NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Christopher Stephen Doyle, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

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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. CHRISTOPHER STEPHEN DOYLE

PANEL MEMBERS: **DR. P. TADROS (CHAIR)**
MAJOR A.H. KHALIFA
DR. P. POLDRE
MR. P. PIELSTICKER
DR. P. ZITER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS A. CRANKER

COUNSEL FOR DR. DOYLE:

MS C. PIOVESAN
MR. P. LEIGH

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date:	January 30, 31, 2018 and February 1, 2018
Finding Decision Date:	February 1, 2018
Penalty Decision Date:	August 7, 2018
Release of Written Reasons:	August 7, 2018

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on January 30, 31 and February 1, 2018. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and is incompetent. After hearing evidence and submissions on penalty and costs, the Committee reserved those aspects of its decision.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Christopher Stephen Doyle committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Doyle is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Doyle admitted the allegations in the Notice of Hearing.

THE FACTS

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

I. FACTS

Background

1. Dr. Christopher Stephen Doyle ("Dr. Doyle") is a psychiatrist who received his Independent Practice Certificate with the College of Physicians and Surgeons of Ontario ("College") in 2001. During the relevant period, Dr. Doyle worked at Cambridge Memorial Hospital and maintained a private practice in Mississauga.

Patient A

2. Patient A was referred to Dr. Doyle by her family physician, Dr. X, in 2013. Together with his referring letter, Dr. X provided Dr. Doyle with approximately 25 pages of medical records for Patient A. Within the records provided to Dr. Doyle are two pages containing reference to Patient A's previous sexual boundary issues with a mental health professional while under the professional's care, and reference to Patient A having developed an infatuation with a prior treating psychiatrist.

3. Dr. Doyle was Patient A's psychiatrist between 2013 and 2014 during which time Dr. Doyle focused on Patient A's medications. By December of 2013, Dr. Doyle's working diagnosis was "a borderline woman with increased anger and increased depression." Attached at Tab 1[to the Agreed Statement of Facts] is a copy of Dr. Doyle's medical records, including the records provided by Dr. X, for Patient A.

4. During this time she was Dr. Doyle's patient, Patient A perceived that Dr. Doyle's demeanour towards her changed, in that he became increasingly casual during her

appointments, including sitting back with his feet up on the coffee table and using profanities in front of Patient A.

5. Patient A told Dr. Doyle that she was depressed and not motivated to exercise anymore. She had previously reported to Dr. Doyle that she enjoyed cycling and running. Dr. Doyle told Patient A about his own interest in cycling. Dr. Doyle also showed Patient A an app on his cell phone that he used to track cycling progress and that showed his progress against other cyclists in the online community. Dr. Doyle told Patient A that she could use the app as well to track her exercise progress and keep motivated.

6. Patient A explained in her complaint and in her interview with the College that as a result of Dr. Doyle's casual demeanor and the information that he shared with her during the sessions, Patient A began to feel that Dr. Doyle wanted to foster a friendship or relationship with her.

7. In 2014, Patient A told Dr. Doyle about her feelings for him. Dr. Doyle indicated that he was flattered but that her feelings were not appropriate for the physician-patient relationship. Patient A perceived that Dr. Doyle seemed extremely uncomfortable by her disclosure. Dr. Doyle stopped the session. He asked Patient A to see his secretary to make a subsequent appointment. In the past, Dr. Doyle had scheduled all subsequent sessions himself on his cell phone at the end of Patient A's session. Patient A booked a follow up appointment for a date in the following month in 2014 with Dr. Doyle through the secretary.

8. Patient A recalls that she left the session feeling confused, ashamed and humiliated.

9. The following day Patient A sent Dr. Doyle an email attached at Tab 2 [to the Agreed Statement of Facts] apologizing and seeking clarity as to what had transpired in her appointment. She wrote "I guess the reason I ask is because in my mind I believe it's me. I've never been one to follow rules too much, with the exception of things that would be illegal or hurtful to another person."

10. Dr. Doyle responded explaining that he could no longer see Patient A. He wrote: "It is understandable but not appropriate for our relationship. [I]t is called eroticized transference and really due to my previous issues not something that I can safely manage at this time. I appreciate your honesty but it does prevent us working together therapeutically…"

11. Patient A described the emotional impact of Dr. Doyle's response to her disclosure and the termination of her care as "devastating." Patient A went to see her family physician reporting suicidal thoughts and self-blame as a result of this interaction with Dr. Doyle. On that day she told her family physician that she would go to the Hospital if she began making a suicide plan.

12. Patient A went to the Hospital with a suicide plan.

13. After a further visit with her family physician, Patient A was voluntarily admitted to Hospital for several days.

14. Further to the email exchange which Patient A perceived as notice of termination, Patient A had no further contact with Dr. Doyle. Patient A did not attend the subsequent appointment that she had booked with Dr. Doyle.

15. Patient A submitted a complaint to the College on July 28, 2014, describing mixed feelings" because Dr. Doyle "does seem to care about what he does and is extremely competent with the medications".

16. Dr. Doyle states that he waited for Patient A during her scheduled [follow-up] appointment, at which point he says he planned to properly terminate the patient-physician relationship. Later that same day, Dr. Doyle received notice of Patient A's complaint to the College.

17. Dr. Doyle did not take any action in respect to the transfer of care for Patient A. Dr. Doyle did not send a termination letter to Patient A. He did not communicate with the referring physician about the end of the therapeutic relationship. He did not make arrangements for the prescription of Patient A's medications nor did he assist in finding another psychiatrist for Patient A.

18. Dr. Theresa-Ann Clarke was retained by the College to review this matter. Dr. Clarke opined in her report dated January 22, 2016, attached at Tab 3 [to the Agreed Statement of Facts], as follows:

A) *Does the care which Dr. Doyle provided to the patient meet the standard of practice?*

> "In my opinion, Dr. Doyle failed to meet the standard of practice of the profession in this case. . . . The medical record keeping was inadequate to serve as a record to 'tell the patient's story,' and to support diagnostic decision-making and treatment planning. It was illegible for the majority of the record. The typed summaries of these written notes were not contemporaneously written. . . . If Dr. Doyle's [sic] behaved as described by the patient A, this would be a failure to uphold the professionalism, and boundaries essential to the physician-patient relationship. . . . Dr. Doyle failed to meet the standards of the profession in the conduct of terminating the doctor patient relationship."

B) *Does Dr. Doyle's care display any or all of the following: lack of skill, knowledge or judgement?*

> "The deficits in clinical record keeping are very significant. These may arise from lack of knowledge on the standard of care requirements, or poor judgement. . . . Dr. Doyle's notes reflected an awareness of the patients' vulnerabilities though this was not incorporated into his treatment plan. The boundary crossings, failures in professionalism and in recognition/management of the dynamics in the

therapeutic encounter could reflect a lack of skill, knowledge, judgement or a combination of the above. . . . The failure to maintain the standard in the profession of patient termination may result from lack of knowledge, or lack of skill in managing the situation, or lack of judgement."

C) *Are you of the opinion that Dr. Doyle's clinical practice, behaviour or conduct exposes or is likely to expose his/her patients to harm or injury?*

"If this clinical record is representative of Dr. Doyle's practice of medical record keeping and his self described 'informal style', with patient, and boundary crossings, it is likely that patients would be exposed to harm. This risk of harm is estimated to be higher than what would be expected from care provided by a practitioner who maintained the standard of care in these areas."

