OPSDT Ontario Physicians and Surgeons Discipline Tribunal
TDMCO Tribunal de discipline des médecins et chirurgiens de l'Ontario

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *Doyle v. College of Physicians and Surgeons of Ontario,* 2026 ONPSDT 1
Date: January 12, 2026
Tribunal File No.: 23-025

BETWEEN:

Christopher Stephen Doyle

Applicant

- and -

College of Physicians and Surgeons of Ontario

Respondent

REINSTATEMENT APPLICATION REASONS

Heard: October 1, 8, 9, 15 & 16, 2025

Panel:
Raj Anand (panel chair)
Stephen Bird (public)
Stephen Hucker (physician)
Camille Lemieux (physician)
Linda Robbins (public)

Appearances:
Victoria Cistrone and Ada Jeffrey, for the College
Tracey Tremayne-Lloyd, for the registrant

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The Ontario Physicians and Surgeons Discipline Tribunal is the Discipline Committee established under the Health Professions Procedural Code.

Introduction

[1] Dr. Christopher Doyle has applied under s. 72 of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991,* SO 1991, c. 18 (Code) for reinstatement of his certificate of registration.

[2] The Discipline Committee (as it was then called) revoked Dr. Doyle's certificate of registration in 2018 based on his admissions that he was incompetent, he had failed to maintain the standard of the profession, and he had engaged in conduct relevant to the practice of medicine that was disgraceful, dishonourable or unprofessional.

[3] Since 2018, Dr. Doyle has made a concerted effort to achieve and demonstrate rehabilitation. He has worked within the health care field, completed education on boundaries, taken steps to stabilize his finances and his marriage, engaged in intensive psychotherapy and undertaken an intensive treatment program with a rehabilitation coordinator. At the hearing, he presented two expert witnesses to provide their opinion that with proper terms, conditions and limitations, Dr. Doyle's reinstatement would benefit patients in his specialized field, while minimizing the risk to the public interest and public confidence in the regulation of the profession.

[4] The College opposed this application, pointing to three separate incidents of serious misconduct by Dr. Doyle in a time frame that essentially spanned his entire career as a physician. Before he received his Independent Practice Certificate, he took paid employment, contrary to the terms of his postgraduate education certificate. About ten years later, he engaged in a boundary violation with a patient, for which he received a one-year suspension. Six years after that, the College investigated his improper termination of a professional relationship with another patient. That investigation led to a review of his clinical practice, which found shortcomings in record keeping, communications and judgment that placed patients at risk.

[5] The College obtained its own expert opinion on the extent of risk that Dr. Doyle's reinstatement would involve. The College pointed out that because of his regulatory history, Dr. Doyle's entitlement to practise has been the subject of supervision, monitoring, treatment, and rehabilitation conditions for most of his medical career. He received ample warnings and was given several opportunities to fix the problems that led to discipline. Therefore, it is not realistic to expect that his concerted efforts in the seven

years since revocation would acceptably limit public risk now without terms, conditions and limitations (TCLs).

[6] At our request, after we reserved our decision at the end of the hearing, the parties provided their respective versions of appropriate TCLs that should be imposed if we were to conclude that reinstatement with conditions was appropriate.

[7] While acknowledging that this is a difficult case, we have decided, for the reasons that follow, to grant Dr. Doyle reinstatement with appropriate TCLs. The parties provided voluminous information about Dr. Doyle's experience of the last 25 years. This evidence, including Dr. Doyle's and the experts' testimony, suggests some areas in which conditions are necessary and likely to succeed, and others that appear to have been unnecessary or less useful.

[8] This evidence, in our view, allows us to order reinstatement with TCLs. By attempting to provide fairly specific direction on the draft conditions they provided, we will ask the parties to assist us, either through agreement or further submissions, in fashioning the terms of the final order.

The legal test for reinstatement

[9] Under s. 72 of the Code, a person whose certificate of registration has been revoked as a result of disciplinary proceedings (other than sexual abuse findings) may apply for reinstatement after the passage of at least one year from the date of revocation. Following a hearing on the application, the Tribunal may direct the registrar to issue a certificate of registration to the applicant and may direct the registrar to impose specified TCLs on the certificate.

[10] The legal principles governing this application are not in dispute. Dr. Doyle bears the burden of proof on a balance of probabilities to establish his suitability for reinstatement of his certificate of registration. We must be satisfied, under the general requirements for a certificate in Ontario Regulation 856/93 made under the *Medicine Act, 1991,* SO 1991, c. 30, that Dr. Doyle:

(a) is mentally competent to practise medicine;

(b) will practise medicine with decency, integrity and honesty and in accordance with the law;

(c) has sufficient knowledge, skill and judgment to engage in the kind of medical practice authorized by the certificate; and

(d) can communicate effectively and will display an appropriately professional attitude.

[11] Under the seminal decision in *College of Physicians and Surgeons of Ontario v. Gillen*, 2010 ONCPSD 14, the Tribunal addresses two broad issues in a reinstatement application:

1. What is the risk of further misconduct, and if there is a risk, is it manageable with terms, conditions and limitations?
2. Is the applicant suitable to practise both in terms of protection of the public and the confidence of the public in the profession's ability to govern itself?

[12] In deciding these issues, the Tribunal has taken into account a broad range of factors. The following factors were listed in *College of Physicians and Surgeons of Ontario v. Manohar*, 2013 CanLII 96588 (ON PSDT) and adopted more recently in *Kayilasanathan v. College of Physicians and Surgeons of Ontario,* 2024 ONPSDT 27 at para 14:

- the facts giving rise to the misconduct that led to revocation, and other past conduct relevant to the physician's suitability to return to practice;
- changes in the physician's circumstances since the time of revocation;
- the success of rehabilitation, including the degree of insight into past inappropriate conduct;
- the physician's current mental health and future prognosis;
- the physician's attempts at restitution, if any;
- the physician's current knowledge, skill and judgment;

- whether the physician will practise medicine with decency, integrity and honesty and in accordance with the law;

- the protection of the public; and

- the impact of the physician's reinstatement on the reputation of the profession.

[13] Public protection is paramount in our decision. As the Tribunal stated in *Roberts v. College of Physicians and Surgeons of Ontario*, 2018 ONCPSD 2:

> The practice of medicine is a privilege, not a right. Regardless of the personal interests of the physician, reinstatement should only be granted if it is in the public interest to do so…

[14] In these reasons, we address these issues under the following headings:

Regulatory history

Conduct as a postgraduate student

Discipline Committee order in 2009

Suspension of Dr. Doyle's certificate by the ICRC

Discipline Committee decision in 2018

Conduct following his suspension

Circumstances since revocation

Treatment and current mental health status

Education and training

Employment

Expert evidence of risk and risk management

Insight, judgment and acknowledgment of misconduct

Conclusion

Directions

Dr. Doyle's regulatory history

[15] A detailed review of Dr. Doyle's record shows that he has engaged in several forms of serious misconduct on three separate occasions from the time he first obtained a restricted certificate of registration.

[16] Dr. Doyle's argument in this case about the misconduct that gave rise to his revocation pointed to cases in which the Tribunal granted reinstatement despite the applicants having engaged in more egregious misconduct prior to revocation. Their misconduct included partying and sexual intercourse with an unwilling patient, asking the patient to provide false information to the College and offer financial inducements (*Manohar*), or engaging in sexual intercourse, drafting a recantation letter for the complainant and making a false chart entry (*Williams v. College of Physicians and Surgeons of Ontario,* 2018 ONCPSD 70).

[17] The College provided other cases in which reinstatement was denied following a revocation for sexual abuse: *Kernerman v. College of Physicians and Surgeons of Ontario*, 2010 ONCPSD 17; *Seidman v. College of Physicians and Surgeons of Ontario,* 2013 ONCPSD 28; and *Roberts*.

[18] In our view, the jurisprudence does not support an approach to reinstatement that is focused on rating the misconduct that underlies different revocation decisions against each other to determine which was more serious. In *Kayilasanathan*, for example, a reinstatement application following a revocation for sexual abuse, the Tribunal considered the two sexual abuse cases referred to above (*Manohar* and *Williams*) in which reinstatement was granted. Without lining up the facts of the different sexual abuse scenarios, the Tribunal granted the unopposed reinstatement application.

[19] As in penalty decisions, no two fact situations are alike, and as in penalty decisions, there are many factors to be considered in a reinstatement application, as listed above. These factors often weigh in different directions and must be balanced in order to arrive at a final determination that will protect the public interest and confidence in the integrity of the profession and its regulation. The misconduct that leads to revocation is always serious, and the nature and extent of the misconduct is a significant factor among many in deciding whether reinstatement should be granted.

[20] In this case, both parties gave careful attention to, and we received a great deal of evidence concerning, Dr. Doyle's history from childhood onward. Both parties gave particular emphasis to his achievements and his misconduct, beginning more than 25 years ago when he was a postgraduate student, alongside the rehabilitation measures he has put in place, with varying success, culminating in the rehabilitation since revocation that he relies on in this application. We will therefore review this chronology in some detail.

[21] Dr. Doyle overcame significant personal obstacles in his upbringing before achieving a stellar academic record and professional status. From age five he grew up in poverty with a stepfather who Dr. Doyle described as "a physical, sexual and spousal abuser." He moved every year, and was 12 years old when he started his first job. In school he was the captain of sports teams, received leadership awards and graduated with honours but "was always insecure." With part-time work and student loans and bursaries, he excelled as a university student and received degrees in biology and medicine by 1993. That year, he enrolled in post-graduate training in psychiatry and was married.

Conduct as a postgraduate student

[22] In 1994, a sudden death in the family caused considerable disruption and financial hardship. During his residency in psychiatry, he breached his restricted education certificate of registration by taking paid employment for a year outside his medical education program. He worked for a private company from April 1996 to April 1997 and conducted physical exams on patients referred for assessments. He said he did this because of "personal circumstances at the time, which required [him] to earn additional money."

[23] Through advocacy and his professional association, Dr. Doyle tried to get the prohibition on moonlighting overturned. He testified before us that he thought if he did a physical exam, noting findings without a diagnosis or prescription of medications, that would be acceptable.

[24] In fact, the evidence shows that Dr. Doyle and the psychiatric program director Dr. Kaplan "met on a number of occasions [in 1994, 1995 and 1997] and had numerous communications regarding the issue of his moonlighting using his educational license…I made it clear that it was absolutely unacceptable to the CPSO…"

[25] Dr. Doyle and Dr. Kaplan had discussions about financial stress, and Dr. Doyle was told the alternative was to leave the program. Despite this warning, Dr. Doyle obtained employment as a medical consultant with the private company. He only stopped when a colleague he brought into the disability assessment centre reported Dr. Doyle to the hospital, under the mistaken impression that Dr. Doyle was doing psychiatric assessments.

