



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

August 8, 2001

Daniel X. Garcia, M.D.
162 Minges Circle
Battle Creek, MI 49015

Dear Doctor Garcia:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 8, 2001, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Anand G. Garg, M.D. /TAD
Anand G. Garg, M.D.
Secretary

AGG: jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0022 4402 7273
RETURN RECEIPT REQUESTED

Cc: Battle Creek Sports Medicine
2 Heritage Oak Lane
Battle Creek, MI 49015
CERTIFIED MAIL NO. 7000 0600 0022 4402 7266
RETURN RECEIPT REQUESTED

John S. Wasung, Esq.
CERTIFIED MAIL NO. 7099 3220 0009 3046 0246
RETURN RECEIPT REQUESTED

Mailed 8.13.01

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 8, 2001, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Daniel X. Garcia, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Anand G. Garg, M.D.
Anand G. Garg, M.D. /TMO
Secretary

(SEAL)

AUGUST 8, 2001

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

DANIEL X. GARCIA, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 8, 2001.

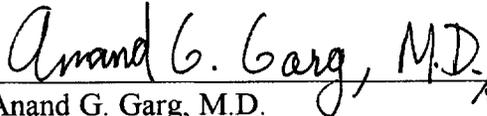
Upon the Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

1. Daniel X. Garcia, M.D., be REPRIMANDED.
2. The certificate of Dr. Garcia to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of thirty days.

This Order shall become immediately upon mailing of notification of approval by the Board.

(SEAL)


Anand G. Garg, M.D.
Secretary

AUGUST 8, 2001
Date

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**REPORT AND RECOMMENDATION
IN THE MATTER OF DANIEL X. GARCIA, M.D.**

The Matter of Daniel X. Garcia, M.D., was heard by Sharon W. Murphy, Attorney Hearing Examiner for the State Medical Board of Ohio, on June 14, 2001.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated March 14, 2001, the State Medical Board of Ohio [Board] notified Daniel X. Garcia, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations that Dr. Garcia had filed a renewal application with the Board and had failed to advise the Board of an action taken against him by the State of Michigan Board of Medicine.

The Board alleged that Dr. Garcia's conduct constitutes "fraud, misrepresentation, or deception in applying for or securing any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code, [and] "[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code."

Accordingly, the Board advised Dr. Garcia of his right to request a hearing in this matter. (State's Exhibit 1A).

- B. On March 29, 2001, Dr. Garcia submitted a written hearing request. (State's Exhibit 1B).

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Hanz R. Wasserburger, Assistant Attorney General.
- B. On behalf of the Respondent: Dr. Garcia, having been apprised of his right to be represented by counsel, appeared at the hearing on his own behalf.

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EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

Daniel X. Garcia, M.D., as upon cross-examination.

B. Presented by the Respondent

1. Daniel X. Garcia, M.D.
2. Cheryl Lindsey
3. Roberta Cossey

II. Exhibits Examined

A. Presented by the State

1. State's Exhibits 1A-1N: Procedural exhibits. (Note: a patient name was redacted from State's Exhibit 1H by the Hearing Examiner post-hearing).
2. State's Exhibit 2: Certified copies of documents maintained by the State of Michigan Bureau of Health Services Complaint & Allegation Division regarding Daniel Xavier Garcia, M.D.
3. State's Exhibit 3: Certified copy of Dr. Garcia's 2000 renewal application.

B. Presented by the Respondent

Respondent's Exhibit A: Packet of documents submitted by Dr. Garcia.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Attorney Hearing Examiner prior to preparing this Report and Recommendation.

1. Daniel Xavier Garcia, M.D., received his medical degree from Creighton University in Omaha, Nebraska. In 1982, Dr. Garcia completed a one-year internship at the same institution. In 1986, Dr. Garcia completed a residency in orthopedic surgery at St. Luke's

Hospital, Case Western Reserve University, in Cleveland, Ohio. Dr. Garcia was certified by the American Board of Orthopedic Surgery in 1988, and was recertified in 1999. (Hearing Transcript [Tr.] at 15, 88-90).

Dr. Garcia practices orthopedic surgery in Battle Creek, Michigan. He is licensed to practice medicine and surgery in Michigan, Ohio, Texas, and Nebraska. (Tr. at 14-15).