19. Dr. Clarke was provided with the information that on one occasion, in the context of discussing Patient A's depression, Dr. Doyle reports that he told Patient A about another one of his patients, whose name he did not disclose, who suffered from severe depression and did not care for himself such that his teeth had fallen out. She provided an addendum to her report on December 9, 2017. She opined:

"This was not simply a story of how severely depression can impact a person. Hypothetically, Patient A could have later seen an edentulous man in the waiting area, and reasonably believe that she could then put a face to the story she heard directly from Dr. Doyle. Although unintended, this practice can lead to confidentiality breaches, and so is best avoided. Dr. Doyle has twice written to the College that he should not have spoken about the other patient to [Patient A]. I agree with him. However, I would describe this practice as ill advised, a slippery slope with potential for confidentiality concerns versus unethical practice. I would not call this a violation of the standard of care."

Section 75(1)(a) Investigation

20. On the basis of information including the complaint of Patient A, the College conducted an investigation into Dr. Doyle's private practice.

21. Dr. Clarke was retained to review this matter. Her report, received September 27, 2016, attached at Tab 4 [to the Agreed Statement of Facts], is based on her review of 24 patient charts and transcribed clinical notes, as well as her interview with Dr. Doyle.

22. Dr. Clarke opined that the care provided by Dr. Doyle failed to meet the standard of practice in 16 of the 24 patient charts reviewed. Dr. Clarke opined that Dr. Doyle's care displayed a lack of knowledge in 1 of the 24 patient charts reviewed. Dr. Clarke opined that Dr. Doyle's care displayed a lack of skill and/or judgment and exposed or is likely to expose his patients to harm or injury in 19 of the 24 patient charts reviewed. Issues/risk identified by Dr. Clarke included, but were not limited to, the following:

- Inadequate documentation/record-keeping;
- Lack of diagnostic clarity/consistency;
- Inadequate risk assessments and/or interventions for self-harm and aggressive ideation;
- Lack of attention to substance use history and/or inadequate assessment of alcohol/substance use;
- Use of non-professional and/or non-objective language in clinical notes
- Inadequate psychotropic medication intervention and/or sub-therapeutic medication dosing;
- Failure to make mandatory report to MOT and/or CAS;
- Inadequate follow-up/frequency of monitoring/appointments;
- Inappropriate prescribing of stimulant medication;
- Inappropriate prescribing of a narcotic;
- Inappropriate prescribing of medical marijuana in patient with primary psychotic illness;

- Ongoing prescribing of a medication (stimulants, benzodiazepines) that patient is known to be abusing;
- Inadequate medication monitoring (efficacy, side effects, interactions, blood work);
- Failure to maintain appropriate/professional boundaries;
- Inappropriate polypharmacy and/or combinations of benzodiazepines, atypical antipsychotics and/or sedative hypnotics; and
- Inappropriate prescribing of medications for non-psychiatric conditions and without notifying the patient's primary care provider.

23. Dr. Clarke conducted an interview of Dr. Doyle. Positive findings made by Dr. Clarke in the interview include but are not limited to that Dr. Doyle was:

- Able to describe the essential elements required in the psychiatric history, mental status examination, for a consultation report leading to a differential diagnosis and treatment plan;
- Able to accurately describe differential diagnoses for different clinical presentations, and the necessary historical detail required to discriminate between these differentials to provide a working diagnosis;
- Able to describe the relevant diagnostic criteria in the DSM-IV framework he used for the common diagnoses he made;
- Generally able to discuss appropriate dosing for psychiatric medications, and the concerns with polypharmacy particularly with combination sedative hypnotics, and combination atypical antipsychotics;
- Mostly able to describe standard of care baseline investigations, and recommended monitoring for the use of atypical antipsychotics and divalproex and lithium;
- Able to describe the requirements for mandatory reporting regarding driving and reporting child safety concerns;
- Able to describe the potential negative impact of cannabis on many psychiatric illnesses, and the lack of empirical evidence of benefit;
- Able to describe appropriate strategies and interventions for patients abusing medications he prescribes;

- Able to discuss the potential hazards to a patient re provision of prescription medications for non-psychiatric conditions that he does not monitor, and the particular risks of doing so with opiates;
- Able to describe appropriate interventions for ill patients who have prolonged absences from the practice, or when there is information about a crisis, clinical deterioration, emergency room visits etc.; and
- Able to identify as inappropriate, the use of non-professional language in the patient records.

24. Concerns identified in the interview include but are not limited to:

- Although Dr. Doyle acknowledged the risks of, and poor evidence for use or combination of antipsychotics, this was commonly observed in his use of these medications, more than would be expected in a similar practice of a general adult psychiatrist.
- Although Dr. Doyle described appropriate lithium monitoring, this was generally not observed in his records. Dr. Doyle generally would not monitor kidney function or serum calcium levels, which increases the risk of patient morbidity and is not guideline support.
- Although Dr. Doyle was able to appropriately describe standard of care strategies for abusing medication he prescribed, he acknowledgement that he did not do so enough. This was a significant concern in the care provided in some of the records reviewed.

YouTube Videos

25. Dr. Clarke was provided with links to a series of YouTube videos posted by Dr. Doyle between 2012 and 2014. The videos were posted on Dr. Doyle's YouTube channel named "DrChristopherDoyle", with the following description:

> Dr. Doyle has an extensive background in the practice of Psychiatry. Graduating in Medicine from McGill University and then specializing in Psychiatry at the University of Toronto, Dr. Doyle has helped hundreds of Canadians in crisis who have struggled with mental health and addictions. Dr. Doyle's goal is to provide care that will enable people suffering from mental or emotional distress to achieve balance and self-control in their lives using not only medicines but also through how people think and behave.

26. In her report dated February 1, 2017, Dr. Clarke describes concerns about the videos that include:

    a. Lack of judgement, professionalism and boundaries with a tone of promotion in a video in which Dr. Doyle is talking about his use of "the juice of the purple" that gave him stamina to compete in a bike race against professional cyclists (video 8).
    b. Lack of judgement, professionalism and boundaries in a video in which Dr. Doyle is pictured after spinning class, shirtless, discussing the benefits of exercise to himself physically and mentally and once again promoting the "purple" drink (video 9).
    c. Lack of judgement, professionalism and boundaries in a video in which Dr. Doyle is depicted in an educational session in which he states marijuana is "excellent" as a PTSD treatment. Dr. Clarke describes that marijuana is not the standard of care for PTSD and has the potential to harm some patients (video 10).
    d. Breach of standard for physician advertising, lack of judgement and professionalism and abuse of a fiduciary relationship with respect to a videotaped patient testimonial in the office by a female patient. Dr. Doyle is seen in the background, as the patient enthusiastically describes her experience of working with him, that he "taps into my creative side and empowers me…. Go Dr. Doyle!" (video 28).

27. Nine of the twenty nine videos reviewed are therapeutic in nature. With respect to these nine videos, Dr. Clarke opined that each falls below the standard of care (videos 2, 3, 12, 13, 20, 26-29).

28. Thirteen of the twenty nine videos are educational in nature. With respect to thirteen videos, Dr. Clarke opined that videos 4, 5, 6, 7, 10, 14, 15, 16, 17, and 18 fall below the standard of care and videos 19 [and] 21 meet the standard of care.

29. Seven of the twenty nine videos are philosophical in nature and show Dr. Doyle's reflections on various topics. With respect to these seven videos, Dr. Clarke opined that six show a lack of judgement (8, 9, 11, 22, 23, 24).

30. Dr. Clarke opined overall that:

- 23 of the 29 videos demonstrated a lack of judgment; and
- discussions contained in 15 of the 29 videos expose or are likely to expose patients to risk of harm.

Copies of the videos are attached at Tab 5 [to the Agreed Statement of Facts]. A detailed summary of excerpts from Dr. Clarke's findings for each video is attached at Tab 6 [to the Agreed Statement of Facts].

31. Dr. Clarke submitted an addendum report dated December 9, 2017 in which she acknowledged that some effort was made by Dr. Doyle to obtain consent from the patients to discuss their clinical material on YouTube, or to post material from their sessions online on YouTube. However, in Dr. Clarke's opinion, the consents are inadequate for reasons including that the consent was not specific to the purpose for which he used it. A copy of Dr. Clarke's report dated December 9, 2017 is attached at Tab 7 [to the Agreed Statement of Facts].

