NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Philip Kernerman, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the name or identity and any information that would disclose the name or identity of any individuals whose names or identities are disclosed at the hearing or in any documents filed at the hearing other than Dr. Philip Kernerman and the names of treating physicians of Dr. Kernerman and experts who have testified at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

Indexed as: Kernerman, P. (Re)

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
By the Registrar to the Discipline Committee of
The College of Physicians and Surgeons
Of Ontario, pursuant to Section 73
Of the ***Health Professions Procedural Code***

BETWEEN:

DR. PHILIP KERNERMAN

- And -

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

PANEL MEMBERS:

DR. M. GABEL (Chair)
G. DEVLIN
B. FEVREAU
DR. P. ZITER

Hearing Dates:	January 7, 8, 11 and 12, 2010
Decision Date:	September 8, 2010
Release of Written Reasons:	September 8, 2010

DECISION AND REASONS FOR DECISION

Dr. Philip Kernerman ("Dr. Kernerman") made an application to the College of Physicians and Surgeons of Ontario (the "College") for reinstatement of his certificate of registration in relation to his revocation on February 9, 2004 for professional misconduct. The Registrar referred Dr. Kernerman's application for reinstatement to the Discipline Committee, and the Committee heard the application on January 7 to 8 and 11 to 12, 2010. At the conclusion of the reinstatement hearing, the Discipline Committee reserved its decision.

BACKGROUND

Dr. Philip Kernerman is a 48-year-old physician who completed his medical training at the Sackler School of Medicine, Tel Aviv, Israel in 1992. He completed a Residency Program in Internal Medicine at McMaster University in Hamilton, Ontario in 1996. He became a Fellow, Critical Care Medicine, in 1998 after completing the program at the University of Toronto. Following that, he was employed in the Greater Toronto Area as an Internist and Intensivist at North York General and Humber River Regional Hospital. He also was employed for a short time at the "Gentle Vasectomy Clinic".

In the time period between 2001 and February 2003, Dr. Kernerman repeatedly behaved in a rude, inappropriate and/or sexually suggestive manner to friends and spouses of patients, staff, and visitors at these hospitals and clinics. He also engaged in unwanted touching of a staff member at a clinic, which resulted in criminal charges for sexual assault. These events led to a hearing before the CPSO Discipline Committee, which resulted in the revocation of Dr. Kernerman's certificate of registration on February 9, 2004.

In the matter now before the Committee, Dr. Kernerman is applying for reinstatement of his certificate of registration and wishes to be reintegrated into the practice of medicine.

APPLICATION FOR REINSTATEMENT

Relevant Statutory Provisions

The following provisions of the *Code* are relevant to applications for reinstatement:

> 72(1) a person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed.
>
> …
>
> (2) An application under subsection (1) shall not be made earlier than,
>
> (A) One year after the revocation or suspension …
>
> 73(1) The Registrar shall refer the application, if the revocation or suspension was on the grounds of,
>
> (a) Professional misconduct or incompetence, to the Discipline Committee.
>
> …
>
> (5) A panel may, after a hearing, make an order doing any one or more of the following:
>
> 1. Directing the Registrar to issue a certificate of registration to the applicant.
>
> 2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
>
> 3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration.

In applications for reinstatement, the burden of proof is on the applicant to establish suitability for reinstatement of his or her certificate of registration. The standard of proof is determined on the balance of probabilities.

As discussed in more detail below, the *Code* does not provide guidance with respect to the factors that the Committee is to consider in determining whether reinstatement is appropriate.

A number of relevant considerations were identified by the Committee in its approach to this application. The protection of the public is, of course, a primary concern, and in that regard, Dr.

Kernerman has to reasonably demonstrate that he no longer represents a risk to the public (including patients, relatives of patients and staff).

The Committee also had to consider whether any terms, conditions and limitations might be imposed to permit reinstatement and, if so, whether they could be monitored and enforced in a practical manner.

In addition, the Committee considered whether the evidence demonstrates:

- That Dr. Kernerman has an understanding of, and insight into, the behaviour which led to his revocation;
- Whether he has complied with his medical and psychiatric intervention and has demonstrated the ability to control his behaviour;
- That Dr. Kernerman understands the harmful impact this behaviour had on his victims, his colleagues and his family;
- That he is motivated to comply with the ongoing therapy needed to keep him mentally and physically healthy;
- That Dr. Kernerman has shown good character, honesty and good faith in his dealings with his community, the CPSO, his treating physicians and the Committee;
- That his proposed reintegration into practice is safe and reasonable; and
- That reinstatement will not impact negatively on, or present future risks to, the reputation of the profession.

The Committee was also cognizant of its responsibility to ensure that Dr. Kernerman has demonstrated a desire to maintain his competency during his period of revocation and that he is agreeable to have his skills evaluated and, if necessary, to participate in further training and education.

POSITION OF THE PARTIES

Counsel for Dr. Kernerman

Counsel for Dr. Kernerman submitted that reinstatement subject to ongoing treatment and supervision should satisfy the Committee's concern for public protection.

Counsel for Dr. Kernerman reminded the Committee that the original penalty for revocation in 2004 was based on a joint submission by counsel. He submitted that ordinarily, the facts in that case would not have warranted a revocation in that none of the original complainants were actually patients. The Committee at the time stated "that while the proposed penalty might be regarded as unusually severe, Dr. Kernerman has many issues in his life…and therefore [he] considers this to be the responsible course of action."

Counsel for Dr. Kernerman further submitted that since revocation, he has participated in rigorous counselling and treatment to address the psychological and emotional issues which led to his inappropriate behaviour toward the female complainants. Assessments conducted by two forensic psychiatrists (Dr. X and Dr. Y) support the application for reinstatement with conditions.

