## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Eleazar Humberto Noriega, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that would disclose the identity of the patients whose names are disclosed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

**Indexed as: Noriega, E. H. (Re)**

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

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

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. ELEAZAR HUMBERTO NORIEGA**

**PANEL MEMBERS:**

**DR. P. CHART**
**D. GIAMPIETRI**
**DR. S. BODLEY**
**DR. E. ATTIA (Ph.D.)**
**DR. A. SHARMA**

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| **Hearing Date:** | July 17 to 19 and September 5, 2012 |
| **Decision Date:** | February 28, 2013 |
| **Release of Written Reasons:** | February 28, 2013 |

# PUBLICATION BAN

## DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons heard this matter at Toronto on July 17 to 19 and September 5, 2012. At the conclusion of the hearing, the Committee reserved its decision on finding.

## ALLEGATION

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

1. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

## RESPONSE TO ALLEGATION

Dr. Noriega denied the allegation in the Notice of Hearing.

## FACTS AND EVIDENCE

### (A) Background

In 2009, Dr. Noriega was referred to the Discipline Committee for allegations, including sexual abuse and sexual impropriety.

On July 22, 2009, Dr. Noriega entered into an undertaking with the College (the "Undertaking"). In the Undertaking, Dr. Noriega said he was aware of the College's concern about protecting the public and that he understood the nature of the allegations against him (sexual abuse). Dr. Noriega undertook, among other things, not to engage in any professional encounters with female patients except in the presence of his practice monitor. He undertook to post a sign in his waiting room and in each of his examination rooms notifying the public of this practice restriction.

Dr. Noriega's practice monitor also entered into an undertaking on July 22, 2009 (the "Practice Monitor's Undertaking"). It required the practice monitor to be present for all of Dr. Noriega's professional encounters with female patients. It further required her to maintain a patient log of all the female patients that Dr. Noriega has an in-person professional encounter with in her presence, including the appointment date, the patient's name and the reason and treatment for the patient's visit. The practice monitor was further obliged to keep and secure the original log.

**(B) Overview of the Allegations and Issues**

The allegations of professional misconduct against Dr. Noriega include breaches of the Undertaking and an allegation that Dr. Noriega was untruthful with the College's compliance investigator. Schedule "A" of the Notice of Hearing specifically alleges that:

1. Dr. Noriega entered into an undertaking with the College on July 22, 2009. Dr. Noriega engaged in disgraceful, dishonourable or unprofessional conduct by breaching the terms of his undertaking with the College and by being untruthful with the College's compliance investigator.

The College raised the following specific questions for the Committee to consider based on the evidence:

- Did Dr. Noriega fail to post the required sign in his waiting room?
- Did Dr. Noriega fail to post the required sign in an examination room including by covering the required sign up with a framed picture?
- Did Dr. Noriega fail to ensure the patient log was properly maintained and stored?
- Did Dr. Noriega fail to ensure a chaperone was present throughout the entirety of his female patient encounters between July 2009 and February 2010?
- Did Dr. Noriega mislead the College's compliance investigator in February 2010 when he told her that he does not see female patients in the consultation room?

**(C) Summary of the Evidence**

The Committee heard the testimony of Ms X (compliance investigator at the College), Ms Y (investigator at the College) and Ms Z (Dr. Noriega's Practice Monitor) on behalf of the College. The Committee heard the testimony of Ms A (Dr. Noriega's wife), Dr. Eleazar H. Noriega, Ms F (parent of patient), Ms G (parent of patient), and Ms Q (parent of patient) on behalf of the defence**.**

**Issue #1 - Did Dr. Noriega fail to post the required sign in his waiting room?**

Paragraph B(2) of the Undertaking states:

> *"I,* ***Dr. Eleazar Humberto Noriega****, undertake to the College that, effective immediately, I shall post a sign in his waiting room and each of his examination rooms, attached hereto as Appendix "A" that states: "Dr. Eleazar Noriega may only have encounters with female patients, of any age, in the presence of a monitor who is a regulated health professional acceptable to the College of Physicians and Surgeons of Ontario. Dr. Noriega may not be alone with any female patient unless this practice monitor is present in the examination or consulting room."*

Ms X was the first witness to give evidence on this issue. Ms X has been a compliance investigator at the College since September of 2009, and prior to that she was an investigator for the College since June of 1995. As a compliance investigator, she coordinates practice assessments and attends for compliance visits at physicians' offices. Ms X testified that her role in the Noriega file was to conduct a compliance visit with respect to Dr. Noriega's July 2009 undertaking with the College. In preparation for the visit, Ms X reviewed material including a memorandum from the compliance monitor and Dr. Noriega's undertaking.

Ms X testified that she attended at Dr. Noriega's office on February 3, 2010 at about 10:30 a.m. for an unannounced inspection. In accordance with her usual practice, Ms X made handwritten notes while she was at the office. Ms X testified that her notes are an accurate reflection of the visit. Ms X testified that when she got back to the office, she

typed her notes into a written memorandum about the visit, which she completed on the same day as the visit when the information was fresh in her mind.

Ms X testified that when she arrived at the Noriega office on February 3, 2010, there was no sign posted on any of the four walls of the waiting room and there was no sign lying on the floor of the waiting room.

Ms X testified that while she was at Dr. Noriega's office, she sent an e-mail to Ms R, the Compliance Monitor for the College, at 11:43 pm regarding the signs. Ms X's email to Ms R stated, "I told him he must post it immediately and he still hasn't done it - I have been here since 10:15." Further, she sent another e-mail to Ms R at 12:51 pm which stated, in relevant part, "waiting room signs just went up..."

Dr. Noriega's wife of 28 years, Ms A, also gave evidence regarding the waiting room sign. Ms A is also Dr. Noriega's office manager. She began working with Dr. Noriega in November of 1982.

Ms A testified that the sign in the waiting room was placed at a level of four feet and was placed close to chairs. She testified that children jumped on the chairs and would remove everything. She indicated that parents or children would tear down the signs and that they did so a couple of times a week and as often as three times a day. She said that she did not check every day to make sure the sign was up. Ms A confirmed that the sign in the waiting room was down at the time of Ms X's visit. However, she also testified that she was not aware that the sign was down at the time that Ms X arrived and she testified that she did not know how long the sign had been down prior to Ms X's visit.

Dr. Noriega acknowledged that when he voluntarily entered into the Undertaking, allegations of sexual abuse and sexual impropriety had been referred to the Discipline Committee. He was aware that if he did not enter into the Undertaking, his practice would be restricted. Dr. Noriega acknowledged that, as a result of entering into this agreement, no interim order was made with respect to his practice. He testified that he sought legal

advice prior to signing the Undertaking, to which was attached the text of the sign and Practice Monitor's Undertaking.

Dr. Noriega testified that his wife took responsibility for the sign in the waiting room and he took responsibility for the signs in the examination rooms. With respect to the waiting room sign, Dr. Noriega testified that he did not check every day to make sure the sign in the waiting room was up. He agreed that although the patients continued to pull down the sign, the sign continued to be posted at one and a half meters high. He agreed that it was Ms X who suggested that the sign be placed higher-up. Dr. Noriega testified that he does not believe that his failure to ensure that the sign in the waiting room was up was unprofessional.