Interim Suspension

32. At its meeting on April 10, 2017, the Inquiries, Complaints and Reports Committee ("Committee") referred specified allegations of professional misconduct to the Discipline Committee and directed that notice be given to Dr. Doyle that it intended to make an

interim order restricting his practice. Subsequently, on May 9, 2017, the Committee issued an Order suspending Dr. Doyle's certificate of registration.

Unprofessional Communication

33. In January of 2017, a medical adjudicator in the Canada Student Loans Program ("the Adjudicator") called Dr. Doyle, attempting to verify the authenticity of a medical report that she was reviewing for an individual who was a patient of Dr. Doyle.

34. The Adjudicator described that after dialing the phone number that had been provided to her by Dr. Doyle's patient, Dr. Doyle answered with profanity and speaking rudely, indicating "if you need your prescriptions filled go to the [profanity] pharmacy."

35. Assuming that she had dialed incorrectly, the Adjudicator dialed again. Dr. Doyle answered with more profanity stating "stop [profanity] calling me". The Adjudicator introduced herself and stated the purpose of the call. Dr. Doyle then identified himself and apologized, indicating that he thought he was talking to a patient who was calling him non-stop.

36. The Adjudicator then reported her experience with Dr. Doyle to the College.

37. In a subsequent telephone call with a College Investigator, the Adjudicator described the profanities used as "f-bombs".

38. Additional allegations with respect to the unprofessional communication described above were added to the Notice of Hearing on July 10, 2017.

ADMISSIONS

39. Dr. Doyle admits the facts above and admits that:

i) he is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991,* ("the Code");

ii) he has committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

iii) he has committed an act of professional misconduct under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional through his posting of unprofessional YouTube videos and through his unprofessional telephone communication.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Doyle's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional. The Committee also found that Dr. Doyle is incompetent.

SUBMISSIONS ON PENALTY

The College submitted that the appropriate penalty was revocation and a reprimand.

Dr. Doyle submitted that the appropriate penalty was a suspension and the imposition of terms and conditions on his certificate of registration that permitted a staged return to the practice of medicine, which included supervision, reassessment, and ongoing remediation.

FACTS ON PENALTY

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

Postgraduate Training

1. Dr. Doyle graduated from McGill University's Medical School in 1993. He commenced a residency program in psychiatry at the University of Toronto. He received a certificate of registration authorizing postgraduate education in 1993. The terms, conditions and limitations of Dr. Doyle's certificate of registration authorizing postgraduate education included:

    1. Dr. Christopher Stephen Doyle shall practice medicine only as required by the postgraduate medical education program in which Dr. Doyle is enrolled at the University of Toronto;
    2. Dr. Doyle shall prescribe drugs only for in-patients or out-patients of a clinical teaching unit that is formally affiliated with the department where Dr. Doyle is properly practicing medicine and to which postgraduate trainees are regularly assigned by the department as part of its program of postgraduate medical education;
    3. Dr. Doyle shall not charge for medical services;
    4. The certificate expires on the earlier of the following dates: when Dr. Doyle is no longer enrolled in a program of postgraduate medical education provided by a medical school in Ontario, or when Dr. Doyle no longer holds Canadian citizenship, permanent resident status or a valid employment authorization under the Immigrant Act (Canada).

2. In 1998, while Dr. Doyle held a Postgraduate Education Certificate, information was received by the CPSO from Dr. M.B. Urowitz, Associate Dean of Postgraduate Medical Education at the University of Toronto and from Dr A. Kaplan, program director for psychiatry at the University of Toronto, that Dr. Doyle breached the terms, conditions and limitations of his certificate of registration. It was reported that Dr. Doyle was employed for a period of one year, by Professional Health Management Inc (PHM), a Designated Assessment Centre by the Ontario Insurance Commission, to conduct physical examinations to determine patients' ability to work from a medical perspective. During the period of employment, Dr. Kaplan had met with Dr. Doyle on three occasions to remind him that, according to the CPSO, this was an inappropriate use of his educational license. Attached at Tab 1 [to the Agreed Statement of Facts on Penalty] is the January 26, 1998 letter of Dr. Urowitz together with the January 23, 1998 letter of Dr. Kaplan.

3. On January 28, 1998, Dr. Judith Shapiro, Clinical Director at PHM, wrote to Dr. Molan Leszcz, Deputy Psychiatrist in-Chief at Mount Sinai Hospital, about the allegations against Dr. Doyle regarding his employment with PHM. A copy of Dr. Shapiro's letter is attached at Tab 2 [to the Agreed Statement of Facts on Penalty]. By letter dated March 18, 1998, Dr. Leszcz wrote to the Dr. Art Van Walrang, Registration Committee at the CPSO, explaining some of the circumstances leading to Dr. Doyle's suspension as Chief Resident, with reference to Dr. Shapiro's perspective. A copy of Dr. Leszcz's letter is attached at Tab 3 [to the Agreed Statement of Facts on Penalty].

4. In 1998, as a result of his employment with PHM, contrary to the terms of his restricted education license, Dr. Doyle was suspended from the role as Chief Resident in Psychiatry at Mount Sinai Hospital.

5. Dr. Doyle [provided] an explanation to the Registration Committee dated March 16, 1998. A copy of the March 16, 1998 letter is attached at Tab 4 [to the Agreed Statement of Facts on Penalty].

6. The Registration Committee considered Dr. Doyle's application for an independent practice certificate. In its decision dated April 30, 1998 attached at Tab 5 [to the Agreed Statement of Facts on Penalty], the Committee directed the Registrar to issue a certificate of registration containing the following terms, conditions and limitations:

1. Dr. Doyle's practice is limited to the practice of Psychiatry in a practice setting acceptable to the Director of the Professional Enhancement Department;
2. Dr. Doyle's practice must be supervised by a specific supervisor who is acceptable to the Director of the Professional Enhancement Department, who will have direct knowledge of Dr. Doyle's practice and who agrees in writing to provide quarterly reports to the Director of the Professional Enhancement Department on Dr. Doyle's professional performance and more specifically on his professional attitudes with the intention that the Registration Committee, will know through the Director of the Professional Enhancement Department, whether Dr. Doyle (1) is practising medicine with decency, integrity, honesty and in accordance with the law and (2) is displaying an appropriately professional attitude;
3. Before the certificate of registration is issued, the supervisor will provide evidence to the Associate Director of the Professional Enhancement Department that he or she has full knowledge of the circumstances resulting in the imposition of these terms, conditions and limitations;
4. Dr. Doyle will continue in therapy with a physician acceptable to the Director of Professional Enhancement;
5. In the event that,
    (a) the Registration Committee receives information which affords reasonable grounds for belief that Dr. Doyle has breached any of the foregoing terms, conditions and limitations, or

(b) the supervisor does not provide the required quarterly reports to the Director of the Professional Enhancement Department on time or the supervisor's reports are,

i. unsatisfactory in form, or

ii. do not afford reasonable grounds for belief that Dr. Doyle (1) is practising with decency, integrity, honesty and in accordance with the law and (2) is displaying an appropriately professional attitude, the Registration Committee may withdraw the certificate of registration and, before the certificate of registration is issued, Dr. Doyle will agree that, under the foregoing circumstances in this paragraph, the Registration Committee may withdraw the certificate.

7. On July 5, 1999, the Registration Committee received a letter from Dr. Doyle requesting that the restrictions on his certificate be lifted. Attached at Tab 6 [to the Agreed Statement of Facts on Penalty] is a copy of Dr. Doyle's July 5, 1999 letter.