2. On October 29, 1998, the State of Michigan, Department of Consumer and Industry Services, Board of Medicine [Michigan Board], Disciplinary Subcommittee, issued an Administrative Complaint in The Matter of Daniel Xavier Garcia, M.D. In the Administrative Complaint, the Michigan Board charged Dr. Garcia with “negligence or failure to exercise due care.” (State’s Exhibit [St. Ex.] 2 at 2-6). The Michigan Board further alleged the following:

- Dr. Garcia diagnosed Patient R.M. with a medial meniscus tear in the right knee and recommended arthroscopic surgery.
- On October 14, 1997, the circulating nurse prepared Patient R.M. for surgery and mistakenly prepped the left knee rather than the right.
- Dr. Garcia began operating on Patient R.M.’s left knee. Dr. Garcia made two stab wounds. He placed an arthroscopic cannula and videoscope in one stab wound site, and placed an outflow cannula in the other stab wound site. After initiating a suction and irrigation system, Dr. Garcia began viewing the inside of the left knee with the videoscope.
- Dr. Garcia immediately realized that he was operating on the wrong knee. He stopped the procedure, drained the knee, removed the instruments, and stitched the two stab wounds.
- Dr. Garcia performed surgery on the right knee, after it was prepped and draped for surgery.
- In an interview with an investigator, Dr. Garcia admitted that he had operated on the wrong site. Moreover, Dr. Garcia acknowledged that he had been responsible for ensuring that the surgical procedure was done properly.
- An Administrative Complaint was also filed against the circulating nurse who had prepped Patient R.M.’s left knee.

(St. Ex. 2 at 3-5).

3. Dr. Garcia testified that Patient R.M. had come out of the surgery with a normal knee, but for the two sutures that had been placed in the quarter inch incisions. Dr. Garcia further stated that Patient R.M. had filed a malpractice lawsuit against him, and that Dr. Garcia's liability insurer had settled the matter for a payment of \$12,500.00. (Tr. at 27).
4. On June 16, 1999, the Michigan Board issued a Consent Order and Stipulation, in which Dr. Garcia admitted that the facts alleged in the Administrative Complaint were true. (St. Ex. 2 at 7-11). Dr. Garcia agreed to pay a fine of \$5,000.00. (St. Ex. 2 at 8).

The Consent Order and Stipulation noted that, in determining the appropriate sanction to be imposed, the following factors had been considered:

- Dr. Garcia had been fully cooperative throughout the administrative process.
- Dr. Garcia had accepted responsibility for his error.
- Since the incident occurred, the hospital had revised its policies and procedures with regard to operative site verification.

(St. Ex. 2 at 10).

5. At some point during 2000, Dr. Garcia signed and submitted to the Board an application for renewal of his Ohio certificate to practice medicine and surgery. Dr. Garcia certified that the information provided on that renewal application was correct. (St. Ex. 3; Tr. at 15-17). Nevertheless, on the renewal application, Dr. Garcia responded "No" to the question: "At any time since signing your last application for renewal of certificate * * * [h]as any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, filed any charges, allegations or complaints against you? (St. Ex. 3; Tr. at 17-18).
6. Dr. Garcia testified that, in filing his 2000 renewal application with the Ohio Board, he had not intended to hide the disciplinary action in Michigan. He stated that he had signed the renewal application "in a rush" and had not paid appropriate attention to the details. (Tr. at 20-21).

Dr. Garcia testified that, in his office, "the paperwork is overburdening." The office administrative staff generally takes care of administrative tasks, such as completing paperwork required by licensing agencies, medical societies, hospital credentialing committees, insurance agents, and HMOs. Dr. Garcia explained that there had been a system in his office, which has since been revised, whereby the assistant office manager copied licensure renewal applications and sent the copies to the physicians. The physicians completed the copies and returned them to the assistant manager. The assistant manager then transferred the information neatly onto the actual renewal application and presented the

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In the Matter of Daniel X. Garcia, M.D.
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completed form to the physician for signature. The completed form was then submitted to the licensing agency. (Tr. at 21).

Regarding the 2000 renewal application for his Ohio certificate, Dr. Garcia stated that the assistant manager had given him a blank copy to complete. He had completed the copy and answered the questions with check marks. Dr. Garcia had also put a question mark next to question 3. Dr. Garcia stated that he had not been sure if any of the events in question—the wrong site surgery, a malpractice lawsuit filed by Patient R.M., or the disciplinary action by the Michigan Board—would have fallen within the two-year period addressed by the renewal application. Dr. Garcia stated that he had intended to investigate the matter, and placed the copy of the application form on his desk. (Tr. at 21, 48-59; Respondent's Exhibit [Resp. Ex.] A at 13).

