

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Ruggiero, this is notice that the Discipline Committee ordered that the Discipline Committee ordered that no person shall publish or broadcast the identity of any of the patients or the complainant, or any information that could disclose the identity of the patients or the complainant, 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.

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: **Ontario (College of Physicians and Surgeons of Ontario) v. Ruggiero, 2016
ONCPSD 28**

**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. DONATO ANTHONY RUGGIERO

PANEL MEMBERS:

**DR. C. CLAPPERTON (CHAIR)
MR. S. BERI
DR. E. STANTON
DR. E. ATTIA
DR. T. MORIARITY**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

**MS. M. KELLYTHORNE
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COUNSEL FOR DR. RUGGIERO:

**MS. J. STEPHENSON
MS. R. ZATZMAN**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

PUBLICATION BAN

Hearing Dates:	January 4 to 6, 2016 and February 1, 2016
Decision Date:	August 23, 2016
Release of Written Reasons:	August 23, 2016
Appeal:	Dr. Ruggiero appealed the decision on October 31, 2016

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto from January 4 to 6, 2016 and on February 1, 2016. At the conclusion of the hearing, the Committee reserved its finding.

ALLEGATION

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

1. under paragraph 27.29 of Ontario Regulation 448/80 (“O. Reg. 448/80”), made under the Health Disciplines Act, R.S.O. 1980, c. 196, in that he engaged in sexual impropriety with a patient.

RESPONSE TO THE ALLEGATION

Dr. Ruggiero denied the allegation that he committed an act of professional misconduct in that he engaged in sexual impropriety with a patient.

THE ISSUE

The allegation of professional misconduct for sexual impropriety in this case arises from alleged conduct by Dr. Ruggiero in relation to his patient, Patient A, in approximately 1986.

The issue to be decided is whether Dr. Ruggiero engaged in sexual impropriety with a patient by placing his penis in Patient A’s vagina during a medical appointment in his office in approximately 1986, when she was in her late teens. Dr. Ruggiero denied that he engaged in such conduct. However, Dr. Ruggiero does not contest that, if the conduct happened as alleged, such conduct would amount to sexual impropriety with a patient.

BACKGROUND

Dr. Donato Ruggiero is a 70-year old family physician who immigrated to Canada from a small town in Italy in 1955 with his family. He has practised medicine since 1973 and received his medical degree from the University of Toronto in 1970. He did some additional training in internal medicine and cardiology. In 1981, he began working at his office located at 1223 St. Clair Avenue West, having previously been at another office at 1670 Dufferin Street. He also had an office in Woodbridge. As of 1981, he had a solo practice and saw patients of all ages.

By 1986, Dr. Ruggiero had a busy practice treating mainly Italian-speaking patients. His office was open six days a week and he saw between 70 and 80 patients a day, working from 8:30 or 9:30 in the morning until 9:00 or 9:30 at night.

Ms. Mary Marchesani is Dr. Ruggiero's current full-time secretary. Except for a 15-month maternity leave beginning in June 1984, she has worked for Dr. Ruggiero consistently since 1980.

Dr. Ruggiero had high school students as part-time help in the 1980s, including Ms. Sarah Spano. Dr. Ruggiero stated that the students would arrive at his office after 3:30 p.m. and would "write up" his charts. To do this, Dr. Ruggiero testified, the part-time high school students would sit at his desk in his office's consultation room, accessible via pocket doors from Examination Rooms 2 and 3, between 6:00 and 8:00 p.m. "Writing up" charts meant that after Dr. Ruggiero made some brief written notes, which were not very legible, the students would use a template and turn his notes into sentences in the patient charts.

Overview of the Evidence

The Committee heard the testimony of Patient A, Mr. Paul Lobsinger (a College investigator), and Ms. Sarah Spano (one of the part-time high school students) on behalf of the College. The Committee heard the testimony of Dr. Ruggiero, Ms. C (the

patient's mother), Ms. Mary Neves (a part-time employee), Mr. Felice Battista (office building owner), and Ms. Mary Marchesani (Dr. Ruggiero's secretary) on behalf of Dr. Ruggiero. The Committee also heard the evidence of Dr. Ashley Bender, who was called as an expert witness on behalf of Dr. Ruggiero. Various exhibits were filed, including photographs and diagrams of Dr. Ruggiero's office and examining rooms.

No medical charts, appointment books, OHIP records or laboratory records documenting Patient A's office visits to Dr. Ruggiero were filed as exhibits in this hearing. This was because OHIP does not keep records for more than seven years, and laboratories do not maintain records of results from decades ago. Dr. Ruggiero destroys his medical records after 10 to 15 years if he is not aware of a reason to retain them. In this case, Dr. Ruggiero testified that he believes these records were destroyed in around 2000.

THE EVIDENCE

Evidence of Patient A

Patient A first saw Dr. Ruggiero in or about 1986 when she was in her late teens. She was employed as a secretary at a local business at the time. Patient A had two older siblings.

Patient A did not have a family doctor of her own, but Dr. Ruggiero was her mother's family doctor. Patient A had upper abdominal pain and nausea, and her mother recommended she see Dr. Ruggiero. She recalled three appointments but could not provide the dates of the appointments.

Patient A's Recollection of Dr. Ruggiero's Office Layout

Patient A described the layout of Dr. Ruggiero's office as she recalled it when she was his patient in approximately 1986. She indicated that Dr. Ruggiero's office was located on the second floor of an office building. She recalled that chairs were located on both sides of the waiting area.

Patient A was presented with several of photographs of the office as it appears today. She testified that, unlike today, there had not been glass around the window to the receptionist's desk in the reception area in 1986 (corroborated by the evidence of Dr. Ruggiero). To the right of the low wall, Patient A remembered that there was an open door to the examining area.

She was also shown a picture of Examination Room 3. She testified that a bookcase in the photo was not present when she saw Dr. Ruggiero. She said that if the bookcase was taken away, Examination Room 3 would look the same as it was when she saw Dr. Ruggiero. Dr. Ruggiero later confirmed that the bookcase was not present in 1986.

Patient A recalled only one door which she used to enter the examination room from the hallway. She could not recall a pocket door between Dr. Ruggiero's consultation room and Examination Room 3. She recalled using a step stool to get on the examination table which had drawers in it. However, she could not recall whether there was an extension on the examination table.

Patient A's First Appointment

Patient A testified that she attended the first appointment with her mother who was present with her in the examination room. At this appointment, Dr. Ruggiero took a history and ordered an x-ray. Under cross-examination, Patient A testified that, if Dr. Ruggiero had examined her at that first appointment, he would have just touched her stomach to see where it was hurting her. She testified that there was nothing unusual or unexpected during the first appointment.

Patient A's Second Appointment

Patient A was also accompanied by her mother at her second visit to Dr. Ruggiero. Dr. Ruggiero showed Patient A her actual x-ray, and she testified that she could see a "hole in her stomach." Dr. Ruggiero told her that it was an ulcer. He prescribed Cimetidine and gave Patient A a pamphlet indicating which foods to eat and avoid. Patient A testified that there was nothing unusual or unexpected during the second appointment.

Patient A's Third Appointment

Because her abdominal pain persisted, Patient A made a third appointment to see Dr. Ruggiero. While she could not recall the month or day of this appointment, she remembered that it was in the winter and that it was very cold, with the wind blowing the snow. Patient A described in detail what she was wearing, which included a long red coat. She testified that she believed the appointment would have been between 4:00 and 5:00 p.m. because she always made her appointments for the afternoon and because she had taken the rest of the day off work. Her mother did not accompany her this time.

Patient A testified that when Dr. Ruggiero saw her in the examination room (Examination Room 3), she thought that Dr. Ruggiero would just touch her stomach. Patient A testified that she did not recall Dr. Ruggiero telling her that he was going to do an internal or vaginal examination. She testified that she believed that there was no reason for Dr. Ruggiero to do a vaginal examination. She testified that she was only there to see Dr. Ruggiero three times "just for my ulcer and that alone."

Patient A recalled that, after telling her to take everything off from the waist down, Dr. Ruggiero left the room.

After she removed her clothing, she lay down on the examining table. Patient A did not believe that Dr. Ruggiero provided her with a drape or gown, but under cross-examination, she acknowledged that there may have been a disposable paper drape or gown.

Patient A testified that Dr. Ruggiero knocked on the door and reentered the examination room. For the duration of the time she was in the examination room, Patient A testified that the door to the examination room was shut.

Dr. Ruggiero then instructed Patient A to move down the table so that she could put her feet in the stirrups.

She recalled Dr. Ruggiero “rummaging through stuff.” She described hearing “some noises” that sounded like they were made by plastic or paper. She testified that although she assumed Dr. Ruggiero was putting on gloves, she did not observe him putting gloves on his hands.

Dr. Ruggiero then asked Patient A to move further down the table. She testified that Dr. Ruggiero was now standing at the foot of the examination table in front of her.

Patient A testified that “something did not feel right” and that she tried to raise herself up to see what was happening at the end of the table, but that Dr. Ruggiero told her to lie back down. She testified that there was no cloth or material covering her knees.

Patient A testified that when she tried to sit up for a second time, she saw that Dr. Ruggiero’s pants were unzipped and that he was wearing a beige condom on his penis. She testified that she saw that his penis was halfway inside her vagina. She testified that she felt Dr. Ruggiero’s penis “going in and out” of her vagina. She did not see Dr. Ruggiero putting on or taking off the condom.

She testified that she heard Dr. Ruggiero “moaning” during the incident. However, she acknowledged in cross-examination that, prior to a December 15, 2015 meeting with Mr. Hickey (a College investigator) and Ms. Kellythorne (College counsel), she had never mentioned the moaning, either in her December 11, 2013 letter of complaint to the College or during her February 20, 2014 interview with Mr. Lobsinger and Mr. Hickey. Patient A also acknowledged that she did not refer to Dr. Ruggiero’s moaning in either follow-up telephone call with Mr. Lobsinger on April 21, 2014 and May 20, 2014. Patient A testified that she did not know why she did not mention the moaning before December 15, 2015.

Patient A testified that she rose for a third time to again try and see what was going on, but that Dr. Ruggiero again told her to lie down.

She testified that Dr. Ruggiero was calm, and that Dr. Ruggiero made no come-ons, sexual comments, or comments about her appearance during the encounter.

After Dr. Ruggiero “was done,” Patient A testified that he told her to get dressed. She testified that Dr. Ruggiero then left the room.

Patient A could not recall how long the incident lasted, but she testified that “it seemed forever.” She agreed that she told the College investigators that it might have lasted a half hour. She testified that, during the incident, she “wanted to scream, but it just didn’t come out.” She also testified that the office was busy the day of the incident.

Patient A testified that after she got dressed, she left Dr. Ruggiero’s office and walked towards the bus stop. She recalled that a woman walking by looked at her in a “weird” way. Patient A testified that it was then that she realized she had been holding her winter coat in her hands and she had not put it on.

Patient A testified that she got on the bus and went straight home. When she got home, she told her mother what Dr. Ruggiero had done to her. Patient A testified that, when she was telling her mother about the incident with Dr. Ruggiero, she had expressed to her mother that Dr. Ruggiero had “raped” her, and not that Dr. Ruggiero had performed a vaginal examination. The Committee was cognizant of the fact that Patient A having told this to her mother cannot be used to bolster her credibility.

Under cross-examination, Patient A acknowledged that her mother initially questioned whether the incident she had described had in fact taken place. However, Patient A testified that her mother eventually did believe her. The Committee did not consider the issue of whether Ms. C believed Patient A to be relevant to what happened during the appointment.

Patient A testified that her mother then spoke to Dr. Ruggiero about the incident.

Patient A testified that she did not report Dr. Ruggiero to the police, the College, or any other authorities because she thought no one would believe her. She testified that she had talked to a friend who worked for a lawyer who dealt with family law. That lawyer referred her to another lawyer whose name Patient A could not recall. She testified that this lawyer told Patient A that hers would be a tough case to win.

Patient A testified that she had never had sex with anyone prior to the incident with Dr. Ruggiero.

Patient A acknowledged that she had told Mr. Lobsinger that, prior to seeing Dr. Ruggiero, she had never had a vaginal examination. However, she did acknowledge that, when she was thirteen, Dr. B had performed a “pretty quick” vaginal examination after the store owner incident, referred to below, that did not involve the use of a speculum.

Patient A also testified that she knew Dr. Ruggiero did not use a speculum in her vagina because she knew what a speculum put in her vagina felt like from subsequent vaginal examinations utilizing a speculum by her gynecologist.

Patient A’s Complaint to the College and her Mental Health History

In her testimony, Patient A addressed the circumstances which led to her complaint to the College, which occurred many years after the alleged sexual impropriety by Dr. Ruggiero.

Because Patient A had been having suicidal thoughts and depression, her family doctor at the time, Dr. D, referred her to the Centre for Addiction and Mental Health (CAMH), in 2013. She was initially seen by a nurse, and then a physician, and a social worker. The staff at CAMH did not feel that Patient A required hospitalization, but recommended she participate in a six-week treatment program.

During the treatment program, Patient A met with a social worker as well as on one occasion, a psychiatrist, Dr. McMaster. Patient A testified that she was diagnosed with major depressive disorder and borderline personality traits.

At the completion of the six-week program, the CAMH social worker referred Patient A to Ms. Jessica Zeyl, a psychotherapist. During cross-examination, Patient A testified that she was also seeing Ms. Zeyl for childhood trauma. The trauma included: issues regarding her father, who was an alcoholic and an abusive husband; her older sibling who had fondled Patient A’s genitals on one or two occasions when she was 10 or 11

years old; experiences being bullied at school; and Patient A's "rape" at the hands of a store owner when she was 13 years old.

Because the incident of the sexual assault by the store owner was relied on by Dr. Ruggiero to explain why Patient A might have a mistaken belief about the alleged impropriety by Dr. Ruggiero, the facts regarding this incident are set out below.

Patient A clarified what she meant by "rape" regarding the incident with the store owner. The storeowner had locked the front door of the store. He grabbed Patient A's arm, dragged her to the back of the store behind a freezer, and began kissing her on the lips. He then started touching her breasts. The store owner also fondled her vagina and rubbed his penis against her back.

Patient A testified, however, that the store owner never took off her, or his, clothes. She said that they never had sex.

During this incident with the store owner, Patient A testified that she felt "frozen and numb" and that she "just wanted it to be done and over with." She could not recall how long the incident lasted, but for her "it felt forever."

When the storeowner was finished, he threatened Patient A, saying that if she told anyone about what he had done, he would kill her and her family. Initially, Patient A did not tell anyone. However, about three weeks after the incident, Patient A heard about another girl's similar incident with the store owner. It was at this point, she testified, that Patient A told her parents about what happened to her.

Patient A's parents called the police, who interviewed her. She also saw her then-family physician, Dr. B. Dr. B performed a vaginal examination using a latex glove. Patient A testified that Dr. B did not use a speculum during that examination.

The store owner was charged by the police and Patient A testified at his trial.

She also testified that she had told Mr. Lobsinger in an interview that she had not told Dr. Ruggiero that the store owner had "raped" her. However, she acknowledged during cross-examination that she may have told Dr. Ruggiero about the incident since Dr.

Ruggiero knew about it. However she also testified that she did not know whether her mother had told Dr. Ruggiero about the incident with the store owner.

During her psychotherapy sessions, Patient A told her psychotherapist, Ms. Zeyl, about the incident with Dr. Ruggiero. Ms. Zeyl informed Patient A that she was obligated to report what Patient A had told her to the College. Patient A consented to having Ms. Zeyl provide her name to the College.

Patient A also wrote a letter of complaint to the College regarding Dr. Ruggiero dated December 11, 2013.

Patient A testified that she was admitted for a night to the Humber River Regional Hospital because she had suicidal thoughts, several months before her treatment at CAMH. She testified that the suicidal thoughts were a result of a culmination of events including the fondling by her sibling, the incident with the store owner, the incident with Dr. Ruggiero, and the bullying she experienced as a child.

While she never attempted to kill herself, Patient A testified that she started cutting herself at the age of thirteen in order to feel pain which made her “feel a lot better.” Patient A testified that would also hit herself. She testified that she never saw a therapist or counselor as a teenager. Patient A testified that she is no longer cutting herself.

Ms. Zeyl recorded in her clinical notes (the relevant portion of which the Committee ordered to be produced to Dr. Ruggiero before the hearing) that Patient A had remarked to her that she “felt violated a third time” in regard to the incident with Dr. Ruggiero. Patient A clarified what she meant by “I felt violated a third time” in regard to the incident with Dr. Ruggiero, which Ms. Zeyl had recorded in her notes. Patient A described the first time she was violated as the incident with the store owner. The second time she felt violated referred to when she had to go to court to testify about the incident with the store owner.

