

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Roche this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name or any information that could disclose the identity of the patient referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

Every person who contravenes an order made under ... section 45... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Roche,  
2017 ONCPSD 13**

**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. SUSAN LOUISE ROCHE**

**PANEL MEMBERS:**

**DR. JOHN WATTS (Chair)  
MS DEBBIE GIAMPIETRI  
DR. JAMES WATTERS  
MR. SUDERSHEN BERI  
DR. CAROLE CLAPPERTON**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:**

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**MR. DAVID ROSENBAUM**

**PUBLICATION BAN**

<b>Hearing Date:</b>	<b>March 13, 2017</b>
<b>Decision Date:</b>	<b>March 13, 2017</b>
<b>Release of Written Reasons:</b>	<b>March 28, 2017</b>

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on March 13, 2017. At the conclusion of the hearing, the Committee released a written Order stating its finding that the member committed an act of professional misconduct and is incompetent. The Order set out the Committee’s penalty and costs order with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Susan Louise Roche committed an act of professional misconduct:

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

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

### **RESPONSE TO THE ALLEGATIONS**

Dr. Roche entered a plea of no contest to the allegations in the Notice of Hearing.

### **THE FACTS**

The following facts were set out in a Statement of Facts and Plea of No Contest which was filed as an exhibit and presented to the Committee:

**PART I: FACTS**

1. Dr. Susan Louise Roche (“Dr. Roche”) is a 68 year-old psychiatrist who received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on June 28, 1989.
2. At the relevant time, Dr. Roche practiced in Ottawa, Ontario.

**A. Disgraceful, Dishonourable and Unprofessional Conduct re Patient A**

3. Patient A, a retired registered nurse, was Dr. Roche’s patient for over 20 years. Dr. Roche treated her for clinical depression. She attended weekly for individual therapy as well as weekly for group therapy.
4. In or around the summer of 2014, in the course of their private therapy, Dr. Roche asked Patient A if she would be interested in moving to British Columbia with her and being her tenant in a home she planned to buy there. All subsequent planning discussions took place during individual planning sessions.
5. A couple months later, in the fall of 2014, Dr. Roche hired Patient A in her professional capacity as a registered nurse to care for her during her recovery from abdominal surgery. Dr. Roche offered to pay Patient A \$500 for nursing care for a one week period as well as gas money for travel to and from the Hospital and to post-operative appointments.
6. Patient A stayed in Dr. Roche’s home following her surgery, to care for Dr. Roche for seven days, in late 2014.
7. While caring for in her home, Dr. Roche was agitated and difficult. She shouted at Patient A and used foul language. She told Patient A that she was dissatisfied with her services.
8. Patient A attended on January 2015 at Dr. Roche’s office for their next scheduled therapy session. At that appointment, Dr. Roche became upset with her and told her she had changed her mind about moving to B.C. In addition, Dr. Roche complained about her nursing services and stated that she decided not to pay her any more money for the services she provided. Patient A attended a subsequent appointment in February 2015 in which Dr. Roche continued to be verbally aggressive.

9. Patient A did not book a further appointment for individual therapy.
10. Following the February 2015 (last) appointment, Dr. Roche left Patient A a voicemail advising her not to attend group therapy until she attended further individual therapy. Patient A learned later that Dr. Roche had advised the group that Patient A was absent because she had “regressed” and there was a parking issue. Patient A did not give Dr. Roche consent to discuss her departure from group therapy with the others.
11. Patient A terminated the doctor-patient relationship by sending Dr. Roche a registered letter of termination. Dr. Roche refused to accept delivery, and did not transfer her patient files until at least seven weeks after receiving a signed consent.

**B. Disgraceful, Dishonourable and Unprofessional Conduct in respect of Other Patients**

12. Dr. Roche requested other patients to do errands for her. Specifically, she asked a patient to retrieve her eye medication, and another patient frequently picked up groceries for her.

**C. Dr. Roche Failed to Maintain the Standard of Practice of the Profession and is Incompetent**

13. The College retained Dr. Gregory Chandler, MDCM, FRCPC, Psychiatry, Associate Professor, Faculty of Medicine, University of Toronto to provide an opinion with respect to Dr. Roche’s care and treatment of Patient A. A copy of Dr. Chandler’s report dated January 18, 2016 and his addendum dated March 8, 2016, are attached as Exhibits “A” and “B” [to the Statement of Facts and Plea of No Contest] respectively.