Dr. Garcia stated that he had forgotten to research the matter and had failed to return the copy of renewal application form to the assistant manager. Nevertheless, the assistant manager completed the original form. She presented the form to Dr. Garcia for signature. Dr. Garcia testified that, "under the duress of the deadline," he had signed it. Dr. Garcia further testified that, because time had passed since he had made the decision to research the matter, he had forgotten that decision by the time he finally signed the completed form. Moreover, Dr. Garcia testified that he had signed the form without carefully reviewing it because, during the first twelve years of practice, he had never had anything to disclose. (Tr. at 22, 25, 44, 57-58, 61).

7. In an April 30, 2001, letter to the Board, Dr. Garcia stated, in part, as follows:

I believe the assistant office manager confused dates and misinterpreted the date of the filing of the [Patient R.M. lawsuit] as related to the two-year window you query. More to the point, the assistant office manager indicates she believed when filling out the application that the date of the filing of the intent to sue preceded the two year window and therefore did not require an affirmative response for a presumed already reported event. Unfortunately, she did not consider the more cogent matter that is the date of settlement of the case and of the consent order entered by the Michigan Board of Medicine. I mistakenly signed the renewal form without thoughtfully reviewing it, likely as an automatic response trusting that her information was entered correctly.

(St. Ex. 1H).

8. Dr. Garcia acknowledged that he had not called the Board for clarification as to how to complete the renewal application. (Tr. at 49).
9. Cheryl Lindsey testified at hearing on behalf of Dr. Garcia. Ms. Lindsey testified that she is the assistant office manager for Dr. Garcia's office. She further testified that, as part of her

office duties, she had been responsible for submitting the 2000 renewal application to the Board. Ms. Lindsey testified that she had provided a blank copy of the renewal form to Dr. Garcia, but that Dr. Garcia had not returned the form. Ms. Lindsey believes that she received another application form and completed it herself. She gave it to Dr. Garcia and he signed it. Ms. Lindsey returned the completed form to the Board. (Tr. at 67-68, 73; Resp. Ex. A at 13, 17).

Ms. Lindsey testified that, due to changes with the administrative staff in the office, she had, at that time, only recently become responsible for completing such tasks. (Tr. at 70-72).

10. Roberta Cossey testified at hearing on behalf of Dr. Garcia. Ms. Cossey testified that she had been the office administrator in Dr. Garcia's office since 1998. Ms. Cossey stated that, for personal reasons, however, in mid-2000, she had started to decrease the amount of time she spent in the office. She stated that she still does a tremendous amount of work from her home, communicating via the facsimile and e-mail. (Tr. at 74-76).

Ms. Cossey stated that, during the first quarter of 2000 and prior to the Ohio renewal period, she been completing a renewal application for Dr. Garcia's certificate to practice in Texas. At that time, Ms. Cossey contacted the other state boards that licensed Dr. Garcia, in an attempt to ascertain what procedures were necessary for advising the boards of the Michigan Board action. During that process, Ms. Cossey telephoned the Ohio Board and spoke with "Penny" in licensure. (Tr. at 77-79, 82, 85; Resp. Ex. A at 4).

Ms. Cossey stated that she remembers her conversation with Penny. She stated she had asked Penny whether she should send the Board notice immediately or wait and provide notice at the time of licensure renewal. Ms. Cossey stated that she had received a noncommittal response from Penny, who had implied that either approach would be acceptable. Ms. Cossey further stated that the conversation had been "odd" and that she had sensed that Penny did not know the answer. Nonetheless, Ms. Cossey acknowledged that she had not understood from Penny that Dr. Garcia had no obligation to inform the Board. (Tr. at 79-80, 87).

Ms. Cossey identified the notes she had taken during the course of a conversation with Penny. Ms. Cossey stated that she had made a note of the names of Debbie Jones and Susanne Milam, but she did not remember speaking with either of them. (Tr. at 78-79; Resp. Ex. A at 4).

11. Ms. Cossey testified that she had also called the Nebraska Board for information regarding the procedure for reporting the Michigan Board action. Ms. Cossey identified the notes she had taken during the course of a conversation with Nebraska Board authorities. (Tr. at 85-86; Resp. Ex. A at 12).