8. The Registration Committee considered Dr. Doyle's request. On October 12, 1999, the Registration Committee issued a decision letter. The Committee denied the request to lift the terms, conditions and limitations, but agreed to reduce the reporting requirements to every six months, from the requirement of every three months. Attached at Tab 7 [to the Agreed Statement of Facts on Penalty] is a copy of the October 12, 1999 decision letter.

9. Dr. Doyle was supervised by Dr. Nabil Phillips, Credit Valley Hospital, and Dr. Clive Chamberlain, Centre for Addiction and Mental Health, both of whom were approved by the College. Dr. Chamberlain took over supervision of Dr. Doyle from Dr. Juan Negrete in 2000, after Dr. Negrete moved. Dr. Phillips, Dr. Negrete and Dr. Chamberlain reported regularly to the College. Dr. Doyle was seen in individual psychotherapy with Dr. George Boujoff. Copies of their reports are attached at Tab 8 [to the Agreed Statement of Facts on Penalty]. No concerns were raised with respect to Dr. Doyle's compliance with the terms, conditions and limitations upon his certificate.

10. On March 15, 2001, Dr. Doyle wrote once again to the Registration Committee, requesting removal of the terms, conditions and limitations upon his certificate. Attached at Tab 9 [to the Agreed Statement of Facts on Penalty] is a copy of Dr. Doyle's March 15, 2001 letter.

11. On May 3, 2001, Dr. Doyle was informed that the Registration Committee had approved his request and removed the terms, conditions and limitations. A Certificate of Registration authorizing independent practice was issued to Dr. Doyle on May 8, 2001.

Discipline History

12. On September 29, 2009, the Discipline Committee, in their decision attached at Tab 10 [to the Agreed Statement of Facts on Penalty], found that Dr. Doyle committed an act of professional misconduct, in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Specifically, Dr. Doyle was found to have failed to maintain appropriate boundaries, in that he commenced a romantic relationship with Patient [Y] shortly after the termination of the doctor/patient relationship and made serious errors in failing to maintain appropriate boundaries with Patient [Y] during the last three months of treatment . Patient [Y] had been engaged in frequent psychotherapy for a long period of time with Dr. Doyle (45 sessions over 15 months); had been diagnosed with a number of psychiatric disorders and dependencies; and was described as "vulnerable."

13. Between April 17 and 19, 2007, Dr. Doyle was evaluated at the Baylor Psychiatric Clinic in Houston, Texas, USA by Dr. Glen Gabbard. Dr. Gabbard's report was provided to the Discipline Committee in 2009. A copy of Dr. Gabbard's report is attached at Tab 11 [to the Agreed Statement of Facts on Penalty].

14. The Committee ordered: a reprimand, a 12 month suspension, terms, conditions and limitations on Dr. Doyle's certificate of registration including that he post security for funding for therapy for Patient A; remain in the Physician Health Program; continue

therapy with a psychotherapist; practice under the guidance of a clinical supervisor; provide ongoing psychiatric care to female patients only in the presence of a practice monitor with the exception of short term assessments and consultation, and be restricted from performing long term psychotherapy.

15. Pursuant to the terms of the Order of the Discipline Committee dated September 29, 2009 (the "Order"), Dr. Doyle's suspension from practice commenced on or around December 22, 2009; six months of the one-year suspension were to be suspended if he successfully completed the College's Medical Ethics and Informed Consent Course, the College's Boundaries Course and the College's Record Keeping Course. Ultimately, Dr. Doyle successfully completed the required courses and returned to full-time medical practice on June 23, 2010.

16. Dr. Doyle successfully sought variation of the Discipline Committee's Order in June 2012 and in May 2013. A copy of the respective Motion Records filed is attached at Tab 12 [to the Agreed Statement of Facts on Penalty] and Tab 13 [to the Agreed Statement of Facts on Penalty]. A copy of the respective decisions of the Discipline Committee is attached at Tab 14 and Tab 15 [to the Agreed Statement of Facts on Penalty].

17. Dr. Doyle did not seek any variations further to May 2013. The following terms, conditions and limitations remained upon his certificate until the ICRC issued an order directing suspension of Dr. Doyle's certificate of registration on May 10, 2017:

    i. Dr. Doyle may perform long term psychotherapy on male patients only.
    ii. Dr. Doyle shall practise under a clinical supervisor who is acceptable to the College ("Clinical Supervisor"), and whom shall be provided with relevant information from the College respecting Dr. Doyle. Such supervision shall consist, at minimum, of quarterly meetings with the Clinical Supervisor; a review at each meeting of a minimum of 15 charts (or more if deemed appropriate by the Clinical Supervisor) which shall include sufficient male patients on long term psychotherapy to allow the supervisor to assess the quality of that care; a discussion at each meeting regarding

any issues or concerns arising from the chart review; and other measures deemed appropriate by the Clinical Supervisor, such as recommendations for continuing medical education; direct observation of patient care; and interviews with staff, colleagues and/or Practice Monitors. The Clinical Supervisor shall be responsible for providing quarterly reports to the College.

18. Dr. Doyle practiced under the supervision of two College-approved supervisors, Dr. Edward Matti and Dr. Jan Malat. Dr. Matti is a psychiatrist practicing at Cambridge Memorial Hospital. The term for Dr. Matti's supervision extended from July 2010 to March 2017. Dr. Malat is a psychiatrist practicing at the Centre for Addiction and Mental Health. The term for Dr. Malat's supervision extended from July 2010 to April 2017.

19. Both supervisors met with Dr. Doyle monthly until May of 2012 and every three months thereafter. At each meeting, the supervisors reviewed approximately 15 of Dr. Doyle's patient charts. The supervisors discussed patient care with Dr. Doyle, arising from their review of the patient charts or if Dr. Doyle brought a particular issue to their attention.

Continuing Medical Education

20. Since May 10, 2017, Dr. Doyle has completed at least 67 CME courses related to his practice area.

EVIDENCE ON PENALTY

The Committee also received the following evidence on penalty.

The testimony of Dr. Ronald Ruskin, Dr. Doyle's treating psychotherapist, Dr. Ruskin's *curriculum vitae*, letters of September 9, 2017 and January 19, 2018 from Dr. Ruskin to Dr. Doyle's lawyer, Dr. Ruskin's standardized questionnaires and psychometric tests performed on Dr. Doyle and a transcript of Dr. Ruskin's clinical notes.

The testimony of Dr. Isaac Szpindel, an expert called on behalf of Dr. Doyle, Dr. Szpindel's *curriculum vitae,* his reports of September 14 and October 9, 2017 and his clinical notes and records.

The testimony of Dr. Jan Malat, Dr. Doyle's clinical supervisor for the period from 2010 to April 2017, and Dr. Malat's *curriculum vitae* and clinical supervision reports.

The testimony of Patient C and Patient D.

Letters from Dr. Doyle, dated September 11, 2017 and January 2, 2018. A list of Dr. Doyle's continuing medical education certificates. Letters of support submitted on behalf of Dr. Doyle.

Testimony

Dr. Donald Ruskin

Dr. Ruskin conducted an assessment of Dr. Doyle at the request of Dr. Doyle's counsel for the purpose of providing a clinical opinion regarding Dr. Doyle's diagnosis and prognosis, and suggestions for future treatment, and with respect the risk of future boundary violations by Dr. Doyle. Dr. Ruskin interviewed Dr. Doyle on three occasions on May 30, June 7 and June 14, 2017.

Dr. Ruskin testified that since July 2017, he was seeing Dr. Doyle twice a week for psychoanalytical psychotherapy. He said that he developed a positive therapeutic alliance with Dr. Doyle.

Dr. Ruskin testified that he diagnosed Dr. Doyle with an acute adjustment disorder with masochistic and histrionic traits. He found no evidence to support a severe pre-existing health problem, such as an anxiety disorder, a major depression or an issue with substance abuse. He testified that in his opinion, Dr. Doyle is not predatory or narcissistic With respect to the risk of

future boundary violations, Dr. Ruskin opined that Dr. Doyle is at a mild to moderate risk of future boundaries violations.

