepared a report dated September 17, 2017. She concluded that Dr. Garcia had met the

standard of practice of the profession in his care of Patient A.

15. Dr. Garcia's penalty hearing commenced on October 10, 2017. The hearing was contested. Dr. Garcia called his expert to testify on his behalf, in support of his submission that the penalty imposed by the Discipline Committee should be less onerous than the penalty sought by the College.

16. The expert's report was entered into evidence. She also testified in person, opining that Dr. Garcia had met the standard of practice of the profession in his care of Patient A. When she testified, the expert was unaware that her opinion was based on the review of a falsified patient chart.

Penalty Hearing Suspended and Expert Evidence Withdrawn

17. On October 11, 2017, midway through the penalty hearing, Nurse X contacted the College and advised that she had discovered Dr. Garcia tampering with patient charts. As a result of the information Nurse X provided about Patient A's chart, the parties agreed that the penalty hearing should be adjourned.

18. The penalty hearing resumed on January 28, 2018. On that date, counsel for Dr. Garcia withdrew Dr. Chapman's evidence and requested that the Committee not rely on it. The parties submitted a joint proposal on penalty, whereby Dr. Garcia accepted an 8-month suspension.

PART II – PLEA OF NO CONTEST

19. Dr. Garcia does not contest the facts set out above and does not contest that based on these facts, he engaged in professional misconduct in that he engaged in an act or omission that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or

unprofessional, under paragraph 1(1)33 of Ontario Regulation 856/93, made under the *Medicine Act, 1991*.

RULE 3.02 – PLEA OF NO CONTEST

Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states:

> 3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:
>
> a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
> b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
> **c)** that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

FINDINGS

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts and Plea of No Contest. Having regard to these facts, the Committee accepted Dr. Garcia's plea and found that he committed an act of professional misconduct, 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.

PENALTY AND REASONS FOR PENALTY

The following facts were set out in an Agreed Statement of Facts Regarding Penalty, which was filed as an exhibit and presented to the Committee:

PART I - FACTS

1. On February 15, 2017, the Discipline Committee found that Dr. Garcia had engaged in professional misconduct, in that he had failed to maintain the standard of practice of the profession and engaged in an act or omission that, having regard to all the circumstances, would reasonably be considered by members as disgraceful, dishonourable or unprofessional. On January 28, 2018, the Discipline Committee imposed a penalty including an eight-month suspension and terms, conditions or limitations when Dr. Garcia returned to practice. The decisions of the Discipline Committee on Liability and Penalty are attached at Tab 1 and Tab 2 [to the Agreed Statement of Facts Regarding Penalty].

2. Following his suspension, which took effect January 28, 2018, Dr. Garcia did not return to practice. On December 5, 2018, Dr. Garcia resigned his certificate of registration with the College.

JOINT SUBMISSION

Counsel for the College and counsel for Dr. Garcia made a joint submission as to an appropriate penalty and costs order. Counsel jointly submitted that the appropriate penalty would be a public reprimand, revocation of Dr. Garcia's certificate of registration, and that Dr. Garcia pay costs to the College in the amount of $6,000.00 Although the Committee has discretion to accept or reject a joint submission on penalty, the law provides that the Committee should not depart from a joint submission,

unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R*. v. *Anthony-Cook*, 2016 SCC 43).

Penalty principles

In considering a joint submission on penalty, the Committee must also have regard to the basic principles underlying penalty orders. These include: public protection; maintaining the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; specific deterrence; general deterrence; and where applicable or appropriate, rehabilitation. Other principles include denunciation of the misconduct and proportionality.

The Committee also considered the aggravating and mitigating factors in this case and prior decisions of this Committee in similar cases.

Aggravating Factors

- In February 2017, Dr. Garcia underwent a Discipline Hearing. The Committee found that Dr. Garcia had engaged in a number of acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

- In preparation for his Penalty hearing at the College, Dr. Garcia hired an expert and gave this expert a grossly altered chart for one of the patients in question. He had destroyed, altered and invented entries in this chart. His expert and his legal counsel submitted this chart to the Committee without knowledge of what Dr. Garcia had done.

- Dr. Garcia also entered a fictitious encounter into another patient's chart, directly contradicting the patient's medical status and thereby putting this patient at serious risk.

- The fact that Dr. Garcia made incorrect notations in the charts of two vulnerable patients residing in a long term care home, thereby misrepresenting the status of their respective conditions, is an aggravating factor. Residents of long term care homes have multiple health care professionals attending on them, all of whom rely on the clinical notes prepared by others. This would have been known to Dr. Garcia, who altered the charts purely for his own purposes and contrary to the best interests of his patients. The accuracy of clinical notes for residents of long term care homes is especially important given the fact that these patients often cannot provide a history or account of their symptoms or conditions.

- The fact that Dr. Garcia has a prior discipline history is also an aggravating factor.

- Finally, the fact that Dr. Garcia's misconduct was an intentional attempt to mislead his regulator with respect to his standard of care for the purposes of a penalty hearing is an aggravating factor.