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12. Dr. Garcia submitted a July 17, 2000, letter from the Texas State Board of Medical Examiners [Texas Board], acknowledging that Dr. Garcia had advised the Texas Board that a disciplinary action had been taken against him by another state board. (Resp. Ex. A at 5-7).
13. Dr. Garcia stated that he apologizes for the "clerical and serious error on [his] part" in failing to adequately review the renewal application before he signed it and that he takes full responsibility for that failure. (Tr. at 94, 96). Moreover, in this April 30, 2001, letter to the Board, Dr. Garcia stated, in part, as follows:

I assure the Ohio Board that the misinformation was not purposefully submitted and that changes and precautions in our practice have been implemented to prevent another similar occurrence. I will do my utmost to scrutinize more closely licensure applications and other renewals in hopes of avoiding any appearance of impropriety whatsoever.

(St. Ex. 1H).

FINDINGS OF FACT

1. On October 29, 1998, the State of Michigan Board of Medicine filed an Administrative Complaint in The Matter of Daniel Xavier Garcia, M.D., charging Dr. Garcia with negligence or failure to exercise due care. The basis for the allegation was an incident that had occurred on October 14, 1997, when Dr. Garcia performed arthroscopic surgery on the wrong knee of Patient R.M. Dr. Garcia subsequently entered into a Consent Order and Stipulation with the Michigan Board, dated June 16, 1999, in which Dr. Garcia agreed to pay a fine of \$5,000.00.
2. At some point during 2000, Dr. Garcia signed and submitted to the Board an application for renewal of his Ohio certificate to practice medicine and surgery. By signing the application, Dr. Garcia certified that the information provided on that renewal application was correct. Nevertheless, in the application, Dr. Garcia responded "No" to the question: "At any time since signing your last application for renewal of certificate * * * [h]as any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, filed any charges, allegations or complaints against you?"

CONCLUSIONS OF LAW

1. The conduct of Daniel X. Garcia, M.D., as described in the Findings of Fact, constitutes "fraud, misrepresentation, or deception in applying for or securing any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code.

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Report and Recommendation
In the Matter of Daniel X. Garcia, M.D.
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2. The conduct of Dr. Garcia, as described in the Findings of Fact, constitutes “[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or a limited branch of medicine; or in securing or attempting to secure any certificate to practice or certificate of registration issued by the board,” as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

* * * * *

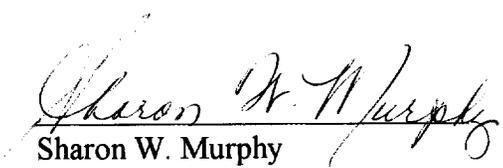
The evidence supports a conclusion that Dr. Garcia submitted his 2000 renewal application to the Board despite the fact that it contained a significant misrepresentation of fact. Nevertheless, the evidence further demonstrates that Dr. Garcia has learned from his mistake and will be more cautious and forthcoming in the future when communicating information to a regulating or licensing agency.

PROPOSED ORDER

It is hereby ORDERED that:

1. Daniel X. Garcia, M.D., be REPRIMANDED.
2. The certificate of Dr. Garcia to practice medicine and surgery in the State of Ohio shall be SUSPENDED for a period of thirty days.

This Order shall become immediately upon mailing of notification of approval by the Board.


Sharon W. Murphy
Attorney Hearing Examiner



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 8, 2001

REPORTS AND RECOMMENDATIONS

Dr. Bhati announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Bhati asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matter of Warrick Lee Barrett, M.D.; Christopher Chen, M.D.; Brian W. Davies, M.D.; Daniel X. Garcia, M.D.; Alan P. Skora, D.O.; Rezso Spruch, M.D.; Tom Reutti Starr, M.D.; Joseph A. Tore, M.D.; Quirino B. Valeros, M.D. and Dirk Gregory Wood, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Somani	- aye
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Agresta	- aye
	Dr. Steinbergh	- aye
	Dr. Bhati	- aye

Dr. Bhati asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Somani	- aye
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Agresta	- aye
	Dr. Steinbergh	- aye
	Dr. Bhati	- aye

Dr. Bhati noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further

adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Dr. Bhati stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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DANIEL X. GARCIA, M.D.

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DR. AGRESTA MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF DANIEL X. GARCIA, M.D. MR. BROWNING SECONDED THE MOTION.

.....

A vote was taken on Dr. Agresta's motion to approve and confirm:

Vote:	Mr. Albert	- abstain
	Dr. Talmage	- aye
	Dr. Somani	- aye
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Agresta	- aye
	Dr. Steinbergh	- aye
	Dr. Bhati	- aye

The motion carried.