While the Committee found Dr. Ruskin to be a credible witness and his evidence informative, the Committee finds Dr. Ruskin's evidence of limited value in determining the appropriate penalty in this case for the following reasons.

Dr. Ruskin was Dr. Doyle's treating physician and as such, he was not an independent expert witness. The Committee accepts that Dr. Ruskin and Dr. Doyle had a positive therapeutic alliance and, therefore, Dr. Ruskin's assessment of Dr. Doyle is not impartial. The Committee also notes that Dr. Ruskin assessed Dr. Doyle's current state of mental health and provided an opinion with respect to Dr. Doyle's risk of future boundary violations; in so doing, he did not undertake a consideration of the numerous and serious deficiencies in Dr. Doyle's practice and professionalism, as identified in the Agreed Statement of Facts.

The Committee further finds that Dr. Ruskin often relied on Dr. Doyle's self-reporting in arriving at his conclusions. The Committee notes that Dr. Doyle often minimized the seriousness of his lack of judgment when reporting incidents from his past to Dr. Ruskin. For instance, Dr. Ruskin was led by Dr. Doyle to believe that Dr. Doyle had to step down as a Chief Psychiatric Resident at the University of Toronto "because of some documentation issues." The evidence clearly shows that Dr. Doyle had to step down, because he was "moonlighting" as a resident and had been warned on more than one occasion that this was unacceptable to the Department of Psychiatry and in contravention of College policies. Despite these warnings, Dr. Doyle continued to "moonlight" which, in the Committee's view, demonstrates a lack of judgment and ungovernability. The Committee finds that Dr. Doyle knew what he had done and the consequences and understated these events to Dr. Ruskin.

Dr. Isaac Szpindel

Dr. Szpindel, an expert witness called by Dr. Doyle's counsel, assessed Dr. Doyle's executive functioning and provided an opinion with respect to Dr. Doyle's possible diagnosis of ADHD or other learning disability.

Dr. Szpindel interviewed Dr. Doyle on two occasions and performed various psychometric tests. Dr. Szpindel reviewed the report and findings of Dr. Clarke, the College expert, including the 24 patient charts reviewed by Dr. Clarke, and the YouTube videos. Dr. Szpindel also reviewed the report of Dr. Gabbard, the physician who evaluated Dr. Doyle at the Baylord Psychiatric Clinic in Houston, Texas, USA, and whose report was provided to the Discipline Committee in 2009.

Like Dr. Ruskin, Dr. Szpindel found no evidence of a serious pre-existing mental health issue and nothing to suggest a deficiency of intellect or lack of knowledge. However, Dr. Szpindel indicated that Dr. Doyle was unable to reproduce thoughts using "hand to paper or finger to key" and had difficulty registering written words into thoughts. Dr. Szpindel diagnosed Dr. Doyle with sensorigraphomotor dyspraxia, a learning disability. However, he found that Dr. Doyle's ability to make decisions and problem-solving were undisturbed by this. He opined that any lack of judgment was not affected by the learning disability.

The Committee notes that Dr. Doyle's counsel did not rely on Dr. Doyle's learning disability as a mitigating factor. The learning disability was not established as a cause of the numerous practice and professional deficiencies.

In the Committee's view, Dr. Doyle's learning disability is a relevant factor in considering whether Dr. Doyle's proposed remediation plan might be effective or not. However, the Committee finds this to be of little assistance in deciding whether revocation is the appropriate penalty, given the need for public protection in the circumstances of this case.

Dr. Jan Malat

Dr. Malat is a psychiatrist who practises at the Centre for Addiction and Mental Health and who supervised Dr. Doyle's practice from July 2010 to April 2017, pursuant to the 2009 discipline finding and order. The terms of this supervision initially included monthly meetings, review of 15 randomly selected charts and discussions of cases and how they were diagnosed and managed by Dr. Doyle. With time, these meetings became quarterly and Dr. Malat sent written reports to the College. Dr. Malat's understanding was that Dr. Doyle should not take on patients for long-term psychotherapy or take on patients with complex borderline diagnoses. Dr. Doyle was to report to the College any recognized deficiencies or any issues that he felt would put patients at risk. He testified about his observations of Dr. Doyle over this seven-year period.

Dr. Malat testified that he discussed boundaries issues with Dr. Doyle on a regular basis. He said he found no deficiencies in Dr. Doyle's knowledge, comprehension or treatment plan. However, he testified that he found many charting deficiencies and made some recommendations, such as using dictating tools, templates with subheadings and using the SOAP method when charting.

Dr. Malat specifically reviewed the chart of Patient A, the complainant in this matter. He read the letter of complaint and discussed it with Dr. Doyle. He stated, "I did not see any evidence of misconduct or sexualizing of the treatment relationship. However, it is my impression that occasions where Dr. Doyle behaved in a more casual manner may have contributed to the patient's confusion about the nature of the treatment relationship. I think it was appropriate for Dr. Doyle to terminate the relationship, since this patient had developed erotic feelings towards him." He further stated, "In my opinion, Dr. Doyle handled the termination appropriately." He recommended that Dr. Doyle might benefit from a refresher course on professional boundaries, which addresses these issues.

The Committee notes the differences between the reports of Dr. Malat and the serious deficiencies noted by Dr. Clarke in her assessment of Dr. Doyle's care of Patient A and other patients, as set out in the Agreed Statement of Facts. The Committee found that Dr. Malat, in his supervising capacity, was focused on individual case management. He was a colleague of Dr.

Doyle and they completed their residency programs together. He supervised Dr. Doyle over several years, discussed cases with him more informally and relied on Dr. Doyle's verbal input regarding cases. The nature of Dr. Clarke's assessment was entirely different. Dr. Clarke conducted an independent assessment, which included an in-depth review of charts and videos, an interview with Dr. Doyle and the provision of an opinion regarding the standard of care, knowledge, skill or judgment, and if patients were at risk of harm. As a result, the Committee afforded little weight to the evidence of Dr. Malat regarding Dr. Doyle's treatment of patients and his view of Dr. Doyle's remedial needs.

Patients' Testimony and Letters of Support

The Committee heard testimony from two of Dr. Doyle's patients. The Committee finds both patients credible and their evidence reliable.

The Committee also reviewed numerous letters of support provided on behalf of Dr. Doyle.

Although this evidence both by way of oral testimony and written letters of support indicated positive individual patient experiences, the Committee did not find it helpful or mitigating with respect to the multitude of serious deficiencies in Dr. Doyle's practice and professionalism as enumerated in the Agreed Statement of Facts.

The weight that should be given to supporting letters and testimony of patients is best described in *Bolton vs. Law Society*, [1993] EWCA Civ J1206-6, [1994] 1 WLR 512:

> It often happens that a solicitor appearing before the Tribunal can adduce a wealth of glowing tributes from his professional brethren. All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness…The reputation of the profession is more important than the fortunes of any individual member.

PENALTY DECISION AND REASONS

In coming to its penalty decision, the Committee carefully considered the submissions and case law presented by counsel for the parties, the advice of Independent Legal Counsel, the facts and the evidence presented.

The Committee also considered the well-recognized principles regarding penalty including: protection of the public; maintaining public confidence in the integrity of the medical profession and in the College's ability to regulate the profession in the public interest; specific and general deterrence; and, where appropriate, rehabilitation of the member. The Committee further considered aggravating and mitigating factors.

For the reasons that follow, the Committee determined that to ensure public protection and maintain public confidence in the integrity and regulation of the profession, revocation is the appropriate penalty in this case.