Dr. Kernerman's counsel submitted that these assessments demonstrate that Dr. Kernerman now has insight into his diagnosis, is compliant with treatment and serious about his rehabilitation. He states that circumstances have changed since revocation and that he has demonstrated compliance with treatment and is able to control his prior acting out conduct.

Dr. Kernerman's counsel indicated that his client understands that he bears the onus on this application but that, on a balance of probabilities, he is an appropriate candidate for reinstatement and that he has "met the test". He stated that fairness demands that Dr. Kernerman be given another chance, as long as there is no risk to the public in doing so.

College Counsel

College counsel took the position that the evidence in this case demonstrates that Dr. Kernerman has not met the burden of proof for reinstatement.

College counsel reminded the Committee that Dr. Kernerman's past behaviour is in no way

limited to the facts set out in the decision from 2004, and that his behaviour included a "pattern of compulsive sexual acting out with the relatives of his patients as an intensive care specialist" and that he "used his power held as a physician to further his sexual exploits".

College counsel submitted that Dr. Kernerman was manipulative and deceitful in dealing with his victims and his treating physicians. Dr. Kernerman demonstrated a pattern of relapse despite extensive inpatient and outpatient treatment by "at least 15 different specialists in Canada and the United States over the past 7 years".

The College's position is that Dr. Kernerman is simply not ready to assume the responsibilities needed to reenter practice.

THE EVIDENCE

(a) Overview of the Evidence

The Committee heard evidence from Dr. Kernerman, Dr. Z, Dr. X, Dr. J, Dr. Q, and Dr. T. The Committee also received into evidence 22 exhibits which included various *Curriculum Vitae* and volumes of Dr. Kernerman's personal medical records from various psychiatrists, therapists, group therapy documents, and psychometric testing.

Documents were also included from various psychiatric treatment facilities (Keystone, Bellwood Health Services, and The Meadows) where Dr. Kernerman was treated.

The DSM-IV criteria that set out the criteria for diagnosis of Personality Disorders and Conduct Disorders were reviewed.

A victim impact statement was also submitted as an exhibit.

The Committee carefully considered all of the evidence before it including all of the documentary evidence. We set out below a concise summary of the salient evidence.

Testimony

Dr. Philip Kernerman

The Committee found Dr. Kernerman to be cooperative while giving testimony, for the most

part. The Committee relied heavily on this testimony in coming to its decision.

He testified that he graduated from medical school in Tel Aviv, Israel. He returned to Canada and completed his specialties in Internal Medicine and Critical Care Medicine in Ontario. He is married and has three children, but he has not lived with his wife since 2005, and has been living with a woman since July 2008. He describes this second relationship as the first healthy relationship he has had with a woman.

Dr. Kernerman gave testimony regarding his employment history at Etobicoke General, North York General, Humber River Regional Hospital and the Gentle Vasectomy Clinic. He acknowledged that his dysfunctional behaviour toward women, both in and out of his work environment, led to the termination of his employment at all of these institutions, criminal charges being laid, and the College's revocation of his certificate of registration. By Dr. Kernerman's own admission, he has not had any meaningful employment since April 2006, and relies on his elderly father for financial support. The Committee was struck by Dr. Kernerman's lack of effort in seeking any meaningful employment or volunteer work.

Dr. Kernerman recounted the treatment he has received for his "hypersexuality" in the last several years at various inpatient facilities and with numerous psychiatrists, psychologists and counselors, both in individual and group therapy. It was very clear to the Committee, through his testimony, that Dr. Kernerman has spent hundreds of hours in treatment and has made significant progress in dealing with his mental and emotional issues.

He also gave testimony in support of his assertion that he has not acted out inappropriately with women since April 30, 2005**.** This is the day he perceives as his "day of sobriety", which is also referred to as May 2005**,** even though at that time he was still having sex with a woman who was seriously mentally ill and was warned by his therapist that the relationship was not a healthy one.

Dr. Kernerman testified that he was now committed to ongoing medical management with psycho-pharmaceutical agents as well as group and individual psychotherapy which would ensure that he is not at risk of recidivism.

In giving testimony, the Committee perceived that Dr. Kernerman was at times evasive in answering difficult or unpleasant questions. When uncomfortable with a question, he would

answer: “It is what it is”. He acknowledged that he continued to exhibit dysfunctional behaviour towards women despite extensive medical intervention prior to that “sobriety date”, but explains the treatment failure by rationalizing: “It was obvious that because of where I was in my process I wasn’t getting what I need”, until he saw Dr. Z, who he views as “a proper adult ADHD specialist”. In his testimony, Dr. Kernerman stated that he was unable to control his hypersexuality because there was a delay in the diagnosis of adult ADHD, which led to treatment failure.

Dr. Kernerman also cites other milestones that he believes were turning points on his road to recovery. In particular, he places a lot of credit on reading the book “The Six Pillars of Self Esteem” and to his group therapy sessions with Drs. J and F in their “Relationship Laboratory”. He states that these sessions helped him learn about himself. “I was always like a 15 year old, didn’t have a pause button. I was impulsive…I didn’t have insight. Now I am more like a 25 year old not a 47 year old because I still have things I , that I…it’s just the way it is.” (Vol. I, p.155)

He answered many questions with respect to a “sobriety date” of May 2005, which he stated was the date at which he last acted out inappropriately. The Committee however finds that his dysfunctional behaviour went far beyond this date due to the fact that he had sexual relations with his wife long after this date while living with another woman. His therapists had told him that his involvement with this woman was unhealthy and that she had a borderline personality.