State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

March 14, 2001

Daniel X. Garcia, M.D.
162 Minges Circle
Battle Creek, Michigan 49015

Dear Doctor Garcia:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) On a date not specifically known between July 1, 2000 and January 2, 2001, you signed and submitted to the State Medical Board of Ohio your application for renewal of your Ohio certificate to practice medicine and surgery. You certified that the information provided on that renewal application was correct.

You responded "No" to the question "At any time since signing your last application for renewal of certificate [March 12, 1998]:

- 4.) [h]as any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, filed any charges, allegations or complaints against you?"

In fact, the State of Michigan Board of Medicine filed an Administrative Complaint, dated October 29, 1998, charging you with negligence or failure to exercise due care for an incident which occurred on October 14, 1997, when you performed arthroscopic surgery on the wrong knee of patient R.M. You subsequently entered into a Consent Order and Stipulation, dated June 16, 1999, in which you agreed to pay a fine of \$5,000.00.

The Michigan Board Administrative Complaint and Consent Order and Stipulation are attached hereto and incorporated herein.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "fraud, misrepresentation, or deception in applying for or securing any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(A), Ohio Revised Code.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[m]aking a false, fraudulent, deceptive, or misleading statement in the solicitation of or advertising for patients; in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or a limited branch of medicine; or in securing or

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Daniel X. Garcia, M.D.

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attempting to secure any certificate to practice or certificate of registration issued by the board," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

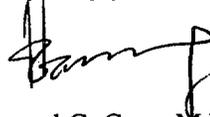
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Anand G. Garg, M.D.
Secretary

AGG/jag
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5140 0722
RETURN RECEIPT REQUESTED

Battle Creek Sports Medicine
2 Heritage Oak Lane
Battle Creek, Michigan 49015

CERTIFIED MAIL # 7000 0600 0024 5140 0715
RETURN RECEIPT REQUESTED

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

DANIEL XAVIER GARCIA, M.D. /

Complaint No. 43-98-0578-00

ADMINISTRATIVE COMPLAINT

Attorney General Frank J. Kelley, through Assistant Attorney General Amy L. Rosenberg, on behalf of the Department of Consumer & Industry Services, Office of Health Services (Complainant), files this Administrative Complaint against Daniel Xavier Garcia, M.D. (Respondent), alleging upon information and belief as follows:

I. GENERAL ALLEGATIONS

1. The Michigan Board of Medicine (Board), an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq*; MSA 14.15(1101) *et seq*, is empowered to discipline licensees under the Public Health Code through its Disciplinary Subcommittee.

2. Respondent is currently licensed to practice medicine in the State of Michigan.

STATE MEDICAL BOARD
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II. APPLICABLE STATUTORY PROVISIONS

3. Section 16221(a) of the Public Health Code authorizes the Disciplinary Subcommittee to take disciplinary action against a licensee for "a violation of general duty, consisting of negligence or failure to exercise due care...whether or not injury results..."

4. Section 16221(b)(i) of the Public Health Code authorizes the Disciplinary Subcommittee to take disciplinary action against a licensee for incompetence. "Incompetence" is defined at section 16106(1) of the Public Health Code as a "departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs."

5. Section 16226 of the Public Health Code authorizes the Disciplinary Subcommittee to impose specified disciplinary sanctions for violations of §16221.

SPECIFIC ALLEGATIONS

6. On September 15, 1997, Respondent saw patient R.M. (initials will be used to protect patient privacy), who presented with pain in his right knee. On that date, Respondent diagnosed R.M. with a medial meniscus tear in the right knee, and recommended arthroscopic surgery to repair this injury.

7. On October 14, 1997, Respondent was scheduled to perform the arthroscopic surgery on R.M.'s right knee. The circulating nurse on the surgical team mistakenly prepped patient R.M.'s left leg, instead of the right leg, for surgery.

8. Without recognizing that the wrong leg had been prepped for surgery, Respondent began operating on R.M.'s left knee. Respondent made two stab wounds in the left knee, placed an arthroscopic cannula and videoscope in one stab wound site, and placed an outflow cannula in the other stab wound site. A suction/irrigation system was then started in the left knee, and Respondent began viewing the inside of the left knee with the videoscope.