**Issue #2 - Did Dr. Noriega fail to post the required sign in an examination room, including by covering up the sign with a framed picture?**

As noted above, by way of paragraph B(2) of the Undertaking, Dr. Noriega also undertook to post a sign with the required text in each of his examination rooms. The Committee notes that the Undertaking does not require that Dr. Noriega post a sign in his consultation room, unless it is being used as an examination room.

Ms X testified that the required sign was posted in the first examination room but there was no visible sign present in Dr. Noriega's second examination room. Ms X testified that when she inquired with Dr. Noriega as to the presence of the sign in the second examination room, he removed a piece of art, exposing the covered sign. Dr. Noriega told Ms X that he found the signs humiliating.

Ms A also gave evidence about the signs in the examination rooms. She testified that she knows one was posted in the examination room in front of her desk where Dr. Noriega examines all of the children over two or three years old. This is the room Ms A said she goes to most because it contains supplies which she is responsible for re-filling. Ms A testified that she did not know the sign in the other examination room was covered up.

She was surprised to learn that it was covered up when Ms X went into the room and testified that she was upset with Dr. Noriega when she learned that he had covered it up.

With respect to the covered up sign in the second examination room, Dr. Noriega testified at the hearing that he thought that the sign was only for female patients. He explained that he would cover up the sign in the second examination room, referred to as the "baby room", at four o'clock, with a picture of a baseball game, and would thereafter see only male patients in that room. Dr. Noriega testified that he "usually" removed the baseball picture when he would arrive in the office and he acknowledged that, at the time of Ms X's visit, on February 3, 2010, at 10:30 a.m., the sign remained covered. Further, he testified that he did not believe his covering of the sign was unprofessional.

On the subject of the posting of a sign in the consultation room, the evidence of Dr. Noriega was that this room was only used as an examination room for a short time. There was no specific evidence before the Committee regarding the posting or lack of posting of a sign in the consultation room during the short period that the room was being used as a third examination room.

**Issue #3: Did Dr. Noriega fail to ensure the patient log was properly maintained and stored?**

Paragraphs B(6) and B(7) of the Undertaking state:

> *(6) I, **Dr. Eleazar Humberto Noriega**, acknowledge that the Practice Monitor is required to maintain a log of all female patient encounters (attached as Appendix "C"; the "Log"), and that the Log shall provide the name of the female patient, and the purpose and date of the appointment. I acknowledge that the Practice Monitor will sign and date the corresponding entry on the female patient's medical record.*
>
> *(7) I, **Dr. Eleazar Humberto Noriega**, acknowledge that the Monitor is required to submit copies of the Log to the College on a monthly basis; and that the Monitor is also required to submit reports (as described in the Monitor's undertaking) to the College on a monthly basis.*

The Undertaking also states that Dr. Noriega has reviewed the Practice Monitor's Undertaking and understands what is required of the Practice Monitor.

Paragraphs 9 and 10 of the Practice Monitor's Undertaking state:

> *(9) I agree to keep a patient log (Appendix "C") of all the female patients that Dr. Noriega has an in-person professional encounter with in my presence. I agree to record the appointment date, the patient's name, reason and treatment for the patient's visit and initial it to confirm that I was in the presence of Dr. Noriega at all times during the in-person professional encounter.*
>
> *(10) I agree to submit by facsimile my completed patient log and a written report to the College on the 1st of each and every month beginning on August 1, 2009. I agree to keep and secure the original Log. The report will indicate my compliance with my Undertaking, Dr. Noriega's compliance with his Undertaking, and any other information I believe will assist the College in their monitoring of Dr. Noriega.*

Ms Z, Dr. Noriega's practice monitor, testified that her duties included completing a female patient log. Although it was Ms Z's responsibility to complete the log, Ms A, office secretary and wife of Dr. Noriega, partially completed the log due to the nature of the challenging Spanish names of Dr. Noriega's patients. Ms Z testified that, with some exceptions, Ms A would write the majority of names of the patients into the log until June 2010. Ms Z testified that prior to June of 2010, it was Ms A who prepared and copied the log to send to the College. During cross-examination, Ms Z stated that the log was kept on Ms A's desk until June of 2010, but currently the log is kept in a little desk beside Ms A's desk.

Ms A's evidence with respect to the logs was generally consistent with that of Ms Z. Ms A testified that she wrote the names of Dr. Noriega's patients in the patient log until June of 2010. She indicated that by doing so she was not changing the rules, but rather helping, as the Spanish names were challenging for Ms Z. During cross-examination, Ms A also agreed that the Log was kept on her desk until June of 2010.

Dr. Noriega acknowledged that, as the physician who entered into the Undertaking, he had the responsibility to ensure that the practice monitor was following the terms of the Practice Monitor's Undertaking. He testified that although it was the Practice Monitor's responsibility to put the patient name in the Log, he delegated this responsibility to his wife as, in the beginning, the names of his patients were foreign to Ms Z.

**Issue #4: Did Dr. Noriega fail to ensure that a chaperone was present through the entirety of his female patient encounters between July 2009 and February 2010?**

Paragraphs B(1) and (4) of the Undertaking provide:

> *(1) I, **Dr. Eleazar Humberto Noriega**, undertake to the College that, effective immediately, I shall not engage in any professional encounters with female patients in any jurisdiction, unless the patient encounter takes place in the presence of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor"), and unless the other requirements provided in this Undertaking are fulfilled. For further clarity, I understand that I may not be alone with any female patient, for any length of time, during any professional encounter, whether or not the parent or guardian of the patient is also present.*
>
> *(4) I, **Dr. Eleazar Humberto Noriega**, acknowledge that the Practice Monitor must remain in the examination or consultation room at all times during all professional encounters with all female patients.*

**Evidence of Ms X**

Ms X testified that, during her February 3, 2010 visit to Dr. Noriega's office, she spoke to Ms Z, Dr. Noriega's Practice Monitor. Ms X testified that her discussion with Ms Z took place in the computer room on the sofa where Ms Z usually sits and that she took notes while they were speaking. Ms X testified that she created a typed copy of her notes when she returned to her office later that day.

Ms X explained that she was seeking to determine if Ms Z was present in the examination room at all times with female patients. Ms X testified and recorded in her notes that Ms Z told her that all patients, male and female, are seen in consultation with Dr. Noriega in his

office, and that she waits outside the office in the computer/file room. After Dr. Noriega comes out of the consultation room and calls her, she goes with Dr. Noriega into the examination room with the patient.

Ms X also testified that she informed Ms Z that she was to be present during all patient encounters, not just in the examination room. Ms X testified to her belief that she showed Ms Z a copy of her undertaking. On cross examination, Ms X testified that Ms Z did not seem confused, nor did she seem like someone who could easily become mixed up and give answers that were not correct. Ms X testified that Ms Z seemed alert and was forthright in the information she provided to Ms X. Ms X also testified that Ms Z seemed to easily understand what Ms X was asking.

Ms X also testified that it was her usual practice to let the Compliance Monitor know via email if a subject physician doesn't seem to be carrying out all of the stipulations of the undertaking, or if there is something she needs the Compliance Monitor to know right away. During her visit to Dr. Noriega's office, she sent an email to Ms R, Compliance Monitor at the College, at 12:51 p.m., which read: "Waiting room just went up…adding one to consult room where he also sees pts. Monitor is not going into consult room with the pts - he calls her to go to exam room after consult; no monitor present."

