NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Paul Michael Porter, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the complainant or the complainant's husband, or any information that could disclose the identity of the complainant or the complainant's husband under subsection 47(1) of the *Health Professions Procedural Code* (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

The Committee also made an order that there shall be a ban on the publication or broadcasting of the names of Dr. Porter's patients, or any information that could disclose the names of Dr. Porter's patients under section 45(3) of the Code.

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

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

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THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PAUL MICHAEL PORTER

PANEL MEMBERS:

DR. W. KING (CHAIR)
MS D. DOHERTY
DR. E. STANTON
MR. P. GIROUX
DR. P. CHART

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. B. DAVIES

COUNSEL FOR DR. PORTER:

MR. T. CURRY
MR. R. BUCHOLZ

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

PUBLICATION BAN

Hearing Dates on Finding: September 14-17 and November 23-25, 2015
Decision Date -Finding: February 11, 2016
Release of Written Reasons on Finding: February 11, 2016

Penalty Hearing Date: June 29, 2016
Penalty Decision Date: September 28, 2016
Release of Written Reasons on Penalty: September 28, 2016

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on September 14 to 17, 2015 and November 23 to 25, 2015. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

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

1. under clause 51(1)(b.1) of the Health Professions Procedural Code which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the "Code") in that he engaged in sexual abuse of a patient; and
2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, S.O. 1991 c. 30 in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO ALLEGATIONS

Dr. Porter denied the allegations in the Notice of Hearing.

BACKGROUND

Dr. Porter is a 67-year-old psychiatrist who currently maintains an independent clinical practice in general psychiatry in a city in Ontario. He obtained a Bachelor Degree in Honours Psychology in 1984 and completed the MD Program at McMaster University in 1987. He received a Specialist Certificate in Psychiatry in 1992 and currently maintains a Fellowship in the Royal College of Physicians and Surgeons of Canada.

The allegations against Dr. Porter arise from a mandatory report to the College received in May 2012 from Dr. Z, which was followed by a letter of complaint from Patient A, received in June 2012.

Patient A was a patient of Dr. Porter from April 2008 until her last visit in April 2012. The allegations in this matter relate specifically to the period from February 2009 to April 2012 (the "Material Time") when Patient A alleges the misconduct occurred.

At the Material Time, Dr. Porter's certificate of registration was subject to certain terms, conditions, or limitations, which included the following:

> *Dr. Porter shall install in his office a video system which will, with the consent of each patient, tape each entire psychiatric session and which can be monitored by the office staff and preserved for inspection.*

As a result of a prior order of this Committee, Dr. Porter had also been required to discontinue treating certain disorders; engage a practice monitor; and seek/obtain supervision of his practice by a psychiatrist, among other terms, effective July 10, 2003. Dr. Porter's practice is currently restricted to only male patients. A newspaper article referring to a reprimand and suspension in May 2012 stemming from certain financial dealings Dr. Porter had with patients was also tendered as an exhibit during the hearing.

The Committee wishes to make it clear at the outset that the facts noted above – namely, the restrictions on Dr. Porter's practice, terms, conditions, or limitations; the newspaper article; and Dr. Porter's history with the College – have not factored into its decision on the current allegations. This information has simply assisted the Committee in understanding the parameters of Dr. Porter's practice at the Material Time and, specifically, why he was required to have video recordings of his interaction with patients. These video recordings, as will be discussed below, were an important part of the evidence at this hearing.

FACTS AND EVIDENCE

DOCUMENTS:

The Committee received 31 exhibits into evidence, including: the Notice of Hearing; a joint book of documents; patient charts and OHIP records; photographs; videos; a news article; various website pages; a map; a school document; Dr. Porter's CV; documents related to the current complaint; time sheets; a court judgment; diagrams; fax logs; physician and psychologist reports; published articles; information regarding the College's course on maintaining boundaries; the 2002 Decision and Reasons and Penalty Decision in respect of Dr. Porter; and a monitor's report.

In addition, the following facts were set out in an Agreed Statement of Fact that was filed as an exhibit:

Patient B

1. Patient B was a patient of Dr. Porter.

2. Patient B was diagnosed as suffering from Bipolar II disorder.

3. Patient B's first appointment with Dr. Porter was in March 2011 at 9:50 am.

4. Patient B also saw Dr. Porter on the following dates and times:

Date	Time
April 2011	3:39 to 5:30 p.m.
April 2011	5:10 to 5:56 p.m.
May 2011	4:24 to 5:10 p.m.
June 2011	1:17 to 2:03 p.m.
June 2011	1:17 to 2:03 p.m.
September 2011	3:38 to 4:24 p.m.

5. Patient A also had appointments with Dr. Porter on a certain date April 2011 and on a certain date in May 2011. Patient A's appointments on those days were immediately before Patient B's.

Patient C

6. Patient C was a patient of Dr. Porter's from 2008 to 2012.

7. Patient C was in a relationship with Patient D.

8. Patient C and Patient D also saw Dr. Porter on a few occasions for counseling as a couple.

9. Patient D was a police officer.

10. Patient C and Patient D had a son together who was born in August 2010.

11. Patient C and Patient D separated in January 2011.

12. Patient C and Patient D's relationship was highly conflictual. Patient D was angry, verbally abusive and controlling.

13. Patient C saw Dr. Porter on the following dates and times:

Date	**Time**
November 2011	2:51 to 3:37 p.m.
November 2011	2:51 to 3:37 p.m.
December 2011	2:51 to 3:37 p.m.
January 2012	2:51 to 3:37 p.m.
January 2012	2:51 to 3:37 p.m.

January 2012	2:51 to 3:37 p.m.
January 2012	2:51 to 3:37 p.m.
February 2012	2:51 to 3:37 p.m.

On each of the dates listed above in paragraph 13, Patient A also had appointment with Dr. Porter. Patient A's appointment on those dates was from 3:38 to 4:24 p.m., immediately followed Patient C's appointment.

TESTIMONY

The Committee heard testimony from six witnesses. The evidence of Patient A and Dr. Porter will be presented in narrative form. The Committee's assessment of their respective credibility will be addressed fully in its reasons. A summary of the testimony of the four remaining witnesses and the Committee's view of their evidence will follow.

Evidence of Patient A and Dr. Porter

Patient A is married to Mr. E. She and Mr. E have five adult children. Patient A has lived in the matrimonial home except for a period of separation from March 2010 to April 2012 when she lived in an apartment. Patient A's daughter stayed with her until December 2010. Patient A then lived alone in the apartment until she moved back to the matrimonial home. Patient A testified that she is currently a supervisor at a coffee shop and has been employed there since October 2009. This was her first job outside the home and she started working there part-time.

Patient A first saw Dr. Porter in April 2008 for treatment of panic attacks, anxiety, and an eating disorder. Her panic attacks were severe. Her first appointment with Dr. Porter was on an urgent basis in April 2008, which was shortly after an emergency admittance to the hospital as a result of a panic attack. These facts are not in dispute and are confirmed by the medical record. They are accepted by the Committee.

April 2008 to February 2009

Treatment Frame form

Patient A testified she recalled signing a document entitled "Treatment Frame" on her first visit to Dr. Porter prior to seeing him. She testified that he did not discuss it with her. She said that she did not read the form, indicating that she is not good at reading fast. She accepted that it was the office's typical form and signed it.

Dr. Porter testified that he reviewed this form with Patient A, but clarified in cross examination that he had no independent recollection of reviewing the Treatment Frame with Patient A, but assumed that he did.

Both Patient A and Dr. Porter signed this form, which include the following bulleted items:

- Treatment consists of verbal communication between the doctor and patient;
- No physical contact between doctor and patient will occur;
- All sessions are videotaped in their entirety, monitored by office staff and preserved for inspection; and
- All patients should wait in the general waiting area and the receptionist will come out to get you. <u>This is necessary to ensure patient confidentiality in the office</u>. [Emphasis in original]

Videotaped sessions

Patient A testified she was aware from the beginning that sessions would be videotaped, but that she did not know at the beginning whether the recording would be video only or both audio and video. She said that Dr. Porter told her about the videotaping, but she could not recall the exact circumstances. She testified that some months into therapy, Dr. Porter told her the videotaping was a result of accusations made by a woman against him long ago, and that taping her was for both of their protection and was mandated by the Medical Board (assumed to be the College). She testified he told her that he was totally

innocent and that nothing became of it because the patient did not testify. Dr. Porter was not examined on this point.

Check-in process at Dr. Porter's office

There was a regular check-in process in Dr. Porter's office. Patient A testified that she would sit in a waiting room that Dr. Porter shared with three other doctors. Either Dr. Porter's secretary, Ms. F; his wife, Ms. G, who worked in the office; or Dr. Porter himself would come to get Patient A when Dr. Porter was ready. Patient A testified she would sign a sign-in sheet which was in the secretary's office on each visit. Dr. Porter agreed that this was the sign-in process and this was consistent with the evidence of Ms. G and Ms. F. The Committee accepts that this was normal office routine.

When neither Ms. G nor Ms. F was present, the secretary's office was kept locked. Dr. Porter had keys to the secretary's office, and Patient A testified that Dr. Porter would unlock the door so that she could sign in. Dr. Porter testified that if he was seen unlocking the door on video, this meant that neither Ms. F nor Ms. G was in the office at that time. The committee accepts that this was the usual routine as demonstrated in video clips (dated July 13, 2011, July 29, 2011, June 24, 2011, and July 25, 2011).