When asked about his remorse with respect to his victims, he said: “I have never confronted…I have never made amends to my victims. I wanted to write a letter to this person you know just to say I am truly sorry.” (Vol. I, p.162)

When asked how he deals with stressful situations now, Dr. Kernerman testified that rather than acting out in an inappropriate sexual way, “when life is overwhelming and I am feeling so much pain, what I, you know, this year I would just to bed and stay in bed for three days, because…sometimes I don’t have hope of what’s going to happen - - and I have a lot of guilt.” (Vol. I, p.165) Also, “I’ve got so much fear of what I’ve done to my parents, and my kids, and my profession, women, their families, and I know I am able to see things; because I am forced to see things for what they are, I have to deal with it.” (Vol. I, p.156)

The Committee found that Dr. Kernerman often depersonalized his situation by answering in a self-referential manner: “In a perfect world people might say, Phil the evidence is that Phil is ready to go back. He was clearly not a positive influence on his profession before to put it mildly....” (Vol. I, p.183) When asked about possible options in medicine if reinstated he said: “If I were someone else looking at Phil, I would have reservations.” (Vol. I, p.185)

The Committee felt that Dr. Kernerman exhibited shallow levels of remorse with respect to his victims. When asked about the Victim Impact Statement, he stated: “I have never confronted – I have never made amends to my victims.” (Vol. I, p.162)

Dr. Kernerman admitted that for various reasons he has not done any formal CME required to maintain his skills and knowledge in his specialty while his certificate was revoked. He testified that he has done some on-line reading and has read some medical journals. He rationalized this by saying that the costs of CME were a factor and that the lengthy process of reinstatement were obstacles: “It’s taken a very long time. Listen, it’s been, in the whole scheme of things, while I may want to put blame on others besides me, I couldn’t be an intensivist tomorrow.” (Vol. I, p.176)

Dr. Z

The Committee heard testimony from Dr. Z as one of Dr. Kernerman’s treating physicians, and not as an expert witness. Dr. Z is a certified psychiatrist who has a private practice in Toronto and has been involved in the treatment of Dr. Kernerman in relation to ADHD since November 2007. He gave testimony that supported his own system of diagnosis and treatment of ADHD but acknowledged that he had no formal training in ADHD nor had he authored any peer review papers on the subject.

Dr. Z reported that Dr. Kernerman’s ADHD was controlled with the combination of Adderal 50 mg, Wellbutrin 300 mg and Cipralex 5 mg, and that remaining on these medications and ongoing psychotherapy should be a condition of reinstatement.

The Committee felt that he was a strong advocate of Dr. Kernerman, and that he lacked impartiality. His opinion was ultimately not helpful to the Committee and therefore was given relatively little weight in making its decision.

Dr. X

The Committee accepted Dr. X as an expert witness qualified in forensic psychiatry who was able to offer an opinion with respect to psychiatric diagnosis, treatment and risk of reoffending behaviour.

The Committee found Dr. X to be a credible, knowledgeable witness with a wealth of experience in his stated areas of expertise. Dr. X acknowledged that he did have a doctor-patient relationship with Dr. Kernerman and, by definition, was biased in this regard. The Committee respected this disclosure and felt that despite this, Dr. X's testimony was factual, honest and very useful in helping us come to a decision.

Dr. X first met Dr. Kernerman on April 11, 2005, for an initial assessment after a referral by Dr. V, one of Dr. Kernerman's treating physicians. His assessment of Dr. Kernerman at that time was that he was suffering from a sexual deviation known as Paraphilia, with problems of self-esteem and insecurity that led to sexually inappropriate behaviours that had a compulsive quality. His recommendations at the time included counselling and insight-oriented therapy.

In January 2006, Dr. Kernerman began group sessions with Dr. J in his "Men's Introspective Group" for cognitive behavioural therapy and at the same time continued his individual psychotherapy sessions with Dr. X.

In January 2007, after one year of involvement with these methods of intervention, Dr. X was asked to make another assessment by Dr. Kernerman's lawyer. Dr. X's assessment of Dr. Kernerman's status was based on these experiences, as well as the review of documents from a number of other treating physicians and psychologists in various institutions in Canada and the USA. These included reports from three inpatient addiction treatment centers: Bellwood Health Services, The Meadows, and Keystone Centre.

Dr. X felt that after one year, "[Dr. Kernerman] had developed good insight into himself or at least adopted that introspective attitude which I wanted to see happen." His diagnosis was one of Sexual Deviation or Non-Specific Paraphilia. He did not see Dr. Kernerman as suffering from an Anti-Social Personality Disorder. In his testimony he referred to the criteria for Personality Disorder in the DSM-IV Manual and stated that Dr. Kernerman doesn't come "remotely close"

to having that kind of disorder in that there was no evidence of a Conduct Disorder prior to age 15.

The testimony of the various experts did not unequivocally support the diagnosis of a Personality Disorder. The Committee did not attach much weight to whether Dr. Kernerman had a diagnosis of Personality Disorder or not in coming to its decision.

Dr. X did feel that Dr. Kernerman had a compulsion to seek out sexual contact with adult females and had fetishistic interests in shoes, legs, and pubic hair. He felt his personality was characterized by these prominent obsessive-compulsive traits, low self-esteem and lack of self confidence in relationships. He also agreed that Dr. Kernerman did have Adult ADHD as well.

In his testimony, Dr. X stated that "this is an individual who has gained cognitive insight, who has gained emotional insight, who has some better control of his attention deficit disorder which would have contributed to his impulsive behaviour in the past."