Ms X testified that during her visit she also spoke with Dr. Noriega. She testified that Dr. Noriega said that he did not see female patients in his consultation room, only male patients. Ms X testified that she did not see any patients in the consult room during her visit that day.

Ms X came across as reliable, clear, confident, and convincing during her testimony. Her testimony did not change during cross examination. She was very clear about the events that unfolded at Dr. Noriega's office. The Committee finds no reason for Ms X to misrepresent herself or the information in this case. The Committee finds her evidence to be clear, convincing and cogent. The issue of the admissibility of Ms X's evidence

regarding Ms Z's statements to her for the truth of their contents is considered in more detail later in this decision.

**Evidence of Ms Y**

The Committee also heard evidence from Ms Y, an investigator with the College, on this issue. Ms Y started working at the College as an investigator in September of 1998, and prior to that she worked with the Toronto Police as a police officer for approximately 10 years. Ms Y became involved in the Noriega matter after Ms X's visit to Dr. Noriega's office.

Ms Y testified that on April 23, 2010, she attended at Dr. Noriega's office to follow up on Ms X's observations about compliance with the Undertaking. Ms Y explained that, while at the Noriega office, she made notes, as per her usual practice. When she returned to the College on the same day as her visit, she reviewed the notes, and, from the notes, she drafted a summary.

Ms Y testified that when she arrived at Dr. Noriega's office, she identified herself to Ms Z and Ms A. At that time, Dr. Noriega was with a patient. Ms Y explained that this was a follow-up visit to Ms X's first inspection visit on February 3, 2010.

Ms Y testified that Ms Z explained to her that they had made changes in their practice since Ms X's visit in February 2010. Specifically, Ms Y testified that Ms Z explained to her that she now attends in the consult room with female patients. Ms Z also explained to Ms Y two other changes made since the last inspection, in that, since the last inspection, she signs the patient chart when she does a vaginal swab, and that the chair which had previously been obstructing her view had been removed.

Ms Y testified that her impression of Ms Z was that she was a very honest individual and that she seemed very conscientious. According to Ms Y, Ms Z was very open about the fact that she was now, since the last inspection, attending in the consult room with female patents.

Ms Y subsequently conducted telephone interviews with several of Dr. Noriega's patients on May 21, 25 and June 2 of 2010. The purpose of the telephone interviews was to verify that the practice monitor was present and what her role was. She stated that, with the patient encounters that occurred before Ms X's visit, she would not have asked about who was present in the consultation room because Ms Z had told Ms X that she was not in the consultation room. The phone interviews with respect to visits that occurred after Ms X's visit were to confirm that the Practice Monitor was present. No concerns were raised during the phone interviews about the presence of the Practice Monitor during encounters with female patients.

The Committee finds Ms Y's evidence to be very clear, convincing and her evidence about what she was told was supported by her contemporaneous notes.

**Evidence of Ms Z**

Ms Z, Dr. Noriega's Practice Monitor, was called as a witness by the College. Ms Z testified that she has worked full time at the Noriega office since the summer of 2008. Ms Z was named in Dr. Noriega's Recognizance of Bail. She was told at the time that she had to be a chaperone for Dr. Noriega and be in the room with him when he was examining female patients. During this period, she did not have to be present in the consultation room with Dr. Noriega.

Ms Z testified that in July of 2009, she was asked by Ms A to sign an undertaking with the College in order to act as Dr. Noriega's practice monitor. Ms Z said she does not recall when the next time was that she looked at the Practice Monitor's Undertaking, but she thinks it was when was when she was asked to come to the College. Ms Z believes that a copy of her undertaking was kept in the office.

At the hearing, Ms Z testified that her duties as Dr. Noriega's practice monitor (after signing the Practice Monitor's Undertaking) included staying with Dr. Noriega during the female patient examinations at all times, as well as being present in the consultation room. She further testified at the hearing that, after she signed the Practice Monitor's

Undertaking, she stayed with Dr. Noriega for his examinations of female patients and for his consultations with female patients. With respect to Ms X's visit, Ms Z testified that she understood that Ms X was at the office to see if they were following everything asked by the College. Ms Z also testified at the hearing that, at the time that Ms X came to visit, Dr. Noriega was seeing both male and female patients in the consultation room.

When asked if she remembered telling Ms X about this, she said that Ms X asked her questions and she thinks she mentioned this practice to Ms X, including that Dr. Noriega came to get her every time. Ms Z testified that during Ms X's visit she told Ms X that she usually waited in the computer room until Dr. Noriega came to do the consultation in the consultation room. She then went in with him and sat down as Dr. Noriega asked the history. This applied, according to Ms Z, for female patients and male/female patients who were seen together, but not for male patients.

Ms Z testified that when Ms Y visited, she told Ms Y that she was attending with Dr. Noriega in the consultation room with female and male/female patients seen together, but not male patients.

Ms Z testified that, when Ms Y visited Dr. Noriega's office in April 2010, Ms Y was happy that all changes suggested by Ms X were made. Ms Z testified that she was signing the charts when she did a vaginal swab, the garbage can had been moved and that she was attending with female patients with Dr. Noriega in the consultation room. At the hearing, Ms Z testified that she did not remember saying the word "since" when telling Ms Y that she was present in the consultation room once the recommendations were made by Ms X.

Ms Z's testimony at the hearing was inconsistent with Ms X's evidence about what Ms Z told her in February 2010, and with Ms Y's evidence about what Ms Z told her in April of 2010. The College asked the Committee to admit the evidence regarding Ms Z's prior inconsistent statements to both Ms X and Ms Y for the truth of the contents of the statements. This admissibility issue is considered in more detail below.

Ms Z provided some evidence about the possible reasons for the inconsistency in her evidence during cross-examination. Specifically, during cross-examination by the College (after having been declared an adverse witness), Ms Z testified that in May of 2012, Ms P, counsel for Dr. Noriega, along with a private investigator, came to her home. She spoke with them about the process in 2009 when she signed the Practice Monitor's Undertaking. She told them that she may have gotten mixed up with the dates when she was speaking with Ms X. She explained that there was one point, maybe in 2009, when Dr. Noriega changed the rooms. Dr. Noriega started to contemplate changing the baby room into a consultation room as well as an examination room. It took him a while to institute this plan. She testified that when this change was instituted in 2009, the room was too small. Thus, this attempt failed and Dr. Noriega went back to doing his consultations in the consultation room and examinations in the exam room. Ms Z admitted that it was during her meeting with Ms P that she realized she was confused about the transition. She also explained that, at the time of Ms P's visit, she had a number of personal issues, including having cancer and her mother passing away and that it was a very stressful period for her.

Ms Z testified that after the visit from Ms P and the private investigator, for the first time she got her own copy of the Practice Monitor's Undertaking. She agreed that it was after she got her copy of the Practice Monitor's Undertaking that she decided that she had always been following the rules since she signed the paper, and she convinced herself of such because she always tried to follow the rules. Ms Z further acknowledged that when she spoke with Ms R, the College's Compliance Monitor, she told Ms R that Dr. Noriega was wonderful, a very good doctor, intelligent and responsible. She admitted that she feels bad that a patient accused Dr. Noriega and agreed that she does not want to get Dr. Noriega in trouble.