14. Dr. Chandler provided the following opinion:

... However, in our training as psychiatrists, we are taught that non-clinical relationships, including but not limited to romantic ones, would never be acceptable if a psychiatrist patient relationship has ever existed; this includes when there has been only one meeting or after the clinical relationship is terminated.

... This context also makes psychiatrists more at risk for taking advantage of a patient’s vulnerabilities, even if done unintentionally. Furthermore, patients

will usually be seeing therapists because they feel psychologically vulnerable. When this is the case, it can feel especially important for patients to ensure good relationships with their therapists.

... In hiring a patient she had worked with extensively, Dr. Roche did not meet the standard of practice as a physician. In not considering the aforementioned ways this could have affect the psychotherapeutic relationship, it also demonstrated a lack of skill and judgment as a therapist. The risks of the employment relationship should have been easily foreseeable to Dr. Roche. In this case, it caused harm to the patient in that it led to the termination of what had been a 20 year long therapeutic relationship.

... Dr. Roche stated that there “is no pressure” for Patient A to accept her offer to be her nurse. As an experienced therapist, the expected standard would be for Dr. Roche to recognize that there is an inherent pressure which cannot be eliminated by attempting to convince the patient otherwise.

... .... the offer of tenancy would be below the standard. If it had ultimately been entered into, the risk of harm would be the same as what the employment situation led to, namely tension in the relationship and an ultimate severing.

... Asking patients to perform errands for her would be taking advantage of a therapist patient relationship for personal gain and would be considered unprofessional and below the standard of care. If somehow [Dr. Roche] did not consider these [patient performing errands] as transgressions, then at best she would be showing poor judgment for not recognizing them as such.

15. Dr. Chandler also opined:

- It is uncommon for a therapist to provide both individual psychotherapy and group psychotherapy for the same patient, though it does occur. In this scenario, there is a requirement for confidentiality around the material discussed during the patient’s individual therapy. Sharing information about co-patients during individual sessions and sharing information about one patient during a group session would constitute

breaches of confidentiality contrary to the CPSO policy. As such, Dr. Roche falls below the standard of care.

- Dr. Roche was inappropriately billing for family therapy instead of individual or group therapy. There is a financial advantage to coding therapy sessions as family therapy.
- Dr. Roche's documentation failed to maintain the standard of practice of the profession. There is little mention of the particular symptoms of major depressive disorder for which the patient was receiving treatment. It was difficult to ascertain the patient's clinical status of any given time which is essential. There was no suicide risk assessment.

16. Ultimately, Dr. Chandler concluded that the most notable demonstrations of falling below the standard of care related to the lack of boundaries between Dr. Roche and certain patients. Dr. Roche's response to his report only exacerbated his concern regarding her lack of clinical judgment.
17. The College also retained the opinion of Dr. Brian MacDonald, M.D., FRCPC, a psychiatrist in private practice in Kingston, Ontario. A copy of his opinion dated December 6, 2016 is attached as Exhibit C [to the Statement of Facts and Plea of No Contest.]
18. Like Dr. Chandler, Dr. MacDonald opined that Dr. Roche did not meet the standard of practice and showed a lack of knowledge skill and judgment with respect to observing appropriate boundaries with her patient:

...Dr. Roche violated the ethical boundaries of her doctor/patient relationship in hiring [Patient A] to be her private duty nurse at home...she used the patient to meet her own personal needs. ... Dr. Roche changed from the neutral and compassionate psychiatrist to the critical angry patient with [Patient A]. This caused great injury to [Patient A] in that she lost her long term therapy which she claimed had been a great help to her, shattered her trust in Dr. Roche and left her with a sense of abandonment and injury. In such circumstances, she regressed and slipped back into depression. These were serious consequences of the boundary violation by Dr. Roche.

19. Dr. Macdonald also found she breached the standard of care by billing her individual sessions with Patient A as family sessions, at a higher rate than she was entitled.