Psychiatric treatment of Patient A

Dr. Porter diagnosed Patient A with panic attacks, agoraphobia, social anxiety disorder, and anorexia in partial remission. He believed, based on a review of her school history, that she probably had a comprehension learning disorder. He describes her as "terribly afraid of people and this adds to her isolation and her reliance on her immediate family." Central to her background were a controlling husband and mother. Dr. Porter treated her with medication for her anxiety and panic attacks and set out a program of weekly visits to engage in psychodynamic psychotherapy to promote self-reliance and independence.

Dr. Porter recorded in his clinical notes dated May 2008 that Patient A's relative had died the week before, and that the death comprised part of their session that day. Patient A recalled her relative as a difficult person and an alcoholic, but described that her relative had mellowed with time. The family of origin was fractured, but they joined together for the funeral, with the common-law spouse in attendance. Dr. Porter's clinical notes describe Patient A as being tearful when talking about her relative.

In the course of her early sessions with Dr. Porter, Patient A discussed her relationship with her husband, who she described as dominant and inflexible. He refused to allow her to work and there were disagreements about the children. The matter of her weight and restrictive eating pattern was explored in her therapy sessions as was her childhood, in which there had been a high degree of verbal and psychological abuse. In August 2008, Dr. Porter invited Patient A to ask her husband to join in one of her therapy sessions, but she dismissed the suggestion.

By the time Patient A's August 2008 appointment came about, she had been making positive progress in asserting herself with her husband. Throughout the fall of 2008, she gained more self-reliance and independence. Her life was changing because most of her children gaining independence and anticipating leaving the home. Patient A became more aware of the damage caused by her husband to her and the family. Dr. Porter recorded in his notes that he read the definition of Narcissistic Personality Disorder to Patient A. Patient A noted that Christmas was a difficult time. This was confirmed by Dr. Porter and accords with the medical record.

The course of treatment and Patient A's improvement with therapy thus far is common ground between the parties and is accepted by the Committee.

February 2009 to April 2012 (the Material Time)

Patient A testified that, at some point, her relationship with Dr. Porter changed. They became more like friends enjoying each other's company. Dr. Porter would talk about his life as well. She testified that she envied that he would sit and watch movies with his wife

and son because her husband never did the same with her. Dr. Porter was not examined on this point. Dr. Porter did agree that he shared information with Patient A about his two older adolescent children and the difficulties they posed.

Patient A travelled to a city in the U.S. with a friend in February of 2009. She told Dr. Porter how she had been frightened on the airplane and how her friend had held her hand. Patient A testified that Dr. Porter responded, “Oh, I would love to be the one holding your hand up in the airplane.” Patient A testified that this comment “kind of broke the ice.” Patient A testified that he also told her he was buying a place in the American city she was traveling to, and that it would be nice for the two of them to go there together. Dr. Porter denied telling her he wanted to be on an airplane with her or go to the U.S. with her. The medical chart documents that Patient A reported to Dr. Porter that she was leaving for a conference in the American city with a friend on February 2009 and that she returned later in February 2009.

Patient A testified that she and Dr. Porter flirted. She testified that he said he thought she was perfect just the way she was and that she had a youthful, very young body. Patient A testified she liked hearing that. Dr. Porter gave evidence that he would never make such comments to a patient with anorexia.

Patient A testified that Dr. Porter liked her brown leather jacket which he said made her breasts perk up. On an occasion when they both had sore backs, Patient A testified Dr. Porter said “we would look funny making love together with the two of us with our sore backs.” The medical chart confirms that Patient A reported a MVA in May 2011, which accords with her memory of back pain. Patient A testified that Dr. Porter made comments to her about making love on more than one occasion but probably less than ten times. Dr. Porter testified that he had no romantic feelings towards Patient A and denied making these statements.

Patient A testified that she took his photograph because she was going to her trailer for a few days. Patient A testified that they agreed to look at the moon at 9:00 p.m. every night and think of each other. Dr. Porter denies saying this to Patient A. Dr. Porter agreed that

the video clip appeared to show Patient A taking his picture. Otherwise, Dr. Porter testified he had no recall of this event.

Patient A testified that Dr. Porter told her that he had a two-year plan in which he would leave his wife and that he and Patient A would be together after his son graduated from school. Dr. Porter denied speaking to Patient A about making future plans of a life together.

Patient A testified that she and Dr. Porter hugged on a number of occasions and always hugged at the end of each session. Patient A described the hugs as frequent during 2011. She testified the first hug probably occurred about a year and a half after starting to see him, at a time when she was dwelling on her relative's death. Dr. Porter testified that supportive hugs began about a third or half of the way into her treatment. She admitted in cross examination that that she could not recall the dates specifically.

Patient A testified the hugs usually took place over by the window because Dr. Porter had told her this was out of camera range. She testified that he initiated the hugs, which were short at first and then a little longer. Her hands were around his neck and his hands were around her back. She testified his hands moved along her back. She testified at first they would end their hugs when she said, "I have to go," and that later, they would each say, "I love you." Selected screen shots from video clips demonstrate the nature of the hugs and accord with her description, although there is no audio.

Dr. Porter testified that the hugs were meant as supportive gestures and in some cases were celebratory. Dr. Porter testified that he did not think the hugs were a psychiatric technique and agreed, in retrospect, it was not an appropriate thing to be doing. He was surprised that there were 14 hugs on the video clips. He testified that he would not hug a patient again after looking at all the distress that it has caused. Dr. Porter testified that he considered hugs on a limited basis under appropriate circumstances to be an acceptable boundary crossing, but not to be a boundary violation.

Dr. Porter testified that he knew that part of the office was not captured by the video camera, but that he never made the connection that "here's an area where—that isn't

covered by the video." He agreed that there were times when Patient A was out of camera range. Dr. Porter further agreed that, on reviewing the video of January 2011, Patient A went off the screen and he hugged her, even though this was not fully visible on video. Dr. Porter also agreed that, on reviewing the March 2011 video, Patient A was in an area of his office that was not captured on video and that there may have been a hug on that occasion.

Dr. Porter agreed that there were 14 documented hugs on video clips, the majority of which were clustered in late 2010 and 2011. He agreed that there may have been more hugs. Further, when questioned about the eight missing video tapes in the relevant time frame, he agreed there could have been as many as twenty hugs in total. Dr. Porter testified that some of the hugs were supportive or congratulatory, but others he could not explain.

Dr. Porter agreed that he had told Dr. Y, his psychiatric supervisor, that there were two Christmas hugs, but that he had been a passive participant and that Patient A had initiated the hugs. Dr. Porter also agreed that, in his response to the complaint, he had told the College that there were only a handful of occasions when hugs did occur.

Dr. Porter agreed during testimony that he was not a passive participant in the hugs. When presented with video of October 2010, he agreed that he had rubbed Patient A's back with his hand and that Patient A did not initiate the hug.

Dr. Porter testified that he talked to Patient A about the hugs perhaps on five occasions, but he did not record in Patient A's chart that he had done so. He testified that Patient A felt safe being hugged.

Patient A testified that Dr. Porter held her hand on two occasions when he was walking her down the hallway. This occurred when she was the last patient of the day or if the secretary was not there and he would have to get the next patient. Dr. Porter denied doing so.

Patient A testified that Dr. Porter kissed her three times. She testified that she was not sure of the date of the first kiss, but remembers he was wearing a green sweater she liked

and they were in his office by the window. It started with a hug and then he just started kissing her. She described the kiss as very tender, caring and passionate and very nice. It ended with them saying, “I love you.” She testified that it made her feel great. Dr. Porter denied ever kissing Patient A. Patient A testified that he telephoned her that night embarrassed that he may have had bad breath. Dr. Porter denied making a telephone call to Patient A.

Patient A testified that at her next session he apologized for the kiss, to which she responded that she did not mind. At some point in 2011, after the first kiss, Patient A testified that Dr. Porter told her he was stepping over the lines with her. She knew it was wrong. He agreed that he told Patient A that he had crossed a boundary with her, or words to that effect.

Dr. Porter agreed that maintaining professional boundaries was important and that there were risks to crossing boundaries which could lead to sexual abuse or become a boundary violation. Dr. Porter testified that violations have to do with putting physician’s needs first. He also agreed that harming or exploiting patients was a violation.

Patient A testified the second kiss occurred when she sat on his lap on his office chair and they were looking at pictures of his family on social media. Dr. Porter denied that she ever sat on his lap or that he kissed her. He also testified that he never looked at his children’s Facebook page with Patient A.

Patient A testified that they looked at the computer together on two occasions and she was uncertain which time the kiss occurred. A video clip of April 2011 illustrates what she interprets as her sitting on his lap and kissing. She identifies the jacket she was wearing that day as the one he liked to watch her put on. This video clip shows a reflected image in the glass of a picture on the wall which appears to show her head moving from a standing position to a lower or sitting position. Another video clip of October 2011 demonstrates both Patient A and Dr. Porter looking at images on the computer; she testified that she was showing him her social media page.

She testified that on the occasion of their last kiss, when they were about to walk out, he told her to wait a minute and that he wanted to show her something in the secretary's office. He unlocked the door, took her in, and then held and kissed her. Patient A described the kiss as on the lips and very passionate. She thought this was near the end of the summer of 2011. Dr. Porter, after seeing the video clip of July 2011, while he denied ever kissing Patient A, agreed that he and Patient A were in the secretary's office for longer than it would take to sign in, and that neither Ms. G nor Ms. F were in the office at that moment.

Patient A testified that she saw Dr. Porter on two occasions outside the office: The first was when she left a smiley face note on his windshield and he just happened to come out of the office at that time. They briefly talked. The second occasion took place in 2012 when Dr. Porter came to Patient A's coffee shop after she had called to cancel her appointments. They spoke briefly, and she went back to see him once in the office again. Dr. Porter did not dispute either of these meetings. As to the latter, he testified he went to the coffee shop while she was at work to talk to her because he thought she was in crisis.