Mitigating Factor

- Dr. Garcia submitted a plea of no contest, saving the College the time and expense of a contested hearing and sparing witnesses from testifying. The Committee notes, however, that Dr. Garcia did not admit his misconduct and has provided no evidence of insight or remorse. The fact that Dr. Garcia entered a plea of no contest was given very little weight by the Committee in considering the joint submission.

Prior Cases

Counsel provided the Committee with a Joint Book of Authorities to demonstrate that the proposed penalty lay within the range of penalties ordered in previous decisions in similar matters.

The Discipline Committee reviewed the following cases: *Ontario (College of Physicians and Surgeons of Ontario) v. Taylor, 2017 ONCPSD 17 (CanLII)* and *Ontario (College of Physicians and Surgeons of Ontario) v. Jamal, 2018 ONCPSD 21 (CanLII)*.

In *CPSO v. Taylor*, the Committee found after a contested hearing that Dr. Taylor had committed an act of professional misconduct in that he 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. Dr. Taylor had engaged in deliberate overbilling for non-OHIP services. The deliberate and planned nature of the improper billing and cover-up were factors that the Committee considered in assessing the seriousness of the misconduct. Dr. Taylor's overbilling was calculated and deliberate, as demonstrated by the associated medical chart alterations done in an attempt to cover up the overbilling. To make matters worse, Dr. Taylor directed members of his professional staff to make these chart alterations. This caused significant emotional distress to at least two employees who testified at the hearing. After a contested penalty hearing, the Committee ordered a reprimand and revocation of Dr. Taylor's certificate of registration.

In *CPSO v. Jamal*, the matter proceeded on the basis of an agreed statement of facts and admission and a joint submission on penalty. Dr. Jamal admitted that she had committed and act of professional misconduct in that she had failed to maintain the standard of practice of the profession, had 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 and had

engaged in conduct unbecoming a physician. Dr. Jamal had intentionally and repeatedly falsified research data. Her dishonesty in altering the research data, denying her actions, blaming others and making attempts at cover-up were deliberate and repeated. It did not end until she was confronted with the full report completed by the Investigative Committee of Women's College Hospital in October 2015. The Committee found that her professional misconduct was not a momentary lapse of judgment. The Committee accepted the joint submission and ordered a reprimand and revocation of her certificate of registration.

Like the two cases above, Dr. Garcia's misconduct was deliberate and self-serving. Much like the other two cases, he engaged in falsifying information without any regard to the potential impact on his patients or the public.

A public reprimand denouncing Dr. Garcia's acts of misconduct will send an unequivocal message to the profession and the public that the College will not tolerate such egregious behaviour. Revocation will serve to protect the public and should also serve as general deterrence to the profession. Revocation is necessary to uphold the integrity of the profession and to maintain public confidence in the College's ability to regulate the profession in the public interest. Specific deterrence and rehabilitation were secondary in importance to the principles of protection of the public and maintaining public confidence in the integrity of the profession, given the facts of this case.

Therefore, the Committee accepts the jointly-proposed penalty as reasonable, falling within the range of penalties in similar cases as reviewed, and being consistent with relevant penalty principles.

COSTS

The Committee has the power pursuant to section 53.1 of the Code to award costs. Costs are always in the discretion of the Committee. Any costs order must be reasonable, and based on the costs actually incurred, or pursuant to Tariff A.

The Committee finds that the amount agreed by the parties, $6,000.00, is an appropriate costs order in this case, given that this matter was completed as a half-day hearing.

CONCLUSION

Dr. Garcia is ungovernable and dishonest.

He has demonstrated he is not only unwilling and unable to practice appropriately, but also that he does not put the welfare of his patients before his own selfish goals. He was willing to put a patient's health status in serious risk in order to receive a lesser penalty. Nurse X, mentioned above, who preserved the evidence of Dr. Garcia's dishonest acts, should be commended.

The public and our physician colleagues expect physicians always and without exception to put the care of their patients first.

ORDER

The Committee stated its findings in paragraph 1 of its written order of January 24, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Garcia attend before the panel to be reprimanded.

3. The Registrar to revoke Dr. Garcia's certificate of registration effective immediately.

4. Dr. Garcia pay costs to the College in the amount $6,000.00 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Garcia waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered January 24, 2020
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. YELIAN GARCIA

Dr. Garcia, the Committee is dismayed and appalled by the professional misconduct which you have committed. Wilfully and deliberately falsifying the medical records of your patients for the purpose of obscuring your own failures to maintain the standard of practice of the profession is transparently dishonest, deceitful and manipulative.

Such behaviour is contrary to the most basic values of the medical profession, which require all physicians to act, first and foremost, in the interests of their patients and of the public at large.

Medical records are legal documents, the integrity of which is crucial in the maintenance of a functional healthcare system. The falsification of records for self-serving purposes is an egregious betrayal of public trust. Such betrayal places patients and the public at serious risk of harm. This behaviour cannot be excused and tolerated.

You attempted to undermine the integrity of the disciplinary proceedings by providing your expert witness inaccurate information contained in the falsified patient chart. In so doing, you knowingly compromised the reputation of the expert.

Your disregard for the authority of the College persuades this Committee that you are ungovernable. Your Certificate of Registration will be revoked.