

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Assefa Fersha Noza, this is notice that the Discipline Committee ordered that no person shall publish the name and any information that could disclose the identity of the patient referred to orally or in the exhibits filed 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 ... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Noza,
2019 ONCPSD 19**

**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. ASSEFA FERSHA NOZA

PANEL MEMBERS:

**MR. P. GIROUX
DR. P. CASOLA
MR. M. KANJI
DR. R. SMITH
DR. M. DAVIE**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. SIMMY DHAMRAIT

COUNSEL FOR DR. NOZA:

**MS. JENNY STEPHENSON
MS. LEAH OSTLER**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. GIDEON FORREST

**Hearing Date: March 27, 2019
Decision Date: March 27, 2019
Written Decision Date: May 10, 2019**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on March 27th, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Noza committed an act of misconduct in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

THE ALLEGATION(S)

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

1. under clause 51(1)(b. 1) of the Health Professions Procedural Code which is schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c.18 (the "Code") in that he engaged in sexual abuse of a patient; and
2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has engaged in 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 THE ALLEGATIONS

Dr. Noza entered a plea of no contest with respect to the second allegation in the Notice of Hearing, that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the first allegation in the Notice of Hearing.

THE FACTS

The following facts were set out in a Statement of Uncontested Facts on Liability, which was filed as an exhibit and presented to the Committee:

A. BACKGROUND

1. Dr. Assefa Fersha Noza (“Dr. Noza”) is a sixty-two (62) year old physician, practising family medicine in Etobicoke, Ontario. Dr. Noza received his certificate of registration authorizing independent practice on December 6, 2001.
2. Dr. Noza is a member of the Humber River Family Health Team (“Humber River FHT”). At all relevant times, Dr. Noza practised at the Humber River FHT clinic site in Etobicoke.

B. PATIENT A: DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

3. Patient A was a patient of Dr. Noza between 2013 and 2016.
4. In May 2016, Dr. Noza saw Patient A for a periodic health examination. At this appointment, Patient A underwent a blood test and a urine test.
5. Upon receiving Patient A’s blood and urine test results, Dr. Noza’s secretary called Patient A and told her that the doctor wanted to see her for a follow-up appointment.
6. Patient A saw Dr. Noza to discuss her results. Patient A’s urine culture was positive for Group B Beta Hemolytic Streptococcus. Dr. Noza discussed this with Patient A and asked her whether she had been experiencing any symptoms related to a urinary tract infection. Patient A told Dr. Noza that she did not have any problems. Dr. Noza told Patient A that if she did experience any issues she could return to see him. Patient A then left the clinic.
7. A short time later on the same day, Patient A remembered that she had been experiencing heavy vaginal bleeding for the past few days but she had forgotten to mention this to Dr. Noza. Patient A returned to Dr. Noza’s clinic and asked the secretary to see him again. The secretary placed Patient A into an examination room and Dr. Noza saw Patient A for a second time that day.
8. Patient A told Dr. Noza about her heavy vaginal bleeding. Dr. Noza told Patient A to lay down on the examination table.

9. Dr. Noza first palpated Patient A's abdomen and asked whether she had any pain. Without adequately explaining, Dr. Noza then told Patient A to pull down her underwear. She was not offered a drape or gown. Dr. Noza put on a glove and conducted a vaginal examination.

10. Patient A was not expecting Dr. Noza to conduct a vaginal examination. Dr. Noza had never conducted a vaginal examination of Patient A. In the past, only Dr. Noza's female staff had conducted pap smears for Patient A.

11. Following the examination, Dr. Noza told Patient A to get dressed and return to see him if she had any continuing concerns.

12. Prior to conducting the vaginal examination, Dr. Noza failed to:

- Advise Patient A that he was going to conduct a vaginal exam;
- Explain to Patient A the reason for the exam and what the exam would involve;
- Obtain Patient A's informed consent before proceeding;
- In accordance with his usual practice, ascertain whether Patient A wanted a chaperone present in the room; and
- Provide Patient A with proper draping or a gown.

13. As a result, Patient A felt confused and upset.

14. Dr. Noza did not make any notes in Patient A's medical chart of her having returned to see him for a second time. He failed to document her concerns about vaginal bleeding and failed to document the physical and vaginal examination.

PART II: PLEA OF NO CONTEST

15. Dr. Noza does not contest the facts set out in paragraphs 1-14 above, and does not contest, for the purposes of the College proceedings, that he engaged in professional misconduct, in that:

- a) he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as

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

FINDING

As noted above, Dr. Noza has entered a plea of no contest. Under Rule 3.02 of the Rules of Procedure of the Discipline Committee, where a member enters a plea of no contest, the member consents to the following:

- (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purpose of the College proceeding only;
- (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purpose of College proceedings only; and
- (c) that the Discipline Committee can dispose of the issues of what finding ought to be made without hearing evidence.