**Evidence of Ms A**

Ms A testified in chief that when Ms Z found out there was going to be a hearing, Ms Z became anxious. Ms A testified that Ms Z told her that she was confused with respect to some dates and that she gave a wrong answer to Ms X. Under cross-examination, Ms A

agreed that she suggested that Ms Z review the Practice Monitor's Undertaking and the date that she signed it in order to alleviate her confusion with respect to the date upon which the process changed in the office.

Ms A testified, in discussing her role in completing the Log required by the Undertaking, that the important thing was that Ms Z be in the room with Dr. Noriega at all times and that, to her knowledge, this happened. She also said she was in a position to actually observe that from where she was sitting. Ms A testified that at the time of the criminal bail conditions (prior to the signing of the Undertaking), Ms Z was supposed to go only for the examination. Dr. Noriega would first meet with the patient and their parent(s) in the consulting room. The patient and their parent would then leave the consulting room to go in to the examination room. Ms Z would weigh the patient and then call the doctor in to examine the patient.

Ms A testified that at some point after the Undertaking was signed, Dr. Noriega's patients were complaining about having a stranger, Ms Z, attend with them in the consult room. So Dr. Noriega started seeing patients right away in the examining room with Ms Z and would take their history in the examining room. However, she explained that Dr. Noriega's patients started complaining to Ms A that Dr. Noriega used to take time with them in his office to take their history and now he was working in an exam room like any other doctor. Then, after the end of February or March of 2010, according to Ms A, he changed again how he worked and went back to having consultations in his office and Ms Z was present with all the female patients for the history and for the examination. Ms A also testified that she thinks there was a period of time that Dr. Noriega tried to use the consult room as an exam room but it didn't work out. Ms A testified that she couldn't remember anything more about that.

The Committee finds that, on certain issues, Ms A testified with the intent of assisting her husband and, in respect of these issues, her evidence lacked credibility. For example, the Committee finds that Ms A's evidence on the posting and maintenance of the sign in the waiting room (i.e. that children pulled the sign down a couple of times a week to as often

as three times a day and that they simply kept putting it up at four feet with tape over and over) was, at the very least, exaggerated. On the issue of whether Dr. Noriega saw female patients with a practice monitor present for the entirety of their encounters with him, the Committee again finds that Ms A testified with the intent of assisting her husband and that her evidence lacked credibility. In addition to the Committee's general assessment of Ms A's credibility on this point, the Committee finds that Ms A's evidence was limited by the fact that she could only testify as to her knowledge. Ms A testified that, to her knowledge, Ms Z was in the room with Dr. Noriega at all times and that she was in a position to actually observe that from where she was sitting. However, the Committee also heard from Ms A about her many responsibilities in the office, which included taking messages, calls with patients, booking appointments, taking the charts, typing letters, sending bills and more. The Committee finds it unlikely that, given all of her other responsibilities at the office, Ms A would have been in a position to observe whether Ms Z attended with Dr. Noriega during every encounter with a female patient, and, in any event, disbelieved her evidence on this point.

**Evidence of Dr. Noriega**

Dr. Noriega testified in chief that, during the time of the criminal bail restrictions and before entering into the Undertaking with the College, he would discuss patient history and presenting complaints with the families in the consultation room. Ms Z was not present. After the consultation, the family would proceed to the examination room and he would ask Ms Z to come to assist with the height and weight and she would be present in the examination room. He described that after the examination, the family would return to the consultation room to discuss his findings. He explained that he practised with the use of a consultation room for 40 years, up until he entered into the Undertaking.

Dr. Noriega testified during his examination in chief that the Undertaking required that Ms Z be with him at all times when he had a professional encounter with female patients, and that he followed that requirement. He further testified that once he signed the Undertaking, he did not have encounters or discussions of any kind or visit with a female patient when Ms Z was not there.

Dr. Noriega testified in his direct examination that after entering into the Undertaking in the summer of 2009 until April of 2010, he decided to try doing everything in the two examination rooms. He believed that this would be less intrusive to the privacy of the patient. He testified that he was not using the consultation room during this time.

Under cross-examination, Dr. Noriega retracted the time frame he had provided in direct examination. He testified that he could not pinpoint the dates when he made any of the changes, but that he knows that at the time Ms X's visit he was not seeing patients in the consultation room. Dr. Noriega testified that he told Ms X that there was no sign in the consultation room because "I don't see female patients here."

On cross examination, Dr. Noriega acknowledged that it would have been clearer if he had said he didn't see any patients in that room, since that is what he says he meant. He would not agree that if what he meant was that he didn't see any patients in the consultation room, that is what he would have told Ms X.

Dr. Noriega testified that at some point he made another change in that he tried using the consult room as a third examination room. Dr. Noriega initially testified that this change was made in the winter of 2009 but then testified that it was probably made after Ms X's visit (which was in February 2010) but that he is not sure. Dr. Noriega added that he only used the consult room as an exam room for a week or so.

Dr. Noriega was given the opportunity to respond to the College after Ms X and Ms Y visited his office. Dr. Noriega learned what information Ms X and Ms Y had collected and he submitted a detailed response through his lawyer. The response provided was four pages long and addressed the absence of a sign in the waiting room, covering up of the sign in the examination room and Dr. Noriega's reasoning for not posting a sign in the consultation room. Dr. Noriega agreed that nowhere in this detailed response did he correct Ms Z's statement to Ms X that she was not present for his consultations with female patients. He testified that this was not addressed because he never thought that it

was an issue. He testified that it was at the hearing that he first learned that the College was concerned that the Practice Monitor was not with him at all times.

Finally, the Committee heard evidence from three witnesses who were parents of patients of Dr. Noriega on the issue of whether Ms Z was with Dr. Noriega throughout each patient visit with their respective children. Each of the witnesses testified that Ms Z was always with Dr. Noriega during their child's visits, at least since the time of the Undertaking or earlier than that. However, one of the witnesses agreed on cross examination that Dr. Noriega's records showed that her child did not see Dr. Noriega between July 9, 2009 and March 22, 2010. Another witness testified that her daughter had always been taken directly to the examination room and she therefore did not provide evidence regarding the presence of Ms Z in the consultation room. The third witness testified that she could not recall any visit during which Ms Z was not present for the consultation, which would include a visit to Dr. Noriega on February 2, 2009, a date which falls within a period of time during which all other testimony was that Dr. Noriega saw patients in the consultation room without Ms Z before taking them to the examination room. This caused the Committee to doubt the reliability of this witness' evidence.

**Issue #5: Did Dr. Noriega mislead the College's compliance investigator in February 2010 when he told her that he does not see female patients in the consultation room?**

The evidence heard by the Committee on this issue is set out in the Summary of Evidence relating to issues 1 to 4 above.