ANALYSIS

Mitigating Factors

The Committee notes that Dr. Doyle's agreement to the facts and his admission to professional misconduct and incompetence, and his agreement to certain facts on penalty, saved the College the time and expense of a fully contested hearing. It also spared the complainant, Patient A, and other witnesses from the stress of having to testify at the hearing.

Aggravating Factors

1. The Seriousness of the Professional Misconduct and Incompetence

Dr. Clarke, the expert retained by the College, conducted an objective and impartial review of Dr. Doyle's care of Patient A and 24 additional patients and outlined multiple serious and

pervasive deficiencies in his care and professionalism, as set out in the Agreed Statement of Facts.

Patient A

Dr. Clarke opined that Dr. Doyle failed to maintain the standard of practice of the profession and displayed a lack of knowledge, skill or judgment in relation to: his medical recordkeeping, his failing to uphold professionalism and boundaries in therapeutic encounters; and his failing to appropriately terminate the doctor-patient relationship. His awareness of Patient A's vulnerabilities was not incorporated into her treatment plan. Dr. Clarke further opined that "If this clinical record is representative of Dr. Doyle's practice of medical record keeping and his self-described 'informal style', with patient, and boundary crossings, it is likely that patients would be exposed to harm. This risk of harm is estimated to be higher than what would be expected from care provided by a practitioner who maintained the standard of care in these areas."

Section 75 Investigation regarding Other Patients

Regarding the s.75 investigation and Dr. Clarke's review of 24 patient charts, 16 out of 24 charts showed that the care did not meet the standard of practice of the profession. Some of the more significant deficiencies found included:

- Absence of mental status exams;
- Diagnoses were impressionistic and inconsistent over time;
- Poor documentation of substance abuse problems;
- Inconsistent action on addressing substance abuse behaviours;
- Inappropriate use of medications contraindicated in documented diagnoses;
- Unconventional dosing of drugs;
- Use of potentially harmful combinations of drugs and polypharmacy;
- Frequent prescribing of stimulant medication without a clear indication;
- Inappropriate prescribing of opiates for 3 of the 24 patients;

- Inappropriate prescribing of marijuana in 4 of the 24 patients;
- Lack of professionalism in the use of language in some of the records;
- Lack of monitoring of drugs prescribed, i.e., lithium levels;
- Failure to notify Children's Aid Society or Ministry of Transport in mandatory cases.

The Committee reviewed each of these 24 patient charts and found noteworthy Dr. Clarke's conclusion that "in all of the records reviewed the standard of medical record-keeping was very poor" and that this is a significant risk factor with negative impact on patient care.

The finding of incompetence relates to Dr. Doyle's significant lack of knowledge, skill or judgment in relation to his professional care of patients. As noted, Dr. Clarke found that Dr. Doyle's care of Patient A displayed a lack of knowledge, skill or judgment and, in relation to the 24 charts reviewed, that:

- 1 out of 24 charts showed that his care displayed a lack of knowledge;
- 19 out of 24 charts showed that his care displayed a lack of skill or judgment;
- 19 out of 24 charts showed that his care is likely to expose patients to harm or injury.

In addition, Dr. Clarke reviewed Dr. Doyle's 29 YouTube videos and concluded the following:

- 9 out of 29 videos were therapeutic in nature and fell below the standard of care for a psychiatrist;
- 13 out of 29 videos were educational in nature and 12 fell below the standard of care;
- 7 out of 29 videos were philosophical in nature and 6 of them showed lack of judgment;
- 2 out of 29 videos showed lack of judgment and were likely to expose patients to risk of harm;

Dr. Clarke's report indicated that in many cases, there was inadequate patient consent to these videotapes and in some cases, there was a risk of patient identification.

Dr. Doyle also communicated in an unprofessional manner, as follows:

- in January 2017, a medical adjudicator from the Canada Student Loans program reported that when she called Dr. Doyle to verify the authenticity of medical reports on an individual, Dr. Doyle answered the phone twice with profanities, but apologized for his language once he knew that he was talking to an adjudicator and not a patient;
- Dr. Clarke's report highlights Dr. Doyle's inappropriate use of language in his charting;
- Patient A, in her letter to the College, reported that Dr. Doyle's casual demeanor included the use of profanities.

Dr. Doyle acknowledged that he failed to maintain the standard of practice of the profession, that he engaged in conduct that would be regarded by members of the profession as disgraceful dishonorable or unprofessional and that he is incompetent.

2. Prior History

Dr. Doyle has demonstrated unprofessional conduct and a serious lack of judgment over many years and in many circumstances.

1) Professional Transgressions during Residency

Dr. Doyle admitted that he worked for an insurance company from April, 1996 to April, 1997 and conducted physical exams on patients referred for assessments, while he was in a residency program. He indicated that he did this because of "personal circumstances at the time, which required [him] to earn additional money."

The psychiatry program director, Dr. Kaplan, stated, "I reminded Dr. Doyle that we had met on a number of occasions and had numerous communications regarding the issue of his moonlighting using his educational license. I made it clear that this was absolutely unacceptable to the College for a trainee to use an educational license outside of the training program and its institution." Despite this warning, Dr. Doyle chose to seek employment in 1998 as a medical consultant with a company called Professional Health Management (PHM).

In a letter to the College, dated March 16, 1998, Dr. Doyle stated "the realization that moonlighting within the OHIP structure was in fact no longer an option for residence caused me great distress… I was very involved in the efforts to change the decision on moonlighting and never hid my disapproval of this revision and policy… the company (PHM) was perhaps misrepresenting my qualifications and [that I] was guilty of a lack of diligence in monitoring [the company's] activities using my name and credentials. This situation is due strictly to my own naivety in the realm of a private industry, rather than any attempts to misrepresent myself."

The Registration Committee at its meeting on April 3, 1998, decided that it would issue a certificate of registration with terms, conditions and limitations. The Registration Committee had serious concerns regarding Dr. Doyle's professional attitudes, ethics and governability. The terms, conditions and limitations on Dr. Doyle's certificate of registration stated that his practice must be supervised by a specific supervisor acceptable to the College and that this supervisor must provide a quarterly written report to the College. Dr. Doyle complied with the terms, conditions and limitations imposed on his certificate of registration and quarterly reports were submitted to the College by various psychiatrists until 2001.

2) 2009 Discipline Finding

In 2009, despite his prior dealings with the Registration Committee requiring that he practise under restriction, including an extensive period of monitoring, Dr. Doyle found himself before the Discipline Committee in relation to serious boundary violations regarding Patient Y. Dr. Doyle admitted that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all circumstances, would reasonably be regarded by members as disgraceful dishonorable or unprofessional. Dr. Doyle acknowledged that he made serious errors during the last few months of treatment of Patient Y and was not maintaining boundaries, in that his conduct during the summer and fall of 2006 developed into a romantic relationship which included dates, kissing, oral sex and sexual intercourse shortly after the end of the doctor-patient relationship.

Following a joint submission on penalty, the Committee ordered a 12-month suspension of his certificate of registration, the requirement to successfully complete a medical ethics and informed consent course, a boundaries course, and the record keeping course.

Other terms conditions and limitations imposed by the Discipline Committee included that Dr. Doyle remain in the Physician Health Program with a monitor, that he continue in psychotherapy, and that he be restricted from performing long-term psychotherapy. Dr. Doyle was restricted from providing ongoing psychiatric care to female patients, except in the presence of a monitor.

In relation to the events with Patient Y, Dr. Doyle was referred for an assessment at the Baylor College of Medicine by the OMA Physician Help Program (PHP) in 2009. Dr. Doyle was assessed by Dr. Gabbard. The purpose of the assessment was to answer the following questions:

- what, if any, are the diagnoses of Dr. Doyle; does he suffer from any medical condition?
- what treatment suggestions would you recommend? In particular, any specific psychotherapeutic recommendations;
- if possible, please provide a risk assessment focusing on recent boundary violations and the potential for future transgressions;
- do you find there is any concern with Dr. Doyle working or any recommendations for the workplace?
- would you have any specific recommendations with regards to monitoring of this physician?