9. Shortly after beginning this procedure, Respondent realized that he was operating on the wrong knee. Respondent stopped the procedure, drained the left knee, pulled the instruments from the knee, and stitched the two stab wounds in the left knee. Respondent then began surgery on the right knee, after the right leg was prepped and draped for surgery.

10. In an interview with an investigator from the Department of Consumer and Industry Services on June 17, 1998, Respondent admitted the above facts. Respondent indicated that he did not inquire before beginning the surgery whether anyone had verified the procedure to be done. Respondent also indicated that he did not know whether he reviewed the patient's record before the procedure. Respondent acknowledged that he was responsible for ensuring that the surgical procedure was done properly. Respondent also acknowledged that he bore some of the responsibility for the error in starting surgery on the wrong knee.

STATE MEDICAL BOARD
OFFICE
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11. An Administrative Complaint has also been filed against William W. Vaughn, R.N., the circulating nurse who prepped R.M.'s wrong leg, in Complaint No. 47-97-1833-00.

COUNT I

Respondent's conduct, as set forth above, evidences negligence or failure to exercise due care in violation of section 16221(a) of the Public Health Code.

THEREFORE, the People request that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid license. If compliance is not shown, the People further request that formal proceedings be commenced pursuant to the Public Health Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*; MSA 3.560(101) *et seq*.

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(7) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Department of Consumer & Industry Services, Office of Health Services, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned Assistant Attorney General. Further, pursuant to section 16231(8) failure to submit a written response within 30 days shall be treated as an admission

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of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully submitted,

FRANK J. KELLEY
Attorney General



Amy L. Rosenberg (P47297)
Assistant Attorney General
Health Professionals Division
G. Mennen Williams Bldg., Room 620
525 West Ottawa Street
Lansing, Michigan 48913
Telephone: (517) 373-1146
Fax: (517) 241-1997

Dated: 10 / 29 / 98

drr.cases.AL98.Garcia.Garcia.P.Complaint

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STATE OF MICHIGAN
DEPARTMENT OF CONSUMER & INDUSTRY SERVICES
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

DANIEL XAVIER GARCIA, M.D.

Complaint No. 43-98-0578-00
CONSENT ORDER AND STIPULATION

CONSENT ORDER

An administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on October 29, 1998 charging Daniel Xavier Garcia, M.D. (Respondent) with having violated sections 16221(a) and (b)(i) of the Public Health Code, 1978 PA 368, as amended; MCL 333.1101 *et seq*; MSA 14.15(1101) *et seq*.

Respondent has admitted by stipulation contained in this document that the facts alleged in the complaint are true and constitute violation of the Public Health Code.

By stipulation contained in this document, the parties have agreed that the Disciplinary Subcommittee shall dismiss Count II of the complaint alleging violation of section 16221(b)(i) of the Public Health Code.

The Disciplinary Subcommittee has reviewed the stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding complaint.

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Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the complaint are true and constitute violation of section 16221(a) of the Public Health Code.

Accordingly,

IT IS ORDERED that for this violation Respondent is assessed a FINE in the total amount of \$5,000.00 to be paid by check, money order or cashier's check made payable to the State of Michigan (with Complaint No. 43-98-0578-00 clearly indicated on the check or money order) within 90 days from the effective date of this order. The timely payment of the fine shall be Respondent's responsibility.

The payment of the fine shall be mailed to the Compliance Unit, Office of Health Services, Department of Consumer & Industry Services, P.O. Box 30185, Lansing, Michigan 48909.

IT IS FURTHER ORDERED that Count II of the complaint is DISMISSED.

IT IS FURTHER ORDERED that should Respondent violate any term or condition set forth here, it may be determined that Respondent has violated an order of the Disciplinary Subcommittee, 1996 AACCS, R 338.1632, and section 16221(g) of the Public Health Code.

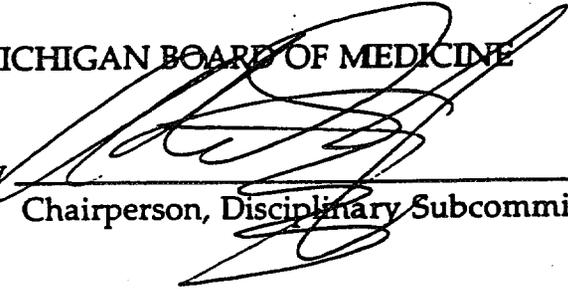
IT IS FURTHER ORDERED that this order shall be effective on the date signed by the Disciplinary Subcommittee or its authorized representative, as set forth below.