He acknowledged that he made his recommendation on the basis of Dr. Kernerman's self-reporting:

> This is something that has not been tested out in a real life situation as a doctor. He reports having jobs in the community. I have no reports from any of those jobs or that he was associated with to indicate that, indeed, for cognitive changes that he has made and emotional insight that he has acquired has translated into real change in the community. (Vol. 4, p.55)

He went on to say, "but in order to test it out, if he were to practise as a physician, these positive gains that I observed in group need to be tested in a real life situation." (Vol.4, p.56)

Dr. X also testified that he did not validate these clinical impressions as he otherwise would like to, with work performance reports, supervisor's reports and other external psychometric tests such as the MMPI or the PCL-R.

It appears on the evidence that Dr. Kernerman misinformed Dr. X to give the impression that he actually had some meaningful community work experience. The Committee also felt that Dr. X was misled as to the stated "sobriety date" of May 2005 in that the evidence demonstrates that Dr. Kernerman was involved in a dysfunctional, unhealthy relationship with a woman, other than his wife, long beyond that date.

In addition, Dr. Kernerman self-reported to Dr. X using the services of paid sexual workers on about 300 occasions, when in fact his testimony at this hearing confirmed there were over 5000 occasions.

Dr. X reported that Dr. Kernerman was attending two group sessions per week and was very committed to these sessions. There were no female participants in these groups. These groups were made up of individuals who have problems with inappropriate sexual behaviour. One of these groups was composed only of physicians.

Dr. X would also have private counselling sessions with Dr. Kernerman when needed to help focus on specific areas. He acknowledged that these sessions were "*pro bono*" because of Dr. Kernerman's financial situation.

Dr. X testified that as a condition of reinstatement Dr. Kernerman should continue his group sessions and even increase the number of sessions: "[A]s Dr. Kernerman starts becoming exposed to more and more complex situations in his practice, if he were to practise, it would be useful to bump up therapy, to make sure that the therapy is now focusing on specific aspects in the workplace...so to me its a work in progress." (Vol. 4, p.70)

With respect to returning to work as a physician, Dr. X was supportive of Dr. Kernerman having a multi-layered treatment approach which included the following supervisory restrictions:

- continued group and individual therapy;
- working under the supervision of another physician for one year (but not a chaperone) and perhaps a nurse always being present when he sees patients;
- inform his workplace and supervisor of his problem with dealing with women and allow them to communicate freely with his treating physicians; and
- provide timely updates of work performances and relationships to the College.

Although his report in 2007 stated "I am not concerned that his Attention Deficit Disorder is of any serious concern", in his testimony he supported continued treatment through medication to address his ADHD as well as supervision of his ADHD by a treating physician with expertise in

this area for at least his working life.

He also recommended use of serotonin re-uptake inhibitors (SSRIs) like Prozac, Paxil, Celexa or Zoloft to treat his compulsive behaviour. He had some concerns with respect to drug interactions and that some of the stimulants used for ADHD may exacerbate his hypersexuality.

When asked about his opinion with respect to the risk that Dr. Kernerman could relapse to his old behaviour, Dr. X testified that: "there is no actual risk assessment tool you can use". He stated it is more complex to assess risk in someone like Dr. Kernerman because we must be concerned with inappropriate sexual behaviour as well as boundary violations and intrusive behaviour. He had no information that Dr. Kernerman is breaking boundaries. His information was based on Dr. Kernerman's self-report. The Committee notes that Dr. X's risk assessment was based on observing Dr. Kernerman in a clinical environment and not in a real life setting where Dr. Kernerman would be exposed to various triggers.

Dr. X noted that the College would be interested to know whether Dr. Kernerman's behaviour would impact patients, their relatives and the general public. He felt it would be difficult to monitor his behaviour with the general public (even though it may bring disrepute and disgrace to the profession), but relatively easy to monitor his behaviour if he was restricted to a "strongly rooted in hospital based practice rather than a community based practice".

Dr. J

The Committee heard testimony from Dr. J as an expert witness in his subject area as a forensic psychologist, with the capacity to give evidence as Dr. Kernerman's treating psychologist and with the ability to give any opinion he has with respect to the risk that Dr. Kernerman might re-offend.

Dr. J received his Master's degree in Psychology from the University of Toronto in 1975, followed by his Ph.D. in 1980. He holds a position as an Assistant Professor in the Department of Psychiatry at the University of Toronto and is the Director of Psychological Services at the MANASA Clinic. This clinic focuses on the assessment and treatment of adult behavioural problems.

He has been involved with The Ontario Review Board, Correctional Services Board and the Ontario Criminal Injuries Board as well as Forensic Services at the Clarke Institute of Psychiatry. He has also been involved with programs dealing with abusive men and sex offenders. He has co-authored many books and papers in his stated areas of expertise. The Committee found him credible and his testimony to be very informative and unbiased.

Dr. J has worked with Dr. Kernerman since November 16, 2005, when he started with his "Relationship Laboratory" group. Dr. Kernerman continues to be involved in that group and at the same time started to participate in a Physicians' Group on February 8, 2007. Each group meets weekly and the sessions are two hours in duration. These groups are similar in nature and are designed to treat men with sexually inappropriate behaviours. These groups function and are based on the theory of interpersonal psychology:

> …the idea behind the group is that…people define themselves in their relationship with other people. And if one wants to achieve some change in personality, functioning or character, then the most effective way to do that is through one's relationship with other people. So the group…focuses on the relationships between the group members… (Vol. 5, p.33)

Dr. Kernerman has attended over 300 group sessions spanning four years since November 2005. Dr. J reports that he rarely misses a session and shows a strong commitment to treatment as demonstrated by this attendance record.