Patient A testified that she cannot forget the traumatic events in her life and that her memories are crystal clear, as were recorded in Ms. Zeyl’s notes. As an example, she

described in detail what she was wearing during the incident with the storeowner, which included the type of stockings and shoes, the type of jeans and underwear as well as her top, bra and cardigan. She also described the storeowner and what he was wearing that day.

Patient A has not worked since October 2010. While she testified that she has never been put on antidepressants, she said that she was on Apo-Trazodone and Percocet. The Committee notes that Apo-Trazodone is an antidepressant that is also prescribed off-label for management of insomnia.

Following the incident with Dr. Ruggiero, Patient A refrained from seeing a doctor until 1990. Since then, she has only seen female family doctors. She testified that the first time she had a pelvic examination after the incident with Dr. Ruggiero was in 2008 when she saw a gynecologist.

Evidence of Mr. Paul Lobsinger

Mr. Lobsinger, an investigator for the College, was assigned to investigate Patient A's complaint. Previously he was employed by the Toronto Police Service and had worked in the Sex Crimes Unit and the Behavioural Assessment Section.

Mr. Lobsinger testified that he visited Dr. Ruggiero's office on October 6, 2014 to document its layout. He testified that he took a series of photographs that were entered as Exhibit # 2 as well as taking various measurements in the office. He described in detail the layout of the waiting area, the reception area, the doorway leading to hallway outside the examination rooms, the three examination rooms, the washroom, Dr. Ruggiero's office, and the doorways to Ruggiero's office.

Mr. Lobsinger indicated that the doorway to Dr. Ruggiero's office from the hallway was closed and that there was a scale in front of the door. Mr. Lobsinger testified that, although the left side of the bookcase and a portion of the chair in Examination Room 3 were visible from the waiting room if the door was left open, one could not see inside Examination Room 3 from the waiting area.

In addition to the doorway that led into Examination Room 3 from the hallway, there was a second door that led into the stairwell. However, Mr. Lobsinger had been informed that this door was not present when Patient A was a patient of Dr. Ruggiero.

Mr. Lobsinger described a third “pocket door” that separated Examination Room 3 from Dr. Ruggiero’s office/consultation room. He described Dr. Ruggiero’s office, indicating where the desk and chairs were in relation to Examination Room 3 and the pocket door, as well as indicating that there was a window behind Dr. Ruggiero’s desk.

Mr. Lobsinger described the view of Examination Room 3 from Dr. Ruggiero’s desk with the pocket door open. He also described the location of the sink and examination table in Examination Room 3.

During cross-examination, Mr. Lobsinger drew a rough sketch of the office floor plan which was not to scale (exhibit #3). He acknowledged that the base is attached to the examination table at the foot of it and forms a step when the table extension leaf is down. In response to a question during cross-examination as to what position Dr. Ruggiero would have to be in to “rape” a patient lying on the examination table, Mr. Lobsinger testified that he could not say what position Dr. Ruggiero would have to be in. However, he testified that the obvious would say that he (Dr. Ruggiero) would have to stand on that step (the base of the examination table). Mr. Lobsinger did go on to qualify his answer by saying that a lot of things that happen are not obvious.

Mr. Lobsinger also acknowledged that, prior to retaining a lawyer, Dr. Ruggiero was polite, receptive, and spoke freely with him. He had been cooperative and answered all of Mr. Lobsinger’s questions. Mr. Lobsinger also testified that Dr. Ruggiero was unsophisticated with respect to handling legal manners.

Mr. Lobsinger testified that, prior to retaining counsel, Dr. Ruggiero provided the College with a handwritten response to the complaint.

Mr. Lobsinger acknowledged that it can be difficult for witnesses and people to remember things many years after the event.

Counsel for Dr. Ruggiero put to Mr. Lobsinger a transcript of the interview Mr. Lobsinger and Mr. Hickey conducted with Ms. C, Patient A's mother, on February 20, 2014. Counsel for Dr. Ruggiero emphasized that the transcript was not being put to Mr. Lobsinger for the truth of the contents as to what Patient A said to her mother or what Dr. Ruggiero said to Ms. C but rather as part of the narrative of events.

Mr. Lobsinger confirmed that it is standard practice to audiotape investigative interviews. An audio tape of portions of the interview was played for Mr. Lobsinger. Mr. Lobsinger, on hearing the audiotape, confirmed that Ms. C provided the answers to questions recorded on pages 4 and 12 of the transcript of the February 20, 2014 interview.

Mr. Lobsinger testified that he had a telephone conversation with Dr. Ruggiero on March 31, 2014 after Dr. Ruggiero had been notified about the complaint against him. Mr. Lobsinger testified that he made notes on his computer while he was speaking with Dr. Ruggiero. Mr. Lobsinger testified that in response to his question to Dr. Ruggiero "Do you have any idea when you could provide a response to the letter of complaint?" Dr. Ruggiero replied, "Give me a day or so and I will run it by a friend who is a lawyer. I remember she (Patient A) was dressed very, very seductively that day. We made a comment about her red fingernails and toenails." Mr. Lobsinger then asked Dr. Ruggiero, "Who is we?" to which Dr. Ruggiero responded, "Mary and I".

Under cross-examination, Mr. Lobsinger acknowledged that if Dr. Ruggiero had read Patient A's letter of complaint against him that he would have seen the following regarding Patient A's outfit on the day of the incident: "I was wearing a long red coat black gloves, a long peach-coloured skirt with white stripes on the bottom with matching long-sleeved V-neck top, black shoes and nylons."

Mr. Lobsinger acknowledged that during his interview with Ms. C, she made reference to her daughter "dressing and looking nice."

Evidence of Ms. Sarah Spano

Ms. Spano worked in Dr. Ruggiero's office part-time when she was a high school student. She recalled working for Dr. Ruggiero in 1986 or 1987 one night a week anywhere between 5:00 p.m. and 9:00 p.m. She also worked on Saturdays from 8:00 a.m. until 4:00 p.m. She testified that she worked for Dr. Ruggiero for a couple of years, and that her maiden name at the time she worked for Dr. Ruggiero was Sarah Signorile.

Ms. Spano's duties at Dr. Ruggiero's office included taking out and filing away patient charts and calling for specialist appointments.

Ms. Spano testified that she never worked or sat in Dr. Ruggiero's personal office. If the full-time secretary was sitting at the reception desk, Ms. Spano testified that she would use the window ledge at the back of the reception area if she needed to do any writing.

Ms. Spano was also able to describe the changes that were made to the office from reviewing the photos of the office that were admitted as exhibits. She testified that the flooring is now different. She described a wooden ledge that was different. She also indicated that the glass at the opening to the reception area was not present when she worked in the office.

The Committee found that Ms. Spano was a credible witness. She has no self-interest in the outcome of the hearing. The changes she described in the office were confirmed by other witnesses. She testified in a forthright manner. She described working at the window ledge, which other witnesses also described working at.

Evidence of Dr. Ruggiero

Dr. Ruggiero testified that, in the mid-1980s, he worked Monday to Friday and also on weekends between 8:30 a.m. and 9:00 to 9:30 p.m. He testified that he would see between 70 and 80 patients a day. Under cross-examination, Dr. Ruggiero

acknowledged that he saw 350 to 400 patients per week and, as a result, had tens of thousands of patient encounters throughout his career.

Dr. Ruggiero testified that he sees four to five patients each day with a presenting problem of abdominal pain.

His full-time secretary at the time was Ms. Mary Marchesani, who had started working with Dr. Ruggiero in 1980. Ms. Marchesani took about a year and a half of maternity leave between 1984 and January or February 1986. The secretary who replaced Ms. Marchesani during her maternity leave was a woman who Dr. Ruggiero believed was named “Angela.”

Dr. Ruggiero testified that his secretary would greet patients at the front desk, answer the phone, and retrieve patient charts when they were being shown into the examination room. Dr. Ruggiero testified that the full-time secretary would not leave the reception desk for an extended period.

Dr. Ruggiero testified that, in the 1980s, he also employed high school students part-time. While he could not remember the names of all of his part-time employees, Dr. Ruggiero did remember that Ms. Frazzano, Ms. Neves, and two young women named Nicki and Sarah worked for him part-time in the late 1980s.

Dr. Ruggiero testified that these students would arrive at the office between 3:30 and 4:00 p.m. and leave between 6:00 and 9:00 p.m. Dr. Ruggiero testified that the students would do filing and “write up” his charts on the ledge behind the reception desk or at his desk in his consultation room which was connected by a pocket door to Examination Room 3.

Dr. Ruggiero detailed what he meant by the students “writing up his charts.” He would make brief handwritten notes about patients that were not very legible. The students would then write out this information more legibly in full sentences into a pre-formatted template in the Purkinje system (the electronic medical record).

Dr. Ruggiero testified that there were times when the high school students would be in the office by themselves after Ms. Marchesani or Angela left for the day at 5:00 or 6:00 p.m. In addition, Dr. Ruggiero testified that Ms. Marchesani did not work on Saturdays.

Dr. Ruggiero described the layout of the office and confirmed that the photographs (exhibits 4 to 8) represented his office as it appears today. He testified that he kept his instruments for doing pap smears in Examination Room 3, which he used for examining female patients. Dr. Ruggiero also testified that the hallway door with the scale in front of it leading into his office (exhibit 7) has been closed for several years.

Dr. Ruggiero testified that his office has been renovated since 1986. He acknowledged in his testimony that, when he was first asked about renovations to his office during the College's investigation, he did not remember that renovations had occurred.

Dr. Ruggiero testified that the office was renovated in 1998 or 1999 due to a change in the building's ownership about four or five years earlier.

Dr. Ruggiero testified that part of the renovations included the construction of a ceiling-height wall to the right of the wall where the secretary sits. He testified that this new wall had replaced the three-and-a-half to four-foot high wall that had been located there before.

Dr. Ruggiero also testified that, in approximately 1988, another short wall was erected to replace a swinging gate that had been adjacent to the secretarial seating area. This short wall was extended to the ceiling in 1998 or 1999. He also testified that glass (blocks) was installed in front of where the secretary sat.

He also testified that the flooring was changed and there had been some painting.

Dr. Ruggiero testified that, prior to the renovations, the wall between the waiting room and the secretarial desk in exhibit 6 was about half as narrow as it was after the renovations. He testified that, prior to the renovations, this wall was more angled

towards the waiting area, which would have allowed the secretary a more direct line of vision to the bathroom door and door to Examination Room 3.

Dr. Ruggiero testified that the doorway at the foot of the examination table in Examination Room 3 was installed in 1998 or 1999. He also testified that the stand-up cabinet (bookcase) to the left of the examination table in Examination Room 3 was acquired around 1998 or 1999.

Dr. Ruggiero described his usual procedure for performing pelvic examinations. He testified that, in the 1980s and 1990s, he always wore a white coat. He would take a history, ask the patient to take off her clothing from the waist down, and instruct her to put on a disposable paper gown which would cover up to the knees when the patient was lying down. He would leave the room for a few minutes while the patient undressed and knock on the door before re-entering.

He testified that he would then instruct the patient to lie down on the table and move her bottom down the table to the "black line" so that she could put her feet in the stirrups. Dr. Ruggiero testified that he would have the table extension up so that he could place his instruments on it.

Dr. Ruggiero testified that he would stand at the right side of the examination table, and not at the foot of it, when he did the pelvic examination. He would put on beige disposable latex gloves, which he kept in the examination table drawer near the stirrups. Dr. Ruggiero could not recall whether the gloves were in a box or individually wrapped.

Dr. Ruggiero testified that after using his left hand to open the outer labia of the vagina, he would insert a disposable plastic speculum into the vagina. He would then inspect the cervix and vagina, perform a pap smear, and take a vaginal swab. Next, he would remove the speculum and do a bimanual pelvic examination by introducing two fingers from his right hand into the vagina while placing his left hand on the abdomen. He would move his hand in and out of the vagina to examine the uterus, right and left ovaries, and ovarian tubes.

After the examination, Dr. Ruggiero testified that he would remove his gloves and leave the room while the patient got dressed. He would then return and give the patient the results of the examination.

Dr. Ruggiero testified that he did not utilize a chaperone while conducting pelvic examinations in the mid-1980s, but that occasionally, he would have his secretary help elderly patients get onto the examination table.

Dr. Ruggiero testified that he would leave the pocket door from Examination Room 3 to his consultation room half open during pelvic examinations. He testified that he would also always have the door from the hallway to Examination Room 3 approximately four to six inches ajar when he did pelvic examinations in order for his secretary to be able to “see what was going on.” Dr. Ruggiero testified that, with the door ajar four to six inches during pelvic exams, the secretary would be able to see part of the examination table and part of the patient from her desk.

Under cross-examination, Dr. Ruggiero testified that he would close the door whenever he examined a patient in Examination Room 1 or 2. He also testified that if patients were in either Examination Room 1 or 2 while he was performing an intimate examination in Examination Room 3, the doors to Examination Rooms 1 and 2 were closed at all times, but he would leave the door to Examination Room 3 partially open. He acknowledged that his secretary might bring patients into Examination Room 1 or 2 while he was seeing a patient in Examination Room 3.

However, Dr. Ruggiero later testified that if he was doing a pelvic examination in Examination Room 3, his secretary would hold off on showing other patients into Examination Rooms 1 and 2. Dr. Ruggiero testified that, if he was seeing a patient in Examination Room 3 for a respiratory tract infection, he would close the door to provide privacy. However, he reiterated that he would leave the door partially open four to six inches for a pelvic examination. He stated the reason he left the door open is because sometimes he did not have a chaperone in Examination Room 3 during pelvic examinations.

In response to a question from his counsel, Dr. Ruggiero stated that he was testifying based on his independent recollection of Patient A's visits with him, and not based on what was his usual practice.

Dr. Ruggiero testified that Patient A first saw him because she was having abdominal pain. However, he testified that he had destroyed her patient chart ten to 15 years after he last saw her and therefore he could not recall the year he saw her.

Dr. Ruggiero testified that he recalled Patient A coming for only two visits. He testified that he was able to recall the details of Patient A's visits with him because the first time she came to his office, she had told him that she had been raped in the past and that this was the first time a female patient had told him she had been raped in the past. He testified that he also recalled the details of her visit because Patient A's mother had been his patient from the late 1970s or 1980s until 1998 or 1999 and that she had referred her daughter to him.

Dr. Ruggiero testified that Patient A came alone on her first office visit. This was in contrast to Patient A's testimony that her mother had accompanied her on her first visit.

Dr. Ruggiero testified that Patient A told him that for several weeks she had been having abdominal pain for which she had been taking Maalox. Dr. Ruggiero testified that Patient A also told him on that visit that "somewhere along the line, she had been raped" by an owner or manager of a convenience store, but that Dr. Ruggiero did not know when that had occurred.

Dr. Ruggiero testified that Patient A also told him that she was also having problems with stress, anxiety, and depression. Dr. Ruggiero testified that he recalled taking a history of Patient A and then examining her chest, heart, and abdomen. After the physical examination, he recalled ordering blood work, a urinalysis and an "upper G.I. (series)." He testified that he gave Patient A a prescription for Cimetidine 300 mg one pill twice a day and told her to return to his office in three to four weeks to get the test results.

Dr. Ruggiero testified that he recalled the results of these tests. He indicated that he checked for anemia and the blood work was normal as was the urinalysis. He testified that the upper G.I. series demonstrated gastritis or a small peptic ulcer.

Dr. Ruggiero testified that, on Patient A's second visit, she was not accompanied by her mother. Dr. Ruggiero testified that he recalled that Patient A was "dressed in brighter colours and differently than the ordinary young lady that would come to my office in 1985, especially from the Italian community." He testified she had red nail polish on her fingers and toes, and that this was a "rarity" in the Italian community.

Dr. Ruggiero testified that he told Mr. Lobsinger during an interview that Patient A was dressed seductively when he was asked "what did she (Patient A) look like" and "if she was attractive, if she was seductive." Dr. Ruggiero also testified that when he said "seductive" that he meant "different," because Patient A was dressed in brighter colours. However, Dr. Ruggiero denied that he was sexually or physically attracted to Patient A or that she was personally seductive to him. Dr. Ruggiero also denied that Patient A "turned him on" and denied that he took Patient A up on what he perceived was an "invitation" to have sex.

Dr. Ruggiero testified that, during the second visit, Patient A told him that she was still having some abdominal pain which had not quite resolved. She also told him that she was having burning in the lower abdominal area. Dr. Ruggiero testified that he recalled that he thought Patient A was probably sexually active but that he was not sure.

Dr. Ruggiero testified that it was at this point in the appointment that he told Patient A he wanted to do a pelvic exam in order "to rule out some causes of abdominal pain," including diseases of the uterus or some other infection or inflammation.