[26] The hospital's psychiatry department removed Dr. Doyle as chief resident and reported him to the College. In its letter, the department explained that this was "a serious breach of professional conduct" that was "enormously painful and humiliating for Dr. Doyle," and there was "no question that Dr. Doyle has learned a very painful lesson…and that this is a lesson that will last a lifetime" because "he has expressed his regret and remorse with strong emotion and sincerity. It is my expectation that he is not at any greater risk for future violation of professional conduct than any other resident or colleague."

[27] When he obtained his restricted certificate of registration in 1998, the Registration Committee imposed TCLs, including the following:

- clinical supervision and quarterly reports by a College-approved supervisor on Dr. Doyle's performance, including whether he is practising medicine with decency, integrity, honesty and compliance with the law and is displaying a professional attitude;
- continued therapy for Dr. Doyle with a College-approved physician;
- withdrawal of the certificate of registration if the supervisor's reports indicate he is not meeting the above requirements of professional practice.

[28] Between 1998 and 2001, three approved supervisors at Credit Valley Hospital and the Centre for Addiction and Mental Health issued reports to the College, indicating no concerns with Dr. Doyle's compliance with the terms of his certificate. Dr. Doyle was also seen in individual psychotherapy.

[29] On July 5, 1999, Dr. Doyle asked the Registration Committee to lift the restrictions on his registration. On October 12, 1999, the request was refused as premature, "considering the severity of your actions," but the Committee relaxed the reporting requirements to every six months. On March 15, 2001, Dr. Doyle renewed his

request, stating "I have spent a great deal of time reflecting on my past failings and can say with sincerity that I no longer feel I require the supervision and therapy which remain conditions for my continued practice of psychiatry." This time his request was granted, and on May 2, 2001, he received a certificate of registration authorizing independent practice.

Discipline Committee decision in 2009 (*College of Physicians and Surgeons of Ontario v. Doyle*, 2009 ONCPSD 30)

[30] Between April 2005 and July 2006, Dr. Doyle provided psychotherapy on 45 occasions to a vulnerable patient who had multiple diagnoses. Boundary issues and impulse control were two main focuses of the sessions. On his recommendation, the patient obtained work in a housing project where Dr. Doyle was effectively acting as her supervisor. On August 22, 2006, he issued a letter indicating that the therapeutic relationship had ended the previous month due to an inability to maintain a strict doctor/patient relationship.

[31] Dr. Doyle and the former patient commenced a romantic relationship in late summer 2006 which extended into the fall of that year. At the time, Dr. Doyle felt betrayed because his wife was having affairs with other men. The police became involved when Dr. Doyle's wife tried to stop him from seeing the former patient.

[32] Dr. Doyle acknowledged that he made serious errors during the last few months of the therapeutic relationship in failing to maintain boundaries. He began weekly psychotherapy sessions in September 2006 with Dr. Graham Berman that extended more than five years. Dr. Doyle was placed on leave from Credit Valley Hospital in late December 2006 while an evaluation was done by the Physician Help Program (PHP) of the Ontario Medical Association. Upon his return in January 2007, Dr. Doyle's practice was supervised by another physician from January 2007 to December 2009, and no clinical issues occurred during that time.

[33] The PHP referred him for a three-day evaluation at the Baylor Psychiatric Clinic, which took place in April 2007. Its director Dr. Glen Gabbard wrote a lengthy evaluation report in 2007, which Dr. Doyle relied on at the hearing before us. Dr. Gabbard said Dr. Doyle understood it was unethical for a physician to cross boundaries with a patient, but "he feels he was bullied into it by his patient." Dr. Gabbard diagnosed Dr. Doyle with acute adjustment disorder and indicated that the boundary transgression was best

understood as involving “a convergence of longstanding personality traits and marital stresses that reached an extreme point prior to the involvement between Dr. Doyle and his patient.” He also “manifests an impairment in judgment at times. He does not always accurately anticipate the consequences of his actions.”

[34] Dr. Gabbard expressed the opinion that because of “intense neediness stemming from early life and continuing into the present and because he does not fully understand his intra-psychic motivations for transgressing boundaries,” Dr. Doyle would “continue to be at mild to moderate risk of repeating boundary violations of one form or another until he has had an adequate treatment and rehabilitation program.”

[35] He stated that Dr. Doyle was safe to practise medicine within a rehabilitation program that included long-term psychoanalytic psychotherapy, couples therapy to address his marital relationship, education on boundaries and boundary violations, weekly supervision including monitoring at work, supervision of his cases with attention to boundary phenomena and countertransference, mentorship by an older male figure, and practice limitations to screen out patients with borderline personality disorder, avoid any psychotherapy, and restrict himself to 20 minutes med checks, emergency room consultations and addictions evaluations.

[36] Based on a joint submission, the Discipline Committee ordered a 12-month suspension, together with terms that accepted several of Dr. Gabbard’s recommendations. The suspension was reduced to six months upon his completion of three College courses on medical ethics and informed consent, boundaries, and record keeping as well as several terms, conditions and limitations. He was also required to continue psychotherapy, practise under a clinical supervisor with monthly meetings and quarterly reports to the College, provide ongoing psychiatric care to female patients only in the presence of a practice monitor, and was restricted from performing long-term psychotherapy.

[37] In June 2012 and May 2013, Dr. Doyle obtained variations of the Discipline Committee’s 2009 order. Both were granted with the consent of the College.

[38] The June 2012 variation decision (*College of Physicians and Surgeons of Ontario v. Doyle*, 2012 ONCPSD 2) indicated that Dr. Doyle had “made significant progress.” He had complied with the 2009 terms, conditions and limitations and changed his practice type and location. His workplace monitors, clinical supervisors and chaperone at his

office indicated no concerns. Importantly, the Committee accepted that Dr. Doyle was "remorseful and insightful into his past transgressions and has continued to work toward ensuring his boundary violations never reoccur."

[39] The Committee removed the requirements that Dr. Doyle remain in the PHP and have a practice monitor present, and the meetings with his clinical supervisor were reduced to quarterly. He could discontinue his own psychotherapy upon confirmation from his practitioner that it was no longer necessary.

[40] In May 2013, the Committee removed the prohibition on the provision of long-term psychotherapy, but only for male patients, and provided for charts for some of those patients to be reviewed: *College of Physicians and Surgeons of Ontario v. Doyle*, 2013 ONCPSD 20.

[41] Between 2010 and 2017, Dr. Doyle practised under the supervision of two College-approved supervisors, Dr. Edward Matti at Cambridge Memorial Hospital and Dr. Jan Malat at the Centre for Addiction and Mental Health (CAMH), both of whom submitted regular reports during that period to the CPSO.

[42] Dr. Malat was Dr. Doyle's colleague, and they had completed their residency programs together. His supervision was focused on individual case management. Writing in support of the current application in 2024, Dr. Malat described Dr. Doyle as "a competent, caring and knowledgeable psychiatrist," without any significant deficiencies in his knowledge, skill or judgment. "To the extent that I had recommendations for improvement, it was mostly regarding his record-keeping." Dr. Malat noted that "Chris struggled to keep his progress notes clear and organized when they were handwritten, whereas his typewritten reports and consultations were superior and very much in accordance with the standards of practice of psychiatry." Dr. Doyle implemented Dr. Malat's suggestion to use a template using the SOAP (subjective, objective, assessment, plan) format as a guide.

[43] Dr. Matti indicated that Dr. Doyle kept detailed and thorough clinical notes, and his assessment of patients, decision-making and therapeutic choices were appropriate. In Dr. Matti's opinion, Dr. Doyle was practising safely and meeting the standard of care expected of a psychiatrist.

Suspension of Dr. Doyle's certificate by the Inquiries, Complaints and Reports Committee

[44] During the investigation and review process that we describe under the next heading, Dr. Doyle's registration was suspended on an interim basis by the Inquiries, Complaints and Reports Committee (ICRC) on May 9, 2017, and he has not been permitted to practise medicine since then. At the reinstatement hearing, the College presented evidence (which we review later in these reasons) to suggest that Dr. Doyle did not comply with that suspension order in 2017 and 2018.

Discipline Committee decision in 2018 (*College of Physicians and Surgeons of Ontario v. Doyle*, 2018 OCPSD 41)

[45] In 2014, a year after the second set of restrictions on his certificate was removed, Dr. Doyle terminated a physician-patient relationship in an inappropriate manner after a vulnerable patient expressed interest in a personal relationship with him. On the basis of the patient's complaint and other information, the registrar appointed investigators under s. 75(1)(a) of the Code. As part of the investigation, the College retained Dr. Theresa-Ann Clarke to provide an expert opinion on specific questions.

[46] The evidence that was collected in the investigation and the referral resulted in a Discipline Committee finding of professional misconduct based on his admissions in an agreed statement of facts that he was incompetent, he had failed to maintain the standard of practice of the profession, and he had engaged in an act or omission (referring to the videos and telephone call described below) that would be regarded as disgraceful, dishonourable or unprofessional.

[47] In this case, Dr. Doyle was aware from the referral that the patient had previous sexual boundary issues with a mental health professional, and infatuation with a prior treating psychiatrist. Dr. Doyle's working diagnosis while she was his patient in 2013 and 2014 was "a borderline woman with increased anger and increased depression." Over this period, she perceived that Dr. Doyle became increasingly casual, including sitting back with his feet up on the coffee table and using profanities in front of her.

[48] When the patient told Dr. Doyle about her lack of motivation to continue cycling, he told her about his own interest in cycling and showed her an app on his cell phone that showed his progress against other cyclists in the online community. As a result of

Dr. Doyle's casual demeanour and sharing of information, the patient began to feel that Dr. Doyle wanted to foster a friendship or relationship with her.

[49] In 2014, the patient told Dr. Doyle about her feelings for him. Dr. Doyle indicated he was flattered but her feelings were not appropriate for a physician-patient relationship. He ended the session but asked her to make a follow-up appointment. The patient left the session feeling confused, ashamed and humiliated.

[50] When she sent an email the next day seeking clarity and blaming herself for what had taken place, Dr. Doyle responded that he could no longer see her. He wrote "it 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."

[51] The patient said the emotional impact of Dr. Doyle's response and the termination of her care was devastating. She reported suicidal thoughts and self-blame to her family physician, and the same day she went to the hospital with a suicide plan. The patient was then voluntarily admitted to the hospital for several days.

[52] There was no further contact with Dr. Doyle. She did not attend the follow-up appointment, when Dr. Doyle had planned to properly terminate their patient-physician relationship. The same day, Dr. Doyle received notice of the patient's complaint to the College. He did not send her a termination letter, communicate with her referring physician, make arrangements for her prescriptions, assist in finding another psychiatrist or otherwise assist in transferring her care.