**Admissibility of Ms X's and Ms Y's Evidence about Prior Inconsistent Statements by Ms Z for the Truth of their Contents**

As set out above, the Committee heard evidence from two College witnesses, Ms X and Ms Y, about statements made to them by Dr. Noriega's practice monitor, Ms Z. The Committee accepts that Ms Z made the statements to Ms X and Ms Y that she is alleged

to have made. However, Ms Z did not adopt her prior statements in the testimony she gave at the hearing. In fact, as set out above, she gave evidence that was inconsistent with those statements.

In the course of the College's closing submissions, the College asked the Committee to make an exception to the usual hearsay rule (that the hearsay evidence is not to be admitted for the truth of its contents) and to accept the hearsay evidence of Ms X and Ms Y regarding the statements Ms Z made to them during their respective visits to Dr. Noriega's office for the truth of the contents of the statements. The Committee had the benefit of thorough written argument from the parties on this issue.

***The College's Position***

The College argued that Ms Z's prior inconsistent statements should be admitted and deemed ultimately reliable as the statements are surrounded by sufficient circumstantial guarantees of trustworthiness to overcome the dangers that are usually associated with hearsay evidence. The College argued, among other things, that the statements were made under serious circumstances, were carefully recorded and Ms Z attended at the hearing and was thoroughly cross examined. The College argued that the Committee must first decide the question of threshold reliability (whether there are sufficient guarantees of trustworthiness and reliability to make the hearsay evidence admissible), and that the Committee is only required to consider the ultimate reliability of the statements if the test for threshold reliability is met.

After a review of the evolution of the case law regarding the admissibility of prior inconsistent statements, beginning with the Supreme Court of Canada's decision in *R v. B. (K.G.),* [1993] 1 S.C.R. 740, the College argued that a trial judge considering the admissibility of prior inconsistent statements for their truth is now required to consider two broad questions:

(i) on the basis of the evidence presented, is the trier of fact able to sufficiently test the truth and accuracy of the statement in issue;

(ii) if the answer to question one is "yes", are there overriding policy considerations that would prevent the statement from being admitted for its truth? *(R.v. Hamilton,* [2011] OJ No. 2306, Ont. C.A.)

With respect to the first question, the College submitted that this can be determined in some cases by examining the circumstances in which the statement came about, and that in other cases this will also require looking at circumstances other than the making of the statement to test the statement's truth and accuracy. With respect to the second question, a policy consideration which could prevent the statement from being admitted would be conduct that would bring the administration of justice into disrepute, such as beating a witness to obtain a statement.

The College argued that the admission of Ms Z's prior statements is necessary because at the time of the hearing she recanted the information she previously provided to the College on a key issue in the hearing. With respect to reliability, the College submitted that there are sufficient circumstantial guarantees of trustworthiness to overcome the hearsay dangers. Finally, the College argued that there are no policy considerations which should prevent the admission of the prior inconsistent statements.

***Dr. Noriega's Position***

Counsel for Dr. Noriega took the position that Ms Z's earlier statements as recorded by Ms X and Ms Y should not be admitted and, if admitted, they should be given minimal weight. Counsel for Dr. Noriega argued, consistent with the submissions by counsel for the College, that the case law is now clear that the Committee can only admit the statements for the truth of their contents if there are sufficient circumstantial guarantees of reliability surrounding the statement. Counsel for Dr. Noriega also relied on the test as articulated by the Ontario Court of Appeal in *R. v. Hamilton.* In applying that test to this case, counsel for Dr. Noriega argued that: (i) the Committee should not admit the statement either based on the evidence observed and heard from Ms Z (specifically, because Ms Z testified at the hearing that she may have been confused when speaking with Ms X); and, (ii) the Committee should not admit the earlier statement for the truth of

its contents based on other evidence presented at the hearing by Ms A, Dr. Noriega and the patient witnesses which, it was argued, did not support the accuracy of Ms Z's statements to Ms X and Ms Y. Finally, counsel for Dr. Noriega argued that, if the evidence of the statements is admitted for the truth of its contents, it should be given minimal weight.

***The Law re: Admissibility of Prior Inconsistent Statements***

The Committee considered the case law regarding the admission of hearsay evidence in the form of prior inconsistent statements for the truth of their contents. The case law on this issue is clear and there was no significant disagreement between counsel for the College and counsel for Dr. Noriega regarding the legal test to be applied.

In some cases, because of the circumstances in which it came about, the content of the hearsay statement may be so reliable, that contemporaneous cross-examination of the declarant would add little if anything to the process. In other cases, the evidence may not be so cogent but the circumstances will allow for sufficient testing of evidence by means other than contemporaneous cross-examination. In these circumstances, the admission of the evidence will rarely undermine trial fairness. However, because trial fairness may encompass factors beyond the strict inquiry into necessity and reliability, even if these two criteria are met, the trial judge has the discretion to exclude hearsay evidence where its probative value is outweighed by its prejudicial effect. (*R. v. Khelawan*, [2006] 2 S.C.R. at para 49, as cited in *R. v. Hamilton* at 144).

The Committee considered whether the evidence of Ms X and Ms Y regarding Ms Z's prior inconsistent statements was necessary. The Committee found it necessary to admit the evidence of Ms Z's prior inconsistent statements. At the hearing, Ms Z recanted the information she had previously provided to the College, namely, that Dr. Noriega was conducting consultations with female patients without her presence. Whether Dr. Noriega conducted consultations without Ms Z is a key issue in this hearing, which is concerned with Dr. Noriega's lack of compliance with several of the terms of his July 2009 undertaking with the College.

The Committee also considered whether there were sufficient circumstantial guarantees of reliability surrounding Ms Z's statements to Ms X and Ms Y to justify admitting the statements for the truth of their contents. The Committee considered that Ms Z's statements to both Ms X and Ms Y described the practice in Dr. Noriega's office at the time when the statements were made. The Committee found it unlikely that Ms Z would have been confused when describing her actual practice at Dr. Noriega's office at the time of these respective visits. This speaks to the reliability of the statements made to Ms X and Ms Y.

The Committee also considered Ms X's evidence that when Ms Z told her that she would wait in the computer room during the consultations and that Dr. Noriega would call her into the room when the consultation was finished, Ms X clearly recorded this in her notes on the day of her visit and sent an email to the College to report on what Ms Z had told her. Similarly, the Committee considered Ms Y's evidence that when Ms Z advised her that, since Ms X's visit, she was also attending with Dr. Noriega for the consultations, Ms Y made clear and contemporaneous notes of the discussion.
The Committee considered the testimony of Ms X and Ms Y to be highly reliable in view of their experience as described to the Committee and their specific training in note taking. Both confirmed that their contemporaneous notes and memos from their visits to the Noriega office accurately summarize their visits. Both Ms X and Ms Y were clear and consistent in giving their evidence and there was no evidence presented of any motive that either would have to lie or report anything other than what they observed during their respective visits.

The Committee also considered Ms Z's evidence regarding her undertaking of the importance of the visits from the College. For example, on cross-examination by the College, Ms Z testified that, when Ms X visited, she knew Ms X was coming to check whether they were following the Undertaking and she knew the Undertaking had replaced the criminal bail conditions. Ms Z also agreed that she knew it was important at that time to be accurate in the information she was giving to her and that she did her best to be truthful in speaking with Ms X. Ms Z agreed that she wanted to be sure that Ms X had all

of the proper information so that she could evaluate whether the Noriega office was following the rules. The Committee found that Ms Z understood the importance of the visits from Ms X and Ms Y, which speaks to the reliability of the statements that she made to both Ms X and Ms Y.

