IN THE MATTER OF: "*THE MEDICAL ACT*", C.C.S.M. c.M90;

AND IN THE MATTER OF: Dr. David Warren Corder

RE: DR. DAVID WARREN CORDER
APPLICATION FOR REINSTATEMENT

REASONS FOR RESOLUTION AND ORDER

INTRODUCTION AND BACKGROUND

On September 19, 2014, the Executive Committee of the College of Physicians & Surgeons of Manitoba (the "College") heard oral submissions from counsel for Dr. David Corder (Dr. Corder) and counsel for the Investigation Committee of the College (the Investigation Committee) with respect to Dr. Corder's application to have his license to practice medicine in the province of Manitoba reinstated. The Investigation Committee opposed Dr. Corder's application for reinstatement. The oral submissions of counsel of September 19, 2014, supplemented their written submissions which had been previously exchanged and provided to the Executive Committee.

Dr. Corder's license to practice medicine had been revoked in June, 2010 for reasons which will be described below.

Dr. Corder is a family physician who, prior to the revocation of his license in June 2010, had practiced medicine in rural Manitoba since 1986.

In May 1993, the Registrar of the College wrote to Dr. Corder with respect to indications of a pattern of boundary violations in the early 1990's and

related concerns about poor record keeping. In March 1995, the College request that Dr. Corder participate in a Boundary Training Program, to which Dr. Corder agreed. The Boundary Training Program commenced in June 1996 and concluded in October 1996.

Following Dr. Corder's participation in the Boundary Training Program, he wrote a letter thanking the College, in which he assured the College that the Program had been beneficial to him. However, shortly thereafter (and unknown to the College until much later), Dr. Corder became involved in an exploitive sexual relationship with a patient.

Dr. Corder's license to practice medicine in Manitoba was revoked in June 2010 as a result of very serious professional misconduct on his part, as set forth in two separate Amended Notices of Inquiry (dated September 28, 2009 and May 17, 2010), involving two different female patients, who will be referred to hereafter as patient X and patient Y. Patient X was the patient with respect to whom Dr. Corder had engaged in an exploitive sexual relationship shortly after completing the Boundary Training Program referred to above.

Dr. Corder entered pleas of guilty to the charges set forth in both Amended Notices of Inquiry, thereby acknowledging that the facts as alleged in the Notices of Inquiry were true and that those facts constituted either professional misconduct and/or breaches of the By-laws of the College, and/or the Code of Conduct of the College, and/or a Statement of the College.

The charges as set forth in the Amended Notice of Inquiry dated September 28, 2009 can be summarized as follows:

1. Dr. Corder violated his professional and ethical obligations to patient X by failing to maintain proper physicians/patient boundaries and/or exploiting the patient for his personal advantage in circumstances where he knew or ought to have known that she was a vulnerable patient thereby breaching Article 2 of the Code of Conduct and/or committing acts of professional misconduct;

2. Dr. Corder failed to create and maintain adequate clinical records in breach of record keeping requirements of By-Law #1 of the College in effect at the material time;

3. Dr. Corder failed to maintain an adequate plan to manage and appropriately prescribe Benzodiazepines to a patient and thereby displayed a lack of knowledge or lack of skill or judgment in the practice of medicine.

The charges as set forth in the Amended Notice of Inquiry dated May 17, 2010 can be summarized as follows:

1. Dr. Corder violated his ethical obligations to patient Y by failing to maintain proper patient/physician boundaries and/or exploiting the patient for his personal advantage and thereby breached Article 2 of the Code of Conduct, and/or committing acts of professional misconduct;

2. Dr. Corder failed to create and maintain adequate clinical records in breach of the record keeping requirements of By-Law #1 of the College and/or statement 805 of the College and inappropriately prescribing Fiorinal and/or Benzodiazepines to a patient and

thereby displayed a lack of knowledge or lack of skill and judgment in the practice of medicine.

In order to illustrate the seriousness of the above noted charges, it is useful to set forth in these Reasons, the Summary and Conclusion, of the Inquiry Panel which heard and determined the charges, with respect to Dr. Corder's relationship to patient X.