[53] Dr. Clarke's expert report, which the parties put forward on consent, stated that Dr. Doyle failed to meet the standard of practice of the profession in several respects:

- in his termination of the therapeutic relationship, which reflected boundary crossing, failures in professionalism and recognition or management of the dynamics in a therapeutic encounter and could indicate a lack of skill, knowledge, and/or judgment;

- in the "very significant" deficits in his clinical records, which were mostly illegible, inadequate to "tell the patient's story," with typed summaries that were not contemporaneously written. Dr. Clarke attributed these deficiencies to a lack of knowledge of the standard of care requirements,

or poor judgment. While his notes showed awareness of the patient's vulnerabilities, this was not incorporated into his treatment plan.

[54] Dr. Clarke expressed the view that if Dr. Doyle's level of record keeping, his self-described "informal style" with patients, and the boundary crossings were representative of his practice, "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 from a practitioner who maintained the standard of care in these areas."

[55] As part of the investigation, Dr. Clarke provided a report on September 27, 2016, based on her review of 24 patient charts, transcribed clinical notes, and her interview with Dr. Doyle. She concluded that he failed to meet the standard of care in 16 of the 24 charts, and in one chart his care displayed a lack of knowledge. In 19 of the 24 charts, he showed a lack of skill and/or judgment and exposed or was likely to expose his patients to harm or injury.

[56] In addition to inadequate documentation, Dr. Doyle's charts indicated several substantive clinical deficiencies, such as lack of diagnostic clarity or consistency, inadequate risk assessments and/or interventions, lack of attention or inadequate assessment of substance use, use of non-professional or non-objective language in clinical notes, inappropriate prescribing of several different types of medication, inadequate medication monitoring, and failure to maintain appropriate professional boundaries.

[57] Dr. Clarke's interview with Dr. Doyle elicited a mixed assessment of his knowledge, skill and judgment, and she gave a list of strengths and weaknesses that she observed. For example, he was able to describe appropriate strategies and interventions for patients who were abusing the medications he prescribed, but he acknowledged that he did not implement these standard of care strategies enough. While Dr. Doyle acknowledged the risks and poor evidence for use of or combination of antipsychotics, he used these medications more than would be expected in a similar practice.

[58] Dr. Doyle posted 29 videos on YouTube between 2012 and 2014. Several showed a lack of judgment, professionalism and boundaries.

[59] In two of them, including one where he appeared shirtless, he promoted "the juice of the purple" as beneficial to his exercise activities. In another he was depicted in an

educational session stating that marijuana was excellent as a PTSD treatment, which Dr. Clarke rejected as below the standard of care and potentially harmful. One video that was played for us recorded a patient testimonial in his office, enthusiastically describing her experience of working with him, with Dr. Doyle seen in the background. Dr. Clarke viewed this as lack of professionalism and judgment, abuse of a fiduciary relationship and breach of the standard for physician advertising.

[60] Nine of the videos were therapeutic in nature, and all of them fell below the standard of care, according to Dr. Clarke. Eleven of the thirteen educational videos fell below the standard of care. Six of the seven videos that were philosophical in nature showed lack of judgment.

[61] Overall, Dr. Doyle's discussions in 15 of the 29 videos exposed or were likely to expose patients to a risk of harm.

[62] In January 2017, a medical adjudicator with the Canada Student Loans Program called Dr. Doyle to verify the authenticity of a medical report for one of Dr. Doyle's patients. Dr. Doyle answered with profanity; the adjudicator called back, thinking she had the wrong number, and he answered with more profanity. After they both identified themselves, Dr. Doyle apologized, indicating he thought he was talking to a patient who was calling him non-stop.

[63] At the contested penalty hearing in 2018, the Discipline Committee heard testimony from Dr. Jan Malat and Dr. Ronald Ruskin. In the reinstatement hearing before us, Dr. Doyle put forward similar evidence from these two witnesses in the form of affidavits.

[64] Dr. Donald Ruskin interviewed Dr. Doyle three times in May and June 2017 and then saw him twice a week for psychoanalytical psychotherapy before testifying about Dr. Doyle's diagnosis, prognosis, recommended treatment and risk of future boundary violations at the 2018 hearing. Dr. Ruskin diagnosed Dr. Doyle with an acute adjustment disorder with masochistic and histrionic traits, but no evidence to support a severe pre-existing health problem such as anxiety disorder, major depression or substance abuse. In his view, there was a mild to moderate risk of future boundary violations by Dr. Doyle.

[65] The Discipline Committee gave limited weight to Dr. Ruskin's evidence. It did not view Dr. Ruskin as an independent witness, because he was Dr. Doyle's treating

physician, and he did not consider the full range of Dr. Doyle's practice deficiencies. The Committee noted that Dr. Ruskin relied on Dr. Doyle's self-reporting, and was led by Dr. Doyle to believe that he had to step down as chief psychiatric resident "because of some documentation issues." To the contrary, the evidence showed that "Dr. Doyle knew what he had done and the consequences and understated these events to Dr. Ruskin" (para. 23).

[66] Dr. Ruskin continued to see Dr. Doyle after the Discipline Committee hearing, and his affidavit, updated to 2024, was filed on consent before us. We return to his evidence in the context of Dr. Doyle's post-revocation rehabilitation and his current status.

[67] The 2018 Committee also heard from Dr. Malat. As we noted earlier, he supervised Dr. Doyle's practice at CAMH from 2010 to 2017 pursuant to the 2009 Committee's order. He testified that he discussed boundary issues with Dr. Doyle regularly. He found no deficiencies in Dr. Doyle's knowledge, comprehension or treatment plan, but his charting needed improvement, and Dr. Malat made recommendations, including dictation, templates and use of the SOAP method.

[68] Dr. Malat in fact reviewed the chart of Dr. Doyle's patient who had made the complaint to the College in this case. Dr. Malat disagreed with Dr. Clarke, and saw no evidence of misconduct; it was appropriate for Dr. Doyle to terminate the relationship because of the erotic feelings the patient had developed, and Dr. Doyle handled the termination appropriately. Dr. Malat did accept that Dr. Doyle's casual behaviour may have contributed to the patient's confusion about the nature of the professional relationship.

[69] The Committee gave little weight to Dr. Malat's opinion about Dr. Doyle's treatment of patients and his ongoing remedial needs. Unlike Dr. Clarke, Dr. Malat had a longstanding relationship with Dr. Doyle as a colleague and a supervisor, and he relied on Dr. Doyle's input as they discussed cases informally. The Committee accepted the objective and independent opinion of Dr. Clarke.

[70] In its lengthy reasons on penalty, the Committee considered Dr. Doyle's misconduct, and his professional and disciplinary history back to the 1990s. The Committee then looked at two other groups of issues: Dr. Doyle's ongoing or underlying psychiatric health needs and consequent risk, and his lack of insight and judgment, as well as his failure to appropriately apply his knowledge. We highlight the Committee's

reasons, because the Committee found that little had changed in these areas over time to reassure the Committee that Dr. Doyle could practise safely in 2018. The College made a similar argument in the reinstatement hearing as of late 2025, based on the evidentiary record up to 2018, Dr. Doyle's activities and treatment post-revocation, and his testimony before us.

[71] On the first point, the Committee compared Dr. Gabbard's and Dr. Ruskin's evidence, written more than a decade apart, which we received as well. They provided opinions on Dr. Doyle's diagnosis, risk to the public and recommended treatment and practice monitoring and supervision. The penalty decision found that their "information and recommendations were not substantially different, even though their assessment was done years apart and after many years of monitoring and counselling" (para. 34).

[72] In his 2006 report, Dr. Gabbard stated that because of Dr. Doyle's early history of trauma, he would "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." Even as of 2018, Dr. Ruskin stated that because of his trauma and neglect in childhood, Dr. Doyle would "try and make up to the patients what was not given to [himself]." Dr. Doyle could "have difficulty in dealing with vulnerable patients…and struggle with limits setting."

[73] Based on this evidence, as of 2018, the Committee found "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."

[74] On the second point, the Committee reviewed the misconduct findings, in light of the reports of the various experts including Drs. Gabbard, Ruskin, Malat and Clarke. Dr. Doyle exercised very poor judgment in taking on the complainant patient, given his knowledge of her vulnerabilities, his own serious sexual boundary transgression, and Dr. Gabbard's advice not to see patients with borderline issues. Pointing to several of Dr. Clarke's findings with respect to Dr. Doyle's patient care and records, the Committee held that he was aware of the profession's guidelines, but "he described himself as a maverick, a lone wolf, who had his own way of treating mental illness." He lacked insight, thinking his record-keeping was good, and his failure to appropriately apply his knowledge put patients at serious risk of harm.

[75] In ordering the revocation of Dr. Doyle's certificate, the Committee concluded:

> 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's conduct following his suspension

[76] The College submitted evidence of Dr. Doyle's conduct between the suspension of his certificate on May 10, 2017 and its revocation on August 7, 2018, that did not result in a formal disciplinary finding, because it was investigated and came to the ICRC after his certificate was revoked. The ICRC does not make factual or legal findings. The ICRC considered the information before it and decided to take no further action, but noted that the circumstances could come forward if Dr. Doyle later applied for reinstatement.

[77] Dr. Doyle was obliged to advise his patients of his suspension and facilitate the transfer of their care. The College received information that Dr. Doyle breached the suspension order by providing medical advice to patients and former patients.

[78] Dr. Doyle testified before us that in most cases, the reason he saw former patients after his suspension was that they could not grasp, because of cognitive limitations, that he could no longer provide care. His records however indicate that he took histories and gave advice that extended beyond that situation.

[79] In May and June 2017, he gave advice about medication to a former patient, KB, asked how she was doing with her new psychiatrist, and told her that her current treatment with the new psychiatrist was "on track." There were 82 text messages and long telephone calls between Dr. Doyle and KB, which he attributed to her illness with cancer and his concern for her. Another former patient, MC, contacted Dr. Doyle on July 19, 2017 to ask for suggestions about her family disputes. He agreed to take MC's family history and meet with her and her daughter to make a suggestion about ongoing family

therapy. Dr. Doyle then arranged to see MC with two members of her family on August 24, 2017, but only MC attended.

[80] Dr. Doyle met with two former patients on July 6, 2017. In the case of one patient, he encouraged her to speak to her family physician to find a counsellor and discuss her medications. In the other, he noted details of the former patient's medical condition and her mood and gave her advice on presenting to the emergency room if she entered into a suicidal state. Dr. Doyle's notes provide details on June 21, 2017 of a meeting with a former patient's father, who was wondering about adjustment of his daughter's medications. He referred the father back to his family doctor while conveying his view about the efficacy of the "newer antipsychotics" for his daughter's diagnosis.