Patient A testified that Dr. Porter told her that he wanted to visit her at her apartment but that she said it was not an option, since had an easily-recognizable license plate. She testified that she stopped believing him at a certain point because some things just did not make sense: he would miss appointments because of sickness; he went to the U.S. with his family; and he encouraged her to go out and date other men.

She testified there was a lot going on in her life at that time: Her friends who knew about her relationship with Dr. Porter were encouraging her to stop seeing him; Dr. Porter was in and out of hospital; and the weight of knowing that their secret relationship was wrong but that it was a big secret she had promised to keep. She testified that Dr. Porter told her he was under a lot of stress because he had to go to trial to testify as a witness. Dr. Porter told her that he was seeing a therapist because of his stress. She testified that she just wanted to stop it all. Dr. Porter testified that he never told Patient A that he was in therapy.

Patient A testified that, during the course of their relationship, she gave him donuts and an owl picture she had made. In December 2010, she gave him two Christmas decorations "so he would remember me always." Patient A and Dr. Porter never communicated by mail, internet, Facebook, or other social media. Dr. Porter confirms the testimony about the gifts and that there were no emails.

In the summer of 2011, Patient A put on weight because Mr. H, a man she had started dating, made her eat a lot. Around the beginning of 2012, Dr. Porter weighed her, as he did on occasion. She had gained weight, and since this was an issue that upset her, Dr. Porter covered up the numbers on the scale. She testified that he then asked her to look at him. He subsequently uncovered the numbers on the scale, which she saw. This upset her because she felt she had gained too much weight and she felt that Dr. Porter had tricked her.

Dr. Porter testified that it was clear to him that she had put on weight and that he thought the numbers were good news. He thought she said she wanted to know the numbers, which is why he told her what they were. He agreed she was upset that he showed her and that he had misinterpreted her message believing she wanted to know.

Patient A told Mr. H about Dr. Porter after a month of dating. Mr. H was very concerned and angry, and he told her not to go there anymore. She testified that she liked both Mr. H and Dr. Porter. She testified that she felt like a hypocrite, but Dr. Porter could not see her outside the office and Mr. H could do things with her.

Patient A testified that she started dating a man named Mr. I in early 2011. They started out as friends and would talk about their respective marriage troubles. She testified that on one occasion, Mr. I forced himself on her and sexually assaulted her in her apartment. She testified that she did not want to see Mr. I after that. Patient A testified that she told Dr. Porter. This episode is noted in her medical record.

Patient A testified that she was also seeing a church counselor named Ms. J for help with her relationship issues with her daughter and husband. Patient A told Ms. J about her relationship with Dr. Porter in September 2011 and Ms. J advised her to stop seeing him.

She could not recall when this counselling started, but she remembered that it ended in May or June 2012. Dr. Porter noted in Patient A's medical record that she had been seeing a church counsellor.

Patient A testified that she received a long letter from her husband in December 2011 apologizing for his failures as a husband and father and asking her to come back to him. She described the letter as heartfelt.

In February 2012, Patient A invited her husband to her apartment and told him about her relationship with Dr. Porter, as well as about her relationships with Mr. I and Mr. H. Patient A testified that, upon hearing this, her husband said nothing for a while, and then said, "I love you no matter what. You are my wife and I still want you back."

Patient A moved back to the matrimonial home in March 2012. She recalled that she refrained from mentioning this to Dr. Porter because she had feelings for him and did not want to hurt him. Patient A testified that although she talked about going back to her husband with Dr. Porter a number of times, she was unsure whether she told him when she decided to do so. She and her husband had planned to live separately in the same house as they did not know what the future would hold. Patient A testified that she got the idea to live separately in the same house from Dr. Porter's description of his own living arrangements with his wife. Dr. Porter denied sharing such information with Patient A.

Patient A testified that Dr. Porter disclosed personal information to her over the course of their relationship. She said he told her that he had two grown boys and one younger son living at home. He said that the two older boys were from his first marriage and that his wife had left him to raise his sons on his own. Patient A testified that Dr. Porter told her about his childhood and his separation from his parents. She testified that he told her that he had been athletic growing up, and that coaches and others had mentored him in high school and university. Dr. Porter agreed that he had given Patient A some information about his childhood, high school and college years, and that she would have had no other way of knowing this information.

She also testified that Dr. Porter told her about his various health issues, including that he was suffering from back pain and that he was being treated for anxiety. Patient A testified she knew he was anxious for several reasons, including because of their relationship, his health issues, and his involvement in a court case in early 2012. She thought he was having some financial difficulties because he mentioned to her that he had to pay tens of thousands of dollars in taxes. Dr. Porter told her that his was an open marriage and that he and his wife were living separate lives. Patient A testified that learning all of this personal information made her feel like she was a part of Dr. Porter's life. She felt that he was "far from her class" because she was merely a coffee shop employee. She would ask herself why someone like Dr. Porter would ever like her.

Dr. Porter agreed that he probably explained to Patient A that he had back pain and that was why he had missed some of their appointments. He agreed that he was seeing a psychiatrist for post-traumatic stress disorder and depression. He then clarified that while Patient A was a patient, he was under the care of a psychologist as opposed to a psychiatrist. Dr. Porter testified that he never told Patient A anything about his treatment for anxiety. He agreed, however, that if she knew he was on anti-anxiety medication, she would have to have known about it from him. Dr. Porter testified that he was not involved in more than one court case while Patient A was his patient. He agreed, however, that he was involved in two Human Rights Commission cases. He denied telling Patient A about the human rights cases. He testified he did not tell her about his tax problems or about his living arrangements with his wife.

Patient A testified that Dr. Porter shared information with her about his youngest son, KB. He told her that KB was his adopted grandchild. She testified that Dr. Porter told her that KB's mother had been unfit and had signed over the rights to raise KB to Dr. and Ms. G. Patient A testified that she learned this information when she was discussing her own son's learning disability with Dr. Porter. He told her that KB had a learning disability as well, and the two discussed common strategies. Patient A testified that her husband had taught KB music in grade nine and that Dr. Porter told her he had met with her husband at a parent-teacher interview. She testified that she discussed neither the parent-teacher interview nor the fact that KB had a learning problem with her husband.

Dr. Porter confirmed the facts of KB's birth circumstances as outlined above. He testified that he did not believe that he gave that information to Patient A. He believed that he may have said something about it in a patient-teacher interview with Mr. E before Patient A became his patient. He agreed, however, that KB was not close to Mr. E, and that the reports in KB's student file did not particularize his birth circumstances.

Patient A testified that Dr. Porter shared information with her about Patient B and specifically his diagnosis of bipolar disorder. While Patient A did not socialize with Patient B's parents, she did know them. Patient B's father and Mr. E both taught at the local school and were prayer partners. They had been neighbors at one point about ten years prior. Patient A testified that sometimes Patient B's appointments with Dr. Porter were scheduled after Patient A's. On one occasion, upon seeing Patient B when she came out of the office, Patient A said, "Oh, hi, Patient B." She then felt embarrassed and walked away. Dr. Porter testified that he never discussed this patient by name with Patient A. Patient A testified that her husband never told her that Patient B had any mental health problems. The office sign in sheet demonstrates that in April 2011 and May 2011, Patient B had an appointment with Dr. Porter scheduled right after Patient A's.

Patient A testified that Dr. Porter told her about another patient, Patient C, who had a young child and an abusive husband. Patient A testified that Dr. Porter never identified Patient C by name. However, Patient A testified that Patient C had an appointment with Dr. Porter preceding Patient A. Patient A testified she never spoke to Patient C nor knew her name. She was not aware of any public information which may have been available regarding the circumstances of Patient C because Patient A does not read the newspaper. She did not know about a court decision involving Patient C. Dr. Porter testified that he spoke to Patient A generally about Patient C's circumstances, including having an abusive husband. He denied identifying her to Patient A as "the patient before you." He testified that he did not know how Patient A knew that he was referring to Patient C unless she just surmised it.

Dr. Porter testified that he has attended Dr. Y for monitoring and supervision of his practice since 2003. He takes charts to the meetings, reviews patient cases and raises any

concerns or particular problems. His office monitor reported to Dr. Y, and Dr. Y reported to the College. Dr. Porter testified that, on one occasion, Patient A struck him as dressing in a young, flashy and sexualized way. He thought this was interesting or unusual, given that his wife was present that day in his office. He noted in the chart his intention to discuss this with Dr. Y, but agreed that he did not end up doing so. He testified that when Patient A cancelled appointments and he felt she was withdrawing from therapy, he reviewed her case with Dr. Y.

May 2012 and After

Patient A testified that she called her family doctor, Dr. Z, to ask whether she could prescribe the medication that Dr. Porter provided to her so she could stop seeing him. Patient A told Dr. Z about her relationship with Dr. Porter. Patient A testified that Dr. Z instructed her to write the letter to Dr. Porter (the May 2012 letter) to inform him she would no longer be his patient. Dr. Z asked for permission to write to the College of Physicians and Surgeons of Ontario, but Patient A testified that she did not want the College to be contacted and that she wanted to drop the issue. Dr. Z then looked up Dr. Porter's name on the computer and informed Patient A that Dr. Porter had twice appeared before the Discipline Committee regarding two couples he had befriended. Patient A then agreed that the College could be contacted.

After leaving Dr. Z's office, Patient A testified she told her friend Ms. M about what occurred. Ms. M found a news clipping dated May 12, 2012, which she gave to Patient A. Other than looking Dr. Porter up on Google, Patient A did not seek out more information about what he did in the past. Patient A testified that the information she found on Google was a small paragraph indicating he had been reprimanded and that this referred to the financial matter referred to in the news clipping. Otherwise, Patient A had no information about any other complaint made against Dr. Porter in the past. Patient A denied being pressured by her husband to make a complaint to the College.

