ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Sharma,* 2025 ONPSDT 5
Date: March 3, 2025
Tribunal File No.: 24-008

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Vijay Sharma

Registrant

FINDING AND PENALTY REASONS

Heard: January 24, 2025, by videoconference

Panel:
David A. Wright (Tribunal Chair)
Markus de Domenico (public)
Catherine Grenier (physician)
Rob Payne (public)
Janet van Vlymen (physician)

Appearances:
Elisabeth Widner, for the College
Brookelyn Kirkham, for the registrant

RESTRICTION ON PUBLICATION

Pursuant to Rule 2.2.2 of the OPSDT Rules of Procedure and ss. 45-47 of the Health Professions Procedural Code, no one shall publish or broadcast the names of patients or any information that could identify patients or disclose patients' personal health information or health records referred to at a hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this restriction.

The Ontario Physicians and Surgeons Discipline Tribunal is the Discipline Committee established under the Health Professions Procedural Code.

Introduction

[1] Dr. Vijay Sharma is an anesthesiologist. He does not contest that he committed three types of misconduct. First, he failed to meet the standard of practice of the profession in his care of patients during two procedures, notably through a lack of vigilance. Second, when these patients experienced adverse outcomes, he manually changed electronically recorded oxygen saturation readings in their charts. Third, a review of his charts showed improper OHIP billing in nearly 80% of them.

[2] The parties jointly proposed that the penalty include a suspension of 10 months and a reprimand. They also proposed extensive conditions to improve his skills and conduct after he returns to practice. He will undergo supervision, monitoring, reassessment and education.

[3] This is a joint submission, and the panel must implement it unless it would bring the administration of the professional discipline system into disrepute. The suspension is within a reasonable range considering other cases, and there is an extensive rehabilitation plan to protect the public on his return. We therefore made the order requested, for the reasons below.

[4] Tribunal Chair David Wright conducted case management conferences in this matter and sits on the panel with the consent of both parties.

Findings of Professional Misconduct

Plea of No Contest

[5] For the purposes of this proceeding, Dr. Sharma did not contest the facts put forward by the College in the Statement of Uncontested Facts nor that those facts supported a finding of misconduct. The following summary of what happened relies on that statement and the expert opinion of Dr. Jeff Dugas that was appended to it.

[6] Dr. Sharma's lawyer emphasized that while he has accepted the facts for this hearing and does not contest that others raised concerns about him, he strongly disagrees with the conclusions in the expert report. He wanted the panel to know that he provided the College with a report from his own expert, who disagrees with Dr. Dugas. Had he contested the allegations, he would have provided important context, including about the condition of the patients, the limitations of the equipment and the context of his

decision to change the readings in the chart. As Dr. Sharma accepts, however, our decision must be based on the uncontested facts, which are the only formal evidence before us.

Insufficient Vigilance During Procedures and Changes to Oxygen Saturation Records.

[7] Both procedures took place in March 2023. In the first, Dr. Sharma was the anesthesiologist for an emergent gastroscopy performed on a 74-year-old patient who had various comorbidities. During the procedure, the patient experienced a decrease in oxygen saturation in their blood. Dr. Sharma was at the computer and had his back to the patient. A nurse reported that she stepped in to increase the oxygen and alert Dr. Sharma to what was happening. The nurse and endoscopist reported their concerns about the incident. Dr. Sharma then manually changed the oxygen saturation levels on the patient's record to reflect the higher values of oxygen saturation than had been automatically recorded.

[8] The second procedure took place five days after the first one. Dr. Sharma was the anesthesiologist for an emergent gastroscopy performed on an 83-year-old patient with various comorbidities. During the procedure, the patient experienced hypoxia (lowered oxygen level in tissues), hypotension (abnormally low blood pressure) and bradycardia (abnormally slow heart rate). A nurse reported that when she found the patient "dusky" with "no respiration," Dr. Sharma was at the computer, with his back to the patient. After nurses alerted them, physicians found respirations were shallow. Patient B's code was DNAR (do not attempt resuscitation)/DNI but because the patient was still in the procedure room, chest compressions were started. Resuscitation resulted in a return of spontaneous circulation. The patient died a short time later.