Dr. J acknowledged that he has had very limited opportunity to observe Dr. Kernerman's behaviour in mixed company or any interactions with women. He has not had the opportunity to observe him outside of a therapeutic group session setting.

Dr. J testified that, "in my experience of him in the group, he recognizes that he violated boundaries and that he had problems in that area." (Vol. 5, p.59) He also had discussions in the group regarding what he describes as 'preying on vulnerable women'. Dr. J's report notes that Dr. Kernerman felt safe in group.

It is the opinion of Dr. J that Dr. Kernerman is strongly motivated for treatment on an ongoing basis and that he would be a low risk for re-offending. He qualified this opinion by stating that

there is no evidence of substance abuse, and no evidence of "deviant sexual interest beyond, of course, harassing women." (Vol. 5, p.64) The Committee felt that his opinion was sincere, but was limited by the fact that it was based on self-reporting with no outside validation.

Dr. J also raised the issue that some types of Paraphilia are associated with a higher risk of re-offending. The presence of more "malignant" types of Paraphilia (such as hyper-dominance, sadism, and pedophilia) can be unmasked with phallometric testing, which was not done in Dr. Kernerman's case.

Dr. Q

The Committee heard testimony from Dr. Q, and recognized him as an expert on addictions and concurrent disorders. Dr. Q is a certificant of both the Canadian and American Societies of Addiction Medicine. He presently works two to three days a week in private practice, seeing about 20 patients a week for treatment of addiction disorders. He acknowledges that a very small percentage of addicts are sexual addicts.

He met Dr. Kernerman for the first time when he was retained by lawyers with the CMPA to do an assessment in March 2002. This assessment was to be part of a report being prepared for the Medical Advisory Committee of North York General Hospital to determine whether Dr. Kernerman had a sexual addiction, and if so, whether there was any treatment, and what the likely prognosis was.

He saw Dr. Kernerman several times from March 2002 until November 2, 2002. During this time, his follow-up with Dr. Kernerman was interrupted because of Dr. Kernerman's treatment at other institutions, including the Meadows, the Sexual Recovery Institute in California, the Keystone Program in Philadelphia, and the Bellwood Program.

Dr. Q's testimony included a very comprehensive recounting of Dr. Kernerman's sexual history dating back to ages 15 to 17 and up to the incident at North York General that led to his involvement with the CMPA.

Dr. Q testified that his initial assessment was that Dr. Kernerman was a sexual addict. He described to the Committee his approach when dealing with addictions, which is to first detoxify

by putting them in a treatment centre, then to correct the neurochemical imbalance.

He described a sexual addict as one with:

> Multiple extra-marital affairs, using a position of power to gain sexual access, using prostitutes and escorts, indecent telephone calls, excessive expenditure of time and money on pornography, cyber and phone sex, multiple anonymous sexual encounters, touching without permission. (Vol. 6, p.45)

He testified that Dr. Kernerman fit the criteria: "He was 100 per cent…". (Vol. 6, p.46) He recommended these inpatient treatment centres and, in time, prescribed Prozac, eventually using a maximum dose of 80 mg.

The Committee heard evidence to suggest that Dr. Kernerman did not improve with any of these treatment modalities and it was suggested by various treatment sources that he was manipulative, dishonest, and prone to conning. Dr. Q entertained the diagnosis of an Anti-Social Personality Disorder with a poor prognosis.

The Committee found that Dr. Q was a credible witness with a sound knowledge in his area of expertise, but it gave his testimony little weight because he assessed Dr. Kernerman very early on and has had no involvement with him since November 2002.

Dr. Y

The Committee heard evidence from Dr. Y, Professor and Head of the Division of Forensic Psychiatry at the University of Ottawa. He has done extensive research and authored many papers on Forensic Psychiatric Behaviour and recidivism as well as assessment tools needed to assess and monitor risks of recidivism. He is involved in the actual writing of the DSM-IV with respect to the Sexual Disorder Group of diagnoses. He was qualified as an expert witness in this field.

He was asked to make a detailed sexual behaviour evaluation of Dr. Kernerman by the College in November 2007.

In preparing his report, Dr. Y reviewed seven volumes of medical records as well as numerous other documents. One month later, he conducted a telephone interview with Dr. Kernerman, and

completed a report on February 25, 2008.

Subsequently, he saw Dr. Kernerman on two occasions: March 20, 2009 and December 21, 2009.

Dr. Y's provisional Axis I diagnosis was ADHD, Nonparaphilic Hypersexuality, Dysthymic disorder and Paraphilias (telephone scatologia, fetishism, partialism). His Axis II diagnosis was Possibility of Mixed Personality Disorder. He did not support a diagnosis of Anti-Social Personality Disorder and gave many reasons consistent with those given by Dr. X.

Dr. Y testified in the hearing that ADHD combined with hypersexuality presents a challenging treatment situation in that both conditions must be treated simultaneously, because both contribute to impulse control and if left unchecked will feed each other.

He supported using an SSRI like Prozac 40-60 mg for control of the hypersexuality and Dexedrine 20 mg for the ADHD. If the SSRI does not work, he discussed the use of newer anti-androgen receptor blockers. He testified that psychologically-oriented treatment alone would not suffice and that a biological pharmacology approach was needed in tandem. He felt strongly that any treating physician must be comfortable with dealing with both diagnoses.

Dr. Y testified that the highest risk of recidivism was in the first five years, and that many things had to be monitored to determine this risk. He mentioned various psychometric testing (*i.e.*, PCL-R), phallometric testing, serum testosterone testing, and ruling out brain lesions with diagnostic brain imaging. He testified regarding statistics that support the need for serial drug screening in people with ADHD because of the high level of dual diagnosis of ADHD and substance abuse.