Dr. Ruggiero testified that he told Patient A to remove her clothes from the waist down and to put on the disposable paper examining gown. Dr. Ruggiero testified that he stepped out of the room while she changed and then knocked on the door before he re-entered the room.

Dr. Ruggiero testified that, once back inside the room, he told Patient A to lie down on the examination table, move her bottom to the table's "black line," and put her feet in the stirrups. He turned on the light at the end of the table. He testified that the table extension was in the up position during this time.

Dr. Ruggiero testified that he proceeded to perform a pelvic examination on Patient A while wearing latex gloves. He testified that he stood at the side of the examination table and used a small disposable plastic speculum to perform a pelvic examination and pap smear. He testified that he also took swabs.

Dr. Ruggiero testified that he used a small speculum because, to his knowledge, it was the first time that Patient A had a pelvic examination. He also testified that he did a pap smear looking for dysplastic cells because Patient A told him she had been raped.

Dr. Ruggiero testified that the entire examination took three to four minutes. When it was complete, Dr. Ruggiero testified that he took off his latex gloves. He testified that he then told Patient A to come back in three or four weeks. He also gave her another prescription for Cimetidine.

Dr. Ruggiero testified that Patient A never returned for a third appointment.

Dr. Ruggiero denied unzipping his pants, putting on a condom, or inserting his penis in Patient A's vagina.

Counsel for Dr. Ruggiero reviewed several photographs with Dr. Ruggiero during examination in chief which depicted him standing at various positions at the end of the examination table in Examination Room 3. The photographs showed Dr. Ruggiero standing by the table with the table extension both up and down (exhibits 9 to 11).

Dr. Ruggiero testified that it would have been impossible to have done what Patient A alleged, regardless of where he was standing in relation to the examination table or whether the table's extension was up or down.

However, Dr. Ruggiero conceded later in his testimony that it would be "awfully difficult," but not impossible, to have a sexual encounter with a female patient while

standing in the position as depicted in exhibit 10 and while placing one foot up on the base of the table.

Dr. Ruggiero testified that Patient A's mother was his patient until 1998 or 1999. He testified that Patient A's mother had told him that her daughter suffered from anxiety and depression and was apparently seeing someone professionally, perhaps to get counseling.

Dr. Ruggiero testified that, at the end of the day of Patient A's second visit, her mother phoned to ask him what had happened at the appointment. Dr. Ruggiero testified that he told Patient A's mother on the telephone that he had performed a pelvic examination on her daughter. He testified that he went through the procedure "step by step" with her.

Dr. Ruggiero testified that, at the end of the call, Patient A's mother made an appointment to come to the office, which he testified did occur, to talk with Dr. Ruggiero about the incident. During this visit, Dr. Ruggiero testified that he explained what he did again to Patient A's mother.

Counsel for the College suggested to Dr. Ruggiero that if he had been accused of rape by Ms. C, he would have had good reason to remember his appointments with Patient A. Dr. Ruggiero initially responded "not necessarily." Dr. Ruggiero added that, "over the years, I had forgotten all about the various visits [with Patient A]".

However, he acknowledged that if he was accused of raping Patient A that he would "remember [the visits] somewhere along the line."

Dr. Ruggiero testified that, during this visit with Patient A's mother, he had also given her mother her daughter's test results, which he testified were "normal."

Dr. Ruggiero testified that Patient A's mother never told him that Patient A had been raped by a store owner, but that she had told him that Patient A was anxious and depressed. He also testified that Patient A's mother never came with Patient A when she saw Dr. Ruggiero.

Dr. Ruggiero testified that the first time he became aware that Patient A was alleging that he had raped her was when he was notified by the College.

Dr. Ruggiero acknowledged that he had told Mr. Lobsinger that there had not been any structural changes made to the office since 1985, including walls being moved. Later in his testimony, Dr. Ruggiero said that structural changes had indeed been made at the office in 1998 or 1999.

Dr. Ruggiero agreed that, prior to the renovations (i.e., as the office appeared when Patient A saw him), the secretary seated at her desk would not be able to see the examination table through the partially-open door to Examination Room 3 and that she would not be able to hear a conversation between Dr. Ruggiero and his patient during the examination.

Dr. Ruggiero confirmed that the bookcase seen in exhibit 6 was not present in the 1980s. He also confirmed that the glass blocks seen in exhibit 4 were not present in the 1980s.

Dr. Ruggiero acknowledged that initially, he told Mr. Lobsinger that he left the door half way open connecting Examination Room 3 to his consulting room where his part-time secretary, Sarah (Spano), would do his paperwork.

Dr. Ruggiero testified that, before he consulted any legal counsel, he wrote a letter to the College dated April 4, 2014 in response to Patient A's complaint. In that letter, he wrote that his "other secretary Sarah" was writing up his clinical notes at his desk and was able to see him and Patient A during the physical examination. Dr. Ruggiero also had indicated that, because Sarah (Spano) had since gotten married and he did not know her married name, he had no information on how to reach her. Dr. Ruggiero acknowledged during cross-examination that he may have been mistaken about Sarah being the one who sat at his office desk during Patient A's appointment.

In his testimony, Dr. Ruggiero also acknowledged that he did not mention the doorway from Examination Room 3 to the hallway being open anywhere in his April 4, 2014 letter to the College.

Dr. Ruggiero testified that his current evidence was that both doors to Examination Room 3 (the door to the hallway and the pocket door into his office) were probably open during Patient A's examination. When asked why he would keep the door to the hallway open while the secretary was sitting at his desk in his office with a view of Examination Room 3, he responded, "That is the way I used to do it in those days."

Dr. Ruggiero acknowledged that he had previously advised the College on more than one occasion that there was only one appointment with Patient A. He agreed that it was an incorrect statement and that she had actually visited him on two occasions.

Dr. Ruggiero testified in examination in chief that Patient A presented with abdominal pain. He acknowledged under cross-examination that after he received the January 9, 2014 letter from Mr. Lobsinger informing him of the complaint of sexual impropriety against him by Patient A, he left a voicemail for Mr. Lobsinger stating that, "Patient A came in and complained that she was having some problems vaginally."

Dr. Ruggiero also acknowledged that, after leaving Mr. Lobsinger the voicemail, he received a letter dated February 24, 2014 with several enclosures, including Patient A's complaint letter where she indicated that she saw Dr. Ruggiero for abdominal pain.

Dr. Ruggiero subsequently spoke with Mr. Lobsinger on March 31, 2014 and told him that Patient A "came in complaining of abdominal and some epigastric pain."

Dr. Ruggiero testified that he forgot to mention to Mr. Lobsinger in his voicemail that Patient A was having "abdominal problems." Dr. Ruggiero testified that he subsequently recalled that Patient A was complaining of upper and lower abdominal pain. Dr. Ruggiero also conceded that stating Patient A was having lower abdominal pain would provide more rationale for performing a pelvic examination than solely upper abdominal pain.

Dr. Ruggiero agreed that, "in the ordinary course," he would not have any reason to recall, in the absence of a clinical record, whether one patient he had seen 30 years earlier had been experiencing vaginal or abdominal pain or in what part of the abdomen the pain had been located. However, in the case of Patient A, Dr. Ruggiero

testified that, “I remember she was complaining of abdominal pain.” He additionally testified that he recalled writing a prescription for Cimetidine 300 mg one twice a day on the first visit. He also recalled seeing Patient A between two and four weeks after the first visit and giving her the results the results of the x-ray and a diagnosis of possible gastritis. However, Dr. Ruggiero acknowledged that, in Patient A’s case, the Cimetidine could have also been prescribed for a peptic ulcer. Dr. Ruggiero also testified that he remembered Patient A telling him she was taking an antacid for abdominal pain and which he thought would have been Maalox but acknowledged that he did not mention this to anyone prior to the hearing.

Dr. Ruggiero testified that he had an actual recall of performing a physical examination of Patient A’s chest, heart and abdomen on her first visit and examining of her abdomen and performing a pelvic examination on her second visit. However, Dr. Ruggiero acknowledged that in a letter to the College from his counsel dated February 25, 2015, he had indicated that he saw Patient A “on only one occasion”. The February 25, 2015 letter also indicated that he “believed that he would have taken the pulse and blood pressure and examined the abdomen” and that “he knows that he performed a speculum exam, followed by a bimanual exam” at which time he took swabs that were normal. He also testified that he recalled that Patient A’s bloodwork and urinalysis were within normal limits. However, Dr. Ruggiero acknowledged in cross-examination that that there was no reference to bloodwork, a urinalysis, or an upper GI series in his counsel’s February 25, 2015 letter to the College or in his own April 4, 2014 letter.

Dr. Ruggiero acknowledged that he had left a voicemail for Mr. Lobsinger that indicated that Patient A told him that “she was forced to have sex with the store manager of the store where she worked” in order to keep her job. In a letter to the College in response to Patient A’s complaint, Dr. Ruggiero indicated that he had seen her several weeks after the alleged forced sex with the store owner.

Dr. Ruggiero also acknowledged that he told Mr. Lobsinger that Patient A was feeling guilty because she was having sex with her boyfriend and that she wanted to get

“checked out,” meaning she wanted a pelvic examination. Dr. Ruggiero also testified that he recalled that Patient A was not a virgin when he examined her.

Dr. Ruggiero disagreed with the suggestion of counsel for the College that there would be no reason to recall details of Patient A’s appearance 30 years later unless something “stood out” about the appointment.

Evidence of Dr. Ashley Bender

Dr. Bender was qualified by the Committee as an expert in psychiatry, with special expertise in psychological trauma in adults.

Dr. Bender received his medical degree from the University of Western Ontario in 1999 and completed a residency in psychiatry at the University of Toronto in 2004. He received his FRCP(c) in psychiatry in the same year. He is an assistant professor of psychiatry at the University of Toronto. He was the deputy clinical director for the mood and anxiety program at CAMH until 2012 and he leads a psychological trauma programs for adults part-time at the Scarborough Hospital.

The Committee found that Dr. Bender provided a fair and balanced perspective and was not an advocate for either party.

Dr. Bender testified that he spends approximately 75 percent of his time dealing with workplace trauma. Until recently, he was the head of the psychological trauma program for the Workplace Safety and Insurance Board which was operated under contract by CAMH.

Dr. Bender treats post-traumatic stress disorders particularly in first responders such as police but also in soldiers returning from Afghanistan.

Dr. Bender testified that he has assessed and designed treatment programs for adults that have had traumatic experiences due to sexual assaults or rape.

Ten percent of the patients Dr. Bender sees have sexual trauma as their primary reason for presentation. Of that group, half of them have had sexual assault experiences in childhood.

Dr. Bender testified that he has never interviewed or examined Patient A and that his opinion was based on the entire College disclosure file, including Ms. Zeyl's psychotherapeutic records for Patient A. Dr. Bender was not present for Patient A's testimony. Counsel for Dr. Ruggiero took notes during Patient A's testimony for Dr. Bender to review.

Dr. Bender reviewed Patient A's past traumatic incidents which she had experienced prior to her interaction with Dr. Ruggiero. These included incest at the hands of her older sibling, the incident with the storekeeper when she was 12 or 13, an incident in which her breasts were fondled, and her witnessing violence between her parents.

Dr. Bender testified that childhood trauma, including repeated sexual trauma, contributes to the development of mental health issues, such as post-traumatic stress disorders, mood disorders, and substance abuse disorders. Dr. Bender also explained that multiple traumas have a cumulative effect on an individual's mental health.

He also testified that having multiple childhood traumas without receiving any counseling or assistance can lead to unprocessed thoughts and emotions in an individual. These unprocessed thoughts and emotions can manifest in several types of behaviours including substance abuse, problems with anger, problems with relationships, and persistent psychological symptoms.

Dr. Bender opined as to how Patient A's previous traumatic incidents may have impacted her on her last visit with Dr. Ruggiero. He described a "thematic relationship" in that Patient A's past traumas involved fondling or touching of her breasts and genitals.

Dr. Bender said that the nature of Patient A's previous traumas was important. Dr. Bender explained that specific triggers such as smell, places, or people can activate a memory of past trauma and cause responses such as fear, tearfulness, or anger.

Triggers can also generate dissociative spectrum experiences commonly known as “flashbacks.” As an example, Dr. Bender discussed an individual who had previously been assaulted seeing someone that resembled their attacker out in public but actually sees the face of their attacker on that individual. It is only after the individual calms down that they realize that the person they saw was not actually their assaulter.

Dr. Bender reviewed the dissociative spectrum experience and defined it as an aberration or distortion on how an individual experiences time, people, or places. He described the spectrum of dissociation. This ranges from a normal dissociative experience, such as *déjà-vu*, to dissociative amnesia, where an individual will end up in an alternate location and not be able to recall his or her own identity.

In respect to distortion of time, Dr. Bender explained that individuals experiencing a fear-based response will describe time slowing down for them.

Counsel for Dr. Ruggiero asked Dr. Bender why victims of sexual abuse say things like “I was frozen. I felt like a statue. I was numb.” Dr. Bender responded by reviewing the “fight, flight, or freeze” response to trauma. Dr. Bender explained that there is a release of stress-related hormones during a sexual assault. At one end of the spectrum, victims may describe that they were “numbed out” or on “autopilot.” These victims report being “not actually emotionally attached to the experience.” Distracting themselves emotionally from the experience is their coping mechanism. On the other end of the spectrum, some victims experience such intense fear that it triggers a “panic attack.”

Dr. Bender testified that Patient A had indicated that she felt “numb” during the incident with the store owner and during her interactions with Dr. Ruggiero. Patient A also described losing track of time during the incident with the store keeper and as well the alleged abuse by Dr. Ruggiero.

In cross-examination, Dr. Bender acknowledged that when an individual is feeling numb or being frozen that it does not mean that the entirety of the experience is being misunderstood.

Dr. Bender described the “thematic links” in Patient A’s interaction with Dr. Ruggiero. Dr. Bender’s review of the material indicated to him that Patient A felt that a pelvic examination was not necessary and that she was not expecting to have a pelvic examination. She seemed to question why she was being placed in the stirrups and that there was a sense of disbelief that it was actually happening.

Dr. Bender also pointed out that some of the words that Patient A used in describing the incident with Dr. Ruggiero were “assaultive type” such as “then, he came at me.”

Dr. Bender acknowledged that Ms. Zeyl’s notes indicated that Patient A was certain that she saw Dr. Ruggiero’s penis with a condom on it and that it was going in and out of her vagina. Dr. Bender also testified that there was a new detail that emerged from Patient A’s testimony: that Dr. Ruggiero was “groaning.” Dr. Bender testified that he could not determine whether Patient A actually recalled the groaning or whether she was piecing together what she believed had happened.

While Dr. Bender could not say whether Patient A did have a particular perceptual issue on the day of the incident with Dr. Ruggiero, Dr. Bender testified that, because of her sense of disbelief, it is possible that Patient A may have misinterpreted the events that happened and that it may have been activated by a fear-based response.

Dr. Bender testified that he did not know whether Patient A had ever seen a penis in a condom before the incident with Dr. Ruggiero. Dr. Bender opined that since Patient A was in a vulnerable position, she may have misinterpreted something such as a gloved hand, due to a fear based response mediated by the similarities to the previous interaction with the store keeper which also involved hand to genital contact and an older male in a position of authority similar to Dr. Ruggiero.

Counsel for Dr. Ruggiero reviewed Patient A’s testimony with Dr. Bender in which she stated that she saw a psychiatrist at CAMH and was diagnosed with depressive disorder and borderline personality traits. In reviewing Ms. Zeyl’s notes, Dr. Bender agreed that there were entries suggestive of borderline personality trait features, such

as recurrent suicidal ideation, episodes of rage, and a history of self-harm. Dr. Bender explained that these could be in pursuit of relieving distressing emotions.

Dr. Bender also testified that diagnoses of personality disorders are not made before a patient turns 18. He testified that individuals with borderline traits have a reduced capacity to deal with stressors and can sometimes be prone to misperceptions of what actually happened during incidents. He provided an example of perceiving that someone is there to help, but, if things do not go as expected, feeling harmed, manipulated or preyed upon by that person.

Dr. Bender also distinguished fragmentation from dissociation. Fragmentation is defined as losing one's ability to experience oneself as a whole person, particularly with life stressors. Fragmentation can happen for much longer periods of time than dissociation, which is more of a discrete phenomenon. Dr. Bender testified that fragmentation can also affect one's perception of what is going on around them.

Dr. Bender acknowledged that, in preparing his expert report, he relied on descriptions that Dr. Ruggiero provided the College during the investigation, including Dr. Ruggiero's own description of performing a pelvic examination on Patient A.