[81] In these cases, and many more, Dr. Doyle met with former patients or their family members who contacted him because of his professional status. Dr. Doyle had them sign a waiver form drafted by his counsel stating that he was not registered as a psychiatrist or a psychotherapist, would not be diagnosing or prescribing, but that he would "offer suggestions and give advice as to what he thinks will be helpful for you in your life's journey…from his personal perspective." At the same time, his notes confirm that he gave many former patients specific advice or information on how to address their addiction or psychiatric issues.

[82] In cross-examination, Dr. Doyle ultimately agreed that he put himself at risk by meeting with these individuals, and "I should not have been in that office." He acknowledged that he "was too focused on being a caregiver and not careful enough in maintaining my professional boundaries. I regret even doing that." Shutting down his practice and not seeing anybody "would have been the safer thing to do."

Dr. Doyle's circumstances since revocation

[83] All of the evidence before us post-2018, other than the expert testimony and Dr. Doyle's evidence as a witness, was submitted on his behalf in the form of about nine uncontested affidavits.

<u>Treatment and current mental health status</u>

[84] Dr. Doyle accepted the detailed treatment recommendations 16 years ago in Dr. Gabbard's report, which followed a boundary transgression that Dr. Gabbard understood as a convergence of longstanding personality traits (falling short of a personality

disorder) and marital stresses that had reached an extreme point prior to Dr. Doyle's involvement with his patient. As we discussed earlier, Dr. Gabbard believed that because of his early life experiences, and because he did not fully understand his own intrapsychic motivations for transgressing boundaries, Dr. Doyle would remain at mild to moderate risk of further boundary violations until he completed an adequate rehabilitation program. Even thereafter, he could only practise safely with stringent terms, conditions and limitations, in terms of supervision, treatment, and practice restrictions.

[85] Dr. Doyle felt that prior to revocation, he had not addressed his emotional needs and vulnerabilities because he "did not recognize the extent of my intra-psychic wounds and how they might affect my practice." Dr. Doyle believes he now has sufficient insight, knowledge and training to understand Dr. Gabbard's conclusion, and since revocation, Dr. Doyle says he has tried to change his life by implementing the treatment and rehabilitation program that was recommended in 2009.

[86] The post-revocation evidence about mental health indicates that Dr. Doyle has made significant efforts, described below, to confront and attempt to remove his vulnerabilities and emotional needs through psychotherapy and coaching. Dr. Doyle's evidence about what he has done in this area was largely undisputed by the College and was available to the three experts.

[87] The degree to which he has succeeded, and the current risk to the public interest, are matters that we discuss later in these reasons in the context of the expert evidence.

Dr. Ronald Ruskin

[88] Dr. Doyle has undertaken intensive long-term psychoanalytic psychotherapy. He first saw Dr. Ruskin in May 2017, when he began 48 twice weekly sessions until January 2018. They explored the nature of Dr. Doyle's boundary violations, his character and relational style, and developmental history, in order to provide a diagnostic formulation about the likelihood of further boundary violations. Dr. Ruskin thought Dr. Doyle had a good response to therapy, and as of January 19, 2018, the risk of further repetition was minimal.

[89] Dr. Ruskin met less frequently with Dr. Doyle until May 2024, with eight sessions in 2023-2024. In his April 29, 2024 letter, Dr. Ruskin stated that "in supportive-

expressive psychodynamic therapy Dr. Doyle was increasingly able to reflect on his professional working style which at times was overly casual with some patients and did not include careful monitoring of the therapeutic frame and awareness of his own feelings, longing to be helpful and liked by patients."

[90] In his April 29, 2024 opinion, Dr. Ruskin stated that Dr. Doyle does not suffer from a condition that would make him a high risk for repetition of a sexual boundary violation. Dr. Ruskin recognized Dr. Doyle's assessment and treatment at Acumen Institute (discussed below) as steps toward a return to practice.

[91] The College's expert witness Dr. Treena Wilkie (referred to in more detail later in these reasons) regarded Dr. Ruskin's assessment and understanding of Dr. Doyle's circumstances and presentation up to 2018 as comprehensive and aligned with Dr. Gabbard's assessment. More recently, however, she viewed their work as more supportive in nature, "likely due to Dr. Doyle's employment, his engagement with other therapy/program, and improvement in his overall mental state."

Dr. Rebecca Stead

[92] Dr. Stead, a clinical psychologist, provided an affidavit about her treatment of Dr. Doyle from January to July 2020, which involved 11 psychotherapy sessions. She used a cognitive behavioural therapy framework to discuss Dr. Doyle's unresolved childhood issues that Dr. Stead felt had an impact on his current behaviours, including his difficulty in setting appropriate boundaries with assertive and emotionally labile female patients.

[93] Writing in 2020, Dr. Stead believed that Dr. Doyle had made progress in improving his insight into his past professional errors, but he "continues to struggle with reverting to defence mechanisms of defensiveness and minimization of his actions at times, which may interfere with him being able to effectively maintain his insight and implement effective boundary setting on a consistent basis." She stated that Dr. Doyle "has persistent personality traits that make for a somewhat guarded prognosis," and he would benefit from ongoing treatment to break down his defences and "change persistent personality traits that make it difficult to achieve and maintain full accountability for his past and future actions."

Dr. Robert Madan

[94] Dr. Madan's affidavit, also admitted on consent, describes his physician coaching of Dr. Doyle through seven sessions in 2024. Dr. Madan is a geriatric psychiatrist who has experience coaching physicians in academic and community settings. Dr. Doyle was an engaged participant who "learned to use self-reflection to improve his communication and collaboration with others…His self-awareness and ability to use self-reflection in his work communications improved during the course of the sessions."

Marital and financial issues

[95] The College did not dispute the evidence that Dr. Doyle has taken significant strides toward rehabilitation by reducing the likelihood that marital and financial issues will recur as factors that have led to unethical conduct and the exercise of bad judgment.

[96] Dr. Doyle has engaged in marital therapy with his wife, and they both described their marriage to Acumen as "stronger than ever." Ms. Doyle confirmed to Dr. Wilkie that the marital relationship was stable and she was "1000% confident" in his ability to return to practice. Dr. Wilkie thought Ms. Doyle was "providing an overly simplistic and positive view of current and past circumstances," but recognized the clear support she offered to her husband.

[97] To start afresh from a financial perspective, Dr. Doyle sold his home, made an assignment in bankruptcy on April 22, 2019 and attended insolvency counselling sessions on February 6 and April 2, 2020.

Education and training

[98] Dr. Doyle has devoted a great deal of time to continuing education to maintain and improve his substantive knowledge in advance of a potential reinstatement as a College registrant.

Continuing medical education courses

[99] Dr. Doyle has completed a substantial amount of continuing medical education. After his certificate of registration was suspended, Dr. Doyle completed some 67 continuing medical education (CME) courses before the 2018 ICRC decision. Between 2020 and 2024, he completed 174 hours of self-study, 50 hours reading American Medical Association guidelines, 60 hours researching and cataloguing neuropsychiatric

articles for a concussion clinic, 40 hours researching and writing a Truth and Reconciliation training module, and 24 hours researching and writing a training manual for dealing with trauma. He obtained certifications in addiction medicine on October 29, 2018 and in substance abuse, counsellor ethics, confidentiality and boundaries on February 26, 2019 based on online continuing education.

Dr. Michael Pare

[100] Dr. Pare, a physician practising psychotherapy, testified that he provided three continuing professional development courses in primary care psychotherapy from 2021 to 2023, where he did interactive coursework that included topics such as clinical and ethical boundaries. Dr. Pare wrote that Dr. Doyle was one of the better participants in the programs, and he is “an informed, astute and knowledgeable psychiatrist.”

Employment

[101] Here as well, Dr. Doyle has undertaken considerable remedial activity. He has been employed in the health care field, including in the areas of addiction counselling and mental health, even though he cannot provide medical services. Dr. Doyle’s employer witnesses all state, in their own words, that apart from maintaining his links to the treatment of mental health, Dr. Doyle exhibited honesty, decency and integrity in his work in a health care setting.

Dr. Dahir Hashi

[102] Dr. Hashi is a licensed chiropractor in Toronto who is the Director of a physiotherapy clinic and a multidisciplinary disability management firm. He indicated that Dr. Doyle has worked for him since 2022 as “a vital part of my team,” reviewing and summarizing medical information about the mental health and medical history of clients who have suffered catastrophic injuries. Dr. Doyle passed his summary on to a licensed practitioner, who reached conclusions and formulated recommendations for the client. Dr. Hashi refers to Dr. Doyle as extremely intelligent, reliable, courteous and attentive to detail.

Dr. Michel Rathbone

[103] Dr. Rathbone is a Professor of Medicine at McMaster University, where Dr. Doyle has worked for four years, researching medical-scientific issues and summarizing aspects of complicated medical briefs to assist Dr. Rathbone in preparing specialist

neurological medical-legal assessments. As in the case of Dr. Hashi's organization, Dr. Doyle has not interacted with patients. Dr. Rathbone describes the applicant as humble, thoughtful, professional, intelligent, and a respectful and hard-working team player.

Dan McGann

[104] Mr. McGann's affidavit was filed by the parties on consent. He is a social worker who has worked with Dr. Doyle in different contexts including Credit Valley Hospital many years ago. He indicates without details about Dr. Doyle's services that he has positively influenced numerous individuals in Mr. McGann's private practice "over the past several years."

Holly Stewart

[105] Ms. Stewart is the Managing Director of a private addiction and mental health residential treatment facility in Ontario that provides services for physical and sexual abuse victims, and individuals with substance or behavioural addiction and concurrent mental health disorders. She indicates in her 2024 affidavit that Dr. Doyle is the program director for the addiction counselling service, where he has other staff reporting to him. Ms. Stewart describes Dr. Doyle as professional, caring, trustworthy, compassionate, and approachable. In her affidavit, she says Dr. Doyle is very talented at abuse counselling and that he advises the younger counsellors on best practices in navigating boundary issues.

Karen Parsons

[106] Karen Parsons is a retired Executive Director of a non-profit agency that provides addiction services, including assessments, counselling and referrals. She knew Dr. Doyle as a psychiatrist at Credit Valley Hospital many years ago, and then he obtained employment as an addiction counsellor with her agency following his revocation. She describes him as an exceptional addiction counsellor who was a pleasure to work with. She also discusses the College's unannounced compliance visit to the agency in March 2018 to investigate whether Dr. Doyle's duties involved the practice of medicine. She rejects that allegation, specifying that the agency's personnel, including Dr. Doyle, were prohibited from performing psychotherapy, making diagnoses or prescribing or recommending medications.