After reviewing all of the evidence and applying the relevant case law, the Committee found that there is enough evidence of circumstantial guarantees of reliability present in this case to find that the statements made to Ms X and Ms Y by Ms Z are admissible for the truth of their contents. Thus, the Committee admits the evidence of Ms X and Ms Y regarding Ms Z's prior inconsistent statements for the truth of their contents.

**FINDINGS AND REASONS**

It is alleged that Dr. Noriega has committed an act of professional misconduct under section 1(1)(33) of Ontario Regulation 856/93, in that he engaged in an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The College has the burden of proving that Dr. Noriega engaged in professional misconduct. The Committee must decide whether, on the basis of the evidence before it, it is more likely than not that the conduct occurred. As stated by the Supreme Court of Canada in *F.H. v. McDougall*, [2008] S.C.J. No. 54, there is no sliding scale for the standard of proof in civil cases. Rather, there is only one standard of proof: proof on a balance of probabilities (i.e. whether it is more likely than not that an event occurred). This is very different from the standard of proof of "beyond a reasonable doubt" that is applied in a criminal proceeding. In all civil matters, regardless of the nature of the allegations, evidence must always be clear, convincing and cogent in order to satisfy the balance of probabilities test. Although the Committee takes into account the seriousness of the allegations and the consequences of a finding of liability, this does not alter the standard of proof.

**Issue #1 - Did Dr. Noriega fail to post the required sign in his waiting room?**

The Committee is satisfied that the evidence establishes on a balance of probabilities that Dr. Noriega failed to post the required sign in his waiting room. Ms X's evidence that the waiting room sign was not up when she performed her inspection of Dr. Noriega's office on February 10, 2010, was not challenged. Counsel for Dr. Noriega argued that what Dr. Noriega and his wife had done regarding the waiting room sign was reasonable. The Committee does not accept this submission. Rather, the Committee finds that it was Dr. Noriega's responsibility, pursuant to the Undertaking, to ensure that the sign was posted in the waiting room and does not consider the evidence that patients and their children took the sign down to be sufficient to relieve Dr. Noriega of the obligation to have the required sign posted in his waiting room.

**Issue #2 - Did Dr. Noriega fail to post the required sign in his examination rooms, including by covering up the required sign with another picture?**

The Committee is satisfied that the evidence establishes on a balance of probabilities that Dr. Noriega failed to post the required sign in his second examination room. Ms X's evidence that the sign in this room was covered up with a baseball picture when she performed her inspection of Dr. Noriega's office on February 10, 2010, was not challenged.

In fact, Dr. Noriega admitted that he covered up the sign. The Committee finds that Dr. Noriega interpreted the Undertaking to his own convenience with respect to his duty to post the signs, and finds that he chose to cover the signs up in breach of the Undertaking. The Committee also considered Dr. Noriega's testimony that, in his view, the covering up of the sign was not unprofessional. The Committee finds that Dr. Noriega deliberately disregarded the terms of the undertaking and interpreted the terms to suit his practice and to appease his humiliation. The Committee finds that Dr. Noriega's evidence and attitude regarding the signs shows a flagrant disregard for the terms of the Undertaking.

In Dr. Noriega's closing submissions, counsel argued that Dr. Noriega mistakenly and honestly believed that what he was doing in respect of the examination room sign was not prohibited. The Committee does not accept that this is a reasonable explanation in the circumstances. The wording of the Undertaking regarding the requirement to have a sign in examination rooms is clear. Moreover, in his testimony, Dr. Noriega said that before signing the Undertaking, he spoke with his lawyer and read and understood both the Undertaking and the Practice Monitor's Undertaking. The Committee does not accept that it was reasonable for a well-educated physician who completed training in Pediatrics, who has been in practice for the last 40 years and who had the benefit of legal advice regarding the Undertaking, to interpret the Undertaking as allowing him to cover up the examination room sign to appease his humiliation and suit his own convenience during examinations of male patients.

**Issue #3: Did Dr. Noriega fail to ensure the patient Log was properly maintained and stored?**

It is not in dispute that from July 2009 to June 2010, Ms Z obtained assistance from Ms A in writing the names of patients in the Log. It is also not in dispute that from July 2009 to June 2010, the Log was kept on Ms A's desk. The evidence before the Committee also establishes that the log was kept, as at the time of the hearing, at the Noriega office where Dr. Noriega and Ms A could access it. In addition, Dr. Noriega agreed that, according to his Undertaking, he was solely responsible for ensuring that his Practice Monitor complied with her obligations as defined in the Practice Monitor's Undertaking.

The Committee understands the requirement for the log and appreciates that the reason for maintaining the Log was to provide documentary proof to the College of the number of female patients seen each day and the presence of the Practice Monitor during Dr. Noriega's encounters with these patients. Although patient names were entered by Ms A and the Log was not properly secured, the College regularly received copies of the Log each month and there was no evidence of a general failure to comply with the requirement to keep the Log. As such, the main objective behind the requirement for the

Practice Monitor to "maintain" the Log was achieved. In addition, the duties to "maintain" the Log, as set out in the Undertaking, and the duties specified in the Practice Monitor's Undertaking are not specific enough to ground a finding of professional misconduct on the basis of the evidence as presented at the hearing.

The Committee finds that there was no evidence before it which established a breach by Dr. Noriega of an express provision in Dr. Noriega's Undertaking regarding the Log. In addition, the evidence showed that there was substantial compliance with the spirit of the Log requirements by the Practice Monitor. The Committee finds on this issue that there was not sufficient evidence to ground a finding of professional misconduct by Dr. Noriega.

**Issue #4: Did Dr. Noriega fail to ensure a chaperone was present throughout the entirety of his patient encounters between July 2009 and February 2010?**

The Committee finds that between July 22, 2009 and February 3, 2010, Dr. Noriega's Practice Monitor was not present for all of Dr. Noriega's encounters with female patients, in violation of term B(l) of the Undertaking.

As outlined above, the Committee admits the evidence of Ms X and Ms Y regarding Ms Z's prior inconsistent statements for the truth of the contents of the evidence. For the reasons set out above, the Committee also finds that this evidence regarding Ms Z's prior statements meets the test for ultimate reliability. This evidence is that Dr. Noriega was, at the time of Ms X's visit, seeing female patients for consultations without the presence of a practice monitor, as required by the Undertaking.

The Committee must, however, weigh this evidence against the conflicting evidence presented at the hearing by Dr. Noriega, Ms A and Ms Z. For the reasons set out below, the Committee accepts the evidence of Ms Z's prior inconsistent statements over Ms Z's evidence at the hearing and Ms A's and Dr. Noriega's evidence on this issue.