While giving his opinion that Dr. Kernerman should be reinstated, Dr. Y qualified it with a long list of necessary conditions. These included:

- random urine tests to check for drug compliance as well as substance abuse;
- he should be subject to supervision for at least five years;
- supervision by a senior colleague for two years with reports to the College every three

months;

- supervision by a forensic psychiatrist skilled in dealing with ADHD and hypersexuality; and
- workplace monitoring by at least three people, preferably female, and supervision by a senior nurse.

In testimony, he spoke of the possibility of Dr. Kernerman working at a male-only facility such as a prison, but conceded that even in a prison there will be occasions when he might have to deal with female relatives of inmates.

The Committee was impressed with the knowledge and professionalism of Dr. Y and carefully evaluated his recommendations and concerns in coming to a decision.

Dr. T

Dr. T was accepted as an expert witness in forensic psychiatry. He is a fellow of the Royal College of Psychiatrists in England and in Canada. He teaches the core curriculum in psychiatry at McMaster University where he is a clinical Assistant Professor. He is an associate with the "Psilex Group", Consultants in Behavioural Sciences and Law in Toronto. He was asked to complete a psychiatric report on Dr. Kernerman by his lawyer in January 2004, with a view to the imminent hearing before the Discipline Committee.

The Committee felt that Dr. T was credible and relied on his testimony and the written report of Dr. F as factual evidence of Dr. Kernerman's mental health at that particular point in time.

Dr. T wrote a detailed report on February 13, 2004, based on a four-hour interview with Dr. Kernerman on January 26, 2004, and psychological testing administered and interpreted by Dr. F. These tests were conducted over three days and took sixteen hours to complete.

He also was asked to review documents from the College, synopses of other legal proceedings, as well as numerous other medical documents and phone calls from his treating physicians and institutions.

Dr. T's report contained details of Dr. Kernerman's past and present history as well as results of

the extensive psychometric testing. In his report, Dr. T stated: "The subject was not completely candid on the MMPI or MCMI." The interpretation of previous tests (done twice) was that Dr. Kernerman was a psychopathic deviant, which he wanted to avoid in these assessments by presenting an overly positive impression of himself.

His diagnosis was Axis I courtship disorder (query hypersexualism), and personality change due to a general medical condition (Frontal Lobe Syndrome). The Axis II diagnosis was narcissistic and obsessive-compulsive personality traits. He concluded that although he was diagnosed and treated for ADHD, the psychometric tests suggested that he actually has a Frontal Lobe disorder that can mimic ADHD.

His treatment recommendations included stopping the Dexedrine. He suggested the use of Zoloft as the SSRI of choice, and if it did not control his sex drive, that Cyproterone (an anti-androgenic hormonal medication) should be used.

Dr. T also noted that, "a characteristic of [Dr. Kernerman] is that he tends to change from therapist to therapist and undertakes treatment in an impulsive and haphazard manner."

He felt it was difficult to give a prognosis and hoped that with the addition of sex-drive reducing medication, his prognosis should be fairly good. He testified that he would like to see a period of one or two years without recidivism.

The assessment at that time was brought to a halt by Dr. Kernerman's lawyer, because the report would not be favourable. This was the main reason that the assessment was deemed incomplete, according to Dr. T.

In his testimony, he stated that he had concerns with Dr. Z's pharmacologic treatment choices. His opinion was that the use of a stimulant like Adderal for ADHD is risky because it can increase sex drive.

He also recommended ruling out other organic causes of psychiatric disorders through blood tests such as TSH, LH, FSH, Hg A1C and testosterone levels.

Dr. T felt that there was support for the diagnosis of a Frontal Lobe Syndrome demonstrating minor brain damage with tests already done, such as the Wisconsin card sorting test, MMPI,

WAISIII, WCST, and Bender-Gestalt Testing. These showed deficits in executive neurocognitive functioning. He would investigate this possibility further through MRI brain imaging as well. His prognosis for Frontal Lobe Syndrome was that it is unlikely to be easily treated.

When asked what his opinion was of Dr. Y, he testified that he felt he was highly qualified and absolutely pre-eminent in assessing risks. Indeed he stated that he is "the most qualified person in the world".

When asked if he would support reinstatement for Dr. Kernerman at this point in time, Dr. T testified: "I would not be in a position to oppose it". He did voice concerns that if he were to be reinstated, he must stay in active treatment and be monitored for any sign of deviation. He recommended specific testing with the SVR 20 (Sexual Violence Recidivism 20) to monitor his risk of recidivism, but stated that the reliability of these or any other tests are moderate at best.

Summary of the Evidence

In considering this matter, the Discipline Committee considered the submissions made by counsel for Dr. Kernerman and counsel for the College, and reviewed and relied on the evidence that was filed on consent.

Relevant Considerations

Sections 72 to 74 of the Code govern applications for reinstatement. Section 73(5) sets out the possible dispositions on such an application. The Committee may make an order:

- directing the Registrar to issue a certificate of registration to the applicant;
- directing the Registrar to impose specific terms, conditions and limitations on the applicant's certificate of registration; or
- dismiss the application.

The Code, however, does not set out a standard or test, or a list of considerations to apply on an application for reinstatement. However, case law does provide some guidance to the Committee in coming to a decision.

In *CPSO V. Kulkarni*, the Committee identified and considered several relevant factors:

1) The member's past conduct that led to revocation, as well as factual evidence of past conduct that did not necessarily come into play in the revocation.

2) Any change in the member's circumstances since revocation.

3) The success of rehabilitation and the practicality of measuring continued mental stability in the future.