Patient A was questioned about an interview with Ms. L, an investigator with the College, which took place in Patient A's city in Ontario in June 2012. Patient A also agreed that she had told Ms. L in that interview that she was always Dr. Porter's last patient of the day. She testified at the hearing that she had been mistaken in her remarks to Ms. L and that she was Dr. Porter's last patient most of the time. Her appointments took place late in the day due to her work schedule.

Patient A agreed she had indicated to Ms. L that Dr. Porter hugged her at every appointment, but that this was incorrect. She testified that she was recounting the period around 2011, and was not referring to their entire patient relationship which commenced in 2008. Patient A agreed that she had told Ms. L that Dr. Porter kissed her five or six times. She testified that there were three kisses that she recalled and that she had been "guesstimating" in what she said to Ms. L.

Mr. E

Mr. E testified that he is married to Patient A and father to five children. He was separated from his wife for two years but testified that he always kept in touch with her. He is a music teacher at the local school which he said is a major commitment that includes evening tutorials, on-duty attendance, and bus driving. Mr. E testified that the sharing of student health or psychological information would almost certainly result in his dismissal. He said that shared only generic student information with his wife.

Mr. E testified that he could not recall meeting Dr. Porter or Ms. G at the school. He said he may have met them at a parent-teacher interview. He also agreed that he may have taught KB, but could not specifically recall. He does not remember reading a psychological report on KB or any other student. He would never have discussed such information with his wife. On one occasion, he may have driven KB, Dr. Porter and Ms. G with the student team to the airport when they were attending a conference.

Mr. E testified that he knew Patient B's father through the school. They were prayer partners who would talk about life and the challenges of raising children.

Mr. E testified that he knew nothing confidential about Patient B's health problems and was not aware of any mental health illness. Mr. E was not aware that Patient B was seeing Dr. Porter.

Mr. E testified that he did not blame Dr. Porter for his separation from his wife. He wrote a letter to Patient A in December 2011 acknowledging his faults as a husband and father. Mr. E testified that Patient A told him about her relationship with Dr. Porter along with two other relationships (Mr. H, Mr. I) before she moved back in. Mr. E testified that he was disappointed and surprised. In his own mind, he thought Dr. Porter's behaviour was unprofessional.

Mr. E testified it took a long time for his wife to decide to make a complaint regarding Dr. Porter. He testified that he stayed out of it, but agreed that he would have encouraged her to report Dr. Porter to his professional body. He testified that it was her decision to report him.

Mr. E testified that he knew Mr. I from coaching at school and wanted to report him. He did not as Patient A did not want him to do so.

The Committee accepted the evidence of Mr. E as credible and reliable. He was fulsome in his responses when giving his testimony. His evidence was consistent with that of Patient A and the medical record. The Committee accepted that an overwhelming proportion of his life was spent in school at the expense of family and home life, and that he was overbearing and controlling with others. The Committee accepted that Mr. E sought little detail from Patient A regarding her relationship with other men as he did not want to know.

Ms. L

Ms. L, the College investigator assigned to this matter, testified that following receipt of the mandatory report and letter of complaint, she met with Patient A. She asked Patient A if she had accessed the College website and Patient A denied doing so.

Ms. L testified that she notified Dr. Porter of Patient A's complaint by letter dated July 5, 2012. She attended at Dr. Porter's office on September 26, 2012, unannounced, to obtain materials (medical charts and other documents). Ms. L spoke with Dr. Porter's secretary, Ms. F; collected records, appointment books, and sign-in sheets; and took photographs of the office. She observed a web camera on top of books on a filing cabinet in Dr. Porter's office.

Ms. L spoke with Ms. F to learn how Dr. Porter's video system worked. Ms. F would start the video recordings each day. A VHS system was used at one time, but, in recent years, videos were streamed onto Ms. F's computer. Ms. F would then save several days' worth of recordings onto discs. Dr. Porter stored these discs at his home.

Ms. L testified that she did not know whether the video recording could be stopped from Dr. Porter's office. Ms. L did not observe a remote control in his office. She drove to his home, where he produced patient charts and the videos for her. She testified that a number of the videos were missing and that some, but not all, were produced later. Dates of missing or corrupted videos included February 2010; May 2010; January 2011; January 2011; February 2011; March 2011; April 2011; and April 2011.

Ms. L helped to prepare the video clips submitted as evidence in the hearing. She was particularly interested in those parts of the videos showing physical touching; when Patient A and Dr. Porter went off screen; when they went into the secretary's office together; and when Dr. Porter unlocked the secretary's door.

Ms. L testified that she viewed Patient A's sessions but not those of other patients. The VHS tapes were of such poor quality that they were not useful.

The Committee accepted the evidence of Ms. L as credible and reliable in keeping with her regular business practices. Ms. L is a seasoned investigator and explained her evidence clearly.

Ms. F

Ms. F testified that she has been a medical receptionist for Dr. Porter since October 2006. She testified that she works full time in the office. During the time Patient A was a patient, Ms. F mostly worked 8 a.m. to 3 p.m. from Monday to Friday. Ms. G would then replace her at 3 p.m., as well as on holidays and on weekends. Ms. G was not in the office every day. Ms. F testified that she would sometimes do typing for one of the other doctors at 3 p.m. after finishing with Dr. Porter.

Ms. F testified her duties included typing, faxing, maintaining patient charts, and other office management tasks. Dr. Porter dictates his notes and she types them.

She testified there was a video system in place when she first came to the office. She believed this was set up by the first practice monitor. At that time, the camera was on the ledge in Dr. Porter's office. There were problems with the VHS tapes, so Ms. F suggested a digital system, which would feed the videos directly to her computer. The webcam was on top of the books on a cabinet in Dr. Porter's office.

She testified that her work computer is the computer which receives the video feeds. She explained that in order to see what is happening in Dr. Porter's office, the computer program has to stay open. She said that Dr. Porter would have no way of knowing whether she was watching the video feed, which cannot be viewed from Dr. Porter's office computer.

Ms. F testified that she would not view the videos from appointments late in the day; they would just be burned to a DVD. Ms. F testified that she could minimize the program on her computer while it was running so that the images were not visible. She testified further that it was not part of her job to watch the video.

Ms. F testified that she had keys to the office, as did Ms. G, Dr. Porter, cleaning staff, and building management. When she left the office, the door was always locked, even if she was still in the building.

Ms. F testified that when Ms. O became Dr. Porter's monitor, Ms. O would get the videos and charts for review. Ms. O would review the videos by skimming through them and select a sample of the charts to review.

Ms. F testified that patients read the "Treatment Frame" document on their own. She testified that she asks the patients whether they have any questions and then they sign. She testified that she had no recollection of Patient A signing the "Treatment Frame" document.

The Committee accepted the evidence of Ms. F as credible and as accurately representing her function in Dr. Porter's office. She answered directly and in an unbiased manner. Her responses regarding the video system in particular were clear and consistent with the evidence of others. She freely admitted that she did not know what happened when she was not present and verified that there was not constant real-time monitoring of the videos.

Ms. G

Ms. G testified that she is married to Dr. Porter. They have three children from Dr. Porter's first marriage. KB is the youngest. She described KB as having a possible

learning disability; he had psychological testing done in grade seven as well as in high school. These reports were in his student file.

Ms. G testified that she would fill in at the office when Ms. F was not there. She would often come at 2:30 or 3 p.m. to speak with Ms. F before she left.

After calling a patient in, she testified she would sometimes print off the next day's appointments or make reminder calls. She stayed in Ms. F's office. She would check that the video system was running. She testified that Dr. Porter could not tell if she was watching the video or not in real time. Ms. G testified that she would periodically check the video by maximizing every few minutes. She would minimize if she was working on the computer. At the end of the day, she would tidy up and make sure the video was off. She testified that she would then pick KB up from school. At home, she would label the DVD's and put them in bankers' boxes for storage.

Ms. G agreed that if Patient A signed the sign-in form in Dr. Porter's office that neither she nor Ms. F would have been there. If Dr. Porter were seen unlocking the secretary's door, she testified that she would not be in the office but that she could still have been in the building.

Ms. G testified that she did not observe any videos of Dr. Porter and Patient A hugging while working in Dr. Porter's office. She did see the videos showing hugs later. She never saw Dr. Porter hug any other patients, but she did not review videos other than those referred to in this matter.

Ms. G testified she met Mr. E once at a parent-teacher interview when KB was at the local school when he was in either grade 6 or 7. This was before Patient A became Dr. Porter's patient. Ms. G also testified that Mr. E was the bus driver for an extracurricular team and that he had once driven them to the airport.

Ms. G testified that she and Dr. Porter do not live in separate quarters, and that she does not have a boyfriend.

The Committee found Ms. G to be a credible witness. Her evidence regarding office routine was clear and consistent with the evidence of other witnesses. With respect to her evidence regarding her personal relationship with Dr. Porter and their living arrangements, the Committee found that this evidence is not relevant as it matters not what the arrangements were but rather what Dr. Porter may have told Patient A.

DECISION AND REASONS

LAW AND LEGAL PRINCIPLES

The burden of proof in this matter rests with the College to prove the allegations on a balance of probabilities. The allegations against Dr. Porter must be proven on evidence which is clear, cogent and convincing.

Sexual Abuse

Sexual abuse of patients by a health professional is prohibited by the RHPA. Section 51(1) of the Code provides in part:

> 51. (1) A panel shall find that a member has committed an act of professional misconduct if,
>
> …..
>
> (b.1) the member has sexually abused a patient

Section 1(3) of the Code defines "sexual abuse" as:

> (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
>
> (b) touching, of a sexual nature, of the patient by the member, or
>
> (c) Behaviour or remarks of a sexual nature by the member towards the patient.