The Committee found Dr. Gabbard's assessment report very helpful, in that it answered the above questions and made very specific recommendations with respect to Dr. Doyle's ability to practise and under what conditions. It also addressed many of the pre-existing and ongoing issues that are problematic when considering remediation. For instance, Dr. Gabbard reported about Dr. Doyle's marital problems, "Dr. Doyle believes that events that contributed to his current situation first began in early 2005. He states that he noticed that his wife had not been as affectionate with him...He became concerned she might be having an affair." Dr. Gabbard's

assessment report also documents Dr. Doyle's difficulty in maintaining professional boundaries in the physician-patient relationship, which culminated in the 2009 Discipline Committee decision. Dr. Doyle reported that "he will not be treating extremely demanding patients or those with borderline personality disorder and will not provide psychotherapy to any patients."

According to Dr. Gabbard's assessment report, Dr. Doyle had no significant past psychiatric illness and, in particular, no history of major depression mania or psychosis. After a psychiatric and psychological examination, Dr. Gabbard's diagnosis was that Dr. Doyle was not a predator, nor did he have an anti-social personality disorder. According to Dr. Gabbard, Dr. Doyle did not have a sexual disorder, a substance abuse problem, or a brain based cognitive disorder. Dr. Gabbard diagnosed Dr. Doyle with acute adjustment disorder and indicated that the boundary transgression is best understood as involving "a convergence of long-standing personality traits and marital stresses that reached an extreme point prior to the involvement between Dr. Doyle and his patient." Dr. Gabbard reported: "Dr. Doyle manifests an impairment in judgment at times. He does not always accurately anticipate the consequences of his actions. His poor judgment, global impressionistic cognitive style and emotional neediness converged to form a self-destructive tendency."

Dr. Gabbard opined: "Because of the intense neediness of Dr. Doyle is stemming from early life and continuing into the present and because he does not fully understand his intra-psychic motivations for transgressing boundaries, he will continue to be at mild to moderate risk of repeating boundary violations in one form or another until he has had an adequate treatment and rehabilitation program."

Dr. Gabbard's treatment recommendations included:

- that Dr. Doyle have intense long-term psycho-analytical psychotherapy;
- that Dr. Doyle see a couples therapist on a regular basis to address his marital problems;
- that Dr. Doyle complete education on boundaries and boundary violations;
- that Dr. Doyle's practise medicine under weekly supervision

- that Dr. Doyle carefully screen out patients with borderline personality disorder from his practice and avoid providing psychotherapy;
- that Dr. Doyle obtain debt counselling and financial management counselling;
- that Dr. Doyle use an overall rehabilitation coordinator.

Dr. Gabbard recommended that this entire program should continue for three years with an evaluation at the end to determine if Dr. Doyle can safely practise medicine without the structure outlined for him.

The Committee found Dr. Gabbard's report to be informative, clear, cogent, and convincing. The information and recommendations were not substantially different from the findings and recommendations of Dr. Ruskin, even though their assessment was done years apart and after many years of monitoring and counselling.

Dr. Ruskin in his letter to counsel dated January 19, 2018 stated: "in my evaluation of Dr. Doyle's early life… Dr. Doyle scored high in many areas which paralleled my findings that he was physically and sexually abused in childhood and emotionally neglected, left to himself. It is not unusual for individuals who have been traumatized and neglected in childhood and who are in the helping professions, to try and make up to the patients what was not given to themselves. Hence, they can at times have difficulty in dealing with vulnerable patients… and struggle with limits setting." Dr. Gabbard's report similarly points out that Dr. Doyle's early history of trauma sensitizes him to try to seek the approval of others as a defence against fear of abandonment, but he fails to recognize how this impairs his judgment and how he places himself in vulnerable positions.

The Committee finds that Dr. Doyle has failed to adequately address the personal issues that were identified initially by Dr. Gabbard and which are noted as persisting by Dr. Ruskin. It has been established by the College that Dr. Doyle is not able to practise in a manner that maintains the standard of care for his specialty and his practice puts his patients at risk of harm. He clearly has not adequately addressed his serious marital problems, his financial problems, his early

childhood trauma, nor has he screened out seeing complex patients with a history of boundary issues.

3. Lack of Insight and Failure to Appropriately Apply Knowledge / Lack of Judgment

The Committee finds on the facts and the evidence that Dr. Doyle displays a persistent lack of insight into his deficiencies and a lack of judgement.

Patient A

As documented in the Agreed Statement of Facts, Patient A was referred to Dr. Doyle by her family physician in August 2013. There was clear documentation that she is a high risk patient and had a history of boundary issues with her previous psychiatrist. Despite this information, in the Committee's view, Dr. Doyle exhibited poor judgment and took her on as a patient. He described her as a "borderline female with increased anger and depression." He was her attending psychiatrist from October 2013 until July 2014.

Patient A describes Dr. Doyle's interactions with her as being casual, sitting back and putting his feet up on a coffee table and uttering profanities. She said that he discussed exercise programs with her and she felt that he was trying to foster a friendship with her. When she reported her feelings for him during their session in July 2014, Dr. Doyle abruptly told her that her feelings were inappropriate and that he could no longer continue seeing her that day and told her to make an appointment with his secretary. This was not his usual practise because he would usually make appointments on his cell phone. Patient A felt confused ashamed and humiliated. Dr. Doyle terminated the doctor-patient relationship in an email and did not make Patient A's family physician aware of this, he did not provide for transfer of care to another psychiatrist, he did not document any of this in Patient A's chart, he did not provide for ongoing prescriptions until Patient A found a new doctor. Patient A reported that she became increasingly depressed and sought help from her family doctor and was sent to the emergency room with suicidal ideation.

The Committee reviewed the evidence of Dr. Ruskin, Dr. Malat and Dr. Clarke with respect to this boundary issue. The Committee considers that Dr. Doyle showed a serious lack of judgment in taking on this high risk patient, given his past history and the expert advice he had received from Dr. Gabbard advising against his seeing patients with borderline issues.

The Committee notes that Dr. Doyle had knowledge of Patient A's history of sexual boundaries with another medical professional while under that professional's care prior to accepting her as a patient. With this knowledge of her vulnerabilities and given his history of serious sexual boundary transgressions with a patient and Dr. Gabbard's recommendations to avoid seeing patients with boundaries issues, the Committee 's view is that Dr. Doyle exercised very poor judgment and that it was inappropriate in the circumstances for him to agree to see her as a patient.

Care of Patients

Dr. Clarke interviewed Dr. Doyle on July 21, 2016 to discuss his approach to psychiatric assessment, including diagnosis and treatment. The purpose of the interview was to understand Dr. Doyle's clinical decision-making process.

Dr. Doyle indicated to Dr. Clarke: "I'm pretty good at consults I believe." That assertion is not supported by the review of his patient charts, and demonstrates lack of insight.

Dr. Doyle also asserted that he met the standard of practice of the profession. The Committee notes that this was not observed in Dr. Clarke's or the Committee's review of his records, which reflected multiple deficiencies including conflicting diagnoses for patients, inappropriate prescribing of non-psychiatric medication, doses of medication amounts given, and numbers of repeats prescribed.

When asked about the lack of mental status exams in his records, Dr. Doyle stated: "my supervisor kept encouraging me to kind of write that down and will comment he wasn't seeing it, so I don't know why I just didn't make it prominent in the chart, because I was recording it

mentally and I just wasn't putting it down there." The Committee finds this very concerning because despite prior feedback and suggestions from his supervisor, it continued to be a significant deficit which put patients at risk of harm. It also speaks to Dr. Doyle's failure to implement suggestions that were for his benefit and the benefit of his patients.