The Committee finds the evidence of Ms Z's prior statements to be clear, cogent and convincing and ultimately reliable. In contrast, the Committee finds Ms Z's evidence at the hearing regarding the practices in Dr. Noriega's office unreliable. When Ms Z was asked on cross examination to agree that she would have remembered what she was doing in February 2010 better in February 2010 when she spoke with Ms X than when she gave evidence at the hearing some 2.5 years later, Ms Z reluctantly said "I guess." In addition to Ms Z's own evidence and considering the time that had passed between the time period at issue (2009-2010) to the time of the hearing, the Committee considered Ms Z's evidence about Ms A and lawyers for Dr. Noriega speaking with her about her statements to Ms X and Ms Y prior to the hearing. The Committee also considered the inconsistent evidence of Ms Z regarding a number of changes which had been made at certain points in time to the system used at Dr. Noriega's office.

The Committee also considered the credibility of Dr. Noriega's evidence on this point. The Committee considered that Dr. Noriega's evidence at the hearing (that he did not see any patients in the consultation room at all during the time of Ms X's visit) was inconsistent with both versions of Ms Z's evidence (either, as set out in her prior statements, that at the time, Dr. Noriega saw all patients in the consult room before taking them to the examination room, or, in her testimony at the hearing, that Dr. Noriega only saw male patients in the consult room).

The Committee also finds that Dr. Noriega's evidence in respect of which patients he saw in which rooms at what times was inconsistent in that it differed in material ways at various points during his testimony. For example, on the issue of whether he saw any patients in the consultation room at the time of Ms X's visit, Dr. Noriega testified that after entering into his undertaking with the College in the summer of 2009, until April of 2010 his process was to do everything in the examination rooms. He testified that he was not using the consultation room during this time. In cross-examination, Dr. Noriega retracted the above time frame that he provided in direct examination. He stated that he could not pinpoint the exact dates of when he used the examination room only versus also

the consultation room, but nevertheless stated that at the time of Ms X's visit he was not seeing patients in the consultation room.

The Committee did not find Dr. Noriega's explanation for the changes he said he made to his usual practice following the Undertaking to be credible or believable. Dr. Noriega testified that his patients are very private people and that having Ms Z present in the consultation room and then following him into the examination room would simply be too much for them, at least until they were used to her. For this reason, Dr. Noriega testified that he thought he would try having the consultation and the examination performed all in one room (the examination room). However, Dr. Noriega could not remember when or for what period of time he made this particular change to his office procedure. He also could not articulate in a way that made sense to the Committee why this procedure (of eliminating use of the consultation room) would assist with his patients' privacy concerns when Ms Z was required to attend for the consultation and examination portions of the visit in any event, regardless of whether the visit took place in one room or two rooms.

The Committee also considered the evidence that Dr. Noriega did not correct the information the College had regarding the presence of the practice monitor in the consultation room with female patients when given the opportunity. The Committee did not find credible Dr. Noriega's evidence that he did not know this was an issue in light of the other evidence presented at the hearing.

The Committee finds that the inconsistencies and confusing explanations in Dr. Noriega's testimony were in regards to significant issues. The Committee did not find Dr. Noriega's evidence regarding whether he was seeing female patients in the consultation room at the time of Ms X's visit and whether Ms Z was attending with him during consultations with female patients at that time credible.

Therefore, the Committee finds that Dr. Noriega breached the Undertaking by failing to ensure his practice monitor was present throughout the entirety of his patient encounters with female patients between July 2009 and February 2010.

**Issue #5: Did Dr. Noriega mislead the College's compliance investigator in February 2010 when he told her that he does not see female patients in the consultation room?**

For the reasons set out above, the Committee has accepted the evidence of Ms Z's prior statements to Ms X and Ms Y, that Dr. Noriega was seeing female patients in the consultation room without her being present at the time of Ms X's visit in February 2010. For the reasons set out above, the Committee did not find Dr. Noriega's evidence on this point credible. Accordingly, the Committee finds that Dr. Noriega misled the College's compliance investigator in February 2010 when he told her that he does not see female patients in the consultation room.

**CONCLUSION**

A fundamental aspect of the College's ability to govern itself is its ability to trust that its members will abide by their undertakings. In contrast, Dr. Noriega took a cavalier approach to the Undertaking. He adapted terms of the Undertaking to appease his "humiliation" over the process. He modified terms to suit his own interest and convenience. He compromised the College's ability to monitor his compliance with the undertaking. At the hearing, he failed to see his admitted breaches as unprofessional. The Committee finds the College has met the standard of proof and has demonstrated on a balance of probabilities that Dr. Noriega engaged in professional misconduct based on the following failures to comply with the Undertaking:

- Dr. Noriega failed to post the required sign in the waiting room, which includes the obligation to take reasonable steps to ensure that the sign remains posted;

- Dr. Noriega failed to post the required sign in an examination room, including covering up the required sign with a framed picture;
- Dr. Noriega failed to have a chaperone present throughout the entirety of his patient encounters between July 2009 and February 2010; and
- Dr. Noriega misled the College's compliance investigator in February 2010 when he told her that he doesn't see female patients in the consultation room.

The Committee finds Dr. Noriega has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee directs the Hearings Office to schedule a penalty hearing in this matter.

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Eleazar Humberto Noriega, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that would disclose the identity of the patients whose names are disclosed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

**Indexed as: Noriega, E. H. (Re)**

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

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

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. ELEAZAR HUMBERTO NORIEGA**

**PANEL MEMBERS:**

**DR. P. CHART**
**D. GIAMPIETRI**
**DR. S. BODLEY**
**DR. E. ATTIA (Ph.D.)**
**DR. A. SHARMA**

| | |
|---|---|
| **Penalty Hearing Date:** | **May 27, 2013** |
| **Penalty Decision Date:** | **July 17, 2013** |
| **Release of Written Reasons:** | **July 17, 2013** |

# PUBLICATION BAN

## PENALTY AND REASONS FOR PENALTY

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written decision and reasons on finding in this matter on February 28, 2013, and found that Dr. Eleazar Humberto Noriega has committed an act of professional misconduct, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee heard evidence and submissions on penalty on May 27, 2013, and reserved its decision.

## EVIDENCE AND SUBMISSIONS ON PENALTY

*The Committee's Decision of February 28, 2013*

In 2009, Dr. Noriega was referred to the Discipline Committee for allegations including sexual abuse and sexual impropriety. On July 22, 2009, Dr. Noriega entered into an undertaking (the "Undertaking") with the College, which included a prohibition from engaging in any professional encounters with female patients except in the presence of his practice monitor, and a requirement to post a sign in his waiting room and each of his examination rooms notifying the public of his practice restrictions.

The issues on the hearing giving rise to the Committee's decision of February 28, 2013 included:

- whether Dr. Noriega failed to post the required sign in his waiting room and in his examination room;
- whether Dr. Noriega failed to ensure that a chaperone was present during the entirety of his female patient encounters between July 2009 and February 2010; and
- whether Dr. Noriega misled the College investigator in February 2010 when he told her that he did not see female patients in the consultation room.

In the Committee's decision of February 28, 2013, the Committee concluded, among other things, as follows:

- Dr. Noriega failed to ensure that the required sign was posted in his waiting room. In addition, Dr. Noriega failed to post the required sign in his second examination room as the sign was covered up with a picture. The Committee did not accept that Dr. Noriega mistakenly and honestly believed that what he did with the signs was not prohibited. Rather, the Committee concluded his actions were deliberate and demonstrated a flagrant disregard for the terms of the Undertaking.