Section 1(4) of the Code states for the purposes of subsection (3):

> "Sexual nature" does not include touching, behavior or remarks of a clinical nature appropriate to the service provided.

The Committee also considered the Supreme Court of Canada decision of *R v. Chase,* [1987] 2 S.C.R. 293 which describes the test to be applied in determining whether the sexual integrity of the victim is violated as an objective one:

> *"Viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer". The part of the body touched, the nature of the contact, the situation in which it occurred, the words and gestures accompanying the act, and all other circumstances surrounding the conduct………Implicit in this view of sexual assault is the notion that the offense is one requiring a general intent only."*

Credibility Assessment

The Committee recognizes the importance of a credibility assessment in cases of alleged sexual abuse where conduct is carried out in private. The Committee understands it may accept all of what a witness said, some of it, or reject it entirely. Further, the Committee notes that in assessing credibility of a witness, consistency and inconsistency are both important. Where inconsistencies are of a minor or inconsequential nature, they do not generally affect the credibility of a witness. When inconsistencies are material, they must be properly assessed along with all other relevant factors in deciding whether to accept the witness' testimony**.**

Overview of the Issues

1. Did Dr. Porter engage in sexual abuse of Patient A:

(i) By hugging her, kissing her, having her sit on his lap or holding her hand? or

(ii) By making inappropriate remarks of a sexual nature?

2. Did Dr. Porter engage in conduct in respect of Patient A which would be considered by members of the profession as disgraceful, dishonourable or unprofessional?

ANALYSIS AND FINDINGS

Allegation of Sexual Abuse

The Committee found that Dr. Porter engaged in sexual abuse of Patient A as alleged in the Notice of Hearing.

The Committee sets out its reasons for decision in three sections:

I. Credibility of Patient A and of Dr. Porter;
II. Specific circumstances of the alleged abuse; and
III. Plausibility of events occurring as alleged.

I. Credibility Assessment of Patient A and Dr. Porter

Patient A

Patient A gave her evidence in a direct and simple manner. When she did not understand the question posed, she said so. She did not attempt to deflect questions and was forthright when she did not know the answer. She explained any hesitation in responding to questions was because she wanted to be sure to get it right. She was plain-spoken and unsophisticated.

She was also nervous and emotional; she was easily provoked to tears when touching on sensitive issues e.g. flirtatious comments, the developing relationship, her admission of

liking his attention. The Committee is of the view that this was appropriate, given the substance of her testimony.

She discussed her personal difficulties honestly and openly, even when this was not flattering. She admitted her husband uses a lot of big words, and that she does not always understand what he is talking about. She also admitted to having a learning difficulty, not socializing outside the home, and making bad choices when she was living alone. She spoke to the Committee of sensitive details related to her marriage and her family, including details about her children. This information accords with the medical record.

The Committee accepts Patient A's vulnerability as illustrated in her marked lack of self-esteem. This is best illustrated by her comments regarding Dr. Porter "he is far from my class……… Why would he ever like me?...... I was just a person who worked at a coffee shop, you know." She admitted she liked Dr. Porter's attention, and that it made her feel special.

Her memory of events she experienced in the past is, in the Committee's view, remarkably consistent with the medical record, the videos, and with the evidence of others.

Examples include:

- Her memory was accurate for office procedures which is confirmed by the evidence of Ms. F and Ms. G;
- Her discussion with Dr. Porter about her trip to a city in the U.S. (February 2009), a MVA (May 2011), telling Dr. Porter about Mr. I/Mr. H are all confirmed by the medical record;
- Taking Dr. Porter's photograph is confirmed in the video clip of June 2011;
- That Dr. Porter's son would graduate in two years was confirmed by Dr. Porter;
- Details of hugging, looking at the computer in Dr. Porter's office, and entering the secretary's office with him are confirmed on the video clips; and
- Coincident appointments with Patients B and C are confirmed by office records.

All of these demonstrate that whatever her shortcomings, Patient A had a good memory for events that occurred during the Material Time.

Patient A was consistent in describing her relationship with Dr. Porter. She described how and when it changed. She described the comments made by Dr. Porter which in her view "broke the ice." She spoke of the nature of the friendship she perceived that she had with Dr. Porter and illustrated this with examples of the information they shared. The casual nature of their sessions is seen on video clips with Dr. Porter eating a donut, having his feet up on the table, and Patient A curled up on a chair.

Patient A's description of the nature of the hugs she experienced are consistent with the videos presented in evidence. The gifts she gave him are also reflected. While kisses, hand-holding and lap-sitting are not clear in the videos, what is seen in the video clips is not inconsistent with those events happening as she testified. The videos demonstrate that there were times at which Patient A and Dr. Porter were in the secretary's office out of view of the camera together, in the hallway together, and in Dr. Porter's office out of the view of the camera.

Patient A was forthright in explaining the circumstances of how the complaint against Dr. Porter was generated. Patient A was on medication prescribed by Dr. Porter and she called her family doctor to see if she would prescribe the medication as she did not wish to continue with Dr. Porter. This is a reasonable and expected action in the circumstances. It makes sense that Dr. Z would explore why her patient no longer wanted to see Dr. Porter. This sequence of events logically explains the genesis of the complaint and is confirmed by Dr. Z's mandatory report.

If Dr. Z had not been required to make a mandatory report, it is unlikely that the allegations would have come to light. Patient A testified she just wanted to drop the matter because she did not want to end up testifying against Dr. Porter. She demonstrated no wish for revenge and she stands to gain nothing from these proceedings. She indicated

that she was doing her duty by testifying and did not like having to share the very personal details of her life. The Committee accepts this as accurate.

Patient A's testimony regarding her interactions with Mr. I and with Mr. H recount detail which is reflected in her medical record at the relevant time. There was nothing to suggest that Patient A had reviewed her medical record other than seeing excerpts relating to her discussions with counsel in September 2015.

Patient A testified that Dr. Porter told her about the circumstances of KB's adoption. The Committee accepts that Patient A would have no way of knowing these details unless Dr. Porter had disclosed them to her. While Ms. G and Dr. Porter met with Patient A's husband at a parent -teacher interview, Mr. E had no memory of meeting them. These interviews took place before Patient A became Dr. Porter's patient.

The Committee accepts Mr. E's evidence that he would not have discussed details about KB with his wife. While Ms. G and Dr. Porter indicated they recall an interview regarding their son with Mr. E and that there were psychological reports in KB's student file, the reports available at the Material Time do not describe KB's birth circumstances.

Patient A testified that Dr. Porter shared personal information with her which included a description of his youth, parents, health, that he was being seen for anxiety, that he was taking medication, and that he was involved in court proceedings. Patient A would not have known about these details unless Dr. Porter had disclosed them to her, which the Committee accepts he did. This is supported in the medical record to some extent where Dr. Porter records that, "She responds well to examples that are relevant from my life, which fit with the issue at hand. For example having very damaged parents…." Patient A also testified that Dr. Porter had discussed his open marriage and his living arrangements with his wife. Ms. G's testimony does not confirm such arrangements. The Committee, however, accepts that, whether true or not, this has no bearing on what Dr. Porter may have told Patient A. In the Committee's view, Dr. Porter's personal disclosure goes far beyond any purported therapeutic value.

Patient A testified that Dr. Porter told her that he had diagnosed Patient B with bipolar disorder. The Agreed Statement of Facts confirmed that Patient B has such a diagnosis. Patient A described seeing Patient B in the waiting room and making a brief comment to him. The sign-in sheets confirm the sequence of their appointments. The Committee accepts that Patient A would have no way of knowing about Patient B's bipolar diagnosis unless Dr. Porter told her. The Committee also finds that her encounter with Patient B in the waiting room occurred as she testified it did.

Patient A testified that Dr. Porter told her of the circumstances of another patient, Patient C. While Dr. Porter did not identify Patient C by name, her appointment preceded Patient A's. Patient A said she saw Patient C about three times in the office. Patient C was separating from an abusive husband and had a young son. Patient A testified that she did not know anything of Patient C from her husband or elsewhere. Given that Patient A testified she did not read newspapers, even if there had been media coverage of the Patient C affair, it would be unlikely that Patient A would be aware of the details. The Committee accepts that Dr. Porter shared Patient C's circumstances with Patient A in the manner that Patient A described. Published court proceedings in respect of the matter were not available until 2013, well after the Material Time. Given that Patient A did not know Patient C by name, it would be highly unlikely Patient A would have accessed or read this document.

There are three inconsistencies in the evidence of Patient A which the Committee considered: Patient A agreed she told Ms. L during an interview that Dr. Porter had kissed her five or six times at the most. Patient A testified at the hearing that there were three kisses that she recalled. She describes these as "pivotal times." When challenged on this point, she said there were not a lot of kisses. She did not believe that counting them was that important. She testified that she was "guesstimating."

Patient A further agreed that she told Ms. L that she was always the last patient. She clarified this by saying that most of the time she was the last patient. She admitted what

she said to Ms. L was wrong. She started coming for late appointments with Dr. Porter because it fit with her shift at work.

Patient A also agreed that she told Ms. L that Dr. Porter hugged her "every time." She explained that she was not referring to the entire patient relationship, i.e. 2008 to 2012, and was actually talking about 2011. She agreed it was a mistake but she testified that "It felt like every time during the period when it started."