4) The member's current mental health and prognosis for future mental health.

5) The risk of recidivism and if it is possible to measure and monitor any future risk where it is deemed manageable.

6) Whether the applicant demonstrates insight into past misconduct.

7) Whether an attempt was made for restitution to those the applicant harmed, including the women he targeted, his colleagues, and family and hospital staff.

8) The member's current competency, skills and fitness to practise and whether attempts were made to maintain his skills.

9) The over-riding concern to protect the public as well as to protect the integrity of the profession.

The Committee considered the factors enumerated on page 4 above as well as the factors enumerated in *Kulkarni*. We set out below our analysis of the more significant factors.

In coming to this decision, the Committee had regard to all of the particular circumstances of this case and was mindful of the fact that the primary focus was to protect the public while taking into account Dr. Kernerman's application for reinstatement. All of the considerations referred to above were considered but not all of them were given equal weight.

Last, the Committee was mindful that Dr. Kernerman bears the onus of proof in this application

for reinstatement.

Analysis

The overriding factor in determining whether Dr. Kernerman is given the privilege of reinstatement is whether or not he has reasonably demonstrated that as a physician, he no longer represents a risk to the public, or that any such risk is manageable with the imposition of terms, conditions and limitations on his certificate.

In making this determination the following issues were examined and given considerable weight:

1) The member's past conduct

The Committee came to the conclusion that Dr. Kernerman's past misconduct was extremely serious. Factual evidence and testimony convinced the Committee that his misconduct was understated at the time of revocation and that there were likely many other unreported boundary violations both at his places of employment and in the public domain. Dr. Kernerman himself testified that there were more than we knew. We make the point, not because it merits any further punishment. Dr. Kernerman has already been disciplined for the previous conduct. However, it must be taken into account in determining what should be done with respect to reinstatement today especially with respect to protecting the public appropriately.

The Committee did not give much weight to the argument that Dr. Kernerman had an undiagnosed Personality Disorder, because even without this diagnosis, Dr. Y's diagnosis of Hypersexuality, which the Committee accepted, was of enough concern. The fact that some treating psychiatrists or experts called this a "Paraphilia", "Courtship Disorder" or "Sexual Addiction" made little difference in our decision except to reinforce the fact that all of the treating psychiatrists or experts to a greater or lesser degree recognized that Dr. Kernerman indeed had a significant problem with his interactions with women, and that this conduct was serious enough to warrant revocation.

2) Change in Dr. Kernerman's behaviour since revocation

The Committee relied heavily on the testimony of Drs. X and J in determining that Dr. Kernerman has committed to his present treatment plan with enthusiasm and that he is determined to remain in therapy.

Although the Committee heard evidence that Dr. Kernerman has not "acted out" inappropriately with women since May 2005, it also heard convincing evidence that the accuracy of this date could be questioned.

Dr. Kernerman was living with a woman with borderline personality disorder past that date, and he did have sex with his wife during this time as well. Nevertheless, the exact date of this "sobriety" did not have much influence on the Committee in coming to its decision. What concerned the Committee more was that it had no way of externally validating Dr. Kernerman's assertion that he was not acting out. There was no testimony from his wife, girlfriend, family or friends. There was no "real life" testimony regarding how he conducted himself in the presence of women, not even in the artificial environment of group therapy.

The fact that there were no police records or other accounts of misconduct since his revocation did not, in our mind, relieve him of his evidentiary burden to prove that he can function in a stressful environment in the presence of women without acting out.

3) The success of rehabilitation and the practicality of implementing conditions to ensure continued stability in the future

The Committee was convinced that Dr. Kernerman had taken significant steps toward rehabilitation. This was substantiated by testimony from his treating physicians and psychologists as well as independent assessments. Drs. Y and X recommended reinstatement. Dr. T testified that he would not be in a position to oppose reinstatement. The Committee notes that Dr. T last assessed Dr. Kernerman in 2004. In any event, each of these psychiatrists recommended different terms, conditions and limitations should Dr. Kernerman's certificate of registration be reinstated. The Committee looked carefully at their positions and proposed conditions and determined that it would not be workable to impose conditions that would address

all of their concerns. For instance, should Dr. Kernerman work only in a structured "strongly rooted hospital setting" as Dr. X recommends or "in a male only institution like a prison" as Dr. Y suggests?

All experts agree that Dr. Kernerman has not "acted out" inappropriately with women since some time in 2005, but they qualify this by saying they have not externally validated this observation and it is only based on "self-reporting". Dr. T and others have suggested that there are many other psychometric tests that could have been done to validate the success of rehabilitation and monitor the risk of recidivism.

4) Dr. Kernerman's current mental health

Although there was consensus among the experts, except Dr. Z, on the diagnosis of a sexual disorder**,** there were differing opinions with respect to the diagnosis of ADHD versus Frontal Lobe Syndrome, and Anti-Social Personality Disorder versus Mixed Personality Disorder.

Dr. T was not convinced that the possibility of Frontal Lobe Syndrome was addressed and, therefore, the Committee questions whether this needs to be dealt with before coming to conclusions with respect to his present mental health status and the optimal treatment needed to maintain it. It was suggested that an MRI to rule out other organic brain conditions should be done to get a firm diagnosis.

The differing opinions with respect to the doses and combination of drugs needed to ensure stability of his mental health were also of concern to the Committee. If indeed the diagnosis of ADHD is correct, then stimulants like Dexedrine or Adderal are needed. The Committee heard evidence that these drugs may exacerbate the Hypersexuality.

There were differing opinions as well with respect to the optimal dosing and choice of an SSRI to keep Dr. Kernerman's Hypersexuality in check. No one, except Dr. Z, felt that his present dose of Cipralex 5 mg was optimal.