[9] As with the first patient, Dr. Sharma manually changed the oxygen saturation levels on the anesthetic record to reflect higher values of oxygen saturation than had been automatically recorded. According to the hospital's Chief of Anesthesiology, Dr. Sharma's notes regarding his pre-operative evaluation of the patient appeared to have been pulled from records post-procedure. Information from the hospital, as well as information gathered in the College's investigation, documented ongoing concerns from colleagues and staff at the hospital regarding inattention to patients during procedures.

[10] In his expert report, Dr. Dugas quoted the Canadian Anesthesiologists' Society Guidelines to the Practice of Anesthesia, which state,

> The only indispensable monitor is the presence, at all times, of a physician… mechanical and electronic monitors are aids to vigilance. Such devices assist the anesthesiologist to ensure the integrity of the vital organs and, in particular, the adequacy of tissue perfusion and oxygenation.

[11] He concluded that in relation to each patient,

> The lack of vigilance by Dr. Sharma to appropriately monitor the patient clinically to ensure maintenance of a patent airway and adequate oxygenation under sedation falls below the standard of care. The absence of vigilant monitoring by the anesthesiologist during the provision of anesthesia care falls below the expected standards of the profession.

[12] Dr. Dugas also concluded, in relation to the first patient, that he had "a strong suspicion that the chart was purposefully fabricated to suggest the patient had a patent airway during this timeframe." He noted, commenting on both patients, that "[r]etrospective alteration and falsification of the electronic medical record falls below the standards as set out by the published Canadian Anesthesiologist's Society Guidelines and is a breach of one's professional obligations…."

[13] We find that Dr. Sharma failed to maintain the standard of practice of the profession in his care of both patients, both in his care during the procedures and by modifying electronically recorded readings following an adverse outcome.

OHIP Billings

[14] Dr. Dugas also gave his expert opinion on Dr. Sharma's billings. He reviewed OHIP data corresponding to 19 charts and concluded that in 11 charts, the OHIP claims were inconsistent with the services provided to the patient. Examples included wrongly billing certain codes when providing a colonoscopy, using a code that did not accurately reflect patients' conditions as set out in the medical records, billing a code that should only be billed by the most responsible physician and claiming codes that were ineligible for payment based on the type of procedure actually performed.

[15] Dr. Dugas then reviewed an additional 20 patient charts and corresponding OHIP data. He concluded that, in all 20 charts, Dr. Sharma inappropriately billed a series of fee codes and that the fee codes billed did not correspond to services provided. For example, in several charts, Dr. Sharma inappropriately billed a consultation code, although the routine pre-anaesthetic evaluation of a patient does not constitute a consultation. In other charts, Dr. Sharma inappropriately billed using a code that should only have been used by the most responsible physician. In other charts, the fee codes did not correspond to the patient's documented medical history and/or condition.

[16] Ontario's health care system relies on physicians to ensure that their OHIP billings are careful and accurate. When a physician fails to do so, limited public health care dollars are misused and the physician inappropriately benefits. Even when unintentional, overbilling breaches the trust that Ontarians place in the medical profession regarding the use of public money. Dr. Sharma consistently failed to live up to those expectations. This was disgraceful, dishonourable and unprofessional.

Penalty and Costs

[17] The parties' agreement on penalty and costs must be implemented unless it is so "unhinged from the circumstances" that implementing it would bring the administration of the College's professional discipline system into disrepute: *R. v. Anthony-Cook*, 2016 SCC 43; *College of Physicians and Surgeons of Ontario v. Bahrgard Nikoo*, 2022 ONPSDT 15 at para. 34; *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303 (Div. Ct.).