Expert evidence of risk and risk management for Dr. Doyle

[107] We heard three expert witnesses who reviewed most of the clinical and regulatory evidence we have received, including the extensive record before and after revocation, up to the present. These witnesses were Dr. Scott Stacy and Dr. Joel Jeffries for the applicant, and Dr. Treena Wilkie for the College. They all interviewed Dr. Doyle, and they all reviewed each other's opinions before they testified. They all offered opinions on his risk of further misconduct, and whether the risk is manageable with terms, conditions and limitations.

Acumen Institute

[108] Dr. Doyle engaged in an intensive treatment program with a rehabilitation coordinator at the Acumen Institute in Kansas. We received Acumen's summary report, fitness to practice assessment as well as reports on several phases of Dr. Doyle's treatment during 2023 and 2024. Acumen's now-retired managing partner, Dr. Stacy, testified as a witness, on the agreement of the parties that he was an expert in psychology and the assessment, treatment and risk management of physicians who have committed professional misconduct, including boundary violations.

[109] Acumen offers a service that is unavailable in Canada, with almost 100 years of collective knowledge in the field of forensic fitness to practice assessments, working daily with national and international health care and legal professionals.

[110] Dr. Doyle was first evaluated for fitness to practise by a multidisciplinary team of five examiners for twelve and a half hours over three and a half days between July 31 and August 3, 2023. That evaluation included psychological and cognitive testing and a psychiatric assessment.

[111] The "collateral information" from Dr. Doyle's counsel that Acumen reviewed comprised 690 pages of material. Acumen obtained information from Dr. Doyle's wife, and from two of his employers.

[112] After the initial assessment, Acumen wrote:

> Following the multidisciplinary forensic evaluation, we concluded that Dr. Doyle was mentally fit to practice medicine. He was not suffering from a psychiatric disorder, personality disorder, or cognitive deficits. We felt confident that with proper treatment, Dr.

> Doyle would be in a much better place than he had been in the past to work towards demonstrating the ability to practice with decency, integrity, and honesty in accordance with the law. However, we believed this determination would need to be made during an intensive, all-inclusive professional boundary treatment, coaching, and education process that includes ethics, boundary, and transference management. Knowledge, skill, and judgment are elements of practicing psychiatry that need reinforcement and remediation and can be addressed, resolved, and evaluated within a longitudinal treatment program populated with other physicians with a history of boundary problems.

[113] The conclusion at that point was that Dr. Doyle “could acknowledge and appreciate that his attitude in the past was tainted with a sense of entitlement and lack of humility.” To address residual personality features, he required an intensive day treatment and professional coaching process, encompassing educational, cognitive-behavioural and psychotherapeutic components.

[114] The assessment team was “a bit puzzled about why Dr. Gabbard did not recommend a specialized, intensive treatment program for medical professionals to address sexual misconduct and other deficits in his practice”; in their view, a boundary course and psychotherapy were insufficient. While the intensive treatment program they described was not available in Canada, there were four such programs in the United States that would have equipped Dr. Doyle to manage his private practice and internalize the necessary skills to address and manage the 2014 patient’s feelings compassionately and within professional boundaries.

[115] That is the work the assessment team recommended; there was no question in their view that he was mentally fit to practise medicine, only that he needed to demonstrate the ability to do so with “decency, integrity and honesty and in accordance with the law.”

[116] Dr. Doyle entered into the Longitudinal Professional Treatment Program at Acumen on September 11, 2023. Phase I was a three-week, intensive, partial hospital level of care program that included group and individual interventions. Phase II occurred in two separate one-week sessions at three and six months. Phase III at the one-year anniversary concludes with consolidation of treatment and coaching and reinforcement of relapse maintenance.

[117] As part of Phase II, Dr. Stacy and his colleagues conducted a session in which they confronted Dr. Doyle about his past incidents. Dr. Stacy said he acted like a prosecutor, and wanted to hear whether Dr. Doyle could tell the truth, and had insight, appropriate levels of guilt, and genuine remorse rather than "crocodile tears." Dr. Stacy recognized that part of his goal was to allow Dr. Doyle to communicate his understanding and insight, part was to see how far he was able to "speak straight, and take responsibility," and part of the goal was to help Dr. Doyle communicate with his regulator as part of his reinstatement application.

[118] Dr. Stacy testified that Dr. Doyle disagreed with the Discipline Committee's finding that he was incompetent, but Dr. Stacy went on to clarify the context of Dr. Doyle's comment. Dr. Stacy said Dr. Doyle did not accept that his practice as a whole displayed incompetence, but he admitted that the aspects that Dr. Clarke focused on in her report amounted to incompetence. Acumen did not opine on clinical competence, although Dr. Stacy recognized that that was a component of the Discipline Committee's revocation decision.

[119] At the completion of its work, Acumen's conclusion was as follows:

> 1. Dr. Doyle is mentally competent to practice medicine.
>
> 2. The treatment team is of the opinion that Dr. Doyle can practice medicine with decency, integrity, and honesty and is capable of adhering to the law and the policies and guidelines of the College.
>
> 3. The treatment team believes that Dr. Doyle can practice utilizing sound judgment. Knowledge and skill fall under clinical competency, making this determination beyond the scope of our treatment program.
>
> 4. Dr. Doyle has made significant strides in internalizing the skills needed to communicate effectively and maintain a professional attitude vis-à-vis patients and his professional cohort. Based on past collateral information, he has become a much better communicator. In all of his appointments, he has demonstrated the ability to communicate his thoughts about himself and his peers in the program in a clear, thoughtful, empathic, and concise manner. We do not have any concerns regarding a lack of ability to maintain a professional attitude. He has internalized the skills he needs to function professionally and maintain professional boundaries with patients and staff.

[120] Acumen found Dr. Doyle fit to return to practice, with a risk of further professional misconduct that was lower than the general population of physicians. We asked Dr.

Stacy about other opinions (which were given by Drs. Ruskin and Gabbard) to the effect that Dr. Doyle would pose a low to moderate risk of further boundary violations. Like the other two experts, discussed below, Dr. Stacy was not comfortable with the reliability or precision of such qualitative measures of risk. Acumen did not use those terms in its reports, and it was difficult to say in what way the risk was low or moderate. Moreover, the evidence of risk relating to physicians, as opposed to offenders in the criminal justice system, is only anecdotal. Dr. Stacy rejected the suggestion that his opinion on Dr. Doyle's risk to the public was entitled to less weight because it was not a forensic psychiatric assessment. Asked whether he would object to Dr. Doyle doing psychotherapy, Dr. Stacy said he "would prefer he did not."

Dr. Joel Jeffries

[121] Dr. Jeffries is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in psychiatry who retired from active psychiatric practice about five years ago. He testified for Dr. Doyle based on his longstanding expertise in clinical competence assessment of psychiatric residents, learners and certified psychiatrists, as well as diagnosis and treatment plans for psychiatric patients. Dr. Jeffries reviewed and assessed Dr. Doyle's current clinical competence.

[122] Dr. Jeffries received "the excellent report" prepared by Dr. Wilkie, the College's expert, which we discuss below. He accepted Dr. Wilkie's summary of Dr. Doyle's previous issues, which we have explained in detail in the context of the previous College proceedings. Dr. Jeffries was also aware of Dr. Doyle's assessment and treatment with Acumen.

[123] Dr. Jeffries questioned Dr. Doyle about his previous transgressions and pressed him to discern what Dr. Doyle had learned through intensive psychotherapy, further education and self-reflection. Dr. Jeffries also tested Dr. Doyle on his reaction to several hypothetical challenging patients.

[124] In Dr. Jeffries' opinion, Dr. Doyle's previous diagnosis of adjustment disorder was "possibly misleading," but Dr. Doyle had significant personality issues. Dr. Jeffries agreed with Acumen's assessment of a "sense of entitlement and lack of humility," with "histrionic, turbulent, obsessive-compulsive and dependent traits." In Dr. Jeffries' view, Dr. Doyle's dependent tendencies were not excessive, although his boundary violations probably reflected a need for external validation and a deficiency in internal validation.

[125] Dr. Jeffries viewed Dr. Doyle's personality defects as "remediable, although not with ease." He disagreed with the College's position, as he understood it, that Dr. Doyle's deficiencies were irremediable, and in this respect, Dr. Jeffries' opinion was similar to the one given by the College's expert Dr. Wilkie in her testimony. Dr. Jeffries accepted that Dr. Doyle has the requisite knowledge and skill and judgment to prepare treatment plans as a clinically competent psychiatrist.

[126] Dr. Jeffries disagreed with the suggestion that Dr. Doyle's risk of reoffending was moderate. He thought Dr. Wilkie's assessment of Dr. Doyle's risk evaluation as "low-moderate" made sense, and went on in his report to say that "risk to the public is quite limited and can be approaching zero with certain limitations and directions on his practice." He said he did a risk assessment, not a forensic risk assessment, although it is not clear from his evidence, or that of the forensic psychiatrist Dr. Wilkie, that there is a meaningful distinction in the context of physician recidivism in boundary violations. Like Drs. Stacy and Wilkie, Dr. Jeffries did not rely heavily on categories of "low" or "moderate" risk; he would use the term "limited risk."

[127] Dr. Jeffries recommended oversight, mentoring, and limitations on Dr. Doyle's practice; for example, to exclude psychotherapy, but to perform consultations, provide management plans, and introduce medications. Dr. Jeffries thought Dr. Doyle's clinical skills have never been seriously challenged, by Dr. Wilkie or by Dr. Jeffries, so he saw no need for clinical supervision. Though he said he would have no objection to clinical supervision, he did not view it as necessary. Asked whether he would recommend a return to practice for Dr. Doyle without terms, he replied "absolutely not."

Dr. Treena Wilkie

[128] Dr. Wilkie provided a report and testified for the College as an expert in forensic psychiatry and risk assessment. She too reviewed Dr. Doyle's regulatory history, his treatment over the preceding decades, and the assessments and reports that we have referred to. Dr. Wilkie also conducted an interview and mental status examination with Dr. Doyle on January 3, 2025, in which she obtained Dr. Doyle's "self-report" about each of his regulatory transgressions in order to assess, among other things, Dr. Doyle's acknowledgment, remorse and intended follow-up to these events. Dr. Wilkie did not perform psychological testing.

[129] In her risk assessment, Dr. Wilkie focused on the static and dynamic variables that are at play in Dr. Doyle's case. Static variables are those that are not expected to change over time; for Dr. Doyle, these would include a history of repetition of professional misconduct despite penalties and prolonged therapy, and the dysfunctional personality traits identified by his assessors that relate to his upbringing. Those personality traits "have repeatedly been identified by various assessors as driving factors behind… a need for affiliation, grandiosity and entitlement, lack of judgment and being drawn to chaotic and risky situations." Those static variables would not abate, but they require awareness and ongoing reflection. While personality constructs from childhood can be considered static, behaviours and coping strategies can evolve with therapeutic interventions.