## **PART II: PLEA OF NO CONTEST**

Dr. Roche pleads no contest to the facts set out in paragraphs 1-20 above, and pleads no contest to the allegations that:

1. Dr. Roche failed to maintain the standard of practice of the profession, contrary to under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”)
2. Dr. Roche is incompetent in her care and treatment of Patient A
3. Dr. Roche 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, contrary to paragraph 1(1)33 of O. Reg. 856/93 by:
  - a. failing to maintain appropriate boundaries with Patient A including by her conduct employing Patient A as her personal nurse, discussing with Patient “A” moving to another province and offering Patient “A” tenancy;
  - b. requiring Patient A and others to do errands for her;
  - c. sharing private and confidential information pertaining to Patient A with others in group therapy without her consent;
  - d. failing to transmit clinical information in a timely way following termination of care; and,
  - e. in her inappropriate OHIP billing practices regarding Patient A.



## **FINDING**

Rule 3.02 of the Discipline Committee's Rules of Procedure regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
- (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
- (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

The Committee accepted as correct all of the facts set out in the Statement of Facts and Plea of No Contest. Having regard to these facts, the Committee found that Dr. Roche committed an act of professional misconduct in that she has failed to maintain the standard of practice of the profession, and she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Discipline Committee also found Dr. Roche to be incompetent under subsection 52(1) of the Code, in that her care of Patient A displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that she is unfit to continue to practise or that her practice should be restricted.

## **PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The proposed order called for a reprimand and payment of costs by Dr. Roche. Dr. Roche signed an Undertaking, Acknowledgment and Consent ("Undertaking") on February 17, 2017, in which she resigned from the College effective March 10<sup>th</sup>, 2017 and agreed not to apply or re-apply for registration as a physician in the province of Ontario or any

other jurisdiction after that date. She consented to the Undertaking being posted on the Public Register along with a summary that stated that she had resigned and undertaken not to apply or re-apply, in the face of the allegations of professional misconduct and incompetence that had been referred to the Committee.

The Committee understands that joint submissions on penalty should be accepted unless the proposed penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

There are a number of principles that guide proposed penalties, and the most important of these is protection of the public. As a result of Dr. Roche having signed the Undertaking in which she resigned and agreed never to practise in Ontario or anywhere else, the public will be protected from any further misconduct by her. Had Dr. Roche not resigned, the Committee would have considered revocation of her certificate of registration to be part of an appropriate penalty.

The actions engaged in by Dr. Roche bring into disrepute the reputation of the profession as a whole and erode the public's trust in the profession and its ability to regulate itself. Dr. Roche's resignation and agreement not to re-apply will serve to convey to the public and the profession that a physician who engages in such misconduct will not be permitted to remain a member of the profession. The reprimand expresses and underscores the obligation of every physician to ensure that boundaries with patients are maintained. The penalty as a whole expresses the profession's abhorrence of Dr. Roche's self-serving, selfish, disgraceful and unprofessional behaviour.

The principle of rehabilitation in this case is not relevant given Dr. Roche's resignation and undertaking never to practise again.

## **Analysis**

### **The nature of the misconduct**

The nature and extent of Dr. Roche's professional misconduct are set out in detail in the Statement of Facts and Plea of No Contest. As an experienced, seasoned psychiatrist, Dr. Roche should have had an understanding of the special relationship she had as a therapist dealing with her patient's most psychologically sensitive feelings. The aggravating factors related to Dr. Roche's misconduct are outlined in comments below.

### **Boundary violations**

The majority of allegations involve a long-term (20 year) psychiatric patient of Dr. Roche. This patient had a major depression and dissociative identity disorder, which are very serious disorders.

Dr. Roche conducted discussions with this patient about a move to British Columbia, with the patient potentially being a tenant in the physician's future home. These conversations occurred during times when Dr. Roche was providing therapy. Discussions of this type with a patient are boundary violations that interfere with the therapeutic process. That they occurred during therapy sessions further exacerbates the transgression.

Dr. Roche engaged the same patient to act as a paid nurse after Dr. Roche's major surgery. The patient lived at her house 24 hours a day for seven days. It was entirely inappropriate and self-serving for Dr. Roche to employ the patient in this way.

Dr. Roche aggravated the boundary violations during her post-surgery convalescent period when she was verbally aggressive towards the patient and swore at her. This verbal aggression continued at the patient's next appointment with Dr. Roche.

In addition, Dr. Roche failed to pay the patient the agreed-upon sum for her services, and remunerated her only in part. Dr. Roche violated the patient's confidentiality when she disclosed information about the patient in group therapy.