[18] As stated in *College of Physicians and Surgeons of Ontario v. Matheson*, 2022 ONPSDT 27 at para. 21:

> Deciding whether a penalty meets the test is about the forest, not the trees. Neither the parties' arguments nor the panel's reasons need identify every consideration that a panel would apply if it were deciding what penalty to impose without an agreement. What is important are the key penalty factors that place this misconduct at a general point along the spectrum of potential penalties: see the factors set out in *College of Physicians and Surgeons of Ontario v. Fagbemigun*, 2022 OPSDT 22 at paras. 11–16. Comparing the penalty factors with those in other cases and their results helps the panel determine if the penalty is so far removed

> from what would be expected that it meets the high bar to consider rejection of the joint submission.

[19] Dr. Sharma's misconduct was multifaceted and serious and the 10-month penalty reflects that. There were three different aspects to the misconduct. Dr. Sharma failed to be vigilant in two procedures, involving two different patients, within a week of each other, failing to meet the most fundamental requirement of an anesthesiologist. He then altered both patients' records in a way that covered up what really happened. And while there is no suggestion in this case that he was intentionally overbilling, his billing errors resulted in him getting OHIP funds he was not entitled to receive.

[20] There is a common thread that runs through all this misconduct: a disturbing lack of attention to detail, care in his work and accuracy in record-keeping. These are far more than just errors; they are fundamental breaches of basic ethical principles for physicians.

[21] Ten years ago, Dr. Sharma was disciplined for misconduct involving the same kinds of concerns; *College of Physicians and Surgeons of Ontario v. Sharma*, 2014 ONCPSD 30. In that case he failed to meet the standard of practice for record keeping in relation to multiple patients, made various errors during procedures and improperly left the operating room. He was reprimanded, required to take a communications course and underwent a period of supervision. There was no suspension. Clearly, the penalty in that case did not have the desired impact on him and this penalty must be significantly more serious in accordance with the principle of progressive discipline.

[22] Dr. Sharma pleaded no contest, which avoided the need and expense for a contested hearing, and this is a mitigating factor. However, it is not as strong of a mitigating factor as an admission and demonstration of insight would have been.

[23] The cases filed by the College demonstrate that the length of suspension agreed upon by the parties falls within a reasonable range. In two recent cases involving standards violations—*College of Physicians and Surgeons of Ontario v. Ghumman*, 2023 ONPSDT 9 and *College of Physicians and Surgeons of Ontario v. Young*, 2021 ONCPSD 12, the suspensions were three months. This case involved more multifaceted and widespread misconduct, and the suspension is appropriately longer and closer to the 12-month suspension in *College of Physicians and Surgeons of Ontario v. Martinez*, 2020 ONCPSD 29 (misconduct included standards, OHIP billing, referral practices, orthotics

prescriptions and misleading the College during the investigation). These decisions help show that this penalty is in a reasonable range that would not bring the administration of justice into disrepute.

[24] The joint submission also provides for rehabilitation. Dr. Sharma's clinical work will be supervised for a minimum of 12 months. For at least the first two months, the clinical supervisor will be in the room monitoring his practice, and the supervisor will be ultimately responsible for patient care. After that, he will meet with the supervisor once per month and review at least 15 charts per meeting. After that, he will undergo a reassessment and his superiors at his place of practice will regularly report to the College. A supervisor will also monitor his OHIP billings for three years. He will take the PROBE Ethics and Boundaries Course and engage in one-on-one communications coaching. This is a rigorous and comprehensive program for Dr. Sharma to improve his ethical and practice standards.

[25] The parties have agreed on costs at the tariff rate of $6,000, which is appropriate. A reprimand also meets the principles of penalty, allowing the panel to express both its concerns and expectations moving forward.

Order

[26] We made the following order:

Penalty

1. The Tribunal requires the registrant to appear before the panel to be reprimanded.

2. The Tribunal directs the Registrar to:

    a. suspend the registrant's certificate of registration for ten (10) months commencing on January 25, 2025 at 12:01 a.m.

    b. place the following terms, conditions and limitations on the registrant's certificate of registration effective immediately:

        i. Prior to commencing practice following the expiry of the period of suspension, the registrant shall retain at his own expense a clinical supervisor acceptable to the College (the "Clinical Supervisor") and a supervisor for his Ontario Health Insurance Plan ("OHIP") billings (the "OHIP Supervisor") who have executed undertakings in the form attached at **Schedule "A" and Schedule "B"** to the Order.