The Committee scrutinized these inconsistencies and found her explanation of each to be reasonable and understandable. In the Committee's view they did not detract from the credibility or reliability of her evidence on the key issues. The Committee found her evidence to be credible and reliable. The Committee rests this decision on the above and in particular notes:

- The consistency of her testimony with the evidence of others, the video clips and the medical record;
- Her memory of events;
- The detailed description of the nature of touching;
- The absence of any apparent motive in bringing forward her complaint; and
- The openness with which she described her personal vulnerabilities and other personal details of her life.

Dr. Porter

The Committee observed Dr. Porter to be soft-spoken and older looking than his 67 years. He dressed conservatively and testified clearly. Dr. Porter's medical record for Patient A was also clear, fulsome, and well-organized.

Dr. Porter admitted that he hugged Patient A as demonstrated on the video clips. He was consistent in his denial that the hugs were sexual, that he had touched Patient A in other circumstances, or that he made remarks to her of a sexual nature. In essence, he denied

everything which was not demonstrated or could not be surmised from the video clips. He testified that the kissing, handholding, lap sitting and remarks of a sexual and intimate nature did not happen.

The Committee is troubled by inconsistencies in Dr. Porter's evidence. These are addressed as follows:

Dr. Porter took significant risks in his sessions with Patient A which would or should have been obvious to him. Dr. Porter was well-versed in professional boundary issues: he had taken the College's course, *Maintaining Professional Boundaries*; he had reviewed relevant literature; and he was aware of the College's position on this subject. His background alone in psychology and psychiatry would have reinforced the need for maintaining boundaries with this particularly vulnerable patient. Yet he hugged Patient A repeatedly in the context of their therapy sessions. The fact that he testified that he discussed hugs and boundary issues with her on perhaps five occasions indicates that he at least recognized the problem. He did not document these discussions in her medical records.

Dr. Porter gave no reasonable response to why he and Patient A moved to an area of his office out of range of the video camera. The Committee found that Dr. Porter's response of "not making a connection" was neither fulsome nor honest. He testified that he was involved in setting up the video camera and the Committee found that he was well aware of what was and was not in camera shot. In the Committee's view, Dr. Porter simply did not want his actions with Patient A to be recorded and he therefore made a conscious effort to ensure they were off camera.

Further, in moving out of the camera's view, Dr. Porter purposely thwarted the protection for patients that the College had ordered. Video clips illustrate Patient A and Dr. Porter in his office and off-screen on a number of occasions (January 2011, March 2011, May 2011, November 2011 and December 2011).

Dr. Porter's actions with Patient A that were captured by the video camera put a lie to the "Treatment Frame" document which he said he developed to set patients' expectations as to his care. This specifies no physical touching. The Committee does not accept his explanation that this was only to apply at first.

The Committee found that Dr. Porter's evidence regarding sharing his personal information with Patient A was not convincing. Patient A would have no other way of knowing the details of his personal health and therapy, along with details of his son, KB. Patient A described what she knew about Dr. Porter's personal life. What Patient A detailed goes far beyond the limited information Dr. Porter testified that he had shared with her. In a similar vein, Patient A knew details of Patient B's mental health, which the Committee found came from Dr. Porter.

Dr. Porter minimized his relationship with Patient A in a number of ways. He reluctantly agreed that there may have been up to twenty hugs. He minimized the nature of the hugs in describing them to Dr. Y as two Christmas hugs where he was a passive participant and that Patient A initiated the hug. He described the hugs as a handful in his response to the College investigation. His statement that he was surprised by the fourteen hugs which were demonstrated on video and that he would not do it again appeared disingenuous given that he walked out of camera shot on purpose. The Committee viewed his actions as dishonest and demonstrating a lack of respect of his professional duty.

Dr. Porter's action in going to Patient A's place of work during her shift after she had cancelled appointments was inappropriate. The Committee did not accept that Dr. Porter believed she was in crisis. Had he believed so, he would likely have documented his concerns. There is no corresponding documentation in her medical record of a crisis or any mention of him attending at her workplace. Clearly, she was well enough to go to work. Dr. Y had given Dr. Porter advice as how to handle similar cancellations in the past and Dr. Porter neglected to follow this advice.

In conclusion, the Committee did not find Dr. Porter's evidence on the issues central to the matters to be credible. For the reasons expressed herein, where his evidence and Patient A's differ, the Committee prefers the evidence of Patient A.

II. Circumstances of the alleged abuse

Hugs

Patient A testified that Dr. Porter first hugged her about a year and a half after started seeing him, when she was dwelling on the death of her relative. She was unable to date this accurately as she does not recall dates well. Patient A prepared notes for the meeting with Ms. L which state that she thought Dr. Porter felt bad for her because her relative had passed away and so he said "Here, let me give you a hug." After that, she said they would hug just before she left.

She testified the hugs were frequent in 2011. At the end of a session she would stand up and move towards the window and he would hug her there. He said he was hugging her in that location because it was out of the camera's view. He initiated the hugs, which were short at first and then a little longer, lasting a minute or so. She described her hands being around his neck and that his arms were around her back. Her hands would move along his shoulders and his full hands moved down her back. She described the hugs as caring.

At first the hugs ended when she said "I have to go" and then later on as the relationship developed, they would each say "I love you."

Patient A was shown a series of video clips where she would walk off the screen which she testified was when they would hug by the window. She testified that he would stand there and open up his arms. (January, March, May, and November 2011).

Dr. Porter agreed that he had hugged Patient A. He testified that the hugs were intended to be supportive and/or celebratory. While this may apply, in some situations it is not consistent with the variation in demeanours demonstrated on the videos. Dr. Porter could not provide an explanation for all the hugs even when questioned with the benefit of the patient's chart.

The Committee reviewed the video clips and observed the following:

- The hugs which were captured on video were initiated by Dr. Porter by standing and holding his arms open, welcoming Patient A to the embrace;
- Dr. Porter would generally stand in an area or move to behind his chair where the video camera was unlikely to fully capture the hug;
- The hug was a full body hug with their torsos in contact, conveying a warm and tender embrace;
- Her arms encircled his neck and on occasion his back;
- His arms were observed on her back extending from below the waist and moved up and down;
- A rocking motion from side to side was also observed;
- All the hugs took place in the privacy of Dr. Porter's office with the door closed in the context of a psychotherapy session;
- On some occasions they were alone and no other staff were present in the office as demonstrated by Dr. Porter unlocking the secretary's door; and
- The hugs demonstrated were frequent during the Material Time. The videos for eight of Patient A's session during this time period were missing. It is therefore possible that there were additional hugs that were not recorded.

It was clear to the Committee that the hugs that were observed went beyond purported therapeutic hugs. The Committee accepted that the hugs were tender and mutually satisfying, reflecting an enjoyable, romantic gesture.

This, in the Committee's view, accords with the meaning of "sexual nature" in the legislation. The Committee disagrees with Dr. Porter's position that expert evidence is

required to make this determination. "Sexual nature" is determined on an objective standard. In *R. v. Chase* [1987] 2 S.C.R. 293 the court stated: "*Viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer.*"

Regardless of what Dr. Porter intended, these hugs conveyed a romantic interest to his patient. The hugs also appear romantic to an objective observer, as discussed above. That he discussed boundary-crossing issues with Patient A demonstrated that he was not blind to this. Similarly, moving to an area not well-seen by video camera suggests that he did not wish his actions to be seen by others. This highly vulnerable, loved-starved patient living apart from her husband was a willing recipient. That it made her feel great at the time is no excuse. Dr. Porter, by touching her as he did, promoted her dependence upon him and enhanced the transference which was operative. Dr. Porter willingly indulged in this behaviour, in the Committee's view, in part to meet his own needs. These hugs were wrong especially in a psychotherapy context and in the Committee's view, constitute sexual abuse. The Committee found that Dr. Porter repeatedly hugged Patient A in a sexualized manner.

Kisses/Handholding/Lap-Sitting

The Committee has no clear video evidence of Patient A and Dr. Porter kissing. Patient A testified that she recalled three occasions when Dr. Porter kissed her. The first time occurred when they were standing by the window in his office, a second time when she was sitting on his lap and another when they were both in the secretary's office together. Dr. Porter denies any kissing took place. Their evidence is irreconcilable.

The Committee, after reviewing all of the evidence, accepts the evidence of Patient A. Its reasons for doing so rest principally on our assessment of their respective credibility. The Committee does note that the video clips, while not conclusive, do allow for a period of time when Dr. Porter and Patient A are seen entering the secretary's office, at a time when neither of Dr. Porter's staff were present in the office. Further, Patient A and Dr.

Porter remained in the secretary's office for longer than it would take Patient A to simply sign in, as Dr. Porter has acknowledged.

The Committee also notes there is no video documentation of handholding. Patient A testified that Dr. Porter held her hand on two occasions when they were walking down the hall on her way out after a session. Dr. Porter denies this. Again, their positions are irreconcilable. The Committee notes there is evidence on the video clips of Dr. Porter following Patient A down the hall which would provide an opportunity for such handholding to occur (November 2011; July 2011). Dr. Porter says that the hallway was a busy area and there were always people around. He further offered that the drug cupboard was just across from his office door, supporting his position that it was a busy area. On a video clip (July 2011) at the beginning of Patient A's session with Dr. Porter, the drug cupboard is open and medical staff are seen in the hallway. At the end of Patient A's sessions both in November 2011 and July 2011, the drug cupboard is shut and no one is seen in the hallway except for Patient A and Dr. Porter. Neither Ms. F nor Ms. G were in the office as Dr. Porter is seen unlocking the secretary's door on both of these video clips.

While the common hallway was busy during regular office hours, the Committee was not convinced that this was always the case at the times that Patient A's appointments ended. While the Committee realises the video clips reflect only short periods of time, they do support that there was the opportunity for Dr. Porter to hold Patient A's hand in the hallway unobserved.