- The Committee concluded that Dr. Noriega was in breach of his Undertaking by failing to ensure his practice monitor was present with him in the consultation room when he had encounters with female patients. Dr. Noriega understood that the College was concerned about protecting the public in the face of serious allegations, yet he modified the terms of the undertaking to suit his own interest and convenience. This compromised the College's ability to fulfill its mandate. Simply put, the public places great trust in the medical profession and in its ability to self-govern. Dr. Noriega's actions undermined that trust.

- The Committee found that Dr. Noriega mislead the College investigator when he told her that he did not see female patients in the consultation room.

The foregoing findings are serious as they go to the heart of the governance of the profession. To protect the public, the College must be able to rely upon undertakings made by its members. Accordingly, the penalty must be commensurate with the seriousness of the findings.

*Positions of the Parties on Penalty*

There was no dispute between the parties that a reprimand should be an integral part of the penalty order. The parties also agreed that a suspension of the member's certificate of registration should be ordered, but differed on the length of the suspension. The College proposed a nine month suspension and counsel for Dr. Noriega proposed a two to three

month suspension. Both parties presented case law in support of their respective submissions.

*Evidence on Penalty*

The Committee received in evidence a brief of reference letters in support of Dr. Noriega and a copy of a prior discipline Committee decision concerning Dr. Noriega before the College dated November 24, 2003.

**DECISION AND REASONS ON PENALTY**

As stated above, the foregoing findings are serious as they go to the heart of the governance of the profession. Having regard to the evidence, the submissions of the parties and the case law to which the parties referred, the Committee has concluded that a suspension of six months is appropriate. The Committee's reasons for its decision are as follows.

*Penalty Principles*

In making its penalty decision, the Committee accepts that a reprimand by a professional's governing body can be a significant punishment. A reprimand in this matter is fully supported by the nature of the misconduct.

In addition, it is clear that a suspension of the member's certificate of registration is warranted in this case and both College counsel and counsel for Dr. Noriega submitted that a suspension was appropriate. The only issue was the length of the suspension.

The Committee has concluded that a six month suspension of Dr. Noriega's certificate of registration is the appropriate penalty in this case for the reasons set out below.

Both the reprimand and a six month suspension of Dr. Noriega's certificate of registration address the principles of specific and general deterrence.

This penalty will demonstrate to the member and the membership that disregard for an undertaking given by a member to the College will be dealt with severely. The public will

be protected by the strong and clear message that disregard of a College undertaking is a serious act of professional misconduct which calls for a significant penalty.

*Aggravating and Mitigating Factors*

The Committee accepted as an important aggravating factor that Dr. Noriega had been before the Discipline Committee in the past (exhibit #16). On November 24, 2003, Dr. Noriega pleaded no contest to allegations of sexual abuse and disgraceful, dishonourable or unprofessional conduct. A plea of no contest means that the Discipline Committee can accept the facts alleged against a member and that those facts constitute professional misconduct. The hearing proceeded by way of a statement of facts which was accepted by the Discipline Committee in that case, and sexual abuse and disgraceful, dishonourable or unprofessional conduct were both found. These were serious findings and the Committee would reasonably anticipate that Dr. Noriega would be all the more careful in abiding by the restrictions on his practice that he agreed to in July 2009 by way of his Undertaking.

Furthermore, when Dr. Noriega signed the Undertaking with the College on July 22, 2009, he was aware of further allegations against him of a serious nature and the reasons why the College was concerned about his female patients. His subsequent failure to have a chaperone with him at all encounters with female patients undermined the requirement put in place to ensure patient safety.

It is difficult to understand any misinterpretation of the Undertaking as the wording is specific with respect to both signage and the need for monitoring. The purpose and intent are clear, yet Dr. Noriega did not fully comply. The Committee found that Dr. Noriega deliberately disregarded the Undertaking.

Counsel for Dr. Noriega asked that the letters of reference (exhibit #17) be accorded consideration as a mitigating factor. It was pointed out that those submitting character reference letters were aware of these proceedings and supported Dr. Noriega in any event. There is no doubt that Dr. Noriega is perceived by some of his patients as gentle, respectful, empathetic and dedicated. However, whether Dr. Noriega was meeting and/or exceeding his patient’s expectations more generally must be given little weight, in the

opinion of the Discipline Committee, when determining the penalty for the deliberate and serious breach of an undertaking made to the College.

The Committee was informed that after becoming aware of the College's concern, Dr. Noriega changed his office practice to comply completely with the terms of his Undertaking. The Committee does not consider this to be a mitigating factor. These were steps that Dr. Noriega was required to take from the outset.

*Case Law*

Both parties referred to a number of prior decisions of the Discipline Committee in support of their respective submissions. The range of suspensions in those cases varied between two and ten months. While the Committee is not bound by other decisions of the Discipline Committee, it considers that consistency in decisions of the Discipline Committee is desirable.

The Committee reviewed all of the cases submitted by the parties. A brief review of some of the cases is as follows:

*Deluco (Re), [2005] O.C.P.S.D. No.10*

This case has some similarities to the Dr. Noriega matter, in that the *Deluco* matter included deliberate and flagrant violations of a section 37 order requiring a chaperone for the examination of female patients, putting patients at risk. The penalty included a six month suspension.

*Sweet (Re), [2008] O.C.P.S.D. No. 12*

The issues in *Sweet* were related to narcotic prescribing and abiding by appropriate signage. A two month suspension was ordered.

*Pyne (Re), [2004] O.C.P.S.D. No. 41*

The Committee considered the case of *Pyne,* but found the decision to be of little relevance to the matter to be decided. Dr. Pyne was clearly severely clinically deficient

and continued to practice, putting patients at risk of harm and contravening a direction from the Quality Assurance Committee. A ten month suspension was ordered.

*Gay (Re), [2005] O.C.P.S.D. No.2*

The Committee considered the *Gay* matter which also related to aspects of clinical practice and breach of an undertaking. This case proceeded by an agreed statement and admission. The penalty was a two month suspension and a number of terms were imposed to achieve safe practice. A minority opinion took issue specifically with the length of the suspension and indicated that in the minority's view, the penalty should have been a six month suspension.

*Wu (Re), [2009] O.C.P.S.D. No. 8*

In *Wu*, the misconduct was serious and involved clinical care of patients. The issues were different than in the Dr. Noriega matter and there were a number of mitigating circumstances. A six month suspension was ordered, which was reduced by two months contingent on an educational condition. This case was illustrative in demonstrating the principle that a serious penalty is appropriate for a serious breach.

*Conclusion*

After careful consideration, the Committee's decision is that a six month suspension of the member's certificate of registration is appropriate taking into account the facts in this case. The Committee has concluded that this penalty meets the appropriate penalty principles and is consistent with prior decisions of the Discipline Committee, recognizing that each case is decided on its own unique facts.

**ORDER**

The Discipline Committee therefore orders and directs that:

1. The Registrar suspend Dr. Noriega's certificate of registration for a period of 6 (six) months. The date of commencement of the suspension shall be 30 days after the date of release of this decision.

2. Dr. Noriega attend before the Committee to be reprimanded.

The parties are directed to submit their position in writing to the Discipline Committee through the Hearings Office on an appropriate costs award within 30 days.