Clinical Supervision

ii. For a minimum of twelve (12) months after resuming practice, the registrant will practice only under the supervision of the Clinical Supervisor ("Clinical Supervision"). The period of Clinical Supervision will commence on the expiry of the period of suspension, or on the date that the Clinical Supervisor is approved, whichever is later.

iii. For a minimum of two (2) months after resuming practice, the registrant will practice only under High level supervision, during which time the registrant will not be the most responsible physician (MRP) and the Clinical Supervisor will be in the room directly observing his care of all patients.

iv. During High level supervision, the Clinical Supervisor will provide a report to the College once every two (2) weeks.

v. After a minimum of two (2) months of High level supervision, if the Clinical Supervisor recommends and the College approves, the Clinical Supervisor will meet with the registrant at his Practice Location, or another location approved by the College, once every month for a minimum of ten (10) additional months ("Moderate level supervision").

vi. During Moderate level supervision, the Clinical Supervisor will review at least fifteen (15) patient charts at every meeting, to be selected in the sole discretion of the Clinical Supervisor, together with the registrant's corresponding submissions of claims to the Ontario Health Insurance Plan ("OHIP") and/or the Ministry of Health and Long-Term Care ("MOHLTC");

vii. The Clinical Supervisor will keep a log of all patients whose charts and OHIP claims submissions were reviewed, along with patient identifiers.

viii. The Clinical Supervisor will discuss any concerns arising from the chart and OHIP reviews with the registrant.

ix. The Clinical Supervisor will make recommendations to the registrant for practice improvements and ongoing professional development, and inquire with the registrant's compliance with such recommendations.

x. During Moderate level supervision, the Clinical Supervisor will provide a report to the College once every month, or more frequently if the Clinical Supervisor has concerns about the registrant's standard of practice or conduct.

xi. Clinical Supervision will cease after a minimum of twelve (12) months, only with College approval, in the College's sole discretion.

xii. If, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, the registrant shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule "A". The registrant shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If the registrant is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of

registration and such term, condition and limitation shall be included on the public register.

Supervision—OHIP Billings

xiii. The registrant shall consent to the monitoring of his OHIP billings for a period of 3 years following his return to practice ("OHIP Supervision") or on the date that the OHIP Supervisor is approved, whichever is later, and cooperate with inspections of his practice and patient charts by the OHIP Supervisor and College representatives for the purpose of monitoring and enforcing his compliance with this term of the Order. Monitoring this term shall include making enquiries of OHIP/the MOHLTC.

xiv. The OHIP supervisor will provide a report to the College once every three (3) months, or more frequently if the OHIP Supervisor has concerns about the registrant's billing practice.

xv. If, prior to completion of OHIP Supervision, the OHIP Supervisor is unable or unwilling to continue in that role for any reason, the registrant shall retain a new College-approved OHIP Supervisor who will sign an undertaking in the form attached hereto as Schedule "B". If the registrant fails to retain an OHIP Supervisor on the terms set out within thirty (30) days of receiving notification that his former OHIP Supervisor is unable or unwilling to continue in that role, he shall cease practising medicine until such time as he has obtained a OHIP Supervisor acceptable to the College. If the registrant is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of registration and such term, condition and limitation shall be included on the public register.

Reassessment

xvi. Approximately six (6) months after the completion of Clinical Supervision as set out above in subparagraphs (ii) to (xii), the registrant will submit to a reassessment of his practice ("the Reassessment") by an assessor or assessors selected by the College (the "Assessor"). The Reassessment shall include a chart review of a minimum of fifteen (15) patient charts and the corresponding OHIP billings, and may include direct observation of the registrant's care, interviews with the registrant, colleagues and co-workers, feedback from patients, and any other tools deemed necessary by the College.

xvii. The registrant will co-operate fully with the Reassessment, conducted under the term of this Order.

xviii. The registrant acknowledges that the Clinical Supervisor may receive and review the findings of the Assessor and may discuss with the Assessor any issues or concerns arising from the Reassessment.

xix. The registrant acknowledges that the results of the Reassessment will be provided to him and reported to the College and the Reassessment may form the basis of further action by the College.