> "The Panel notes that there is significant overlap with respect to the evidence supporting all three charges (referring to the charges outlined in the Amended Notice of Inquiry dated September 28, 2009). Dr. Corder's lack of knowledge, skill and judgment in dealing with Ms. X's Benzodiazepine dependency contributed to her vulnerability. His inappropriate prescribing and charting undermined the efforts of other physicians who were attempting to assist her with her dependency problems. Instead of assisting Ms. X, Dr. Corder's conduct made her more vulnerable. Looking at all three charges, Dr. Corder was operating outside of acceptable standards for a lengthy period of time. He crossed a boundary in spite of having recently completed a Boundary Training Program. He lived on the other side of that boundary for approximately five years. There is no explanation for Dr. Corder's Conduct and he offers us none."

As a result of Dr. Corder's admission of guilt to the charges set forth in both Amended Notices of Inquiry, and the acknowledgement by Dr. Corder of the gravity and seriousness of those charges, the Inquiry Panel accepted the joint recommendation of counsel for the College and counsel for Dr. Corder that Dr. Corder's registration and license to practice medicine in Manitoba be revoked and that he pay to the College costs in the amount of $20,000.00 in accordance with mutually agreed upon terms of payment. The Inquiry Panel also ordered that there would be publication, including Dr. Corder's name.

Dr. Corder is now seeking reinstatement of his license to practice medicine. Approximately four and a half years have elapsed since Dr. Corder's license to practice medicine was revoked. Dr. Corder requests that his license be reinstated subject to three conditions, namely, that he not conduct house calls, that he only examine female patients in the presence of a female attendant and that he continue in a program of psychotherapy.

PRINCIPLES APPLICABLE TO REINSTATEMENT APPLICATIONS

The Medical Act provides the statutory authority for reinstatement applications. Section 59.13 of *The Medical Act* states:

> **"Reinstatement**
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> 59.13 The executives committee may, on application by a person whose registration or license has been cancelled, direct the registrar to reinstate the person's name in the register, subject to any conditions that the executives committee may prescribe, and may order the person to pay any costs arising from the imposition of such conditions."

The Medical Act is silent as to the test or tests to be applied by the Executive Committee when considering reinstatement applications.

However counsel for Dr. Corder, and counsel for the Investigation Committee both referred to a recent Manitoba Court of Queen's Bench decision namely *Sowemimo vs. the College of Physicians and Surgeons of Manitoba (2014) MBQB 4*, which sets forth the various principles that have been developed by the common law that should be considered and applied in reinstatement cases. The *Sowemimo* decision referred to *Re Gillen [2010] O.C.P.S.D. No.14 (QL)* which set forth two broad considerations as being

particularly significant in applications for reinstatement. Those considerations are:

1. What is the risk of further misconduct and, if there is a risk, is it manageable with terms, conditions and limitations?

2. Is the applicant suitable to practice both in terms of protection of the public and the confidence of the public in the professions ability to regulate itself?

The *Sowemimo* decision specifically stated that the Executive Committee of the College in that case, had properly articulated and considered the applicable principles and relevant factors for reinstatement. Those principles were that:

- The discretion to be exercised by an Executive Committee must be exercised judiciously and in good faith, meaning that the Executive Committee's discretion must be guided by rules and principles of law, and cannot be exercised in a manner which is arbitrary or biased, or motivated by ill will towards the applicant, or based on information not properly presented to the Committee;

- The purpose of the reinstatement application is to determine whether the present circumstances of the applicant (as opposed to the circumstances which prevailed when the applicant's license was cancelled) warrant reinstatement;

- The applicant bears the onus of persuading the Committee that the applicant's medical license should be reinstated;

- Public safety and patient wellbeing are critical factors which the Executive Committee must consider as part of its assessment of the reinstatement application. When addressing the issues of public safety and patient wellbeing, the following questions are relevant:

  i. Has the applicant been rehabilitated?

  ii. What, if anything, can be done to ensure that the applicant's medical knowledge, skill and judgment are at the level required to currently practice medicine at an acceptable level?

  iii. Has the applicant demonstrated the necessary insight into the factors which caused or contributed to the initial problems and to ensure that he or she will be able to practice safely and ethically if returned to practice?