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts on Liability. Having regard to these facts, the Committee found that Dr. Noza committed an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

AGREED STATEMENT OF FACTS ON PENALTY

The following Agreed Statement of Facts on Penalty was filed as an exhibit and presented to the Committee.

A. Undertaking in lieu of the s. 25.4 Order

1. On April 30, 2018, Dr. Assefa Fersha Noza (“Dr. Noza”) entered into an interim undertaking to the College in lieu of an Order under section 25.4 of the Health Professions Procedural Code, Schedule 2 to the Regulated Health Professions Act, S.O. 1991, C-18. The undertaking is attached at Tab 1 to the Agreed Statement of Facts on Penalty.

No concerns regarding Dr. Noza's compliance with the interim undertaking have been identified by the College's compliance monitor.

Dr. Noza's Undertaking: March 27, 2019

2. Dr. Noza has entered into an undertaking to the College, effective March 27, 2019, by which he has agreed, among other things, that he will not conduct any breast, pelvic or rectal examination of any patient, of any age, in any jurisdiction, unless the examination takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College. The undertaking is attached at Tab 2 to the Agreed Statement of Facts on Penalty.

Prior History

3. On May 14, 2015, the Inquiries, Complaints and Reports Committee (the "ICRC") issued a written caution to Dr. Noza with regard to professional communication. The ICRC also directed a Specified Continuing Education or Remediation Program (a "SCERP") which required Dr. Noza to complete one-on-one instruction on communication, and engage in self-directed learning by writing a report reflecting on how he has changed his communication technique. A copy of the ICRC decision is attached at Tab 3 to the Agreed Statement of Facts on Penalty.

4. Dr. Noza has no prior history with the Discipline Committee.

AGREEMENT AS TO PENALTY

5. The parties agree that the appropriate penalty in this matter is set out in the draft Order filed at this hearing.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order, which included: suspending Dr. Noza's certificate of registration for a period of three months; imposing terms, conditions and limitations on Dr. Noza's certificate of registration; a public reprimand; and payment of costs to the College in the amount of \$6,000.00.

The Committee is aware that a joint submission on penalty should be accepted unless doing so would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony Cook*, 2016 SCC 43).

In assessing the appropriateness of the penalty proposed, the Committee considered the applicable penalty principles. First and foremost, an appropriate penalty must protect the public. The penalty should be a specific deterrent to the member by discouraging such misconduct in the future, and a general deterrent to the broader profession. An appropriate penalty should also maintain the integrity of the profession and the public's confidence in the College's ability to regulate the profession in the public interest. Where applicable, the penalty should also provide for the rehabilitation of the member.

Aggravating Factors

Nature of the Misconduct

Central to the physician-patient relationship is effective communication. When obtaining a patient's informed consent, physicians must explain the rationale for their clinical actions in advance of the proposed procedure. This allows the patient to prepare for the procedure and provide his or her informed consent for the physician to proceed.

Dr. Noza conducted a vaginal examination of Patient A without explanation, causing Patient A to feel confused and upset. Dr. Noza's inappropriate and insensitive approach was further confounded by the fact that he examined Patient A without proper draping or gowning. It is the physician's responsibility to ensure that appropriate boundaries are always maintained. Dr. Noza failed to do so, thereby undermining public trust in the profession.

The Committee also considered it to be an aggravating factor that Dr. Noza was previously cautioned by the ICRC regarding professional communication. While the circumstances involved were different, the fact remains that Dr. Noza was previously cautioned by the College about the importance of communicating professionally.

Dr. Noza did not make any notes of Patient A's second visit on that day regarding her complaints

of vaginal bleeding or of the physical and vaginal examination he performed. Good medical record-keeping is fundamental to providing quality medical care. The medical record provides a comprehensive detailed history of the patient's medical history which in turn optimizes future clinical encounters. Conversely, for the physician, complete and accurate medical records are a powerful tool to support clinical decision-making, enhanced communication, and to facilitate continuity of care. Dr. Noza is responsible for ensuring all patient encounters are documented. It is very concerning to the Committee that Dr. Noza failed to document this second encounter.

Mitigating Factors

Dr. Noza has no prior history before the Discipline Committee. By entering a plea of no contest, Dr. Noza saved the time and expense of a contested hearing, and spared witnesses from having to attend and testify. Further, Dr. Noza has complied with the interim undertaking he entered into on April 30, 2018 requiring that he engage in professional encounters with patients only in the presence of a monitor.