Reporting

xx. For a period of two years following the completion of the Reassessment, the registrant will ensure that the chief of anesthesia, chief of staff and/or medical director of all practice locations at which the registrant practises, submit bi-annual reports to the College regarding the registrant's conduct and practice.

Monitoring

xxi. The registrant must inform the College of each and every location at which he practices, delegates, or has privileges, including, but not limited to, any hospitals, clinics, offices, and any Out-of-Hospital Premises or Independent Health Facilities with which he is affiliated, in any jurisdiction (collectively the "Practice Location" or "Practice Locations"), within five (5) days of this Order. Going forward, the registrant will inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

xxii. The registrant will submit to, and not interfere with, unannounced inspections of his Practice Locations and patient records by a College representative for the purposes of monitoring his compliance with the provisions of this Order.

xxiii. The registrant shall give his irrevocable consent to the College to make appropriate enquiries of the MOHLTC/OHIP, NMS and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with the provisions of this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions.

xxiv. The registrant shall consent to the sharing of information between the Clinical Supervisor, OHIP Supervisor, Assessor and the College as any of them deem necessary or desirable in order to fulfil their respective obligations.

xxv. The registrant shall be responsible for any and all costs associated with implementing the terms of this Order.

Professional Education

xxvi. The registrant will, at his own expense, participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. The registrant will complete the PROBE program within six (6) months of the date of this Order or, if it is not available within that timeframe, at the earliest available opportunity. The registrant will provide proof of their successful completion to the College, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

xxvii. The registrant shall engage in individualized instruction (one-on-one) communication coaching with an instructor acceptable to the College. The one-on-one instructor will receive background information from the

College. The instructor will review the issues with the registrant and assist in helping the registrant to understand how and why the identified issues are of concern and what the registrant can do in order to try to avoid similar situations in the future. Upon completion of the instruction, the instructor will submit a report to the College.

xxviii. The registrant will, prior to returning to practice, satisfy the requirements of the College's Changing Scope of Practice and/or Re-Entering Practice Policy.

Costs

3. The Tribunal requires the registrant to pay the College costs of $6,000.00 by January 31, 2025.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 24-008

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Vijay Sharma

Registrant

The Tribunal delivered the following Reprimand by videoconference on Friday, January 24, 2025.

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr. Sharma,

We have found that you failed to maintain the standard of practice of the profession and engaged in acts that are disgraceful, dishonourable, and unprofessional.

Surgical patients place trust in their anesthesiologist to care for them and keep them safe during procedures. They literally put their life in your hands. A key value for all anesthesiologists is vigilance. Despite the advances in patient monitors, the only indispensable monitor is the presence at all times of a physician with focused and constant attention to their patient. You failed to provide this attention when you had your back to two different patients during procedures and did not respond immediately to changes in their vital signs. When these patients experienced serious adverse events, you falsified medical records by manually replacing critically low values recorded electronically with near normal ones.

In addition, reviews of your OHIP billing practices show widespread submission of claims that were ineligible for payment. Out of 39 charts reviewed, 31 of them had improper fee codes that were inconsistent with the services provided to the patient. You are responsible for ensuring that your billings are proper. Failure to do so results in the misuse of limited public health care dollars. We expect that your 10-month suspension will emphasize to you the seriousness of your actions. It will also send a strong message to all physicians that the College takes such misconduct very seriously.

When you return to practice, you will be required to successfully complete significant periods of clinical and OHIP supervision to ensure you are meeting the standard of

practice, providing safe care, and billing the health care system only what you are entitled. You will be formally reassessed, will participate in the PROBE ethics program, and one-on-one communication coaching. We urge you to take full advantage of all these opportunities to improve your clinical skills, communications, and billing practices. We also urge you to constantly self-reflect on your work, aiming for continuous improvement.

We expect that you will fulfill your future obligations with vigilance, professionalism and integrity. We do not want to see you back before this Tribunal again.