- The passage of time is not sufficient in and of itself to justify reinstatement;

- In cases which involve multiple factors, such as dishonesty and competency, the applicant must introduce evidence which is sufficient to satisfy the Executive Committee that the risk of repetition of any of the multiple behaviours which caused the initial cancellation of the license is low;

- Before considering the types of conditions which should be imposed to protect the public interest and to minimize the risk of

future problems, the Committee must first be satisfied that the applicant is fit to return to the practice of medicine.

THE MEDICAL EVIDENCE

In order to provide the Executive Committee with evidence as to his current circumstances, and the progress of his rehabilitation, and to demonstrate that he is currently capable of practicing medicine safely, Dr. Corder submitted various psychological and medical reports and assessments. Four of those reports are of particular significance to the Executive Committee. Two of those four reports were from Dr. C, an experienced and respected psychiatrist practicing in Ontario. Dr. Cs' reports were dated September 8, 2010 (prepared with the assistance of Dr. B) and December 20, 2012. The other two reports were from Dr. G, an experienced and respected psychiatrist practicing in the United States dated September 13, 2011 (prepared with the assistance of two other physicians) and November 19, 2013, (prepared with the assistance of one of the physicians who also assisted in the 2011 assessment.

There was a general consistency between the four reports with respect to the causes of Dr. Corder's misconduct. The diagnoses reached by Drs. C and B in 2010 and Dr. C in 2012 were similar to that reached by the experts from the United States in 2011.

There were also some similarities, but also a very important difference in the reports and opinions of Dr. C and Dr. G with respect to Dr. Corder's fitness to practice of medicine. The initial opinions of Dr. C and Dr. G were the same with respect to Dr. Corder's fitness and readiness to practice medicine. In Dr. C's report of September 8, 2010, after noting that Dr. Corder had gained some insight into his failure to maintain appropriate boundaries, Dr. C stated that Dr. Corder was not ready to return to the practice of medicine. Dr.

C recommended that Dr. Corder be re-evaluated following another year of regular psychotherapy with his treating psychiatrist and following the completion of another intensive boundary training course. Similarly, the opinion of Dr. G's assessment team, as expressed in their September 13, 2011 report, was that Dr. Corder should not resume medical practice because he had only an intellectual understanding regarding boundaries, at best, and that he also had internal dynamics that would place him at risk for crossing boundaries. Dr. G also recommended, as had Dr. C, that Dr. Corder continue to engage in regular psychotherapy.

However, there is a difference of opinion between Dr. C and Dr. G in their most recent reports. In Dr. C's report dated December 20, 2012, he made note of Dr. Corder's treating psychiatrist's belief that Dr. Corder has "turned the corner" and has made real progress. Dr. C, after commenting upon a number of positive developments, opined that Dr. Corder had made genuine gains and had accepted full responsibility for the sexual abuse of female patients and was committed to and engaged in meaningful therapy with his psychiatrist. Accordingly, Dr. C recommended that Dr. Corder be authorized to return to practice, but with conditions, namely that:

1. He not make house calls;
2. He only examine female patients in the presence of a female nurse or other female clinician;
3. He continue in psychotherapy with his psychiatrist.

In contrast, in Dr. G's report of November 19, 2013, he noted that Dr. Corder was making some progress in his psychotherapy with his psychiatrist, but opined that there was still a considerable way for Dr. Corder to go. Dr. G concluded that Dr. Corder needs more therapy and a greater

internalization of doctor/patient boundaries. Dr. G and his team also concluded that Dr. Corder was not safe to return to practice at that time (November, 2013).

ANALYSIS

Apart from issues relating to Dr. Corder's past misconduct, the College must be satisfied that Dr. Corder's medical skills and knowledge are adequate to enable him to practice medicine competently and safely. Dr. Corder has not practiced medicine for approximately 4 1/2 years and has not practiced family medicine since 2007.