The Committee heard testimony to support conditions that would monitor Dr. Kernerman's Hypersexuality. These included ongoing group and individual counselling as well as psycho-pharmaceutical agents. Dr. X testified that as Dr. Kernerman became exposed to real world

stress, he would expect that he would need to spend more time in group sessions than he presently does. It was reported that for the last three years, Dr. Kernerman has been in group sessions at least for four hours per week, and was unable to pay for these sessions. The Committee had concerns with respect to the feasibility of working the long hours of a physician and being able to devote the extra time and money needed to fulfill this condition. Dr. J's report noted that Dr. Kernerman felt safe in his group. He did not demonstrate to the Committee that he had tested his mental health in an environment outside of the group.

None of these issues in isolation were given much weight by the Committee; however, when taken together, they presented serious logistical barriers to setting out practical conditions to monitor Dr. Kernerman's mental health now and in the future.

5) Risk of recidivism and ways practically to measure and monitor this

In coming to a decision, the Committee was very cognizant of its responsibility to reinstate Dr. Kernerman only if he had demonstrated that he was a low risk to re-offend, that we could validate this in some practical way and that any risk would be manageable by the imposition of terms, conditions and limitations on his certificate of registration.

Studies were cited that demonstrate a high percentage of drug and alcohol use in people with ADHD and it was suggested that serial drug screens would be a necessary condition.

It was also suggested that serial testosterone levels should be checked to measure Hypersexual tendencies. The Committee wondered why this testing was never done, even though he has been treated and followed for this diagnosis since his revocation.

One of the Committee's major concerns is that Dr. Kernerman has failed to demonstrate a low risk of recidivism in real life situations. There was no evidence to demonstrate that he had worked at any meaningful job, with daily exposure to women, and that he was able to interact without misconduct. He has not held a meaningful job or even done volunteer work.

Dr. Kernerman presented no external validation by other employees, colleagues, co-workers, or even women in a volunteer organization. By failing to do so, the Committee was of the opinion that Dr. Kernerman did not meet the test to prove he is capable of working, as a physician, in

contact with female patients, relatives of patients, and female co-workers and hospital staff.

6) That he demonstrated insight into past misconduct; and, 7) That he understands the harmful impact of his behaviour on others

In his testimony, Dr. Kernerman reported that he indeed had remorse for what he put his family through and indeed had gained insight into his past conduct. The Committee recognized that it would be impossible to personally make amends to the hundreds of women he violated over the years.

When asked how he felt when reading the one and only victim statement (only days before this hearing), Dr. Kernerman stated that he wanted to make amends perhaps by writing a letter, but he never did.

The Committee was not convinced that Dr. Kernerman had ever tried to make amends to his wife, children, parents or hospital staff, even though this would have been possible. He presented no evidence to indicate he had made this effort or was trying to make amends in some way.

8) Current competency, skills and fitness to practise

The Committee has no doubt that Dr. Kernerman has not made a significant attempt to maintain his skills since his revocation, other than reading a few journals and looking at some things on-line. He rationalized this by saying CME was too expensive. If reinstated, his skills and competency level would have to be assessed and monitored. Retraining would be suggested if necessary.

The Committee did not put much weight on his present competency in coming to its decision, because skills and competency are things that can be measured and decisions can be made to rectify and monitor any deficiencies in his performance. The Committee did, however, take into consideration and weigh heavily the fact that he had not kept up with meaningful CME or documented any CME, even though he knew that he would be applying for reinstatement.

9) The over-riding concern to protect the public and the integrity of the profession

For the reasons stated, the Committee decided that, when dealing with public safety in the

practice setting, all individuals at risk need to be considered. Restricting Dr. Kernerman to an all-male practice does not address the concerns. He would still have to deal with female staff, and the female relatives of those patients.

The Committee was impressed with the experts' suggestions with respect to potential work scenarios, as well as different methods to monitor Dr. Kernerman's behaviour. Such situations may have a place in Dr. Kernerman's future, if real life situations and experiences are presented to a future panel that prove he is able to work with women without re-offending.

The Committee felt strongly that self-reporting cannot be relied upon in circumstances where the ramifications of relapse are significant. In this case, it is not likely that a clear, direct and expeditious re-integration and monitoring strategy was possible.

DECISION

The Committee concluded that Dr. Kernerman has not discharged his burden to demonstrate that he no longer poses a risk to the public, or that any such risk is manageable with the imposition of terms, conditions and limitations on his certificate of registration.

In coming to this decision, the Committee needed to assess the nature of his past conduct, along with all the circumstances of the case.

This does not necessarily mean that Dr. Kernerman's revocation is permanent, but that his reinstatement will only be possible once his rehabilitation and sufficient public protection measures have been reasonably established.

The Committee is well aware of the significant efforts that Dr. Kernerman has taken to improve his mental health. He is aware that he still has work to do, and his therapist describes him as a "work in progress".

The Committee would encourage him to continue with treatment while putting to rest some of the outstanding diagnostic questions (*i.e.,* Frontal Lobe Syndrome versus ADHD). The Committee would also encourage him to test the strength and stability of his recovery with "real life" experiences, to prove to a future panel that he has externally validated what the experts

suspect, but cannot truly assert (*i.e.*, that he is at a low risk of recidivism).

Participation in and documentation of CME and a proposed assessment and remediation plan would also go a long way to minimize concerns with respect to his commitment to maintaining his medical skills and knowledge in any potential reinstatement.

Therefore, the Committee concluded that Dr. Kernerman's application for reinstatement should be dismissed at this time.