[130] Dynamic factors are issues or events that can provide information about changes in short-term risk. In Dr. Doyle's case, these risk-enhancing circumstances "would primarily be instability in his life circumstances (marital or occupational stressors, isolation, and financial stress)."

[131] Dr. Wilkie's opinion was that Dr. Doyle had fair to good insight into the factors that have contributed to his current circumstances. However, Dr. Wilkie said Dr. Doyle appeared to minimize or rationalize his past behaviour at times. She pointed to his report of the patient in the second transgression in 2014 having narcissistic traits, which would not contravene the conditions of his practice, although this diagnosis was not supported by his clinical notes.

[132] Dr. Wilkie fairly recognized in her report and her testimony that Dr. Doyle had made progress:

> Dr. Doyle is very motivated to return to the practice of medicine, and has a positive attitude toward any potential supervision or conditions of practice. He has undergone an intensive treatment program around professional behavior and boundaries. There is stability in his marriage and finances. He has positive feedback from his employers and has evidenced a prolonged commitment to CME, and health sciences aligned work and skill development. He does not evidence an antisocial personality structure, substance abuse, a paraphilic disorder, or a cognitive disorder.

[133] In her report, Dr. Wilkie concluded that there is a low-moderate risk of recurrence of professional misconduct or boundary violations, in the context of supervised practice. To the extent that there are differences in the language used by the three experts to

express the risk of further misconduct, we do not consider such differences important or determinative. Like the other two experts, Dr. Wilkie frankly acknowledged, in both her report and her testimony, that risk assessment is not a mathematical exercise.

[134] There are at least two risks to be measured: likelihood of a further incident, and the nature, severity, imminence and frequency of such behaviour. We asked each of the experts about these issues – risk of what kind of misconduct, and how much risk – and whether classifications of “low,” “moderate,” and so on were precise or meaningful for our purposes. Dr. Wilkie’s view was similar to what we heard from the other two experts: unlike the criminal justice sphere, which is much more advanced in this area, “there are no specific risk assessment tools that focus on professional misconduct or boundary violations that are not violent in nature, but there are known associated empirical factors.”

[135] Dr. Wilkie also made the important point that risk assessment and risk management are inextricably linked: “a practical, manageable risk management plan that addresses identified risk issues is an important consideration as to management of risk over time.” Consistent with her opinion, we have considered the appropriate terms, conditions and limitations concurrently with the general conclusion of all of the experts that there is some risk that Dr. Doyle will engage again in significant misconduct including boundary violations.

[136] The College asked us to accept Dr. Wilkie’s evidence over Dr. Jeffries’ and Dr. Stacy’s. We decline to do so.

[137] In our view, while there are differences of terminology and emphasis, as befits their different disciplines and specialties, there are no significant inconsistencies for the purposes of this application in the core elements of the three expert opinions.

[138] At the core of their opinions, all of them accept that Dr. Doyle has sufficient clinical knowledge. All of them recognize that he has had record keeping deficiencies that can be remedied by technology. All of them express some concern about Dr. Doyle’s insight and his ability to acknowledge and learn from his errors, but all accept that he has worked assiduously on the underlying factors that impair his judgment.

[139] All of the experts point to static and dynamic variables that will affect Dr. Doyle’s ability to practise without repetition of boundary violations or other significant judgmental

errors. All of them express his risk of recidivism in a range of low, or low to moderate, but none of the experts is prepared to put much weight on a quantified risk scale, given the state of research and the range of misconduct that must be considered if the public interest is to be protected.

[140] Finally, reinstatement with stringent terms is within the acceptable range of outcomes put forward by all three of the experts. Indeed, there is a good deal of commonality among the types of restrictions that they all view as necessary in order to promote the public interest and achieve public safety. We provide more specific direction on the categories of terms, conditions and limitations later in these reasons.

Insight, judgment and acknowledgment of misconduct

[141] It is important to factor into our decision a recurring theme which has appeared in the evidence about Dr. Doyle's three "transgressions," and the 2018 Discipline Committee decision in particular: a concern that he has not fully acknowledged or taken responsibility when he has failed to meet standards of professionalism or competence. Insight is important with regard to public protection, and therefore it is relevant to a consideration of the risk of repeated misconduct: *College of Physicians and Surgeons of Ontario v. Seidman*, 2013 ONCPSD 28.

[142] The College submitted that according to Dr. Wilkie, Dr. Doyle has consistently "minimized, rationalized and externalized his past experience," and that this is important in assessing whether his "articulated insight" is "genuine" rather than "formulaic". We accept the second proposition, but not the first. In our view, it overstates Dr. Wilkie's opinion, which was much more measured than that.

[143] We agree that there is cause for some concern, which was exhibited during Dr. Doyle's testimony before us. He did not readily admit that he had knowingly breached the prohibition on outside employment as a physician during his residency, despite having admitted in the 2018 proceeding that he was told about it three times by Dr. Kaplan. In cross-examination, Dr. Doyle suggested that he did not know he was practising medicine by doing physical assessments. Indeed, Dr. Doyle's closing submissions minimized the wrong, saying he violated a rule that was later changed. At the same time, he acknowledged that he knew he was violating the restrictions on moonlighting.

[144] Referring to the 2018 discipline proceeding, Dr. Doyle essentially told us in his examination in chief that the lawyers agreed to an incompetence finding, and he reduced Dr. Clarke's criticisms of his clinical judgment to poor record keeping. Neither of these was correct; he signed the agreed statement of facts and the admission of incompetence, and Dr. Clarke documented insufficient treatment plans and several other substantive errors. He attempted to justify his YouTube videos, saying they were private, the patient could not be seen, and he was using a pseudonym. Dr. Clarke's review issues an unqualified condemnation of the lack of judgment that he displayed in issuing the videos, and Dr. Doyle ultimately acquiesced to that position in his testimony.

[145] Dr. Doyle initially described his conduct while suspended as little more than telling his former patients they could call him if they needed help in transitioning their care. He initially said he only met with patients who could not grasp that he was unable to provide care any longer. Of course, his notes indicated his advice, communication and follow-up went beyond those parameters. Again, Dr. Doyle ultimately gave an unqualified admission in cross-examination that his interactions were inappropriate.

[146] The College goes further, in asserting that he had former patients sign waivers because he knew his conversations were improper. In our view, that overstates the purpose of the waiver. They were drafted by his lawyers to document his contacts with an unsophisticated and vulnerable population of patients who might not clearly understand what was happening with their care, and why. The fault was not in creating a waiver, but in engaging in conduct that exceeded the terms of his own waiver.

[147] The College pointed to *Kitakufe v. College of Physicians and Surgeons of Ontario*, 2021 ONPSDT 41, where the Tribunal stated at paras. 60-61:

> We are concerned that Dr. Kitakufe was reluctant to acknowledge directly a number of aspects of his misconduct and crimes in Toronto that should be well known to him…
>
> On each of these points, when taken to previously agreed statements of fact and other documentary evidence, Dr. Kitakufe said in essence that if the facts were recorded and he had accepted them in the past then they must be true.

[148] Dr. Doyle's case is very different, in our view. The contrast is captured in another passage, at para. 59 of *Kitakufe*:

> Dr. Kitakufe testified that he has changed and that he now understands and accepts responsibility for his actions. We accept that this is his honest belief. However, beyond the simple statement that he accepts responsibility, he provided very little in terms of explanation, detail or how he now sees his own role in his misconduct. His testimony overall was not clear about where he now believes responsibility for his misconduct lies, if indeed he has resolved this in his own mind.

[149] While Dr. Doyle was defensive at times, and that is to be anticipated where the penalty for admitted conduct was vigorously contested and lost, the points at which he quarrelled with criticisms of his conduct were few and far between. For the most part, he accepts the findings against him. Indeed, the best indicator of his acknowledgment and acceptance of the findings against him has been the design and execution of his rehabilitation plan since revocation. He has shown a commitment to treatment, education and severe limitation and supervision of his practice in order to squarely address the areas in which his performance was found deficient. As the College's expert acknowledged, his insight into what caused his circumstances is fair to good.

[150] Similarly, the evidence in this case can be compared with the facts in *Fagbemigun v. College of Physicians and Surgeons of Ontario*, 2024 ONPSDT 30. In dismissing that reinstatement application, important factors included the excuses Dr. Fagbemigun provided for his misconduct: an oversight due to lack of information, resources, supports and overwork, and refusal to admit intentional fraud. The Tribunal also noted that in preparing to make his reinstatement application, Dr. Fagbemigun took several steps to address stress, anxiety, coping, mental health and a work/life balance, none of which was linked to the earlier findings of misconduct and would thereby lower the risk of future misconduct. To the contrary, the remedial steps Dr. Doyle has taken since 2017 have been focused on the shortcomings and the static and dynamic variables that have been at the forefront of his professional misconduct.

[151] In our view, the longstanding concerns about Dr. Doyle's judgment and insight have not disappeared, but they can be controlled and minimized through supervision and mentoring that will put guardrails around areas and activities he should stay away from, and at the same time maintain attention to and remediation of the areas of his vulnerability.

Conclusion

[152] In our view, Dr. Doyle's reinstatement application should be granted, with targeted terms, conditions and limitations.

[153] During final submissions, we asked the parties to provide us with the TCLs they would ask us to order if we were to accept in principle that reinstatement should be granted. Both of their drafts were lengthy and well considered, but also very different from each other in principle and detail.

[154] In our view there is still a lot of drafting to do. The appropriate list of TCLs lies between the two drafts that were provided by the parties, and we do not favour either side's version as a whole. Rather than attempting to write the intricate terms of the order ourselves, we are issuing broad directions with respect to several topics and remitting the matter to the parties to discuss and agree upon as much as possible. They should then submit their agreed order, or as much of the order as they can agree upon, to us, together with an outline of the differences that remain within the parameters we are setting in the directions that follow. If necessary, we can finalize the TCLs at a hearing management conference, or we can give further directions on how to finalize them, for example, through oral or written submissions.

Directions

[155] We ask the parties to follow these broad guidelines:

- The registrant will enter trauma-focused therapy with a certified Cognitive Behavioural Therapist.
- Dr. Doyle will enter a two-year accountability program with the Physician Health Program.
- The registrant will not perform formal psychotherapy, but may engage in supportive counselling as would be expected in good medical practice.
- The registrant will be restricted to virtual care. In doing so, the registrant will assess whether virtual care is appropriate in the patient's circumstances and refrain from proceeding where it is not in the patient's best interests.