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OFFICE

STATE OF MICHIGAN -- INGHAM COUNTY
We certify that the foregoing is a true copy of the original on file in the office of the Department of Consumer and Industry Services, Office of Health Services.

Signed this 16 day of June, 19 95.

MICHIGAN BOARD OF MEDICINE

By 
Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate and agree as follows:

1. The allegations of fact contained in the complaint are true and constitute violation of sections 16221(a) of the Public Health Code.

2. Respondent understands and intends that by signing this stipulation he is waiving the right pursuant to the Public Health Code, rules promulgated thereunder, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq*; MSA 3.560(101) *et seq*, to require the State to prove the charges set forth in the complaint by presentation of evidence and legal authority, and to appear with an attorney and such witnesses as Respondent may desire present a defense to the charges before the Disciplinary Subcommittee or its authorized representative.

3. Count II of the complaint shall be dismissed by order of the Disciplinary Subcommittee.

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STATE OF MICHIGAN - GRAYBAR COUNTY
We certify that the foregoing is a true
copy of the original on file in the office
of the Department of Consumer and Industry
Services, Michigan Health Division.

4. Factors taken into consideration when determining the proposed sanction include the following:

a. Respondent has been fully cooperative throughout this process and has been willing to accept responsibility for his error.

b. Since the time of this wrong-site surgery, Battle Creek Health Systems revised its policy and procedure manual with regard to operative site verification, to provide additional protections to prevent wrong-site surgery. Respondent indicates that he and his surgical team follow these procedures. A copy of the hospital policy is attached to this consent order.

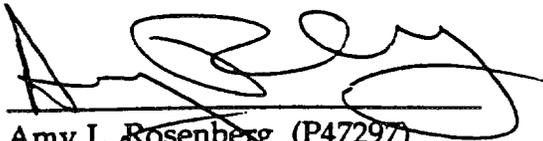
5. The Board's conferee, Kenneth McNamee, M.D., who has indicated support of this proposal, and the Department's representative or the undersigned assistant attorney general are both free to discuss this matter with the Disciplinary Subcommittee and recommend acceptance of the resolution set forth in the consent order.

6. The foregoing consent order is approved by the respective parties and may be entered as the final order of the Disciplinary Subcommittee in this cause.

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7. The foregoing proposal is conditioned upon its acceptance by the Disciplinary Subcommittee, the parties expressly reserving the right to further proceedings without prejudice should the consent order be rejected.

AGREED TO BY:



Amy L. ~~Rosenberg~~ (P47297)
Assistant Attorney General
Attorney for Complainant
Dated: ~~May 5~~ ^{the} May 5, 1999

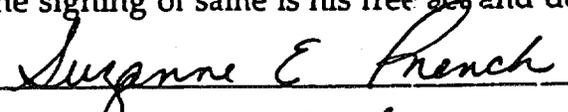
AGREED TO BY:



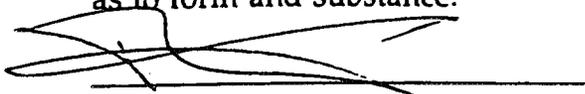
Daniel Xavier Garcia, M.D.
Respondent

State of Michigan)
County of Calhoun)ss

On the 22nd day of April, 1999, before me, a Notary Public in and for said county, appeared Daniel Xavier Garcia, M.D., who upon oath stated that he has read the foregoing consent order and stipulation by him subscribed, that he knows the contents thereof to be true and that the signing of same is his free act and deed.


Notary Public, Calhoun County
State of Michigan
My commission expires: 8/31/99

I have reviewed and approved the foregoing document both as to form and substance.



Richard K. Grover (P37566)
Attorney for Respondent

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This is the last and final page of a consent order and stipulation in the matter of Daniel Xavier Garcia, M.D., pending before the Disciplinary Subcommittee of the Michigan Board of Medicine, and consisting of five pages, this page included.

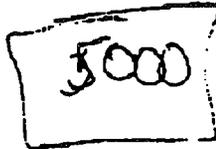
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STATE MEDICAL BOARD OF OHIO
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BATTLE CREEK  HEALTH SYSTEM

March 13, 1999

Dr. Daniel Garcia
2 Heritage Oak Lane
Battle Creek, MI 49017



Dear Dr. Garcia:

This letter will confirm that Battle Creek Health System did make, and continues to make, improvements in policy and procedure since the mishap of wrong site surgery with your patient.