Dr. Corder submitted materials demonstrating that he has taken several continuing education courses to maintain or enhance his medical knowledge and to address deficiencies in his treatment of patients. The Executive Committee is unable to adequately assess his competency based on the materials filed as part of his reinstatement application. However, it does not think it is necessary to comment further on the adequacy of Dr. Corder's medical skills and knowledge, because it recognizes that given the length of time that Dr. Corder has not practised medicine, he will be obliged to comply with the requirements outlined in Statement 500, entitled "Retraining of Inactive Physicians", before being able to resume the practice of medicine. Those requirements include undergoing an appropriate assessment and complying with the retraining requirements resulting from that assessment.

In terms of analyzing the manner in which the principles relevant to a Reinstatement Application ought to be applied in the circumstances of this case, a useful starting point is to consider both the nature and seriousness of the charges which resulted in Dr. Corder's registration and license to practice medicine being revoked in 2010.

The conduct referred to in the Amended Notices of Inquiry was undoubtedly very serious, involving both egregious ethical transgressions and competency issues indicative of a lack of knowledge, or a lack of skill or judgment in the practice of medicine. Counsel for Dr. Corder correctly submits that the Executive Committee should not extend the period in which Dr. Corder is unable to practice medicine as additional punishment for his earlier misconduct. However, the Executive Committee considering the nature and seriousness of the charges which resulted in the revocation of his registration and license, does not constitute additional punishment for the earlier misconduct. Rather, it is an exercise which is necessary in order for the Executive Committee to understand what is required by way of rehabilitation, and for the College to assess the risk of further misconduct.

It is also important to emphasize that Dr. Corder bears the onus of establishing that his registration and licence should be reinstated. He must persuade the Executive Committee that he has gained the necessary insight into the factors which caused his problematic behaviour, that he has been substantially rehabilitated and that the risk of further misconduct on his part is low.

On the basis of the medical evidence introduced as part of the reinstatement application process, Dr. Corder faces a challenge with respect to meeting the onus of establishing that he has been rehabilitated and that the risk of further misconduct on his part is low. The challenge he faces arises from the fact that much of the medical evidence, including the most recent report from Dr. G’s facility dated November 19, 2013, indicates that during the time periods addressed by the reports, the authors of the reports did not think it was safe for Dr. Corder to return to the practice of medicine.

Counsel for Dr. Corder, in her able submission on his behalf, attempted to overcome the effect of the report from the physicians from Dr. G's facility of November 19, 2013 by advancing several arguments, including that:

1. The Executive Committee of the College owes no deference to the position of the Investigation Committee, opposing Dr. Corder's application for reinstatement;

2. The Executive Committee must assess the totality of the information which has been provided to it, and the report of the physicians from Dr. G's facility is only one piece of that information and should not be given disproportionate weight;

3. The C Report of December 20, 2012 concludes that Dr. Corder is ready to resume the practice of medicine with certain conditions and the C Report must be given appropriate consideration;

4. The physicians from Dr. G's facility applied the wrong "test" in terms of assessing Dr. Corder's readiness to return to the practice of medicine and effectively is holding Dr. Corder to a "standard of perfection".

The Executive Committee agrees with the first three arguments of Dr. Corder's counsel as outlined above. Although the Executive Committee respects the work and position of the Investigation Committee, the Executive Committee owes no deference to the position of the Investigation Committee.

The Executive Committee also recognizes its responsibility to assess the totality of the information presented to it including Dr. C's Report of December 20, 2012. The Executive Committee regards both Dr. G and Dr. C

as very knowledgeable and well-qualified psychiatrists. Both of them have provided two reports with respect to their assessments of Dr. Corder with input from certain of their colleagues. The Committee has reviewed and carefully considered the contents of all four of those reports.

With respect to the issue of Dr. G applying the “wrong test”, counsel for Dr. Corder submitted that Dr. G has confused or misapprehended the concept of “fitness to practice” with the concept of “no risk to the public”.

Counsel for Dr. Corder pointed to a sentence in the report dated November 19, 2013, referring to the internalization of doctor/patient boundaries, which stated: “This knowledge needs to be “in his bones”, i.e. in procedural memory, not just on paper”. Counsel for Dr. Corder suggested that Dr. G was in effect saying that Dr. Corder must be “unconsciously competent”, and that such a standard is excessively high.