Even if other physicians / staff were working at the time, it does not necessarily follow that Dr. Porter would not risk such behaviour. He engaged in other risky behaviour when he repeatedly hugged Patient A.

Patient A testified that she sat on Dr. Porter's lap on two occasions while they were looking at his computer. A video clip of April 2011 shows a reflected image in the glass of the picture in his office which suggests her head moved from a standing to a sitting position. Patient A is not seen clearly sitting on his lap or kissing him; however, it does

show that they were close together in an area of the office that was not covered by the video camera. Dr. Porter testified that Patient A did not sit on his lap. Dr. Porter's counsel took the position that it would be impossible for her to sit on his lap and operate the computer mouse or keyboard. Patient A was pressed on the position she was in and stated that she sat on his right leg with her legs between his. She testified that they did not use the keyboard very much and she was not thinking about whether he used the mouse of the keyboard at that time. The Committee notes that there are a lot of variables involved, for instance, how far the chair was from the desk, where the keyboard was located, and where the mouse was situated. The Committee did not agree with defence counsel's argument that it would be impossible for Patient A to have been sitting on Dr. Porter's lap and for them to be looking at images on his computer as she describes. The Committee believes Patient A with respect to her account of these incidents.

The video clips demonstrate a very relaxed attitude in the therapy sessions. Dr. Porter is seen eating a donut which Patient A brought him, she is curled up on a chair, and on one occasion Dr. Porter is seen with his foot on the table. Other times, she is very close to him while they look at his computer screen.

The Committee carefully reviewed the evidence available and considered the credibility of both Patient A and Dr. Porter. The Committee found that it is more likely than not that Dr. Porter kissed Patient A, that he held her hand in the hallway of his office, and that she sat on his lap in his office on one or more occasions.

Remarks of a Sexual Nature

Patient A testified that Dr. Porter made sexual comments to her on numerous occasions. These include telling her he loved her; telling her that they would have a future together in two years when his son graduated; complimenting her on her appearance; saying that he would like to hold her hands on an airplane; and telling her that they would look funny

making love together because of their bad backs. Dr. Porter denied that he made any of these remarks.

Patient A also testified that she took Dr. Porter's picture. Dr. Porter testified that he had no recollection of why the photo was taken. She also testified that they decided while she was away at her trailer camp that they would look at the moon at 9 p.m. each night and remember one another. Dr. Porter denies making such remarks.

The Committee again rested its decision on its assessment of their respective credibility. The Committee also notes that the record indicates that Dr. Porter's son was due to graduate in two years, that there was a discussion about her fear of airplanes in the medical record, and that Patient A can be seen in one of the video clips taking Dr. Porter's picture.

After assessing all the evidence, the Committee found that Dr. Porter made sexual remarks to Patient A just as she testified he did.

III. Plausibility

The Committee considered the relationship between Patient A and Dr. Porter in its totality. Patient A began as a needy and vulnerable patient with significant problems, including panic attacks and low self-esteem. The therapeutic relationship produced positive results and it was Dr. Porter "breaking the ice" with familiarizing comments that moved the relationship in an intimate direction. Hugs, which may have been intended at first to be supportive, became more frequent and romanticized during a period of time when she was living alone. The Committee accepts that this led to the kissing, sexualized remarks, and other touching described previously. The relationship ended when Patient A decided that she would return to the matrimonial home. But for the mandatory reporting of sexual abuse which is required, it would likely have ended there.

The sequence of events noted above make sense, particularly where the therapy was being conducted by a doctor who himself was having problems with anxiety and depression.

Counsel for Dr. Porter took the position that Patient A should not be believed. The Committee disagreed. Dr. Porter stated repeatedly in his notes that Patient A exhibited no disorder in the form or content of thoughts or sensorium. On a number of occasions, he noted her insight is good. The Committee agreed, and found that there is nothing to suggest delusions, confabulation, embellishment or exaggeration on the part of Patient A.

The Committee found it implausible that this patient would be capable of confabulating such a detailed and consistent story. That she would set out to ruin the professional reputation of a physician to somehow promote her relationship with her husband makes no sense. She stands to gain nothing. She said she was before the Committee to do her duty. The Committee found that to be the case. The Committee believed her evidence.

The Committee accepted that Patient A and Dr. Porter did not maintain a relationship outside the office. It was clear she understood this, as illustrated by her comment that she did not want him to drive to her apartment as he had identifiable license plates. They did not email or text. This does not, however, detract from her credibility. These were simply the parameters of their relationship.

Regardless of Dr. Porter's intent, the professional relationship was distorted by a sexual element. The sexual element demonstrated in the video clips alone is compelling. The Committee found that Dr. Porter had a very relaxed attitude towards boundaries with Patient A which he crossed and violated. The Committee found that Dr. Porter knew better. His office policy set out there would be no touching and that sessions would be videotaped. He violated his own policies with Patient A. He was well-aware of maintaining appropriate boundaries from his education and experience. He is well-trained in transference and countertransference. There is simply no way that Dr. Porter did not realize what he was doing was wrong or that he could rationalize his conduct.

The video evidence, the testimony of Patient A and Dr. Porter, the Committee's assessment of their respective credibility, and the plausibility of events as set out provides compelling evidence that Dr. Porter engaged in the sexual abuse of his patient.

Allegation of Disgraceful, Dishonourable or Unprofessional Conduct

The Committee found that Dr. Porter has engaged in disgraceful, dishonourable or unprofessional conduct in sexually abusing Patient A as set out above. In addition, the Committee found that Dr. Porter also engaged in such conduct as set out below:

- Dr. Porter disclosed personal information inappropriately to Patient A when he told her details of his health, personal history, marriage and family;
- Dr. Porter disclosed sensitive and personal information inappropriately about his adopted son;
- Dr. Porter disclosed information about the mental health of another patient, Patient B, and the personal details of another patient, Patient C. In both cases this was inappropriate;
- Dr. Porter purposefully acted to undermine the safeguards put in place to protect patients by having Patient A move to an area of his office which could not be captured on video; and
- Dr. Porter failed to preserve all videos, as he was required to do under a prior College order.

For the above reasons, the Committee found that Dr. Porter engaged in conduct which would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee did not make a finding of disgraceful, dishonourable or unprofessional conduct with respect to the gifts given by Patient A to Dr. Porter. These were inconsequential in the circumstances.

Summary of the Findings

The Committee found that Dr. Porter engaged in the sexual abuse of his patient, Patient A, by hugging her; kissing her; holding her hand; having her sit on his lap; and making remarks of a sexual nature.

The Committee found that Dr. Porter engaged in disgraceful, dishonourable or unprofessional conduct by sexually abusing Patient A; disclosing personal and family information; disclosing information about other patients; intentionally acting to conceal his conduct towards Patient A; and failing to preserve all videos as required by the College.

PENALTY AND REASONS FOR PENALTY

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written decision and reasons on finding in this matter on February 11, 2016, and found that Dr. Porter committed acts of professional misconduct in that he engaged in the sexual abuse of a patient and in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

The Committee heard evidence and submissions on penalty and costs on June 29, 2016, and reserved its decision.

EVIDENCE AND SUBMISSIONS ON PENALTY AND COSTS

The Committee received the following in evidence on consent: a document book (exhibit #32) containing a Victim Impact Statement from Patient A, a copy of the decision of the Discipline Committee on a prior matter involving Dr. Porter (released September 20, 2002), and a copy of the decision of the Discipline Committee on another prior matter involving Dr. Porter (released May 9, 2012).

Counsel for the College submitted that revocation was the only appropriate penalty given the findings in this case. In addition to the required reprimand, the College also asked for costs of $36,200.00 which represents the tariff rate (seven days at $4,460.00 and one day at $5,000.00). The College also asked that Dr. Porter reimburse the College for any funds required by Patient A for counseling and that Dr. Porter provide a letter of credit to certify payment in the maximum amount of $16,060.00.

Counsel for Dr. Porter submitted that a six month suspension followed by a condition that he only treat male patients in the future, a reprimand, and additional remedial/educational terms was the appropriate penalty.

In determining the suitable penalty, the Committee considered the findings in its Decision and Reasons for Decision in this matter dated February 11, 2016. In addition, the Committee carefully considered the totality of the evidence, the submissions of counsel, penalty principles, advice of independent legal counsel, and the case law relied upon by the parties.

DECISION ON PENALTY

For the reasons that follow, the Committee finds that revocation of Dr. Porter's certificate of registration is warranted. The Committee orders that his certificate of registration be revoked, that he be reprimanded, that he pay $36,200.00 in costs to the College, and that he provide a letter of credit to cover any costs of counseling required by Patient A in the amount of $16,060.00.

REASONS FOR DECISION ON PENALTY

The principles relevant to the imposition of penalty in disciplinary proceedings are well-established. The protection of the public is the paramount consideration. Other principles include maintenance of public confidence in the reputation and integrity of the profession and in the principle of effective self-governance; general deterrence as it applies to the membership as a whole; specific deterrence as it applies to the member; and the potential for the member's rehabilitation.

The weighing of these principles, in light of the specific facts and circumstances of the case, is the task to be undertaken by the Committee in arriving at an appropriate penalty. Aggravating and mitigating factors, if any, pertaining to the misconduct in question will be considered. Proportionality is also an important element to be considered by the Committee.

The Committee decision is set out as follows:

Nature of the misconduct

The Committee found that Dr. Porter committed professional misconduct in that he sexually abused a patient and engaged in conduct that would reasonably be regarded by the membership as disgraceful, dishonourable, or unprofessional. The specific facts and circumstances are outlined in detail in the Committee's Decision and Reasons for Decision dated February 11, 2016.