- Dr. Doyle's practice will be restricted to psychiatric and addiction medicine consulting, providing consultations, diagnoses, treatment plans, psychotropic medication, short-term stabilization visits, and medication monitoring visits.
- The registrant will not be restricted to initial consultations. The panel views it as unlikely that a single interview would be sufficient to establish a likely diagnosis and elaborate a treatment or management plan.
- The registrant will not be restricted from seeing patients with some form of trauma history or a borderline or other personality disorder. The panel views this restriction as impractical, as it would rule out a majority of patients needing psychiatric care, and a trauma history or personality disorder may not be immediately divulged or apparent.
- The registrant shall not practise in a setting in which he is the only physician.
- The registrant will document patient encounters through oral dictation only.
- Include high, moderate and low level mentorship and clinical supervision of at least three months each, together with College assessment and monitoring.
- It is not necessary that the clinical supervisor be present or observing remotely during the registrant's consultation with a patient.
- The high level clinical supervision should begin with the registrant as Most Responsible Physician; in other words, there is no "non-MRP" supervision.
- Supervision will involve meeting monthly for the first six months, and will continue every three months thereafter, with an agreed sunset clause.
- The registrant will display a notice of his practice restrictions, but this need not include the method of documentation through oral dictation.
- The registrant will not have any CME requirements beyond those that are required of all specialists.

[156] We direct the parties to discuss and attempt to agree upon the TCLs they ask us to incorporate into the Tribunal's order, having regard to their respective drafts and the above directions. Within three weeks, the parties should advise us of the status of the draft order and their position on next steps. Depending on this information, the Tribunal will issue a final order based on the parties' written positions or agreement, or schedule an HMC with the panel chair, and/or a written or oral hearing before the panel.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 23-025

Date: March 16, 2026

Raj Anand (panel chair)
Stephen Bird (public)
Stephen Hucker (physician)
Camille Lemieux (physician)
Linda Robbins (public)

College of Physicians and Surgeons of Ontario

College

- and -

Christopher Stephen Doyle

Registrant

ORDER

This application, made by the registrant for reinstatement, was heard on October 1, 8, 9, 15, 16, 2025 by videoconference.

1. The Tribunal orders and directs that the Registrar issue a Certificate of Registration to Dr. Christopher Stephen Doyle (the “registrant”) and directs the Registrar to impose the following terms, conditions and limitations on the registrant’s Certificate of Registration:

Practice Restrictions

a. The registrant will have the following practice restrictions:

   i. The registrant shall be restricted to psychiatric and addiction medicine consulting, including providing consultations, diagnoses, treatment plans, psychotropic medication, short-term stabilization visits, and medication monitoring visits;

   ii. The registrant shall not perform formal psychotherapy, but may engage in supportive counselling;

   iii. The registrant shall only see patients virtually, and shall not see patients if virtual care is not in their best interest;

iv. The registrant shall not practise in a setting where he is the only physician; and

v. The registrant shall document patient encounters through oral dictation only.

b. In providing care in a virtual setting, the registrant shall display a sign to the patient in the form set out at Schedule "A" to this Order at the outset of the first patient encounter. If the patient encounter is by telephone, the registrant shall read the sign to the patient at the outset of the first patient encounter. For further clarity, this sign shall state as follows:

Dr. Doyle has the following practice restrictions:

1. Dr. Doyle shall be restricted to psychiatric and addiction medicine consulting, including providing consultations, diagnoses, treatment plans, psychotropic medication, short-term stabilization visits, and medication monitoring visits;

2. Dr. Doyle shall not perform formal psychotherapy but may engage in supportive counselling;

3. Dr. Doyle shall only see patients virtually, and shall not see patients if virtual care is not in their best interest; and

4. Dr. Doyle shall not practise in a setting where he is the only physician.

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

c. The registrant shall display or read a certified translation of the sign described above in subparagraph 1(b) in any language in which he provides services. The registrant will provide the certified translation to the College within thirty (30) days of this Order. If the registrant elects, after this Order is made, to offer services in any other language, the registrant will notify the College prior to providing any such services and will provide the College the certified translation of the signage prior to beginning to provide services in any other language.

Clinical Supervision

d. Clinical Supervision will contain the following elements:

   i. The registrant shall retain at his own expense a Clinical Supervisor acceptable to the College (the “Clinical Supervisor”) who has executed an undertaking in the form attached at Schedule “B” to this Order. The registrant will not practise medicine until he has obtained a Clinical Supervisor acceptable to the College.

   ii. During all phases of Clinical Supervision, the registrant may see patients without the presence of the Clinical Supervisor. The Clinical Supervisor will keep a log of all patients whose charts were reviewed or whose care was observed or otherwise supervised, along with patient identifiers.

   iii. The Clinical Supervisor will discuss any concerns with the registrant, including any concerns arising out of chart reviews.

   iv. Each time the Clinical Supervisor meets with the registrant, they will discuss and review the registrant’s practice restrictions outlined in subparagraph 1(a) for compliance. The Clinical Supervisor will forthwith report to the College if they believe at any time that the registrant is not complying with their practice restrictions.

   v. The Clinical Supervisor will make recommendations to the registrant for practice improvement and ongoing professional development, as indicated and inquire into the registrant’s compliance with the recommendations. The registrant shall abide by the recommendations of the Clinical Supervisor.

   vi. The Clinical Supervisor will perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues that the Clinical Supervisor deems necessary for the registrant’s Clinical Supervision.

   vii. The Clinical Supervisor’s reports to the College shall be in reasonable detail and shall include all information that the Clinical Supervisor believes might assist the College in evaluating the registrant’s standard of practice and conduct, as well as the registrant’s participation in and compliance with the requirements set out in this Order, including practice restrictions.

   viii. If prior to the completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in the role for any

reason the registrant shall, within fourteen (14) days of receiving notice of same, obtain an executed undertaking in the same form as Schedule “B” from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time. If the registrant is not able to retain a College approved supervisor within fourteen (14) days, he shall be required to cease practice and this will constitute a term, condition or limitation on his Certificate of Registration and such term, condition or limitation shall be included on the public register.

ix. The minimum supervision length requirements may be extended if the registrant is not practising at a frequency the College considers to be sufficient to assess suitability to transition to the next stage of Supervision.

High Level Clinical Supervision

x. For at least the first three months of clinical supervision, the registrant will practise only under High Level Clinical Supervision during which the registrant may be the Most Responsible Physician.

xi. The Clinical Supervisor will meet with the registrant at his Practice Location or virtually if approved by the College, once every month. At those meetings the Clinical Supervisor will review the assessments and management plans for each patient that the registrant saw in the previous month and identify if there are any concerns. The Clinical Supervisor’s review will be noted both in the Clinical Supervisor’s log and in the patient chart.

xii. The Clinical Supervisor will provide a report to the College at least once every month.

Moderate Level Clinical Supervision

xiii. After a minimum of three months of High Level Clinical Supervision, if the Clinical Supervisor recommends and the College approves a reduction in the level of supervision, the Clinical Supervision will transition to Moderate Level Clinical Supervision for at least three months, during which time the Clinical Supervisor will meet with the registrant at his Practice Location or virtually if approved by the College, once every month.

xiv. During the period of Moderate Level Clinical Supervision, the Clinical Supervisor will review at least fifteen (15) patient charts at every meeting, to be selected at the sole discretion of the Clinical

Supervisor.

xv. The Clinical Supervisor will provide a report to the College once every month, or more frequently if the Clinical Supervisor has concerns about the registrant’s standard of practice or conduct.

Low Level Clinical Supervision

xvi. After a minimum of three months of Moderate Level Clinical Supervision, if the Clinical Supervisor recommends and the College approves a reduction in the level of supervision, the Clinical Supervision will transition to Low Level Clinical Supervision for at least three (3) months, during which time the Clinical Supervisor will meet with the registrant at his Practice Location or virtually if approved by the College, once every month.

xvii. The Clinical Supervisor shall review at least fifteen (15) patient charts at every meeting, to be selected at the sole discretion of the Clinical Supervisor.

xviii. The Clinical Supervisor will submit a written report to the College at least once every three (3) months for the duration of Low Level Supervision, or more frequently if the Clinical Supervisor has concerns about the registrant’s standard of practice or conduct

Mentorship

e. Prior to commencing practice, the registrant shall retain at his own expense a mentor acceptable to the College (“the Mentor”) who has executed an undertaking in the form attached as Schedule “C” to this Order. The Clinical Supervisor and the Mentor shall be different individuals.

f. The Mentor will

i. Provide emotional support as needed;

ii. Give advice on time management;

iii. Share practical knowledge and experience in the practice of psychiatry;

iv. Give guidance on administrative organization;

v. Give guidance on navigating the evolving clinical and professional landscape;

vi. Assist the registrant in dealing with any negative self-perception he may have;

vii. Provide assistance in career development, work-life balance, personal family life, life style and financial responsibility;

viii. Provide guidance with respect to professional attire and demeanour; and

ix. Assist the registrant in ensuring that his written and oral communications are professional and respectful.

g. The Mentor shall provide monthly reports to the College on the registrant's progress and status with respect to each of the points listed in paragraph 1(f).

h. After six months of mentorship, if the Mentor is satisfied that the registrant's progress and status with each of the points listed in paragraph 1(f) are satisfactory to meet the professional obligations of every registrant, the Mentor may transition to meetings every three months for at least the next six months.

i. If prior to the completion of Mentorship, the Mentor is unable or unwilling to continue in the role for any reason the registrant shall, within fourteen (14) days of receiving notice of same, obtain an executed undertaking in the same form as Schedule "C" from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

Reassessment

j. Within six (6) months after the registrant completes the Clinical Supervision and Mentorship set out above, the registrant will submit to a reassessment of his practice ("the Reassessment") by an assessor or assessors selected by the College (the "Assessor"). The Reassessment shall include a chart review of a minimum of fifteen (15) patient charts, and may include direct observation of the registrant's care, interviews with the registrant, colleagues and co-workers, feedback from patients, and any other tools deemed necessary by the College.

k. The registrant will co-operate fully with the Reassessment.

l. The results of the Reassessment will be provided to the registrant and reported to the College and the Reassessment may form the basis of further action by the College.

Monitoring

m. The registrant must inform the College of each and every one of his Practice Locations within five (5) days of this Order. Going forward, the registrant will inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

n. The registrant will submit to, and not interfere with, unannounced inspections of his Practice Locations and patient records by a College representative for the purposes of monitoring his compliance with the provisions of this Order.

o. The registrant shall give his irrevocable consent to the College to make appropriate enquiries of the Ontario Ministry of Health and Long Term Care, the Ontario Health Insurance Plan ("OHIP") or the Narcotics Monitoring System ("NMS") and/or any person who or institution that may have relevant information, in order for the College to monitor the registrant's compliance with the provisions of this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions.

p. The registrant shall consent to the sharing of information between the Clinical Supervisor, the Mentor, the Assessor and the College as any of them deem necessary or desirable in order to fulfil their respective obligations, for the purpose of monitoring the registrant's compliance with this Order and/or for sharing information that comes to any of their attention which they believe may indicate a potential risk of harm to patients. This shall include, without limitation, providing the Clinical Supervisor, Mentor and/or Assessor with any reports of any assessments of the registrant's practice or prior clinical supervision in the College's possession, and the decisions of the Ontario Physicians and Surgeons Discipline Tribunal (or formerly the "Discipline Committee of the College of Physicians and Surgeons of Ontario").

q. The registrant will consent to the College providing any Chief(s) of Staff or colleague with similar responsibilities at any hospital or medical facility where the registrant practices or has privileges with any decisions of this Tribunal and/or any information arising from the monitoring of the registrant's compliance with this Order.

r. The registrant shall be responsible for any and all costs associated with implementing the terms of this Order.