Dr. Bender also acknowledged that he was not in the position to say whether there was in fact hand-to-genital contact in Patient A's interaction with Dr. Ruggiero.

He further acknowledged that, without examining an individual himself, he would not want to diagnose that person. Dr. Bender testified that a psychiatrist should testify as to the mental state of an individual only if they had an opportunity to examine that person.

Dr. Bender acknowledged that not having examined Patient A was a significant limiting factor in the opinion that he was providing. He also acknowledged that he had not reviewed any of Patient A's clinical records that contained a diagnosis, including those from CAMH. The CAMH records would have been the only time that Patient A would have had contact with a mental health professional in a position to make a diagnosis. He testified that Ms. Zeyl's records did not contain a diagnosis.

Dr. Bender testified that he was opining on hypothetical questions about psychiatric issues based upon his experience and about issues that may be relevant in the case of Patient A. Dr. Bender testified that he could not opine on Patient A's mental state. Dr. Bender also agreed that any examination performed or diagnosis made by a psychiatrist at CAMH was in relation to Patient A's mental health status in 2013, and not her mental health status 30 years earlier.

Dr. Bender also testified that, since he was not in the position to say definitely one thing or the other, where he utilized the words "may" and "suggest" in his expert report, those words could accordingly be substituted with "may not" and may not suggest" in the report.

He also testified that 75 percent of North American adults have been exposed to a traumatic event and many individuals go on to experience another traumatic event in their lives.

Evidence of Ms. C

Ms. C is Patient A's mother. She currently lives with her daughter, Patient A. She testified with the aid of an Italian language interpreter.

Ms. C testified that she first became Dr. Ruggiero's patient in 1982 or 1983 because she had worker's compensation issues and needed a physician to fill out paperwork on her behalf. While she could not remember the year that she ceased being Dr. Ruggiero's patient, she did not disagree that it was on the last visit date recorded in her medical record, which was in April 1999. She testified that she "wanted to leave him [Dr. Ruggiero] when the thing happened with my daughter," but that she could not leave Dr. Ruggiero's care because she needed him to fill out her worker's compensation documentation.

She testified that the "incident" involving her daughter and Dr. Ruggiero took place in 1986. However, during her testimony, she never described what the "incident" was. Ms. C testified that her daughter came back from the doctor and that she was very nervous and that she told her about the "incident." Ms. C testified that she called Dr.

Ruggiero's office to go and speak with him, which she subsequently did. She asked Dr. Ruggiero what had happened with her daughter. She testified that Dr. Ruggiero denied any wrongdoing, and that he told her, "I just examined her and her stomach...because the stomach problem had not gone away, I did a checkup inside, and she misunderstood."

Adverse Witness Argument and Ruling

Ms. C testified that she did not know what "checking up inside" meant and that Dr. Ruggiero did not use the word "vagina" during their discussion.

At this point in the testimony, counsel for Dr. Ruggiero submitted that Ms. C should be declared an adverse witness based upon prior inconsistent statements she had made in an interview with Mr. Lobsinger on February 20, 2014.

During her February 20, 2014 interview with Mr. Lobsinger, which was conducted without the aid of an interpreter, Ms. C told Mr. Lobsinger that Dr. Ruggiero had said the following to her when she went to his office after the incident: "Your daughter make a mistake because she telling me she got a problem inside and I clean up inside, you know. I clean up inside, you know." Ms. C continued, "And just he [Dr. Ruggiero] say, 'I do that you know for you know the lady need to clean up.'"

Mr. Lobsinger then said, "Yes, inside her—in her vagina," to which Ms. C responds, "yes." Ms. C continued, "Yes, he tell me. But my daughter, she say she go for problem with her stomach, you know. But he tell me my daughter tell him to clean up inside to vagina. You know, that's what he tell me."

Counsel for Dr. Ruggiero submitted that during the February 20, 2014 interview with Mr. Lobsinger, it appeared that Ms. C had told him that Dr. Ruggiero had cleaned up inside, meaning her vagina; however, during her testimony at the hearing, counsel for Dr. Ruggiero argued that Ms. C appeared to be saying, "no, it wasn't the vagina. It was just inside." Based upon the apparent inconsistency, counsel for Dr. Ruggiero requested leave to cross-examine Ms. C on this point.

Counsel for the College disagreed that Ms. C made prior inconsistent statements. Counsel for the College submitted that the portions of the transcript of the interview with Mr. Lobsinger that were read were replete with the word “inside,” which was the same word Ms. C used during her testimony. In addition, no interpreter was present at the interview with the College investigators, who were utilizing words such as “vagina” in their conversation with Ms. C.

In response, counsel for Dr. Ruggiero pointed out that, during the February 20, 2014 interview, Ms. C agreed with Mr. Lobsinger regarding Dr. Ruggiero’s “cleaning up inside” that she meant inside the vagina. In addition, counsel for Dr. Ruggiero quoted Ms. C’s words during another point in that interview’s transcript: “And he [Dr. Ruggiero] say, ‘No, I not do this to your daughter. Maybe she no understand. I just to – I go inside for cleanup inside her, you know.’ But the doctor telling me, ‘I visit inside the vagina but I no put, what you call penis you know.’”

In response, counsel for the College emphasized that prior consistent statements cannot be admitted for the truth of their contents; rather, they are hearsay. Counsel for the College pointed out that paragraph 7.44 in the Sopinka text on evidence provides that even where a prior consistent statement can be admitted as part of the narrative, the actual content of the statement is not important. The evidence of the prior statement should be described in general terms only. It should not contain details of what was actually said so as to invite the finder of fact to draw inference of the truthfulness of the evidence.

Independent Legal Counsel for the Committee drew the Committee’s attention to the Ontario Court of Appeal decision in *Wawanesa Mutual Insurance Co. v. Hanes*, [1961] O.R. 495 (C.A.), which says: “The fact that the witness made a previous contradictory statement is relevant, admissible and the most cogent evidence on the issue and that evidence alone may be accepted by [the trier of fact] as sufficient proof of hostility of the witness, irrespective of the demeanor and the manner of the witness in the witness-box.”

Having considered the arguments from counsel, the Committee declared Ms. C an adverse witness on the particular point raised above.

Examination as an Adverse Witness

When Ms. C was asked about the interview on February 20, 2014 with College investigators, she testified that she remembered coming to the College and speaking with a man, but that she did not remember anything else about that day. Accordingly, as Ms. C did not adopt her prior statements, those statements cannot be introduced as evidence as to the truth of the matters asserted, i.e., that Dr. Ruggiero told her that he had examined or “cleaned up” inside her daughter’s vagina.

Ms. C testified that the incident with the store owner had scared her daughter a lot and that she has been afraid of men since that time. She also testified that, after the Dr. Ruggiero incident, her daughter always wanted female doctors.

Ms. C testified that as a teenager, her daughter did not suffer from depression and that she only got nervous during exam time.

Under cross-examination, Ms. C testified that after her daughter told her about the incident with Dr. Ruggiero, she could not remember whether her daughter wanted to tell the police about the incident or whether she discouraged her daughter from going to the police.

Evidence of Mary Neves

Ms. Neves testified that she began working on a part-time basis for Dr. Ruggiero in 1988 at the age of 14. She worked for Dr. Ruggiero for 14 or 15 consecutive years. Ms. Neves testified that she would usually work at the St. Clair office on Saturdays from 8 a.m. to between 3:30 and 5:00 p.m. When the office was closed to patients on Wednesdays, Ms. Neves testified that she occasionally went into the office after 12:00 or 1 p.m. to do paperwork.

Ms. Neves described Dr. Ruggiero’s busy practice in which he would see between 80 and 100 patients during the day. She testified that Dr. Ruggiero would spend between

five and 40 minutes with each patient. She also testified that when she worked on Mondays at the St. Clair office it was also busy.

She testified that she would work with Dr. Ruggiero's full-time secretary, Ms. Marchesani, as well as other part-time employees, including Ms. Spano and two women named Nicki and Franca whose last names Ms. Neves could not recall. Ms. Neves testified that she would also work on occasion at the Woodbridge office.

Ms. Neves testified that her duties were to help Dr. Ruggiero write up his charts, do some filing, and book specialist appointments. Ms. Neves testified that she would balance her time working both in the front reception area and also in the back in Dr. Ruggiero's office.

When she was in the front reception area, Ms. Neves testified that she would stand by the window behind the reception desk, either filing or writing up charts. Ms. Neves testified that Ms. Marchesani would also help out writing up Dr. Ruggiero's charts, do filing, and book specialist appointments. Ms. Neves testified that Ms. Marchesani would sit mainly at the front desk and work between 8:00 a.m. and 5:00 or 6:00 p.m.

Ms. Neves testified that Ms. Marchesani was not always at the office when she was there and that she would therefore work alone. Ms. Neves testified, however, that there were other times when there may have been another part-timer working with Ms. Neves.

Ms. Neves did not recall Patient A but she "vaguely" recalled her mother.

Ms. Neves described the office as it had appeared when she started working for Dr. Ruggiero. She testified there were three examination rooms. She described the front reception area which had a wall with a glass window that could be slid open and closed.

She also described a swinging door to the right side of the wall in front of the receptionist's desk, when viewed from the waiting area. Ms. Neves testified that this swinging door was about "hip height." She testified that it did not obstruct the view

from the reception desk of the door to Examination Room 3 and that one could see partially into Examination Room 3.

Ms. Neves testified that, in 1988, it was standard practice to usually leave the doors into the examination rooms either halfway or fully open, even when patients were inside. Under cross-examination, Ms. Neves acknowledged that patients walking in the hallway to the examination rooms would be able to see into the examination rooms.

Ms. Neves testified that someone sitting at the front desk could only hear sounds from the examination rooms if the doors were open and if the sounds were loud enough. Sounds could not be heard by someone at the front desk if the people in the examination rooms were speaking at normal levels. If the doors were closed, someone sitting at the front desk could hear only muffled sounds.

Ms. Neves testified that, in 1988, the wall in front of the reception desk did not have the glass blocks on the sides. She also testified there was now a wall to the ceiling where the swinging door had been.

Ms. Neves described Dr. Ruggiero's office having a pocket door between it and Examination Room 3. Ms. Neves testified that the pocket door was halfway or fully open when there was a patient in Examination Room 3.

She testified that when she was working at Dr. Ruggiero's desk in his office, she could see into Examination Room 3. What she could see was half of the examination table against the wall and Dr. Ruggiero's rolling chair. She also testified that she could hear a conversation going on in Examination Room 3 when she was sitting at Dr. Ruggiero's desk in his office.

Ms. Neves described a sink, step stool, and small table where Dr. Ruggiero put his "medical things on" in the examination room.

Under cross-examination, Ms. Neves testified that she had never observed a pelvic examination being performed through the open pocket door and, in addition, that she

did not recall Dr. Ruggiero performing any pelvic examinations while she was working at the office.

The Committee put little weight on Ms. Neves' testimony. She was not working at Dr. Ruggiero's office at the time that Patient A was seen and therefore could not testify to how the office functioned at that time. In addition, she could not recall Dr. Ruggiero ever performing a pelvic examination while she was working for him. Accordingly, Ms. Neves was not in a position to testify as to what would have taken place in the office during pelvic examinations.

Evidence of Mr. Felice Battista

Mr. Battista testified that he has owned the office building at 1223 St. Clair Avenue West since 1995. He testified that, in around 1999, there were renovations to Dr. Ruggiero's office, including new flooring, painting, and partitions. However, he provided no further details in regards to what renovations were done.

Evidence of Ms. Mary Marchesani

Ms. Marchesani testified that she has worked full-time for Dr. Ruggiero since 1980. She initially worked with Dr. Ruggiero and three other doctors at an office at 1670 Dufferin Street but after six months she began working exclusively for Dr. Ruggiero.

Dr. Ruggiero and Ms. Marchesani both moved to 1223 St. Clair Avenue West office where she still currently works as Dr. Ruggiero's full-time secretary. She has worked continuously for Dr. Ruggiero since 1980 except for a 15-month maternity leave that began on June 2, 1984. While she was on maternity leave, Nicki Tullo and Angela Spadafora replaced her in the office.

Ms. Marchesani testified that, in the 1980s, she worked Monday to Friday from 9:00 a.m. to 6:00 or 6:30 p.m. Although Dr. Ruggiero worked on Saturdays, she did not. Ms. Marchesani described her duties as answering the telephone, taking out the charts, making appointments, sending out referrals, and writing up charts.

Ms. Marchesani testified that during the 1980s, there were part-time employees who were high school students who came into the office after school. She recalled they included Sarah Signorile, Mary Frazzano, Nicki Tullo, and Mary Chiappetta. Ms. Marchesani testified that the part-timers would sit in Dr. Ruggiero's office at his desk and would transcribe Dr. Ruggiero's dictated notes into the charts. Ms. Marchesani testified that Dr. Ruggiero's handwriting was easy to read.

Ms. Marchesani also testified that the part-timers only came up to the front reception area to drop off charts but never came up front to help her. Ms. Marchesani testified that there were instances when the part-timers would stay in the office after she had left for the day. She testified that Dr. Ruggiero would work until 10:00 or 10:30 p.m. and that the part-timer would stay until Dr. Ruggiero was finished working.

Ms. Marchesani described the office layout in the 1980s. There were three examination rooms. Examination Room 1 was referred to as the baby's room where babies were seen. Examination Room 2 was a consultation room and used to write up forms. Examination Room 3 was for performing internal examinations on women or if Dr., Ruggiero was seeing a husband and wife together. She also confirmed that the examination table that is currently in Examination Room 3 is the same one that was present in the 1980s.

Ms. Marchesani described the renovations that had been made to the office in 1998 or 1999. She testified that tiles were installed and that the office was painted. There was a wall put up to the right of the wall in front of her desk where there had been a swinging gate. There was also a new wooden ledge put in front of the reception desk as well as the glass blocks. In referring to exhibit 6, Ms. Marchesani testified that the wall visible between the waiting room and where her desk is seen was not there at all in the 1980s, during which time she was able to see from her desk the door to Examination Room 3.

Ms. Marchesani testified that, in the 1980s, the doors to examination rooms were usually open, but that sometimes they were shut. However, if Dr. Ruggiero was doing a pelvic or internal examination in Examination Room 3, Ms. Marchesani testified that the door to that room was always open four or five inches.

Ms. Marchesani testified that, sitting at her desk, she could see someone walking back and forth in front of the door to Examination Room 3 (i.e. inside the examination room), but that she could not see everything that was happening in the room. She also testified that, sitting at her desk, she would be able to hear noises coming from Examination Room 3, but that they would be muffled and it would not be clear. She acknowledged that if the door to Examination Room 3 was shut, she would not be able to hear anything from the room. She also testified that the pocket door between Dr. Ruggiero's office and Examination Room 3 would be left partially open if Dr. Ruggiero was performing a pelvic examination.

Ms. Marchesani testified that while Dr. Ruggiero was performing a pelvic examination in Examination Room 3, there would be no patients in the other examination rooms nor would patients be brought into the other examination rooms during the pelvic examination.

While Ms. Marchesani was able to recall Ms. C being a patient of Dr. Ruggiero, she could not recall Patient A.

Under cross-examination, Ms. Marchesani acknowledged that there was a ledge at the back window behind the reception area where it is possible to do some writing. Ms. Marchesani testified that the part-time student workers did not work at the window ledge in the reception area but always worked in the back office (Dr. Ruggiero's office).

Ms. Marchesani could not recall what type or colour of gloves Dr. Ruggiero used but recalled they had white paper gowns for the patients.

LEGAL PRINCIPLES

Avoiding Myths about Victims of Sexual Abuse

The Supreme Court of Canada has made it clear that sexual assault cases should be decided "without resort to folk tales" or stereotyped assumptions about how victims of

sexual abuse are expected to behave. Whether it is a delay in disclosing the abuse, or behaving in a way other than what the Panel might expect or consider appropriate, the law is clear that no adverse inference should be drawn from a victim's response to sexual abuse. As noted in *R v. DD.*:

... there is no inviolable rule how people who are victims of traumas like sexual assault will behave. Some will make an immediate complaint, some will delay in disclosing the abuse, while some will never disclose the abuse. Reasons for delay are many and at least include embarrassment, fear, guilt, or a lack of understanding and knowledge. In assessing the credibility of a complainant is simply one circumstance to consider in the factual mosaic of a particular case. A delay in disclosure, standing alone, will never give rise to an adverse inference against the credibility of the complainant. *R v. D.D.*, [2000] S.J.C. No. 44 at para. 65.