I have attached a copy of the policy update post this incident. In addition, nursing staff and medical staff were re-educated in the importance of following strict protocol in verifying a surgical "side". We need to thank you for your input and assistance in making these improvements—it has been obvious that your primary interest is in the delivery of quality care to our patients. We appreciate your continued recommendations and input.

In addition, we currently are prepared to introduce policy which even further defines the procedure, as recommended by the American Academy of Orthopaedic Surgeons.

Should there be further information needed, please do not hesitate in contacting me.

Sincerely,

Teresa Campbell

Teresa Campbell, MSW
Risk Management

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STATE MEDICAL BOARD
OF OHIO

300 NORTH AVENUE
BATTLE CREEK, MICHIGAN 49016
TELEPHONE 616.966.8000

SURGICAL SERVICES Policy & Procedure Manual	Directive Number: SS-II-24
ISSUED BY: <i>Cynthia Fink</i> Director, Surgical Services	Effective: 11/98 Next Review Date: <u>Oct</u> 97
AUTHORED BY: <i>Mary Ann Ahlers</i> Manager, Surgical Services	Supersedes: 10/95 Review History:
CONCURRENCE BY:	Fulfills Requirements Of:
SUBJECT: Patient/Operative Site Identification	

POLICY

Correct patient identification and operative site verification will occur prior to transporting the patient to the operating room. Patient and operative site verification will be documented in the OR Nursing Record prior to initiation of the procedure.

PURPOSE

To assure a safe environment for the patient.

SPECIAL INSTRUCTIONS

1. Pre-op/Holding RN:
 - A. Patient identification is verified verbally.
 - B. Surgical consent
 1. Is consistent with the scheduled procedure.
 2. Reflects patient/family verbal confirmation of the surgical procedure and site.
 3. Reflects diagnosis identified in the history & physical/progress note/consult.
 4. Is signed, dated, timed, and witnessed.
 - C. Before the patient is sedated, the operative side is marked with the patient's initials at the incision site.
 1. For eye procedures, the forehead is marked above the correct eye with tape.
 2. For spine procedures, an intra-operative film is taken to verify the correct surgical space.
2. The anesthesia provider identifies the patient and proposed surgical procedure prior to invasive anesthesia.
3. The transport person verifies the correct patient before the transport procedure begins.
4. Intra-operative by the circulating RN:
 - A. Patient identification is verified verbally and by wristband. NOTE: If the identification band is removed for any reason, it must be placed on the other wrist, leg, or taped to the patient's chest.

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**BATTLE CREEK HEALTH SYSTEM
SURGICAL SERVICES POLICY & PROCEDURE MANUAL**

- B. History & physical is consistent with the planned procedure.
 - C. Surgical plan of care noted by the surgeon is consistent with the OR Schedule.
 - D. Operative side marked with the patient's initials is verified.
5. When a right or left procedure is scheduled, the surgeon, circulating RN, and a third party verify the site by reading the consent form.

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POLICY

Policy and Procedure Manual

AUTHORIZED BY: Director Surgical Services	Directive Number: 4-III-5
ISSUED BY:	Effective: Supersedes: Review Dates:
DEPARTMENT: Surgical Services SCOPE: Patient Care SUBJECT: Patient/Operative Site Identification	Fulfills Requirement of

POLICY:

Patient/Operative Site Identification

Correct patient identification and operative site verification will occur prior to transporting the patient to the operating room. Patient and operative site verification will be reverified by the intraoperative team and documented on the OR Nursing Record prior to initiation of the procedure.

PURPOSE:

To provide a process which ensures that the surgical procedure is performed at the appropriate site (distinguishing right from left). The surgical procedure and site are verified by the patient, surgeon, scrub, and circulating nurse.

1. Preop/Holding/Circulating nurse or nurse on the patient care unit will:
 - A. Verify patient identification verbally
 - B. Check to make sure that the surgical consent is:
 - Consistent with the scheduled procedure.
 - Reflects patient/family verbal confirmation of the surgical procedure and site.
 - Reflects the diagnosis identified in the history and physical/progress note/consult.
 - Signed, dated, timed and witnessed.
 - If the consent is incorrect, incomplete, or questionable in any way, it will be corrected before anesthesia is administered.
2. Before the patient is sedated either in the holding area or operating room, the patient will identify/indicate the correct site and/or side to be operated on, and the site is marked by the surgeon

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