Dr. Porter saw Patient A on a number of occasions, treating her with psychodynamic psychotherapy for panic attacks, anxiety, and an eating disorder. The clinical records for Patient A describe an extremely vulnerable patient. During this time, Dr. Porter repeatedly hugged her, kissed her, held her hand, and had her sit on his lap. He shared details of his personal life with her and cultivated a closeness characterized by dependence and trust.

Dr. Porter was a seasoned psychiatrist well-versed in transference and countertransference. He was fully aware of appropriate boundaries which he repeatedly both crossed and violated. Dr. Porter was instigative in activating and promoting this sexualized behavior. He minimized his role and clearly misrepresented the relationship with Patient A to the psychiatrist who was his supervisor.

The Committee is of the view that Dr. Porter's conduct was predatory in nature, serious, and inexcusable.

Victim Impact Statement

The harm done by Dr. Porter's behaviour was most poignantly described in Patient A's impact statement from which the following quotes are taken:

"It's hard to find words to express the confusion, fear, and the shame of my experience… that lead me back to a place of fear, uncertainty, and depression…I put my trust in a professional whose primary motive would and should have been my well-being, with the

betrayal of that trust I find it affecting all of my relationships particularly with men, that is, whenever someone says something complimentary I find myself questioning their motives…In his failure to simply admit his wrongdoing, I have had to put my life on hold…..knowing I would have to endure a hearing and brutal cross-examination where every aspect of my private life was questioned…While this was going on, I was not available for my family, especially my youngest who was suffering from serious issues…I still struggle with the feelings of being so naïve as to let Dr. Porter take advantage of my vulnerability, I am not confident in my decision making…I even now suffer anxiety every time I'm required to use the services of a medical professional, the thoughts that enter my mind and the emotions that arise within me the doubts and hurt become so overwhelming that I am willing to the extreme of missing scheduled appointments."

These statements from Patient A clearly illustrate the harm done to this patient by Dr. Porter's behaviour. They also serve to emphasize the damage to the profession where trust is violated.

Repeated Misconduct

Dr. Porter appeared before the Discipline Committee in 2001and 2002 when, among other things, it was alleged that he had sexually abused patients, had engaged in conduct that was unbecoming a physician, and engaged in disgraceful, dishonourable, or unprofessional conduct. It was also alleged that Dr. Porter was incompetent.

This 2001-2002 matter involved two female patients with serious psychiatric disorders. The Committee in that matter found that Dr. Porter was incompetent, that he engaged in conduct unbecoming a physician, and that he engaged in conduct that was disgraceful, dishonourable, or unprofessional (although it did not find that Dr. Porter had engaged in sexual abuse). In making its determination, the Committee in that case commented that Dr. Porter dismissed the gravity of his discrepancies and showed a lack of insight into his problem.

The Committee in that matter imposed a lengthy suspension, a reprimand, and a number of terms on Dr. Porter's certificate of registration addressing re-education and reassessment. Dr. Porter had already completed a record-keeping and boundary course. The Committee wrote in its penalty reasons for that decision that "there was evidence of significant fundamental deficiencies in his practice and a perceived reluctance to accept the Committee's findings." The Ontario Court of Appeal upheld the finding of incompetence but varied the penalty order (shortening Dr. Porter's suspension and requiring video surveillance of all of his psychiatric sessions which can be monitored by the office staff and preserved for inspection).

Dr. Porter appeared again before the Discipline Committee, this time in 2012. That Committee found that Dr. Porter had engaged in disgraceful, dishonourable, or unprofessional conduct when he asked for significant sums of money from patients, one of whom was male. At the time of the request, Dr. Porter had been subject to a suspension order and said he required financial assistance. The 2012 hearing proceeded by way of an agreed statement of facts and admission. Again, Dr. Porter was suspended, reprimanded, and required to pay costs.

When examining this history overall, the Committee in the present case was shocked by Dr. Porter's repeated exploitation of patients. Whether this was for crossing boundaries with respect of sharing private information or for acquiring money from patients, Dr. Porter repeatedly used his professional position for personal gain. Gender restrictions with such a history offer little comfort.

Furthermore, the Committee was struck with the startling similarity of the 2002 findings (when Dr. Porter communicated aspects of his life, his marriage, his children and their social life, his adolescent problems, his previous marital problems and his history of alcoholism) to the findings made in the present case. Indeed, there appears to be an escalation in the degree of Dr. Porter's misconduct, which includes not only the above

but also disclosure of information about other patients and thwarting the intention of the video system ordered for his office.

Breach of Trust

Dr. Porter betrayed the public trust invested in the medical profession in a number of ways at different levels. He betrayed the trust of the following parties:

- His patient, Patient A, whom Dr. Porter sexually abused, as found by this Committee and described in its reasons;
- The College, when Dr. Porter failed, in spite of repeated suspensions, terms, and re-education, to conduct himself in a professional manner;
- The Court, when Dr. Porter purposely moved out of the range of the video camera which had been ordered to be placed in his office to ensure protection of the public. His explanation for doing so when he hugged and kissed Patient A was nothing short of absurd;
- His psychiatric supervisor, when Dr. Porter portrayed his hugs with Patient A as innocent and at her instigation; and
- The public at large in undermining respect for the medical profession. Dr. Porter's actions insidiously weaken the public's faith in the ability of the profession to self-govern effectively.

Public trust is the very core of the medical profession's commitment to the public. Where such misconduct as described above exists, it is inconsistent with the practice of medicine.

Governability

Notwithstanding the effect of repeated suspensions, terms, conditions or limitations of his certificate of registration and considerable costs, Dr. Porter demonstrated willful ungovernability. His education and subsequent re-education, including a course

addressing boundary issues, had little or no effect in preventing Dr. Porter from repeating his misconduct.
Dr. Porter sought out ways to circumvent measures placed to protect the public. The Committee was left to conclude that he neither respects the need to be governed nor does he wish to be governed. In such circumstances, revocation is the only recourse to adequately achieve protection of the public.

Mitigating and Aggravating Factors

There are no meaningful mitigating factors in this matter.

As noted by the Ontario Court of Appeal (Tab #4 exhibit 32), "A mere absence of remorse cannot be used as an aggravating factor as Dr. Porter was entitled to maintain his innocence. At most, an absence of remorse might disentitle him to leniency in the imposition of a penalty." The Committee viewed Dr. Porter's lack of remorse and insight to disentitle him to leniency, just as the court has stated.

The most obvious aggravating factor is that Dr. Porter has appeared three times before the Discipline Committee. The current findings are the most serious and egregious. The Committee accepts that Dr. Porter has a history of repeated and escalating serious professional misconduct. Such behavior cannot be tolerated or accepted within the practice of medicine.

Case Law

The Committee was presented with a number of cases in which aspects of the misconduct were similar to Dr. Porter's. Most of the cases resolved by way of an agreed statement of fact and admission (or plea of no contest) and an agreed penalty. This is a significant distinction, and the Committee placed little weight on these cases as precedent to be applied in this matter.

In *CPSO v. Peirovy* (2016), the Committee made a finding of sexual abuse and disgraceful, dishonourable or unprofessional conduct based on Dr. Peirovy's examination of a number of patients. The Committee did not revoke his certificate of registration in the face of demonstrated insight, commitment to re-education and demonstrable change. Further, this was the first time Dr. Peirvoy had appeared before the Discipline Committee. The Committee also had before it expert evidence which effectively ruled out psychopathy or sexual deviance. These factors distinguish Dr. Peirovy from Dr. Porter where neither insight nor meaningful change after re-education has been demonstrated.

In *CPSO v. Minnes* (2015), the Committee imposed revocation after finding the member had attempted to sexually assault a vulnerable 17-year-old minor who was not his patient. The circumstances of this case are very different from Dr. Porter's case, but illustrate that revocation in some circumstances can be the only appropriate penalty, even when mandatory revocation is not triggered under the legislation.

In *CPSO v. Smith* (2003), the Committee imposed revocation after finding sexual impropriety, failure to maintain the standard of practice, and disgraceful, dishonourable or unprofessional conduct. While some of the circumstances (such as the psychotherapy setting, other boundary violations and sexual abuse) were consistent with Dr. Porter's case, there were other circumstances that were not (degree of sexual interference and risk of re-offence).

In *CPSO v. Seidman* (2003), the Committee imposed revocation after finding sexual abuse, sexual impropriety and disgraceful, dishonourable or unprofessional conduct. The circumstances of this case, which involved a minor, reflect significant different circumstances to the case of Dr. Porter.

After reviewing all the case law submitted, the Committee was of the view that revocation was clearly within the range of acceptable penalties, in particular when there had been sexual abuse and breach of trust.

Conclusion

The Committee orders that Dr. Porter's certificate of registration be revoked immediately and that Dr. Porter be reprimanded.

COSTS

The Committee finds that this is an appropriate case in which to award costs. Costs are ordered in the amount of $36,200.00.

In addition, the Committee orders Dr. Porter to reimburse the College for psychotherapy required by Patient A relevant to the sexual abuse found in this matter and provide a letter of credit in the amount of $16,060.00, in order to provide funding to Patient A under Section 85.7 of the Code. He shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within thirty (30) days of the date this Order becomes final, in the amount of $16,060.00.

ORDER

The Discipline Committee orders and directs that:

1. The Registrar revoke Dr. Porter's certificate of registration effective immediately;
2. Dr. Porter appear before this panel to be reprimanded and that the fact of the reprimand be recorded on the register;
3. Dr. Porter pay costs to the College in the amount of $36,200.00; and
4. Dr. Porter provide to the College an irrevocable letter of credit in the amount of $16,060.00, or other security acceptable to the College, within thirty (30) days of the date this Order becomes final.