The Committee is aware that it is well established that the evidence of a complainant's emotional state after an alleged offence may be circumstantial evidence that the offence occurred, depending on whether the condition was genuine or attributable to another explanation. Post-event demeanor may support a complainant's evidence of a sexual assault. *R. v. Woollam*, 2012 ONSC 2188 at paras. 48 - 49, 64, leave to appeal refused [2013] O.J. No. 5300 (Ont. C.A.). However, in this case, the Committee is aware that Patient A's emotional state after the examination is also consistent with the theory advanced by Dr. Ruggiero that Patient A had an honest but mistaken belief as to what happened during the examination.

Credibility Assessment

The Committee recognizes the importance of assessing credibility and reliability in cases of alleged sexual impropriety where conduct is carried out in private. The Committee understands that it may accept all of what a witness said, some of it, or reject it entirely. The Committee is aware that there are a number of factors relevant to assessing credibility and reliability.

The Committee is aware that credibility has to do with honesty or the veracity of a witness' testimony. Reliability has to do with the accuracy of a witness' testimony and that it relates to the ability to accurately observe, recall and recount the events in issue. *R. v. Sanichar*, 2012 ONCA 117 (CA), at paras. 69 & 75 reversed [2013] S.C.J. No. 4, at para. 1.

In this case, the factors considered by the Committee included:

- The probability or improbability of a witness' story: Did the evidence make sense? Was it reasonable? Was it probable? Was there a tendency to exaggerate?
- Did the witness have an interest in the outcome of the hearing that may influence his or her evidence?
- Did the evidence of another witness whom the Committee considered more worthy contradict the witness' testimony?
- Has the witness given a prior inconsistent statement which affects his or her reliability?
- Did the witness have any memory impairment?
- Was the evidence verifiable?
- Was there any inconsistency between his or her oral testimony and the documentary evidence?
- Was there any internal inconsistency in the witness' oral testimony?

While the appearance and demeanour of the witness and the manner in which he or she testified may be also considered by the Committee, the Committee recognizes that demeanor alone is a notoriously unreliable predictor of the accuracy of the evidence of the witness and therefore placed little weight on demeanor.

The Committee also accepts that when assessing the credibility or reliability of a witness, inconsistencies on minor matters of detail between what the witness said at the hearing and what he or she said on other occasions are normal and to be expected and do not generally affect the credibility or reliability of the witness. When inconsistencies are on a material point about which an honest witness is unlikely to be mistaken, then that inconsistency may demonstrate carelessness with the truth. The

Committee also appreciates that an honest witness can still be mistaken and consequently, his or her evidence while sincerely given may be unreliable. In light of the theory of Dr. Ruggiero's case, the Committee paid particular attention to this aspect in assessing the evidence of Patient A.

FINDINGS

The following facts were not disputed by the parties:

- Dr. Ruggiero saw Patient A as a patient for the first time in or about 1986, when she was in her late teens;
- Dr. Ruggiero was Patient A's mother's family physician;
- Patient A was experiencing abdominal pain when she saw Dr. Ruggiero;
- Dr. Ruggiero sent Patient A for an x-ray and prescribed her Cimetidine;
- Patient A saw Dr. Ruggiero on at least two occasions in Examination Room 3 at Dr. Ruggiero's St. Clair West office, where Dr. Ruggiero continues to practise today;
- There is a doorway from Examination Room 3 into the hallway and a pocket door from Examination Room 3 into Dr. Ruggiero's office, where he has his desk;
- In 1986, the hallway door to Examination Room 3 was sometimes open and sometimes closed when a patient was in the examination room;
- A bookcase with medical supplies as seen in exhibit #7 was not present in 1986;
- Patient A was upset following her last appointment and told her mother what she said happened during her last office visit with Dr. Ruggiero;
- Patient A's mother contacted Dr. Ruggiero by telephone and also met with him in his office to discuss "what had happened with her daughter;"
- Dr. Ruggiero had a busy office and Dr. Ruggiero worked six days a week; and
- On Patient A's last visit with Dr. Ruggiero, she was asked to remove her clothing from the waist down and to lie on the examination table and place her feet in the stirrups.

Credibility of Patient A

The Committee found Patient A to be a credible and reliable witness. She testified in a calm and straightforward fashion. Counsel for Dr. Ruggiero did not dispute that Patient A was a credible witness in that she honestly believed what she said took place with Dr. Ruggiero.

The Committee is aware that prior consistent statements are not admissible to bolster a statement made during a witness's testimony, but that it can be used to form part of the narrative. Accordingly, the fact that Patient A told her mother or others about the alleged assault does not bolster her credibility nor does it make it more likely that the incident happened as she alleged. The Committee did note that there were no inconsistent statements during Patient A's testimony.

Patient A appeared to have a clear recollection of the office visits and the incident with Dr. Ruggiero as well as what transpired when she left the office and returned home. The only new detail disclosed during a December 15, 2015 interview with College counsel and the investigator and her testimony was that Dr. Ruggiero was "moaning during the incident." She could not explain why she neglected to mention this detail previously. In the Committee's experience, it is not uncommon for complainants to add additional details in pre-hearing interviews and in their testimony. Patient A was very clear to distinguish between what she saw, what she assumed, what she heard, and what she was unsure of.

When Patient A was unsure when asked a question, she said so. She acknowledged that, while she believed that she had never told Dr. Ruggiero about the incident with the storeowner, the only way that he would have known is if she or possibly her mother had told him. Patient A also acknowledged that, while she initially did not think she was given a drape or a gown to cover herself when she undressed, she may have been given a disposable paper sheet or gown.

Considering Patient A testified that she was only in Dr. Ruggiero's office on three occasions some 30 years ago, the Committee was impressed that she was able to

identify in detail certain changes that had been made to the office, including the addition of glass blocks at the reception desk as well as a “bookcase” in Examination Room 3 which was not present in 1986.

While Patient A did not recall a “pocket door” between Examination Room 3 and Dr. Ruggiero’s office, if it had been closed on that day, the pocket door may have appeared to be part of a wall. She did not recall a washroom; however, the washroom is for staff use only. If the washroom door had been closed, there would be no reason for Patient A to take notice of it. The Committee noted that no other witnesses contradicted Patient A’s detailed testimony about the structural changes she noted in the office.

Patient A recalled having three appointments with Dr. Ruggiero while Dr. Ruggiero initially only recalled one but subsequently recalled two.

As discussed below, the Committee accepted Patient A’s testimony over Dr. Ruggiero’s on this issue as it simply was more probable that three appointments occurred. Similarly, it made sense to the Committee that Patient A’s mother would accompany her on the first two appointments.

Patient A did not have any interest in the outcome of this hearing. The initial complaint was made almost 30 years after the incident with Dr. Ruggiero, when she disclosed the incident to her psychotherapist during counseling. Patient A was informed by her psychotherapist Ms. Zeyl that she was required to report the incident to the College and as a result Patient A filed a letter of complaint.

Finally, Patient A did not appear to exaggerate when providing responses to questions put to her.

The Reliability of Patient A’s Evidence and the Weight of Dr. Bender’s Testimony

A central element of Dr. Ruggiero’s defence is that, although Patient A honestly believes she was sexually assaulted by Dr. Ruggiero, her reliability as a witness is suspect, such that her evidence should not be accepted.

In support of this theory, Dr. Ruggiero called the evidence of Dr. Bender. Dr. Bender was qualified as an expert witness in psychiatry and the Committee found Dr. Bender's evidence to be credible. However, the Committee found that Dr. Bender's opinion was limited by the fact that he had not personally assessed or examined Patient A.

Dr. Bender acknowledged that he could not make a diagnosis in a patient without examining the patient himself. In addition, while Patient A testified that she was diagnosed by a psychiatrist as having borderline personality traits, Dr. Bender did not have the opportunity to review any of the CAMH documentation, including that of Patient A's treating psychiatrist at CAMH.

Dr. Bender's opinion was further limited because he was able to review only psychotherapy notes of Ms. Zeyl and an informal transcription of Patient A's testimony prepared by defence counsel. Dr. Bender acknowledged that a cross-examination in a legal setting does not normally resemble a psychiatric examination.

Dr. Bender also considered information provided by the College, including information provided to the College by Dr. Ruggiero. While Ms. Zeyl's notes reflected what state of mind Patient A had at the time she saw her, there was no documentation available as to the state of mind of Patient A when she was in her late teens when the incident with Dr. Ruggiero occurred.

While Dr. Bender provided some general comments and examples about how individuals might react to past traumas such as being sexually abused, he was not in a position to determine which of these, if any, applied specifically to Patient A when she saw Dr. Ruggiero. He did describe that victims of past trauma, such as Patient A, can have triggers and that the ability to interpret reality objectively can be impaired under acute stress.

Patient A's past childhood traumas appear to have had a significant impact on her life, including severe depression, exhibiting self-harm including cutting herself, experiencing extreme anger and rage, and contemplating suicide. However, while the Committee acknowledges that misinterpretation of reality can occur in a general sense,

it is not reasonable to infer that Patient A would have misinterpreted a normal pelvic examination as a sexual assault. This issue is addressed further, below.

The Committee found Dr. Bender's comments of an individual experiencing a traumatic experience feeling frozen was consistent with what Patient A described during the incident with Dr. Ruggiero. Dr. Bender also testified that feeling frozen does not mean that the experience that the individual is having is being misunderstood. Similarly, his comments about time slowing down during a traumatic event were also consistent with what Patient A described.

Dr. Bender explained that a traumatic experience in one's late teens can continue to show in terms of behavior many years later.

While Dr. Bender noted that the detail of Dr. Ruggiero moaning was a new detail not previously reported by Patient A, he acknowledged that he was not in a position to say whether it did or did not happen.

Dr. Bender was asked whether the other traumatic experience that Patient A had as a child could influence her psychological state at the time of her encounter with Dr. Ruggiero. Dr. Bender agreed that it was possible that Patient A was distressed by a medical examination and misinterpreted it.

Based upon Ms. Zeyl's psychotherapy notes, Dr. Bender thought there were entries that were suggestive of borderline personality features, but again, Dr. Bender did not have the opportunity to assess Patient A himself. However, he did testify that people with borderline features have a reduced capacity to deal with stressors and sometimes misperceive interpersonal interactions. Dr. Bender, however, would not be in a position to say this was the case with Patient A.

It is also important to note that the observation of Patient A's mental status by Ms. Zeyl was in 2013 and not 30 years ago.

For the reasons set out below, the Committee rejects the suggestion that Patient A misperceived the actions of Dr. Ruggiero.

Patient A showed herself to have an excellent memory for visual detail. She remembered the details of what she and the store owner were wearing at the time of her assault at age 13. She recalled details of Dr. Ruggiero's office, including the fact that a bookshelf was not there when she was in Examination Room 3 and she recalled changes to the reception area. Her visual memory was not perfect. For example, she did not remember that there was a sliding door in the examination room, but as noted above, it would be usual to not notice a pocket door if it were closed.

Dr. Ruggiero's counsel submitted that 'hand to genital' contact triggered misperception of a normal pelvic examination because of Patient A's past experiences of similar contact. While there was hand to genital contact when she was a child by another child (her sibling), this in the Committee's view this is different than touching by adult men. Further, Patient A did not describe Dr. Ruggiero touching her vagina with his hand, rather she was adamant that he was penetrating her vagina with his penis.

The similarities between her previous assault at 13 and this case are examined below.

- In the assault at age 13, Patient A was in a store and was forcibly grabbed, dragged, confined, and the owner fondled her vagina under her underwear and he rubbed his penis against her buttocks and back. This situation was no doubt terrifying to her. In contrast, Dr. Ruggiero was not forcible or aggressive by grabbing or confining her.
- Patient A had threats made against her when she was 13 and she took those so seriously that she did not tell her mother about the assault in the convenience store for about three weeks. There were no threats in this case. Dr. Ruggiero was calm and professional.
- There were elements of violence prior to the sexual assault when Patient A was 13. In contrast, in the prelude to his actions, Dr. Ruggiero acted in a way that ensured her compliance. Patient A got undressed and on the examination table willingly as she thought there was a medical reason for the pelvic examination. Although she was not sure why that was necessary, and admitted she was caught off guard, the circumstances where she was in

an office of her mother's trusted doctor would offset some of that concern. That situation was very different from the physical assault in the back of a convenience store.

- A possible element of similarity is that an element of surprise was involved in both situations. As Patient A said that, "You don't expect to go into the doctor's office to be raped that way."

Dr. Bender testified that the more closely tied the themes are between traumatic events, the more triggering or impactful they can be. He also said that the nature of the previous trauma is important. The stimuli that remind the person of a prior trauma can cause intrusive memories or vivid recollections or a dissociative state, he said. In this case, the previous assault at age 13 was in a situation where Patient A was grabbed against her will and dragged to an area at the back of a store. The setting at the store was very different from the clean, organized, clinical setting of Dr. Ruggiero's examination room. The prelude to Dr. Ruggiero's actions was not physically violent. Patient A was quite aware of what was going on. There would have been no possible "trigger" except the ultimate sexual assault itself with Dr. Ruggiero's penis in her vagina. However, at the time she perceived that, she was present and aware of her surroundings and, therefore, the Committee finds that she was not misperceiving anything.

Patient A described Dr. Ruggiero as coming towards her, which counsel for Dr. Ruggiero suggested indicated that Dr. Ruggiero was likely standing on her right side, as he testified. However, Patient A's evidence was that Dr. Ruggiero was standing at the base of the table with her feet in stirrups and her buttocks at the end of the table. She had to sit up to see what was being inserted in her vagina. The term 'coming towards her' implies that he got close to her with his upper body, which she would be able to see from that position. Dr. Ruggiero's body would have to get close to the table in order to accomplish vaginal penetration with his penis. Describing Dr. Ruggiero as coming towards her would be a reasonable description of how it would appear to her.

Patient A described feeling frozen and as if time slowed down when Dr. Ruggiero put his penis in her vagina. Although Dr. Bender described this as a common occurrence

when there is trauma, in itself it does not indicate that there was any further fragmentation or dissociation that would indicate Patient A misperceived events. In fact, her very detailed recollection of what happened during the incident and immediately after leaving Dr. Ruggiero's office as she rushed out and forgot to put on her coat indicates she was very much aware of what was going on.

Although no reliable records were presented on this point, Patient A testified that she had been diagnosed by a physician at CAHM as having borderline personality traits and major depression. She also had a history of previous trauma. The nature or severity of any borderline traits is not known. There is no evidence to establish that she met the threshold criteria for Borderline Personality Disorder and Dr. Bender testified that borderline traits are not the same as Borderline Personality Disorder.

Dr. Bender testified that there is a strong overlap of past trauma and developmental trauma in the development of borderline personality disorder. He testified that those with borderline traits have a decreased capacity to deal with stress and can be prone to misperceptions of what happened in incidents. Dr. Bender testified about the difficulty in making this diagnosis on one clinical visit, which was the case here, as Patient A saw the psychiatrist only once at the Crisis Unit of CAMH. Dr. Bender did not assess Patient A's mental health himself and did not review any records from CAMH containing any diagnosis. Dr. Bender only had Patient A's evidence and the facts contained in her letter to and interviews with the College, Dr. Ruggiero's responses to the College, a summary of Dr. Ruggiero's evidence and the clinical notes from her current psychotherapist, who as a non-physician psychotherapist would not have been in a position to make any diagnosis.

Dr. Bender testified that nominal levels of support from a family member or caregiver can have substantive effects on a person's subsequent mental health. In Patient A's case, after telling her mother about the sexual assault at age 13, her mother acted appropriately and the police were called. She also saw a family doctor at the time. That she did have support no doubt contributed to her subsequent success in life. At the time of her appointment with Dr. Ruggiero, Patient A was resilient enough to be working at

a good job and interested in her appearance and dressing nicely. Patient A's success in life, despite the considerable trauma she experienced earlier in her life, lends credence to the finding that she was not misperceiving the events in question and any borderline traits were minor and not affecting her perception.

In addition, as noted in *O'Connor*, "The mere fact that a witness has a medical or psychiatric record cannot be taken as indicative of a potential unreliability of her testimony." It would be wrong to subscribe to any myths or stereotypes.

In summary, the Committee found that Patient A's evidence was compelling, credible and reliable.

Credibility of Ms. Marchesani

The Committee placed little weight on Ms. Marchesani's testimony for several reasons.

First, Ms. Marchesani does not recall Patient A and, therefore, was not in a position to testify as to what occurred during Patient A's office visits.

Second, she has served as a longtime and loyal employee of Dr. Ruggiero. Her employment is dependent on Dr. Ruggiero's ability to continue to practise. Therefore, Ms. Marchesani has a significant interest in the outcome of the matter before the Committee.