Prior Cases

Counsel presented a joint book of authorities, which included three prior similar cases: *CPSO v. Wilson* (2016), *CPSO v. Choptiany* (2011), *CPSO v. Heymans* (2018).

In *CPSO v. Wilson* (2016), Dr. Wilson did not adequately explain the pelvic and breast examination that he conducted on Patient A and therefore did not obtain her informed consent. Further, Dr. Wilson did not provide Patient A with adequate draping. Dr. Wilson's actions made Patient A feel exposed and vulnerable. The Committee's order included a four month suspension, a public reprimand and terms, conditions, and limitations on Dr. Wilson's certificate of registration, including the requirement for a practice monitor.

In *CPSO v. Choptiany* (2011), the Committee found that Dr. Choptiany engaged in disgraceful, dishonourable, or unprofessional conduct in relation to his lack of communication, inappropriate comments, and failure to maintain spatial boundaries with patients. The Committee ordered a two month suspension, as well as terms, conditions, and limitations on his certificate of registration, including requiring that he have a practice monitor for patient encounters and office

signage.

In *CPSO v. Heymans* (2018), Dr. Heymans conducted a breast examination on Patient A. He did not explain why he was conducting the exam, nor the steps involved. Dr. Heymans did not ascertain whether Patient A had consented to the examination. The Committee ordered a three month suspension, and terms, conditions and limitations on Dr. Heymans' certificate of registration, including a practice monitor for all professional encounters.

While every case must be determined on its facts, the Committee is of the view that the cases presented by counsel are similar to this case on their material facts. The Committee is cognizant that like cases should be treated alike. The Committee is satisfied that the proposed penalty is in keeping with the range of penalties in prior similar discipline cases.

Conclusion

The Committee accepted the parties' joint submission on penalty as an appropriate penalty in the circumstances of this case. The three month suspension and public reprimand act as specific deterrents to Dr. Noza and general deterrents to the broader profession, sending a strong message that this type of misconduct is not tolerated. The terms, conditions and limitations on Dr. Noza's certificate of registration, such as training in ethics and boundaries, will provide for Dr. Noza's rehabilitation and serve to protect the public.

ORDER

The Committee stated its finding in paragraph 1 of its written order of March 27, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. The Registrar suspend Dr. Noza's Certificate of Registration for a three (3) month period effective immediately.
3. The Registrar impose the following terms, conditions and limitations on Dr. Noza's Certificate of Registration:

- (i) Dr. Noza shall comply with the College's Policy #2-07, "Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation," attached the Order as Schedule "A";
 - (ii) Dr. Noza shall successfully complete the PROBE Ethics and Boundaries Course ("PROBE course"), at his own expense, within twelve (12) months of the date of this Order. Dr. Noza will agree to abide by the recommendations of the PROBE course and provide proof of completion to the College;
 - (iii) Dr. Noza shall inform the College of each and every location where he practices, in any jurisdiction ("Practice Location(s)") within five (5) days of commencing practice at that location;
 - (iv) Dr. Noza shall be responsible for any and all fees, costs, and expenses, associated with implementing and fulfilling the terms of the Order; and
 - (v) Dr. Noza shall provide irrevocable consent to the College to make appropriate enquiries of OHIP and/or any person or institution that may have relevant information, in order for the College to monitor compliance with this Order.
4. Dr. Noza appear before the panel to be reprimanded.
 5. Dr. Noza pay costs to the College in the amount of \$6,000.00 within thirty (30) days of the date of this Order.

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

TEXT of PUBLIC REPRIMAND
Delivered March 27th, 2019
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. ASSEFA FERSHA NOZA

Dr. Noza,

We are dismayed that you are appearing before us today. While you have not been the subject of a discipline matter previously, you have received a written caution and have been directed to a specified education or remediation program, a SCERP, with respect to professional communication.

However, your efforts in this regard still fall short of professional standards. Although the vaginal examination was appropriate in this case, it was performed in an inappropriate fashion, and in a manner that lacked judgment. This resulted in a violation of the patient's dignity and privacy, and was contrary to the standards that have already been established in your practice.

It is imperative that patients are shown the respect due to them by seeking informed consent to an examination, providing the reason for the examination, providing a gown and privacy to change into it, along with modest draping to conduct a proper exam with minimal exposure. Failure to undertake these steps brings the medical profession into disrepute and undermines the public trust therein.

We hope that you will learn from this experience, and you will not appear before a panel again.

You may be seated.