In her expert report, Dr. Clarke discussed her concern with frequent shifts in Dr. Doyle's diagnoses and comments like "bipolar tendencies or attention deficit/hyperactivity disorder moments." She noted that these comments are confusing and not referable to DSM IV diagnostic clarity or criteria. Dr. Clarke reported: "This internal inconsistency of diagnostic understanding was evident in the interview, this leads to concern that patients may be treated for diagnosis they do not have or a diagnosis may be missed."

Dr. Doyle acknowledged the risks of and poor evidence for the use of combination antipsychotics. He acknowledged that it is not supported by guidelines and that the risks were not discussed with the patients, nor documented in their charts.

When asked about lithium prescribing, Dr. Doyle acknowledged that he did not do the monitoring because he "used lower doses." The Committee found that this practice, of using sub-therapeutic doses of lithium and the lack of monitoring levels, thyroid function, kidney function and calcium levels, is not supported in guidelines and increases the risk of morbidity.

When Dr. Clarke questioned his views on the benefit of measured-based care with standardized scales, Dr. Doyle replied, "I find just me using my own kind of judgment and just my knowledge base is what sits with me." He describes himself as a maverick with his own biological way of doing things, despite his knowledge of the scientific evidence and accepted guidelines.

Dr. Doyle was aware of mandatory reporting requirements to the Ministry of Transport for driving safety and to the Children's Aid Society for child protection, but he exercised poor judgment when deciding not to report or document patients at risk. This is documented in the charts reviewed by Dr. Clarke.

Dr. Doyle acknowledged that he often prescribed non-psychiatric medication to his patients in his attempt to meet their wishes. Prescribing of non-psychiatric medication, especially narcotics, is best handled by the family physician. This raises serious concerns of faulty judgment and an inability to maintain boundaries with patients.

When Dr. Doyle was asked about his providing prescriptions for medical marijuana to people with psychotic illnesses, he described this as “very risky obviously.”

When asked about non-objective non-professional language used in clinical records, Dr. Doyle answered: “I’m jotting down while I’m thinking, so I guess inappropriate stuff will come out in that way, right. I should be more careful.”

The Committee finds that these facts demonstrate dangerous lack of judgment on the part of Dr. Doyle. He was aware of the guidelines used in the profession to treat and monitor illnesses. However, he described himself as a maverick, a lone wolf, who had his own way of treating mental illness. The Committee finds that Dr. Doyle lacks insight. He thought his record-keeping was good, when it was not. In the view of the Committee, his failure to appropriately apply his knowledge puts patients at a serious risk of harm.

Patient B

Information with respect to Patient B was contained in Exhibit 16, tab 21, a report in 2015 by Dr. Malat, the clinical supervisor. It should be noted that the incident occurred in 2013 but was only reported by Dr. Doyle to Dr. Malat in 2015. Dr. Malat noted that "Dr. Doyle acknowledged that helping these two patients connect was a boundary crossing - an error in judgment on his part which he admitted to Patient B.

The Committee noted this as an incident in which Dr. Doyle showed poor judgment and a lack of insight in dealing with Patient B while under supervision. This woman had serious psychiatric issues and met a gentleman she was interested in, while waiting in Dr. Doyle’s waiting room. She asked Dr. Doyle for the patient’s phone number and Dr. Doyle felt that if a relationship

developed between these two patients it may be beneficial. He gave her the phone number and the relationship developed, but ended poorly. The Committee found that this shows a very bad lack of judgment at a time when Dr. Doyle was practising under supervision.

Conclusion

Dr. Doyle admitted to failing to maintain the standard of practice of the profession and to engaging in an act or omission that would be reasonably regarded by members as disgraceful dishonorable or unprofessional. Dr. Doyle also admitted that he is incompetent.

The Committee reviewed the agreed facts and the evidence put before it, the submissions of the counsel, and case law. The question before the Committee was to determine whether or not Dr. Doyle could practise with restrictions that would protect the public from harm and whether this would be an appropriate penalty. The Committee concluded that Dr. Doyle poses a serious risk to the public in the way that he practises medicine. The Committee found that Dr. Doyle lacks insight into the depth of his professional deficiencies and he lacks judgement in turning knowledge into action. His failings are fundamental, pervasive and profound. Despite many years of supervision, monitoring and psychotherapy, his patients are still at serious risk of harm because of his deficiencies. The Committee found no evidence to indicate that he has addressed his financial problems, his marital problems, or childhood abuse issues, which are still unresolved and are likely to perpetuate his deficiencies and lack of judgement.

Dr. Doyle did not testify at the hearing and the Committee did not hear directly from him as to why he thinks remediation would work at this time, when it has failed over the past several years. Dr. Doyle practised under supervision for a lengthy period which proved to be ineffective.

On the importance of insight, the Committee considered the decision in *CPSO v. Liberman* (2012), which states that “despite the overwhelming evidence that led to the conclusions that the Committee reached, Dr. Liberman showed little insight into his failing. When someone is going to be remediated they need to be able to look at their actions in an open-minded way. Dr.

Liberman seems to be so entrenched in his view that he does not seem to be able to examine his own actions." Lack of insight is a critical issue when it comes to remediation.

The Committee was mindful of the overriding principle that protection of the public must be paramount in its consideration.

In *Adams v Law Society of Alberta* (2000), the Alberta Court of Appeal states:

> The public dimension is of critical significance to the mandate of professional disciplinary bodies. With this monopolistic right comes certain responsibilities and obligations. Chief amongst them is self-regulation. Self-regulation is based on the legitimate expectation of both the government and 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. [para 6]

The decision further states:

> It is therefore erroneous to suggest that in the professional disciplinary matters, the range of sanctions may be compared to penal sentences and to suggest that only the most serious misconduct by the most serious over offenders warrants disbarment. Indeed that proposition has been rejected in criminal cases for the same reasons it should be rejected here. It will always be possible to find someone whose circumstances and conduct are more egregious than the case under consideration. Disbarment is but one disciplinary option available from the range of sanctions and as such it is not reserved for only the very worst conduct engaged in by the very worst lawyers.

The Committee is of the opinion that there are no other cases that are the same as this case on their facts. In any event, the Committee is aware that the decisions of other panels of the Committee are not binding on it as a matter of law.

Dr. Doyle has been given numerous chances at remediation with many years of psychotherapy, supervision, monitoring and practice restrictions. Despite this, he is still struggling with professionalism, boundary issues, and clinical care. It is clear to the Committee that Dr. Doyle has the intelligence and knowledge to be a good physician, but it is also clear that he lacks insight into his deficiencies. He tends to minimize them, and he demonstrates a clear lack of judgment, which is pervasive. This puts his patients at a serious risk of harm in many areas starting with patient selection, charting, reporting, diagnosing, and prescribing.

The Committee is persuaded that a remedial order, with supervision and restrictions on his certificate of registration, would not protect the public. The Committee finds that revocation of Dr. Doyle's certificate of registration is required in the circumstances of this case to fulfill the Committee's objective of protection of the public.

Revocation will serve as a specific deterrent to Dr. Doyle and a general deterrent to the membership of the profession. It sends a clear message that the College takes very seriously its role to protect the public from professional misconduct.

In addition, the revocation of Dr. Doyle's certificate of registration will serve to maintain public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest.

COSTS

The Committee determined that this was an appropriate case to order that Dr. Doyle pay costs to the College of three days of hearing at the tariff rate that was in effect at the time of the hearing of $5,500.00, for a total of $16,500.00.

ORDER

Therefore, the Committee orders and directs that:

1. The Registrar revoke Dr. Doyle's certificate of registration, effective immediately;

2. Dr. Doyle appear before the Committee to be reprimanded with 90 days of the date this order becomes final;

3. Dr. Doyle pay costs to the College in the amount of $16,500 within 90 days of the date this order becomes final.