Third, Ms. Marchesani's testimony was not credible in regards to where the part-time high school students did their work. She testified that the students always worked at Dr. Ruggiero's desk and not at the window ledge in the reception area. This was contradicted by Ms. Spano, Ms. Neves, and Dr. Ruggiero, all of whom testified that the students would work at the window ledge in the reception area. The Committee accepts the evidence of Ms. Spano, Ms. Neves and Dr. Ruggiero on this point and does not accept Ms. Marchesani's testimony. Further, the Committee finds that Ms. Marchesani was not honestly mistaken in her recollection about where the student worked. The Committee therefore found her evidence on the point to be neither credible nor

reliable. Given this finding, the Committee could not rely on Ms. Marchesani's testimony as to whether the door to Examination Room 3 was open during pelvic examinations or that patients were not in or not brought into Examination Rooms 1 or 2 while Dr. Ruggiero was performing a pelvic examination in Examination Room 3.

She also testified that the students transcribed Dr. Ruggiero's dictations of his patient encounters. However, Dr. Ruggiero made no mention of dictating his notes. Rather, he testified that he would make some brief written entries in the chart which were not very legible and that the students would use a template and turn his entries into sentences.

In addition, as will be discussed below, Ms. Marchesani's testimony about the door to Examination Room 3 being open during a pelvic examination room or patients not being brought into Examination Rooms 1 and 2 does not make sense to the Committee.

Credibility of Ms. C

The Committee found Ms. C to be a difficult witness in part because of her frailty and in part because of the language barrier, despite having an interpreter present. However, the Committee did find her testimony to be credible on two points. The first was Ms. C's recollection that her daughter had been so upset upon her return from her final visit to Dr. Ruggiero that she had called Dr. Ruggiero's office and arranged to see him at his office to find out what had happened in the appointment with her daughter. The Committee found this portion of Ms. C's testimony to be credible because it was corroborated when Dr. Ruggiero testified that Ms. C had indeed phoned him and had come in to meet with him to discuss her daughter's appointment.

The Committee also found Ms. C's explanation as to why she did not cease being Dr. Ruggiero's patient after the incident with her daughter to be credible. The Committee found that Ms. C's testimony that she had indeed wanted to leave Dr. Ruggiero after the incident with her daughter but could not because she needed his assistance to receive worker's compensation was a reasonable explanation for Ms. C's decision to stay with Dr. Ruggiero.

Credibility of Dr. Ruggiero

The Committee did not find Dr. Ruggiero to be a credible witness. He appeared to have an “evolving memory” fraught with numerous inconsistencies. He also made several statements that either had no factual basis or were devoid of logic.

Without the benefit of a medical chart, laboratory reports, or OHIP billing reports, Dr. Ruggiero provided a very detailed account of his visits with Patient A during his testimony. These details included which lab tests he ordered, the results of each of those tests, which parts of the physical examination he carried out, what medication he prescribed, including the dosage, and the details of the pelvic examination including that it was her first pelvic examination, that he used a small speculum and that the examination lasted only three to four minutes.

He testified in chief that Patient A had told him she had taken Maalox for her abdominal pain. However, in cross-examination he said, “I think she [Patient A] told me she was taking an antacid, and at the time, basically, we had Maalox.”

Dr. Ruggiero also indicated for the first time in April 2014 after he received the copy of Patient A’s letter of complaint that he prescribed Cimetidine. He also recalled the dose of the Cimetidine he prescribed. He testified that he prescribed Cimetidine on the first office visit. Conversely, Patient A recalled the Cimetidine being prescribed at the second visit when she was informed that she had an ulcer.

While he acknowledged that Patient A was correct in her letter that she received a prescription for Cimetidine, Dr. Ruggiero denied that his recall of prescribing Cimetidine was as a result of reading the letter; rather, he said he had a memory of writing the prescription and Patient A picking it up at the pharmacy.

Dr. Ruggiero testified that his recollection of Patient A’s visits were not based on his usual practice in dealing with a patient presenting with abdominal pain, but rather an independent recollection of the visits.

The Committee concluded that Patient A's presenting problem was not an exotic or unusual one that one might expect a physician to remember. In fact, Dr. Ruggiero testified that abdominal pain was a common presenting problem in his practice, and that he sees on average four to five patients a day with abdominal pain. However, despite having seen thousands of patients with abdominal pain since seeing Patient A, Dr. Ruggiero testified that he had an independent recollection of Patient A's case.

The Committee found it is simply implausible for a physician to recall specific details of two medical encounters that occurred 30 years earlier for a common presenting problem such as abdominal pain without the aid of any clinical documentation. However, if Dr. Ruggiero had engaged in sexual impropriety during Patient A's last office visit, which one would expect to be a memorable event, this could be a possible explanation why Dr. Ruggiero now recalls specific details of Patient A's medical issues.

While Dr. Ruggiero testified that Patient A's mother did contact him and come to see him at the office to ask him what he had done to her daughter, he denied that Patient A's mother ever accused him of rape and gave evidence that he would have kept Patient A's chart if there had been an accusation of rape. Under cross-examination, when asked if he was "accused of rape by [Patient A's] mother, you would have had a good reason to remember Patient A's appointment, wouldn't you?" the Committee noted that Dr. Ruggiero's initial response was, "not necessarily, as I said over the years I had forgotten all about the various visits."

The fact that Dr. Ruggiero responded that he had forgotten all about the visits would support the proposition that it would be very unlikely, if not impossible, for Dr. Ruggiero to recall the specific details of Patient A's appointments and ailments. However, the Committee also noted that Dr. Ruggiero subsequently acknowledged that, if he had been accused of rape by Patient A's mother, "you would remember somewhere along the line."

Further, there is good reason to question Dr. Ruggiero's memory of the events, as his prior statements and testimony demonstrate.

When initially asked by Mr. Lobsinger if there had been any structural changes to his office since 1985, Dr. Ruggiero responded that there had not been. However, later on, Dr. Ruggiero did recall that there were structural changes made to the office. Other witnesses confirmed that there were structural changes to the office, demonstrating that Dr. Ruggiero's initial memory in this regard was faulty.

The Committee found Dr. Ruggiero's testimony about when examination room doors would be open or closed to be neither credible nor logical. Dr. Ruggiero testified that if he was doing a respiratory examination of a patient in Examination Room 3, he would close the door. However, if he was doing a pelvic examination – a much more intimate examination – in Examination Room 3, he testified that he would leave the door to the hallway ajar. Dr. Ruggiero testified that he left the door open so that his secretary sitting at the reception desk “could see what was going on.”

Ms. Marchesani testified that the door to Examination Rooms 3 was left open four or five inches while Dr. Ruggiero performed a pelvic examination. In reviewing exhibit #7, it is clear that if the door to Examination Room 3 were only four or five inches open, only a part of the chair and a small part of the wall where the bookcase now stands would be visible. The secretary would not be able to see the area of the room where the examination table is and therefore would not be able to “see what was going on.” Although exhibit 7 reflects the office as it was at the time of the hearing and not at the time of the incident, the evidence as to the prior office layout does not support that significantly more of Examination Room 3 would be visible.

Dr. Ruggiero and Ms. Marchesani also acknowledged that a secretary sitting at the reception area would probably not hear the examination if the door to Examination Room 3 was open and would not hear anything if the door was closed.

Dr. Ruggiero testified in chief that that he told Mr. Lobsinger that the door from Examination Room 3 was open while Patient A was in the examination room. However, he acknowledged during cross-examination that nowhere in the transcript of the voicemail left for Mr. Lobsinger or his handwritten response did he mention that

the door to the hallway was open. Rather, he indicated that the pocket door to his office from Examination Room 3 was half open.

Patient A testified that the doorway from Examination Room 3 to the hallway was closed on the third visit. Although Patient A did not recall a pocket door, she testified that no door was open during the third visit. The Committee accepted her evidence in this regard based on its assessment of her credibility as well as the plausibility of the fact that examination room doors would likely be closed to protect patient privacy.

The Committee also noted that Dr. Ruggiero initially told investigators that the pocket door to his office was open and his secretary, Sarah (Spano), was sitting at his office desk when he performed the pelvic examination on Patient A. Dr. Ruggiero had told investigators that Sarah could see into the examination room. If that had been the case, there would be no need to leave the door to the hallway open as well. Ms. Spano testified that she had never sat in Dr. Ruggiero's office, which evidence the Committee accepted. Dr. Ruggiero's evidence at the hearing was that Ms. Spano may not have been in his office during Patient A's examination.

Furthermore, the Committee finds that leaving a door to an examination room open while doing an intimate examination strains credulity, as this would be a serious breach of confidentiality and privacy.

There were also inconsistencies in Dr. Ruggiero's testimony in regard to the doors to Examination Rooms 1 and 2. At one point, Dr. Ruggiero testified that if patients were in Examination Rooms 1 and 2 while he was doing a pelvic examination in Examination Room 3, that the doors to the first two examination rooms would be closed. However, later on, Dr. Ruggiero testified that no patients would be in Examination Rooms 1 and 2, nor would any patients be brought into Examination Rooms 1 or 2, if he was conducting a pelvic examination in Examination Room 3.

The Committee found that it does not make sense to leave two out of three examination rooms in a busy office vacant when the door to Examination Room 3

could be closed to protect privacy and confidentiality. Leaving two out of three examination rooms in a busy office vacant also strains credulity.

Dr. Ruggiero testified that Patient A came to his office on only two occasions, while Patient A testified that she had three appointments with Dr. Ruggiero. There was no patient chart, laboratory records, or record of OHIP billings that to account for Patient A's visits. The Committee preferred Patient A's testimony in regard to the number of appointments Patient A had with Dr. Ruggiero. Patient A's evidence with respect to this issue made more sense. There is no dispute that when Dr. Ruggiero saw Patient A on her first visit, he took a history related to her presenting problem, did a physical examination, and ordered investigations, including an x-ray. It logically follows that, by the second visit, Dr. Ruggiero would have received the results of the investigations and subsequently on the second visit, informed Patient A of the results including of the x-ray. The x-ray indicated that Patient A had a stomach ulcer. There is no dispute that Dr. Ruggiero prescribed Cimetidine, which would make sense, since it is a drug that was used to treat stomach ulcers. It would not make sense from a medical perspective, based on the results of the x-ray, to consider another diagnosis or perform a pelvic examination. Rather, it would be more logical that Dr. Ruggiero would simply treat the stomach ulcer at the second visit with Cimetidine and have Patient A return for a follow-up third visit, as Patient A testified occurred.

Dr. Ruggiero testified that Patient A's mother did not accompany her on any of her appointments, while Patient A testified that her mother accompanied her on her first two appointments. The Committee preferred Patient A's testimony on this point. Patient A's mother was Dr. Ruggiero's patient. Patient A had never seen Dr. Ruggiero previously. Patient A testified she had a mistrust of men generally after the sexual assault at age 13. It was Patient A's mother who asked Dr. Ruggiero to see her teenage daughter for her abdominal pain. Since Patient A had never previously seen Dr. Ruggiero, it would make sense for Patient A's mother to accompany her teenage daughter to introduce her to Dr. Ruggiero on her first visit. It would also make sense that she would want to accompany her daughter on her second visit, when Patient A

would have been informed of the results of the tests that had been ordered on the first visit.

Critically, Dr. Ruggiero's statements about material events, including those concerning the purported vaginal examination, changed on multiple occasions.

Dr. Ruggiero initially indicated to College investigators that Patient A presented with a "vaginal" problem and that there was only one office visit. However, in speaking with Mr. Lobsinger on March 31, 2014 – sometime after receiving a copy of Patient A's letter of complaint – Dr. Ruggiero changed his story and indicated to Mr. Lobsinger that Patient A presented with "abdominal pain and epigastric pain." Dr. Ruggiero subsequently changed his story once again and said that there were two office visits.

Dr. Ruggiero provided at least four different explanations as to why he would have performed a pelvic examination on Patient A. These explanations, some of which had no factual basis and were later abandoned by Dr. Ruggiero were, in the opinion of the Committee, veiled attempts to construct a legitimate reason to explain why he would have performed a pelvic examination on Patient A. For example, Dr. Ruggiero initially said that he did a pelvic examination because Patient A was experiencing vaginal problems, which was not the case because she presented with abdominal pain. Initially, Dr. Ruggiero testified that Patient A was probably sexually active but that did not know for sure. Later in his testimony, during cross-examination, when he was reminded of having told Mr. Lobsinger that Patient A was feeling guilty about having sex with her boyfriend and wanting to be checked out, Dr. Ruggiero was much more definitive and adopted his prior statement. In fact, Patient A testified that she never had sexual intercourse prior to seeing Dr. Ruggiero, evidence which the Committee accepted. The Committee finds that Patient A made no statement to Dr. Ruggiero about having sex with a boyfriend, feeling guilty and wanting to be checked out.

Dr. Ruggiero also stated that he performed the vaginal examination because Patient A recently, within weeks of her appointment with Dr. Ruggiero, had been forced to have sex with her boss to keep her job. Dr. Ruggiero was aware of Patient A's sexual assault at the hands of the storekeeper. However, the incident was not "recent" within weeks

of the appointment, as Dr. Ruggiero stated. The storekeeper incident had occurred several years before, when Patient A was 13 years old.

In addition, Dr. Ruggiero made some inconsistent statements in regard to the incident with the storekeeper. Initially, he testified in chief that Patient A “had been in a convenience store and that somebody had raped her, the owner or manager.” Later on, he testified that Patient A was “forced to have sex” with a storekeeper to keep her job, which is consistent with the letter by his counsel sent on his behalf to the College in February 2015 (his initial April 2014 letter to the College maintained that she was forced to have sex but did not include any reference to having to keep her job). The Committee accepted Patient A’s evidence concerning the incident with the shopkeeper, including that she was only 13 years old at the time of the assault and was not employed by the storekeeper. In addition, Patient A never used the phrase “forced to have sex” and always referred to the incident with the storekeeper as “rape.”

It is to be expected that Dr. Ruggiero may have difficulty accurately recalling all the details of the incident with the store keeper, but his difficulty recalling the incident highlights the difficulty in relying on his memory of his interactions with Patient A.

In his April 2014 letter to the College, Dr. Ruggiero indicated that he did a pelvic examination for “lower abdominal pain.” However, Patient A testified that she was having upper, and not lower, abdominal pain. Dr. Ruggiero also stated that the reason he conducted a pelvic examination was because Patient A was having lower abdominal pain. In addition, if there were only two office visits with Patient A, as Dr. Ruggiero testified, it would not make sense to perform a pelvic examination on the second visit since, at the second visit, there was an obvious diagnosis of a stomach ulcer, which would explain Patient A’s abdominal pain.

The Committee finds that none of Dr. Ruggiero’s explanations as to why he would have performed a pelvic examination on Patient A were credible.

Therefore, the Committee also finds that Dr. Ruggiero was being deceptive when he provided College investigators, this Committee, as well as Patient A’s mother with

various explanations. The Committee finds Dr. Ruggiero's explanations for why he would have performed a pelvic examination not credible as they did not have a factual basis, and finds that they were merely attempts to provide a legitimate explanation to explain why he would have asked Patient A to undress from the waist down and lie on the examination table for a purported pelvic examination.

Findings Regarding the Alleged Sexual Impropriety

As noted above, the Committee found that Patient A had three appointments with Dr. Ruggiero, that Ms. C accompanied her to the first two appointments, and that all doors to Examination Room 3 were closed during the incident.

Patient A testified that Dr. Ruggiero did not perform a pelvic examination on her at any time, and that it was on a third visit, when her mother did not accompany her, that she was asked to undress from the waist down and lie down on the examination table. Dr. Ruggiero testified that he performed a pelvic examination on the second of the only two appointments he testified he had with Patient A.

Dr. Ruggiero testified that he always performs pelvic examinations standing on the right side of the patient, and not from the foot of the examination table. Dr. Ruggiero testified that he would have the examination table extension leaf in the up position where he places his supplies and instruments for performing the pelvic examination.

Patient A was quite adamant that when she raised her head on more than one occasion to "see what was happening" that she saw Dr. Ruggiero at the foot of the examination table. She did not describe Dr. Ruggiero being at her right side. If Dr. Ruggiero was in fact standing at Patient A's right side, there would be no reason for Patient A to lift her head to see Dr. Ruggiero; she would merely have to turn her head to the right to see him.

The Committee accepts Patient A's testimony that Dr. Ruggiero was standing at the foot of the examination table rather than at her right side. The Committee does not accept that the effects of any prior traumatic experience or traits would cause Patient A to be mistaken as to where Dr. Ruggiero was standing.

The fact that Dr. Ruggiero was standing at the foot of the examination table supports Patient A's assertion that Dr. Ruggiero did not perform a pelvic examination on her which she misunderstood or misperceived, because Dr. Ruggiero testified he did given he does not perform pelvic examinations from the foot of the examination table.