Other Terms

s. The registrant shall engage in trauma-focused therapy with a certified Cognitive Behavioral Therapist ("Therapist"). The registrant shall comply with all recommendations of his Therapist. The registrant shall provide his Therapist with a copy of this Order and all of the prior decisions of the Ontario Physicians and Surgeons Discipline Tribunal (or formerly, the Discipline Committee of the College of Physicians and Surgeons of Ontario). The Therapist will report to the College if the registrant fails to attend multiple appointments, without sound reason, within the judgment of the Therapist.

t. The registrant shall, at his own expense, undergo an assessment by the Physician Health Program ("PHP") and abide by any recommendations of the PHP, including but not limited to, entering into a health monitoring agreement with the PHP.

u. The registrant shall request that the PHP enroll him in an accountability program. In the event that the registrant meets the enrollment criteria for the PHP, the registrant shall:

   i. Enroll in a health monitoring agreement with the PHP, with the length of the agreement to be determined by the PHP;

   ii. Ensure the College is provided with a copy of the health monitoring agreement, including any amendments thereto, within two (2) weeks of execution;

   iii. Fully comply with the requirements of the health monitoring agreement, including completing the contractual term of the agreement;

   iv. Ensure that the PHP provides periodic reports to the College in respect of the registrant's compliance with the health monitoring agreement; and

   v. Enter into a further health monitoring agreement, and/or extend his agreement with the PHP if recommended by the PHP upon completion of the PHP agreement.

v. The registrant shall provide his irrevocable consent to information-sharing/reporting between the College and the PHP, as well as any workplace monitors, treating health professionals and any other persons necessary in order for the College to receive information relevant to the registrant's compliance with these or any other terms of the Order.

w. In the event that the registrant terminates his relationship with the PHP or the PHP health monitoring agreement is suspended by the PHP, such action may be reviewed by the College for the purpose of any appropriate regulatory action.

SCHEDULE "A"

TO THE ORDER OF THE ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

IMPORTANT NOTICE

Dr. Doyle has the following practice restrictions:

1. **Dr. Doyle shall be restricted to psychiatric and addiction medicine consulting, including providing consultations, diagnoses, treatment plans, psychotropic medication, short-term stabilization visits, and medication monitoring visits;**
2. **Dr. Doyle shall not perform formal psychotherapy but may engage in supportive counselling;**
3. **Dr. Doyle shall only see patients virtually, and shall not see patients if virtual care is not in their best interest; and**
4. **Dr. Doyle shall not practise in a setting where he is the only physician.**

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

SCHEDULE "B"

TO THE ORDER OF THE ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

UNDERTAKING OF DR. ____________________
TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

("CLINICAL SUPERVISOR")

1. I am a practising member of the College, certificate of registration number ___________.

2. I have read the Order of the Ontario Physicians and Surgeons Discipline Tribunal (the "Tribunal") dated ____________(the "Order") regarding Dr. Christopher Stephen Doyle ("Dr. Doyle"), and the prior decisions of the Ontario Physicians and Surgeons Discipline Tribunal (or formerly the "Discipline Committee of the College of Physicians and Surgeons of Ontario") regarding Dr. Doyle. I understand the terms, conditions and limitations the Tribunal directed the Registrar of the College to impose on Dr. Doyle's certificate of registration in the Order, and I understand the concerns regarding Dr. Doyle's standard of practice. I will review as soon as practicable any additional materials provided to me by the College, including the College's Guidelines for College-Directed Supervision.

3. I agree that commencing on the date of my Undertaking, I shall act as Clinical Supervisor for Dr. Doyle ("Clinical Supervisor").

4. I undertake that during the period of Clinical Supervision, I will, at minimum:

   a. Review the materials provided by the College and have an initial meeting with Dr. Doyle to discuss the objectives for the Clinical Supervision;

   b. Perform the tasks set out in paragraph 1(d) of the Order;

   c. I will be solely responsible for selecting all of the charts that I review, on the basis of the areas of concern identified in the source documents provided to me, and any concerns that arise during the period of Clinical Supervision, independently of Dr. Doyle's participation;

   d. I will maintain a log of all patient charts reviewed and care observed or otherwise supervised, along with patient identifiers;

   e. I will discuss with Dr. Doyle any concerns arising from the care and charts reviewed;

   f. I will make recommendations to Dr. Doyle for practice improvements and ongoing professional development, if necessary, and I will inquire into Dr. Doyle's compliance with my recommendations;

g. I will perform any other duties, such as reviewing other documents or conducting interviews with staff and colleagues, that I deem necessary to Dr. Doyle's Clinical Supervision;

h. At each meeting with Dr. Doyle, I will discuss and review with him his practice restrictions for compliance. I will forthwith report to the College if I believe at any time that Dr. Doyle is not complying with his practice restrictions.

5. I undertake to submit a written report to the College, at least once per month until Dr. Doyle moves to low level clinical supervision, and then once every three (3) months, unless I have concerns about Dr. Doyle's standard of practice or conduct. Such reports shall be in reasonable detail and shall contain all information I believe might assist the College in evaluating Dr. Doyle's standard of practice, as well as Dr. Doyle's participation in and compliance with the requirements set out in the Order.

6. I undertake to remain free of any conflict of interest with Dr. Doyle.

7. I undertake that I shall immediately notify the College if I am concerned that:

a. Dr. Doyle's practice may fall below the standard of practice of the profession;

b. Dr. Doyle may not be in compliance with the provisions of the Order, including the practice restrictions; or

c. Dr. Doyle's patients may be exposed to risk of harm or injury.

8. I acknowledge that Dr. Doyle has consented to my disclosure to the College and all other Clinical Supervisors and Assessors of all information relevant to any of the following:

a. the Order;

b. monitoring compliance with the Order;

c. the assessment of his practice; and

d. the provisions of this undertaking.

9. I acknowledge that all information that I become aware of in the course of my duties as Dr. Doyle's Clinical Supervisor is confidential information and that I am prohibited, both during and after the period of Clinical Supervision, from communicating it in any form and by any means except in the limited circumstances set out in section 36(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

10. I undertake to notify the College and Dr. Doyle in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

11. I undertake to immediately inform the College in writing if Dr. Doyle and I have terminated our Clinical Supervision relationship, or if I otherwise cannot fulfill the provisions of my undertaking,

including but not limited to informing the College immediately of any conflict of interest with Dr. Doyle, including any potential or perceived conflict of interest.

Dated at ________________________, this _____ day of ____________________, 202__.

____

Dr.

_______________________________________ _______________________________________

Witness *(print name)* Witness *(Signature)*

SCHEDULE "C"

TO THE ORDER OF THE ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

UNDERTAKING OF DR. ____________________
TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

("MENTOR")

1. I am a practising member of the College, certificate of registration number ___________.

2. I have read the Order of the Ontario Physicians and Surgeons Discipline Tribunal (the "Tribunal") dated ____________(the "Order") regarding Dr. Christopher Stephen Doyle ("Dr. Doyle"), and the prior decisions of the Ontario Physicians and Surgeons Discipline Tribunal (or formerly the "Discipline Committee of the College of Physicians and Surgeons of Ontario") regarding Dr. Doyle. I understand the terms, conditions and limitations the Tribunal directed the Registrar of the College to impose on Dr. Doyle's certificate of registration in the Order, and I understand the concerns regarding Dr. Doyle's standard of practice. I will review as soon as practicable any additional materials provided to me by the College.

3. I agree that commencing on the date of my Undertaking, I shall act as Mentor for Dr. Doyle ("Mentor").

4. I undertake that during the period of Mentorship, I will, at minimum:

    a. Review the materials provided by the College and have an initial meeting with Dr. Doyle to discuss the objectives for the Mentorship;

    b. Perform the tasks set out in paragraph 1(e) to (h) of the Order.

5. I will be solely responsible for selecting any charts that I review, on the basis of the areas of concern identified in the source documents provided to me, and any concerns that arise during the period of Mentorship, independently of Dr. Doyle's participation;

6. I will make recommendations to Dr. Doyle based on my performance of the tasks set out in paragraphs 1(e) to (h) of the Order, and I will inquire into Dr. Doyle's compliance with my recommendations;

7. I will perform any other duties, such as reviewing other documents or conducting interviews with staff and colleagues, that I deem necessary to Dr. Doyle's Mentorship;

8. Where appropriate, I will discuss and review with him his practice restrictions for compliance. I will forthwith report to the College if I believe at any time that Dr. Doyle is not complying with his practice restrictions.

9. I undertake to submit a written report to the College, at least once per month for the first six months, and then at least once every three (3) months. Such reports shall be in reasonable detail and shall

contain all information I believe might assist the College in evaluating Dr. Doyle's standard of practice, as well as Dr. Doyle's participation in and compliance with the requirements set out in the Order.

10. I undertake to remain free of any conflict of interest with Dr. Doyle.

11. I undertake that I shall immediately notify the College if I am concerned that:

    a. Dr. Doyle's practice may fall below the standard of practice of the profession;

    b. Dr. Doyle may not be in compliance with the provisions of the Order, including the practice restrictions; or

    c. Dr. Doyle's patients may be exposed to risk of harm or injury.

12. I acknowledge that Dr. Doyle has consented to my disclosure to the College and Clinical Supervisors and Assessors of all information relevant to any of the following:

    a. the Order;

    b. monitoring compliance with the Order;

    c. the assessment of his practice; and

    d. the provisions of this undertaking.

13. I acknowledge that all information that I become aware of in the course of my duties as Dr. Doyle's Mentor is confidential information and that I am prohibited, both during and after the period of Mentorship, from communicating it in any form and by any means except in the limited circumstances set out in section 36(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

14. I undertake to notify the College and Dr. Doyle in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

15. I undertake to immediately inform the College in writing if Dr. Doyle and I have terminated our Mentorship relationship, or if I otherwise cannot fulfill the provisions of my undertaking, including but not limited to informing the College immediately of any conflict of interest with Dr. Doyle, including any potential or perceived conflict of interest.

Dated at ______________________, this _____ day of ____________________, 202__.

____

Dr.

______________________________________ ______________________________________

Witness *(print name)* Witness *(Signature)*