Counsel for Dr. Corder asserts that the correct standard is that the College must be satisfied that Dr. Corder is “fit to practice” in the sense that he has undergone sufficient treatment and therapy to understand what caused his misconduct in the first place, that he has progressed to the point of making changes in his life and altering his behaviour to avoid problematic situations in the future, and that he is willing to accept restrictions and limitations which will further minimize the risk of harm to the public. Dr. C has opined that Dr. Corder has reached that point in his rehabilitation, and had done so by December, 2012.

Although the arguments of Dr. Corder’s counsel relating to Dr. G applying the “wrong test” were compelling and persuasively presented, the Executive Committee does not accept them. Dr. G did not say that Dr. Corder must be “unconsciously competent”. Being unconsciously competent is

arguably the hallmark of a seasoned expert and would represent an excessively high standard for reinstatement. Dr. G's comments about "procedural memory" were made in the context of difficulties which Dr. Corder encountered in various role-playing exercises. On the basis of those exercises, and other observations and data, Dr. G and his team concluded that Dr. Corder has trouble both "mentalizing the experience of others" and internalizing the principles he has learned about things such as boundary issues in "real time" as he is confronting a clinical situation.

As a result, Dr. G and his team stated:

> "…In other words, he has trouble converting the theory he has learned into clinical responses in the here-and-now. Hence, he is still vulnerable to using faulty judgment in a clinical encounter.
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> Because we must think about patient safety and assessing his readiness to practice, we cannot conclude that he is safe to return to practice at this time. Obviously, the definitive determination of that capacity is under the purview of the College, but at the present time, we think he needs more therapy and a greater internalization of doctor-patient boundaries…".

The Executive Committee has concluded that Dr. G was not applying an excessively high standard, but was rather identifying legitimate risk factors based on the thorough assessment that had been conducted.

Having concluded that the assessments by Dr. G and his colleagues are part, but only part of the information which should be considered in relation to Dr. Corder's reinstatement application, and that Dr. G and his team did not apply the wrong test in reaching its conclusions, a few comparative

comments are warranted with respect to the most recent reports and opinions of Dr. C and Dr. G.

The medical reports authored by Dr. C and Dr. G and their colleagues were very helpful in identifying the nature of the problems which have been encountered by Dr. Corder and the progress which he has made toward overcoming those problems.

As between the most recent report of Dr. C (December 20, 2012) and the most recent report of Dr. G (November 19, 2013), the report of Dr. G is the more recent of the two, and it also sets forth its analysis and conclusions in significantly greater detail.

Dr. C's report, and his recommendation that Dr. Corder be permitted to return to practice is reliant to a significant degree on the progress Dr. Corder has achieved in his therapy with his psychiatrist. However, Dr. Corder's psychiatrist has specifically declined to express an opinion on Dr. Corder's fitness to practice. Dr. C also places emphasis on the importance of Dr. Corder continuing in psychotherapy with his psychiatrist, but it is not clear from his report whether Dr. Corder regularly sees his psychiatrist when Dr. Corder is in Manitoba. It is apparent that Dr. Corder spends significant time in another province but does not participate in therapy when he is in that province. In addition, Dr. C's report of December 20, 2012 refers to Dr. Corder having "some trouble understanding" why his plan of having a "former nurse who is a friend" attend when he examines female patients, would not be appropriate.

In short, there are reasons why the Executive Committee has reservations about the opinion expressed by Dr. C in the December, 2012 report.

However, nor is the Executive Committee able to unreservedly accept Dr. G's November 19, 2013 report. Initially, the Executive Committee was concerned that correspondence originating from the College, which Dr. G reviewed before conducting his second assessment of Dr. Corder, may have influenced that assessment. The correspondence from the College was not sent to Dr. G by the College. The correspondence consisted of letters from counsel to the Investigation Committee of the College to counsel for Dr. Corder. Those letters were sent to Dr. G by counsel for Dr. Corder. Therefore, it is clear that the College was not attempting to influence Dr. G's opinion in any way. In fact, the College was not involved in that assessment at all. It was undertaken solely at the initiative of Dr. Corder.