The Committee concluded that is unlikely that Patient A simply misinterpreted a speculum or a gloved finger as a penis if, as the Committee found, Dr. Ruggiero was standing in a position during the encounter that he does not stand in to perform pelvic examinations. In addition, Patient A also provided another detail in that she noted Dr. Ruggiero's pants were unzipped. One would not expect this detail to emerge if a pelvic examination was being misinterpreted as something other than what it was. Finally, Patient A recalled Dr. Ruggiero moaning when his penis was in her vagina and one would not expect that detail to emerge if a pelvic examination was simply being misinterpreted.

Patient A also testified that she knows Dr. Ruggiero was not performing a pelvic examination on her because her gynecologist has performed pelvic examination on her utilizing a speculum and that she knows what that feels like. In addition, Patient A did not describe Dr. Ruggiero pressing on her abdomen when Dr. Ruggiero testified he was performing a "bimanual examination" during the pelvic examination. Patient A was also aware what a digital examination of her vagina felt like because she had one performed by a physician at the age of 13 following the incident with the storekeeper. The Committee accepted Patient A's evidence in this regard.

The Committee has set out above its review of, and rejection of, all of Dr. Ruggiero's explanations as to why he would have performed a pelvic examination on Patient A.

When this is coupled with Patient A's evidence, this leads the Committee to conclude that when Dr. Ruggiero asked Patient A to undress from the waist down and lie down on the examination table, it was not his intention to perform a medically-indicated pelvic examination. Rather, his true intent was to take advantage and exploit a vulnerable patient by inserting his penis into her vagina for self-gratification.

In this regard, it is also notable that Dr. Ruggiero had volunteered to Mr. Lobsinger that he recalled that Patient A had been dressed “very, very seductively” the day of the alleged assault. Dr. Ruggiero testified that he told Mr. Lobsinger during the investigation that Patient A was dressed very seductively in a response to a question from Mr. Lobsinger in regard to Patient A’s appearance.

However, Mr. Lobsinger testified that the conversation was as follows. Mr. Lobsinger asked Dr. Ruggiero at the end of a telephone call, “Do you have any idea when you could provide a response to the letter of complaint?” to which Dr. Ruggiero replied, “Give me a day or so and I will run it by a friend who is a lawyer. I remember she [Patient A] was dressed very, very seductively that day. We made a comment about her red fingernails and toenails.” Mr. Lobsinger then asked Dr. Ruggiero, “Who is we?” to which Dr. Ruggiero responded, “Mary [Marchesani] and I.” The Committee accepted Mr. Lobsinger’s evidence on this point.

While there were numerous inconsistencies in Dr. Ruggiero’s evidence, he was able to accurately recall that there was an incident with a storekeeper during which involved a sexual assault, which was true. He also recalled Patient A’s appearance on the day of the incident. Dr. Ruggiero spontaneously disclosed to the College investigator that he recalled that Patient A was dressed very, very seductively. Dr. Ruggiero also recalled that she had red nail polish on her finger and toe nails and wore a brightly coloured coat which Patient A also testified she was wearing when she saw Dr. Ruggiero. He testified that when he saw Patient A that it was unusual for young Italian women in the 1980s to dress in bright colours and they usually dressed in subdued colours. Dr. Ruggiero also testified that Patient A was not a virgin when he saw her. In describing Patient A’s appearance, it is the opinion of this Committee that Dr. Ruggiero’s perceived Patient A in a sexualized manner.

Counsel for Dr. Ruggiero argued that it would be difficult to carry out an act of sexual assault in a small, busy office where the physician is concerned about seeing all of his patients. The Committee disagrees. The Committee does not believe that having patients wait a little longer to be seen would be a significant deterrent to such activity.

Further, there was testimony from Mary Neves that, even on a busy day, an appointment with a patient might take 40 minutes.

Counsel for Dr. Ruggiero further submitted that, since the rooms were close together, Patient A would have been heard if she had screamed or cried out. The Committee disagrees. This Committee has seen physicians before it who have been found to have sexually abused patients in their office during office hours. On the basis of experience, the Committee rejects the argument that a physician would not sexually abuse a patient simply because of the risk of getting caught.

Counsel for Dr. Ruggiero also argued that it would be impossible for Dr. Ruggiero to insert his penis into Patient A's vagina standing at the foot of the examination table with extension leaf either up or down. Several photos of Dr. Ruggiero were entered as exhibits with him standing at the end of the examination table (exhibits 9, 10 and 11.)

Dr. Ruggiero initially testified that, as positioned in the photographs, it would not be possible to rape Patient A. However, he later acknowledged it would be "awfully difficult," but not impossible, to have a sexual encounter with a female patient while standing in the position as depicted in exhibit 10 and while placing one foot up on the base of the table.

Counsel for Dr. Ruggiero argued that if Dr. Ruggiero bent his knees while standing on the base of the table, as in exhibit 11, that the extension leaf being in the down position would prevent him from bending his knees to lower his pelvis. The Committee disagrees. If Dr. Ruggiero was standing slightly back from the lowered extension leaf, he could bend his knees sufficiently to lower his pelvis.

In addition, counsel for Dr. Ruggiero argued that unless the Patient A's buttocks were brought down to the very edge of the table it would be difficult to see how intercourse would be possible. Dr. Ruggiero argues that it is more likely the buttocks were brought down to the "black line" if her feet were in the stirrups.

Counsel for Dr. Ruggiero argued that to move her buttocks to the end of the table, Patient A could not comfortably put her feet in the stirrups and there was no evidence

that the stirrups were adjusted. However, the Committee notes that the distance between the “black line” and the edge of the table is only a few inches. In addition, the photos merely show the position of stirrups on the day that the photo was taken, which may not be the position on the day Patient A was seen. It is possible that the stirrups were further down the rail and would allow Patient A to comfortably put her feet in the stirrups while her buttocks were at the edge of table.

In summary, the Committee finds that exhibits 9-11 do not establish that Dr. Ruggiero could not insert his penis into Patient A’s vagina while standing at the end of the bed.

Counsel for Dr. Ruggiero argued that that because Dr. Ruggiero acted in a “calm professional demeanor” that what Patient A described happened was implausible. In addition, Dr. Ruggiero argues that Dr. Ruggiero did not make any inappropriate or sexual comments or was leering or exhibited behaviours of a sexual nature.

The Committee is careful to avoid myths associated with sexual assault victims. Similarly, the Committee must also avoid assuming that an individual who sexually abuses their victim must behave in a certain manner, such as making inappropriate or sexual comments or remaining calm during the incident. Because Dr. Ruggiero remained calm and did not make any inappropriate comments does not necessarily mean that he could not have sexually abused Patient A.

While Dr. Ruggiero suggests that Patient A would not see what was going on when she lifted her head because her view would be obstructed by a sheet or gown over her knees, Patient A was emphatic that there was nothing covering her knees. Dr. Ruggiero also testified in chief his usual practice in performing a pelvic examination including providing the patient a gown. Dr. Ruggiero testified that he gave Patient A a paper examination gown to put on but did not mention a sheet or drape. However, the Committee notes that Patient A was unsure whether she was given a drape or gown. Initially, she said that she was not given gown or drape, but later acknowledged that “maybe” she was given a “disposable paper.”

There are three possible reasons why there was nothing covering Patient A's knees. Firstly, she was never given a paper sheet or gown. Secondly, if she had been given a gown or sheet it may not have been placed over the knees. Lastly, the paper sheet or gown at some point slipped down off her knees. The Committee finds that even if a paper sheet or gown was provided to her, there is no evidence that it ever obstructed Patient A's view when she raised herself up to see what was going on. The Committee accepts Patient A's evidence that there was nothing obstructing her view.

Counsel for Dr. Ruggiero argued that Patient A misinterpreted a gloved hand for Dr. Ruggiero's penis. Patient A heard some rummaging noises and "assumed" Dr. Ruggiero was putting on gloves. This assumption is reasonable, since a patient would not be expecting their physician to be getting ready to insert their penis into her vagina. However, Patient A testified that she never saw Dr. Ruggiero putting on gloves. When she raised herself, she was emphatic that what she saw was not a gloved hand but a penis with a condom on it. In addition, she provided another important detail in that she specifically noted that his pants were unzipped. If it was simply a gloved finger that she saw and misinterpreted it as a penis, one would not expect her to provide the detail that his pants were unzipped. This clear observation by Patient A also indicates to the Committee that Patient A did not misinterpret a gloved hand for a penis.

In addition, if Dr. Ruggiero was standing at her right side while performing a pelvic examination while wearing a white coat as depicted in exhibits 9 to 11, it would be very difficult, if not impossible, for Patient A to see if Dr. Ruggiero's pants were zipped or not. In addition, Patient A described Dr. Ruggiero moaning during the incident, which would not be expected during a pelvic, or any legitimate medical examination.

In summary, Patient A is emphatic that, when she raised her head to see what was going on, there was no sheet or drape obstructing her view and she saw Dr. Ruggiero's pants unzipped and his penis with a condom on it going in and out of her vagina while hearing him moaning. The fact that Patient A is certain that Dr. Ruggiero was at the end of the examination table during the incident, rather than at the side of the

examination table, places Dr. Ruggiero at a location in which he testified that he does not perform pelvic examinations, and further supports Patient A's allegation that he was not there to perform a pelvic examination but rather to put himself in a position to insert his penis in Patient A's vagina. The only new detail that emerged during Patient A's testimony was that Dr. Ruggiero was moaning while he was inserting his penis in Patient A. She could not explain why she did not mention that fact before her meeting with College counsel and the College investigator on December 15, 2015.

Counsel for Dr. Ruggiero argued that memory or erosion of memory makes it more difficult for a member to provide detailed evidence that could clear his name.

However, Dr. Ruggiero testified he had an independent recollection of the appointments and said he recalled many specific details of what occurred on the two office visits.

Despite testifying to having an independent recollection of details of Patient A's visits with him, Dr. Ruggiero changed his story repeatedly over the course of the investigation and during his testimony on various elements including why he would have performed a pelvic examination on Patient A.

In summary, the Committee did not find Dr. Ruggiero to be a credible witness. There were numerous inconsistencies in his testimony. The Committee found Patient A to be a credible witness and her testimony to be reliable. The Committee finds that Patient A saw Dr. Ruggiero standing at the foot and not at the right side of the examination table with his pants unzipped and his penis with a condom in her vagina.

Therefore, having regard to these facts, the Committee finds that Dr. Ruggiero committed an act of professional misconduct, in that he engaged in sexual impropriety with a patient.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Ruggiero, 2017 ONCPSD 1**

**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. DONATO ANTHONY RUGGIERO

PANEL MEMBERS:

**DR. C. CLAPPERTON (CHAIR)
MR. S. BERI
DR. E. STANTON
DR. E. ATTIA
DR. T. MORIARITY**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

**MS. M. KELLYTHORNE
MS. R. AINSWORTH**

COUNSEL FOR DR. RUGGIERO:

**MS. J. STEPHENSON
MS. R. ZATZMAN**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

PUBLICATION BAN

Penalty Hearing Date:	October 14, 2016
Penalty Decision Date:	October 14, 2016
Release of Penalty Reasons Date:	January 16, 2017
Appeal:	Dr. Ruggiero appealed the decision on October 31, 2016

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario delivered its written decision and reasons for decision on finding in this matter on August 23, 2016, and found that Dr. Ruggiero committed an act of professional misconduct in that he engaged in sexual impropriety with a patient.

The Committee heard evidence and submissions on penalty and costs on October 14, 2016, and delivered its penalty and costs order with written reasons to follow.

BACKGROUND

The Committee’s reasons on finding are set out in its written decision of August 23, 2016. An overview of the Committee’s findings is below.

Patient A first saw Dr. Ruggiero around 1986 when she was in her late teens. He was her mother’s family doctor, so she attended at his office. Patient A recalled that she visited Dr. Ruggiero on three occasions because she was suffering from abdominal pain. Dr. Ruggiero diagnosed her with a stomach ulcer.

Patient A recalled that at her final appointment, Dr. Ruggiero directed her to remove her clothing from the waist down. The Committee found that Dr. Ruggiero’s intention at that time was not to conduct an examination, but rather to insert his penis into her vagina for his own self-gratification. Patient A testified that it was while she was lying on the examination table, with Dr. Ruggiero standing at its foot, that something did not feel right. Patient A described how she tried to sit up and saw Dr. Ruggiero, his pants unzipped, with his penis with a condom on it partway inside her vagina.

She testified that, to her, the incident seemed to go on forever and that she wanted to scream, but that a scream just would not come out.

Although she told her mother about the incident, Patient A never reported Dr. Ruggiero to the authorities, thinking that no one would believe her.

There was no dispute that a physician-patient relationship existed between Dr. Ruggiero and Patient A.

The Committee found that Dr. Ruggiero committed an act of professional misconduct in that he engaged in sexual impropriety with a patient. A penalty hearing was conducted.

EVIDENCE AND SUBMISSIONS ON PENALTY

Counsel for the College submitted that the suitable penalty was the revocation of Dr. Ruggiero's certificate of registration, a public reprimand and costs in the amount of \$25,000.00 based upon five hearing days at a tariff rate of \$5,000.00 per day.

Counsel for Dr. Ruggiero did not contest the proposed penalty because she agreed that revocation was the appropriate penalty for the serious act of sexual impropriety found by the Committee to have occurred.

In determining an appropriate penalty order, the Committee considered the submissions of both parties. In addition, it considered the facts and findings in its Decisions and Reasons for Decision in this matter dated August 23, 2016, as well as the victim impact statement made by Patient A.

THE APPLICABLE LEGISLATION

When the misconduct occurred

It was important for the Committee to consider the relevant legislation given that the sexual misconduct in this case occurred approximately 30 years ago.

Currently, physicians are governed by the *Regulated Health Professions Act, 1991* (the RHPA). The RHPA came into effect on December 31, 1993. Prior to December 31, 1993, the *Health Disciplines Act, 1980* was the governing legislation.

To determine whether the RHPA or the *Health Disciplines Act, 1980*, applies in a given case, the Committee must look at when the misconduct occurred. If the misconduct occurred after December 31, 1993, the RHPA applies. If the misconduct took place prior to December 31, 1993, as it did in this case, the *Health Disciplines Act, 1980* applies.

Sexual Impropriety

As the *Health Disciplines Act, 1980* applies in this case, it is also helpful to note that the *Health Disciplines Act, 1980* uses the term “sexual impropriety”. The regulations under the *Health Discipline Act, 1980* define professional misconduct to include “sexual impropriety with a patient” but do not explicitly define sexual impropriety.

The Health Professions Procedural Code (the Code), which is Schedule 2 to the RHPA, which came into effect on December 31, 1993, uses the term “sexual abuse” to refer to sexual misconduct by a physician with a patient. The Code defines sexual abuse as:

- a) sexual intercourse or other forms of sexual relations between the member and the patient,
- b) touching of a sexual nature, of the patient by the member, or
- c) behaviour or remarks of a sexual nature by the member towards the patient.

Given the *Health Discipline Act, 1980* is the applicable legislation in this case, the Committee has used the term “sexual impropriety” in describing Dr. Ruggiero’s sexual misconduct. In using the term “sexual impropriety”, the Committee uses the terminology of the applicable statute without in any way wishing to understate the very serious nature of Dr. Ruggiero’s misconduct.

What penalties does the *Health Discipline Act* provide for sexual impropriety?

The *Health Disciplines Act*, 1980 does not provide specific penalties for findings of sexual impropriety. The *Health Disciplines Act* 1980 provides a range of penalties for findings of professional misconduct and incompetence.

Section 60(5) of the *Health Disciplines Act*, 1980 describes the penalties the Discipline Committee may consider when it makes a finding of professional misconduct. The Discipline Committee may make an order to do any one, or a combination, of the following:

- (a) revoke the licence of the member, or withdraw recognition of his specialist status, or both;
- (b) suspend the licence of the member or recognition of his specialist status, or both, for a stated period;
- (c) impose such restrictions on the licence of the member for such a period and subject to such conditions as the Committee designates;
- (d) reprimand the member and, if deemed warranted, direct the fact of such a reprimand be recorded on the register;
- (e) impose such a fine as the Committee considers appropriate to a maximum of \$5000 to be paid by the member to the Treasurer of Ontario for payment into the Consolidated Revenue Fund;
- (f) direct that the imposition of a penalty be suspended or postponed for such a period and upon such terms as the Committee designates,

Therefore, the sanctions of revocation of Dr. Ruggiero's certificate of registration and a reprimand are available to the Committee under the provisions of the *Health Disciplines Act*, 1980.

Costs

The Committee noted that there is no provision or authority in the *Health Disciplines Act*, 1980 for the Committee to award the costs that the College is seeking. Notwithstanding the lack of a costs provision in the *Health Disciplines Act*, 1980, counsel for Dr. Ruggiero is not contesting the costs that the College seeks.

Counsel for Dr. Ruggiero acknowledged that the law in Ontario is that the issue of costs is a procedural one as opposed to a substantive one, and that current law can be applied in this matter retrospectively. Therefore, although the *Health Disciplines Act*, 1980 does not provide for the costs that the College is seeking to be ordered, the *Regulated Health Professions Act*, 1991 does. Accordingly, the costs provisions outlined in the *Regulated Health Professions Act*, 1991, can be applied retrospectively.

PENALTY DECISION

For the reasons that follow, the Committee's decision was to revoke Dr. Ruggiero's certificate of registration. The Committee also ordered that Dr. Ruggiero appear before this Committee to be reprimanded and to pay costs of \$25,000.00.

REASONS ON PENALTY

The principles relevant to imposing a penalty in a discipline proceeding are well established. The protection of the public is the paramount consideration.

Others principles include: maintenance of public confidence in the reputation and integrity of the profession and in the College's ability to regulate the profession in the public interest; general deterrence as it applies to the profession as a whole; specific deterrence as it applies to the member; and, where appropriate, the potential for rehabilitation of the member. In arriving at its decision regarding penalty, the Committee must weigh these principles in light of the specific

facts and circumstances of each case. Aggravating and mitigating factors, if any, must be also considered.

Proportionality is also an important factor to be considered by the Committee and the Committee also accepted the principle that the most severe penalties should be imposed for the most serious transgressions. In addition, the Committee acknowledges the general principle that similar cases should be dealt with in a similar fashion.

As stated in *Stevens v. The Law Society of Upper Canada (1979)*:

A conscious comparison should be made between the case under consideration and similar cases wherein sentences were imposed. If the comparison with other cases is not undertaken, there may well be such a wide variation in the results so as to constitute not simply unfairness but injustice. Consideration of such a nature should have as great significance for the professional discipline bodies with the power to impose onerous penalties as they do for Courts of Appeal and of first instance dealing with sentences upon conviction of criminal offences.”

The Committee also considered the passage of time and its potential impact on the penalty, since historical sexual impropriety took place. This is relevant in the case before this Committee since Dr. Ruggiero’s misconduct occurred over 30 years ago.

As stated in *R.v J.R. (Ontario Court of Appeal 2003)*:

“While the respondent’s conduct in the 20 years between the offences and his arrest demonstrates that he pose little risk of re-offending, the passage of time does not diminish the need for a denunciatory sentence given the seriousness of these crimes.”

The principles of specific and general deterrence and denunciation should not be rendered inapplicable or considered of less import merely because there has been a passage of time. As stated in *R. v. Spence (1992)*, 78 C.C.C. (3d) 451 (Alta. C.A.) at pp. 454-456:

When a period of many years has elapsed between the commission of an offence of sexual assault and its discovery by the authorities, that circumstance dictates review of the degree to which the usual principles of sentencing are applicable in such circumstances.

...

The lapse of time does not, in any way, render inapplicable the principles of general deterrence and denunciation. The first of these requires a sentence which will intimidate those other than the offender who might be tempted to follow his example. The second requires a sentence by the imposition of which the court will reflect society's view of the wrongness of the conduct, and persuade those who might be confused about what is right and wrong. These two principles may overlap in their effect on the choice of sentence. The need for the sentence to reflect the community's desire to denounce offences of the kind with which we are concerned is not diminished by the passage of time. Conversely, if the court were to impose a lenient sentence because of the passage of time, some members of the community might regard the sentence as judicial condonation of the conduct in question. That would tend to lessen respect for the administration of justice. In the circumstances we are considering in these appeals, the lapse of considerable time, and (we assume for the purposes of discussion) the intervening years of unblemished conduct, do not lessen the relevance of these two principles.

...

The only sentencing principles which may be affected by the lapse of time are those of individual deterrence and rehabilitation. By individual deterrence, we mean that the sentence should deter the accused from committing a similar offence in the future. By rehabilitation, we mean that the sentence imposed should reflect the hope that somehow, while serving his or her sentence, the accused will be rehabilitated and, at its end, will resume his or her place in society as a useful and law abiding citizen. These two principles overlap. In the case of a sexual offence against a child when, on occasion, the child does not report the offence to the police or any other authority until many years after the event, should the sentence be less than what it would have been if the prosecution had occurred not long after the commission of the offence? If the accused,

during the intervening years, has led an exemplary life in all respects, including non-repetition of sexual offences, and upon the matter ultimately being reported to the authorities, and during the resulting investigation and prosecution he is remorseful, then the principles of individual deterrence and rehabilitation may arguably, by themselves, not justify a stern sentence of the kind which would have been obligatory many years earlier. It will be noted, however, that if despite having led an exemplary life the offender lacks remorse, any potential discount must be less than it otherwise would have been. Indeed, in cases of this sort, of sexual abuse of children by parents, one might well ask whether one could ever have both remorse and lengthy suppression of the facts.”

In the Committee’s opinion, and as further discussed below, similar considerations apply to Dr. Ruggiero’s case.

Victim Impact Statement

Patient A read her victim statement to the Committee (exhibit 18). The Committee was moved by her impassioned and highly emotional statement. It demonstrated to the Committee the long lasting psychological and potential physical harm that can result from a physician sexually abusing their patient.

Patient A described how what Dr. Ruggiero did to her in 1986 has impacted her life. She told the Committee that while she has gone on with her life since that time, it has never been the same. She described how she has suffered and lived with the “pain all these years” since “Dr. Ruggiero raped me in 1986.” She described how she dreamed of getting married and having kids one day, but because of what Dr. Ruggiero did to her “that dream is dead to me.” She added, “I don’t trust men and always question their intentions. I made a choice to be a virgin until I married but you (Dr. Ruggiero) took that choice away from me.” Patient A told the Committee that she would cut herself in an attempt to numb the pain she was feeling and that she also had contemplated suicide. She also described living her life as a lie by pretending to be happy.

Proportionality

The principle of proportionality dictates that the most serious misconduct attracts the most serious sanctions. Revocation of a physician's certificate of registration is the most severe penalty that the Discipline Committee can impose. The Committee, after considering the facts and findings related to this case, concluded that Dr. Ruggiero's sexual impropriety involving Patient A indeed falls into the most serious form of professional misconduct and is deserving of the most severe penalty of revocation.

Trust is a fundamental tenet of the physician-patient relationship. Physicians are granted trust and power by virtue of their professional status, and this makes patients incredibly vulnerable if that trust is violated. Dr. Ruggiero violated that trust and also abused his authority as a physician. He took advantage of Patient A, who was a young, vulnerable patient.

The reason Patient A had been in Dr. Ruggiero's examination room, and the reason she complied with his request to undress from the waist down, was because she trusted that Dr. Ruggiero would help her in his role as a physician. Dr. Ruggiero took advantage of Patient A's trust in him and the vulnerable position he placed her in in his examination room to penetrate her vagina with his penis for his own personal sexual self-gratification. In doing so, he demonstrated to this Committee that he had no regard as to the physical or mental impact his actions would have on Patient A.

Dr. Ruggiero's sexual impropriety with Patient A was indeed heinous. She was left shaken, scarred for life, and with lasting impacts that persist to this day.

Furthermore, Patient A was convinced for a long period of time that no one would believe what Dr. Ruggiero did to her because of Dr. Ruggiero's status as a member of the medical profession. His sexual impropriety went unreported and only came to light during a therapy session many years later when Patient A mentioned the incident with Dr. Ruggiero to her psychotherapist. As a result, her psychotherapist was obliged to make a mandatory report of the incident to the College. Otherwise, Dr. Ruggiero's misconduct may have never come to the attention of this

Committee.

Sexual impropriety in which a physician penetrates a patient's vagina with his penis for self-gratification cannot and indeed will not be tolerated by this Committee, the profession as a whole, or the public, and therefore demands the most severe penalty of revocation.

Protection of the Public

Patients must be protected from physicians who have engaged in sexual impropriety. As highlighted in Patient A's emotional victim impact statement, the psychological effects of such misconduct are long-lasting and the harm and traumatization cannot be overestimated.

When a physician engages in sexual impropriety with a patient, it is not only the patient who is the victim of the sexual abuse who is harmed. The reputation of the medical profession is also tarnished and harmed, through an erosion of public confidence and trust in the profession.

Dr. Ruggiero's misconduct occurred 30 years ago and there have been no findings of sexual impropriety or abuse against him since that time. However, the Committee considered the risk of recidivism. While there have been no other findings of sexual misconduct since the incident in 1986, the Committee is not reassured or confident that the risk Dr. Ruggiero poses to the public has been eliminated. As in the *Minnes (2015)* case, the Committee was not presented with any evidence that would assist it in understanding the origin Dr. Ruggiero's behaviour as found by this Committee, nor did the Committee hear any evidence on what could mitigate the risk of Dr. Ruggiero reoffending in the future.

Therefore, after considering the principle that protection of the public is paramount, the Committee concluded that the revocation of Dr. Ruggiero's certificate of registration was required in the public interest. The public must feel confident that in the future, Dr. Ruggiero will not be in a position to abuse his position of trust and authority as a physician.

Maintenance of Public Confidence

Maintenance of public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest is critical. Therefore, Dr. Ruggiero's behaviour must be denounced in the strongest terms. The Committee concluded that anything less than revocation would not only impeach the integrity of the regulatory process but also bring the administration of justice into disrepute.

This principle of maintaining public confidence in the ability of the profession to self-regulate in the public interest is referred to in *Adams and the Law Society of Alberta (1997)*, which states:

Professional bodies are those to whom the government has seen fit to grant monopoly status. With the monopolistic right comes certain responsibilities and obligations. Chief amongst them is self-regulation. Self-regulation is based on the legitimate expectation of the government and the public that those members of a profession who are found guilty of conduct deserving of sanction will be regulated – and disciplined – on an administrative law basis by the profession's statutorily prescribed regulatory bodies.... A professional misconduct hearing involves not only the individual and all the factors that relate to that individual, both favourably and unfavourably, but also the effect of the individual's misconduct on both the individual client and generally on the profession in question. This public dimension is of crucial significance to the mandate of the professional disciplinary bodies.

The hearing panels of the Discipline Committee of the College of Physicians and Surgeons of Ontario are composed of members of the public and members of the profession. Sexual impropriety, which under current legislation is termed sexual abuse, is recognized by the public and the profession to be a very serious issue. Since the time that the *Health Disciplines Act* of 1980 was in force, public perception of sexual misconduct evolved, resulting in the legislative change effected in the *Regulated Health Professions Act, 1991*. As indicated above, the term "sexual impropriety" was replaced by the term "sexual abuse." Specific penalties for sexual abuse were also enacted. The RHPA requires mandatory revocation for specific acts of sexual

abuse, including sexual intercourse with a patient, and a mandatory reprimand for any act of sexual abuse. Given the Committee's finding that Dr. Ruggiero penetrated Patient A's vagina with his penis during the course of a purported medical examination, revocation would be required if his misconduct was governed by the current Act. Although the revocation is not required under the *Health Discipline Act*, 1980, we consider the behaviour to warrant revocation in this case.

The Committee respects the principle that like cases should be treated alike. In *Noriega* (2015), the Committee found that revocation was the appropriate penalty to be imposed for acts of sexual impropriety committed when the *Health Disciplines Act* was in force. In *Marshall* (2016), which was also decided under the *Health Disciplines Act*, and *Minnes* (2015) which was decided under the RHPA, the Committee concluded that revocation was appropriate where the member had engaged in sexual misconduct with a young person that involved an abuse of trust and an imbalance of power, even where a doctor-patient relationship had not been established and, therefore, revocation was not mandatory under either legislation. The Committee sees no reason in this case to deviate from those cases. In the Committee's view, Dr. Ruggiero's inexcusable and deplorable misconduct requires revocation, a penalty which is consistent with a judicious application of the principle to treat like cases alike and to maintain public confidence in the integrity of the profession and the regulatory process.

The Committee has the discretion whether or not to revoke a physician's certificate of registration for professional misconduct involving sexual impropriety under the *Health Disciplines Act*, 1980. The public must have absolute confidence that a physician will behave in a professional and trustworthy fashion. Given Dr. Ruggiero's extremely serious misconduct, nothing short of revocation of Dr. Ruggiero's certificate of registration will suffice.

General Deterrence

Dr. Ruggiero's misconduct has the potential to bring the reputation of the medical profession into disrepute. Self-regulation is a privilege, not a right. It must not be jeopardized by physicians such as Dr. Ruggiero who abuse their patients. His behaviour must be denounced in the strongest

terms. There is no place in our profession for physicians who sexually harm their patients. All members of the profession must be made aware of how seriously the profession takes such abusive behaviour.

Specific Deterrence and Rehabilitation

Thirty years have passed since Dr. Ruggiero abused Patient A, and no subsequent findings of sexual misconduct have been made against him. The case law indicates that the passage of time is potentially relevant to the penalty principles of specific deterrence and rehabilitation.

As noted above, in *Spence*, the Court noted:

“The only principles which may be affected by the lapse of time are those of individual deterrence and rehabilitation...If the accused, during the intervening years, has led an exemplary life in all respects, including non-repetition of sexual offences, and upon the matter ultimately being reported to the authorities and during the resulting investigation and prosecution he is remorseful, then the principles of individual deterrence and rehabilitation may arguably, by themselves, not justify a stern sentence of the kind which would have been obligatory many years earlier. It will be noted, however, that if despite having led an exemplary life, the offender lacks remorse, any potential discount must be less than it otherwise would have been.”

The Committee agrees that when determining the appropriate penalty or considering an application for reinstatement of a certificate of registration, specific deterrence and rehabilitation are generally principles to be considered.

However, in the case before this Committee which involves sexual impropriety, the principles of denunciation, general deterrence and maintaining public confidence must be given greater weight. Indeed, it is difficult for the Committee to imagine how even the passage of significant time, and even when coupled with no intervening findings of misconduct or abuse, could ever materially mitigate the penalty to be imposed for sexual impropriety of this nature. In any event,

Dr. Ruggiero has demonstrated no remorse. The absence of remorse, while not an aggravating factor, is relevant to mitigation and is particularly relevant when considering the issue of credit for passage of time in light of the analysis required by the *Spence* decision. As in the *Marshall* (2016) case, this Committee concludes that there should not be any credit given on penalty for the passage of time.

Mitigating Factors

There were no mitigating factors relevant to this case. However, the Committee considered the following with respect to mitigation:

The Passage of Time and the Absence of Subsequent Findings of Sexual Misconduct

For the reasons above the Committee, in determining the appropriate penalty, does not consider the passage of time or the fact that there have been no further findings of sexual misconduct to be mitigating factors.

Absence of Remorse

Dr. Ruggiero has never expressed remorse for his actions. Absence of remorse is not an aggravating factor, but it does weigh against any mitigation.

Aggravating Factors

A Position of Trust and Power Imbalance

A “position of trust” is not a defined term under the Criminal Code. It is up to the trier of fact to determine whether such a position existed. When a position of trust exists, it can be considered an aggravating factor: *R. v. R.A.R.*, [2000] 1 S.C.R 163 at para. 32.

It is not disputed that there was an established physician-patient relationship between Dr. Ruggiero and Patient A. Therefore, a position of trust and a power imbalance existed between them. Dr. Ruggiero violated that trust by abusing Patient A, a vulnerable teenager at the time, for his own sexual self-gratification. In this Committee's opinion, the breach of trust, the age and the vulnerability of the patient are significant aggravating factors. There could not be a more significant breach of trust than for a physician to violate a patient in this manner under the guise of a purported medical examination.

CONCLUSION

In conclusion, Dr. Ruggiero's misconduct involved one of the most serious acts of sexual impropriety and therefore falls into the most serious category of professional misconduct. In light of the serious and appalling nature of the offending behaviour involving Patient A, the need to protect the public, the need to maintain public confidence in the integrity of the medical profession and the College's ability to regulate the profession, the need for general and specific deterrence, the Committee concluded that Dr. Ruggiero's certificate of registration must be revoked and that he should attend before it to be reprimanded.

The Committee also concluded that it was an appropriate case for costs to be awarded to the College.

ORDER

Therefore, in its written order of October 14, 2016, on the matter of penalty and costs, the Committee ordered and directed that:

1. The Registrar revoke Dr. Ruggiero's certificate of registration, effective immediately.
2. Dr. Ruggiero appear before the panel to be reprimanded within sixty (60) days of this Order becoming final.
3. Dr. Ruggiero pay costs to the College in the amount of \$25,000.00 within thirty (30) days of the date of this Order becoming final.