Nonetheless, it is clear from the letters in question and from Dr. G's report of November, 2013, that it was unusual in Dr. G's experience for the College not to be involved in such an assessment and that he (Dr. G) was curious about the College's position relating to Dr. Corder's decision to "reapply for licensure".

The Executive Committee is not in a position to know whether Dr. G's review of the College's letters, and his knowledge that the Chair of the College's Investigation Committee was not prepared to recommend that Dr. Corder reapply for licensure, influenced his assessment in any way. The Executive Committee accepts that Dr. G is well qualified to perform the assessments and to make the recommendations which he did with respect to Dr. Corder. His report dated November 19, 2013 was described as a "Multi-disciplinary Evaluation" and consisted of several interviews conducted by Dr. G and other colleagues and psychological testing administered by a neuropsychologist. The Evaluation was thorough and the conclusions and

recommendations contained in the November 19, 2013 flowed logically from the data which was collected and the analysis of that data.

Accordingly, the Executive Committee recognizes that the November 19, 2013 report from the Dr. G's facility is a useful and important part of the entire body of evidence and information which it must consider, notwithstanding its concerns relating to a potential lack of objectivity on the part of Dr. G with respect to the issue of Dr. Corder's fitness to practice medicine.

In the result, after considering all of the evidence submitted in relation to Dr. Corder's reinstatement application, including all of the medical reports (particularly Dr. C's Report dated December 20, 2012 and the report from the Dr. G's facility of November 19, 2013) and after reviewing the contents of those two Reports and assessing those contents in light of the respective criticisms of the reports made by opposing counsel, the Executive Committee has concluded that Dr. Corder has failed to satisfy the onus of establishing that his license to practice medicine should be reinstated. Given the diagnoses and the descriptions of Dr. Corder's psychological functioning, and the explanations for his past misconduct outlined in the medical reports, the Executive Committee has concluded that although Dr. Corder has made significant progress in his rehabilitation, there is still an unacceptable risk that in certain circumstances Dr. Corder may fail to meet appropriate professional standards. The Executive Committee agrees with the report that Dr. Corder is "still vulnerable to using faulty judgment in a clinical encounter"

As noted by Chief Justice Joyal in *Sowemimo, supra:* "Public safety must always be a primary concern for the Executive Committee in reinstatement applications". In circumstances in which the preponderance of the evidence establishes that there is an unacceptable risk that patient safety

and well-being may be compromised, the Executive Committee must proceed in a way which protects the public interest and fosters patient safety.

Furthermore, in this case, the Executive Committee directed its attention to whether the conditions proposed by Dr. Corder, or any set of more rigorous conditions (such as an absolute prohibition against Dr. Corder seeing female patients), would adequately protect the public interest.

The Executive Committee recognizes that in certain circumstances, it is appropriate that a physician be allowed to practice medicine subject to certain conditions. Such arrangements can work when a physician's fundamental ability to practice medicine safely has been established, and the applicable conditions are designed to prevent circumstances from occurring which would increase the risk of problematic behaviour on the part of the physician. For example, conditions on a physician's right to practice may be effective in circumstances in which a physician is taking positive and constructive steps to deal with an addiction.

However, the Executive Committee agrees with the submission of counsel on behalf of the Investigation Committee that the Executive Committee cannot reinstate an individual whose fitness to practice medicine has not been established, in the hope that it can prevent the effect of the unfitness from damaging the public by the imposition of carefully crafted safeguards.

The Executive Committee has concluded that Dr. Corder has not fulfilled the onus of establishing that he is currently able to practice medicine safely. In such circumstances, it would be inappropriate for the Executive Committee to impose conditions as a way of attempting to protect the public

from his deficiencies. Such an approach has the potential of undermining the confidence of the public in the medical profession's ability to regulate itself.

To summarize, the Executive Committee, which is mindful of its responsibilities to protect the public, has decided on the basis of its review of all of the evidence available to it, that there remains an unacceptable risk of further misconduct or a breach of professional standards by Dr. Corder, and that the risk which exists is not properly manageable through placing terms and conditions on Dr. Corder's license.

Therefore, Dr. Corder's application for reinstatement to the Medical Register and for the reinstatement of his license to practice medicine in the Province of Manitoba, is denied.

DATED this 12th day of December, 2014.