The effect of this behaviour was a relapse in the patient's psychiatric disorder.

Dr. Roche's violations of boundaries were serious, long-standing and multiple. They involved a patient who Dr. Roche knew, or ought to have known, was particularly vulnerable. Dr. Roche's actions and subsequent abandonment of the patient destroyed the trust of a twenty-year doctor-patient relationship and caused explicit harm to the patient.

The Committee concurs with the analysis by Dr. MacDonald, who spoke of the great injury to the patient, whose trust was shattered, and who was left with a sense of abandonment and injury. Dr. Roche showed a lack of knowledge, skill and judgment in not observing boundaries with the patient. Dr. Roche's statement (recorded in Dr. Chandler's report), that the patient was under "no pressure" to act as her nurse, reveals her lack of comprehension of the dynamics in a therapeutic relationship, and her incompetence.

### **Boundary violations with other patients**

Dr. Roche also arranged for other patients to provide services for her, such as running errands, and picking up medications and groceries. She also shared medical information about other patients during individual sessions. Dr. Roche used her patients for her own ends and she should have known better. As one of the experts, Dr. Chandler, pointed out, patients seeing psychiatrists usually feel psychologically vulnerable and it is especially important that patients have good relationships with their therapist. Dr. Roche took advantage of the therapist-patient relationship for personal gain, which is not only unprofessional, but also fails to maintain the standard of practice of the profession in the Committee's view.

**Failure to provide records**

Dr. Roche refused to accept a registered letter, in which the patient terminated the doctor-patient relationship. Dr. Roche also failed to provide her records in a timely way to the patient's family physician when the patient terminated the doctor-patient relationship. This was unprofessional.

**Documentation deficiencies**

Besides the above serious boundary violations and failure to provide records, Dr. Roche did not document the symptoms of the patient's major depressive illness, nor did she document suicidal ideation. These deficiencies are serious for the record of a psychiatric patient and constitute a failure to maintain the standard of practice.

**Inappropriate OHIP billing**

Dr. Roche billed for family therapy when she saw Patient A, which resulted in a higher payment that was not warranted for a single patient.

**Summary of Aggravating Factors**

Dr. Roche's misconduct spanned several areas: from a lack of respect for doctor-patient boundaries to verbal and financial abuse, inappropriate OHIP billing, deficient documentation and failure to provide clinical records in a timely way. The majority of these examples of misconduct stemmed from Dr. Roche using Patient A and other patients for her own selfish needs. Dr. Roche seemed to give little thought to the devastation that her actions caused Patient A in particular.

**Mitigating factors**

Dr. Roche has no prior discipline history with the College. By pleading no contest, she spared Patient A, and other patients, the stress of having to testify at a hearing, and she expedited the process of the College dealing with the professional misconduct.

## Case Law

The Committee considered three previous cases, with the understanding that each case must be decided on its own facts and no two cases are alike.

In *Re Laing* (2013), Dr. Laing was a general practitioner who practised psychotherapy exclusively. His case was similar to this one in that he failed to document his therapy and to record progress notes and in some files, he did not even record an address or birth date. His care was substandard in that he did not always diagnose his patients, and he failed to record appropriate histories, mental status examinations and treatment plans. He also failed to formulate and record psychiatric diagnoses. There were myriad ways in which Dr. Laing engaged in boundary violations that were even more egregious than those in the present case. His care fell even further below the standard of practice than did Dr. Roche's, and it affected more patients. The similarities to the present case include the fact that the patients were very vulnerable, as was Patient A in Dr. Roche's practice. It is the extreme vulnerability of the patients in both cases that serves to link the two cases as alike in addition to the grievous boundary violations. In the *Laing* case, Dr. Laing admitted to having failed to maintain the standard of practice. The Committee ordered that the doctor be reprimanded and pay costs. Like Dr. Roche, he had resigned prior to the hearing and he undertook never to apply or re-apply for registration as a physician. The Committee commented that had Dr. Laing not agreed to such an undertaking, it would have revoked his certificate of registration.

In *Re Jiaravuthisan* (2016), Dr. Jiaravuthisan's misconduct included reaching below the waist band of a patient's trousers to the suprapubic area below her navel. He committed similar acts with another patient and held his hand on her suprapubic area for about 30 seconds. He also touched the patient's buttocks in what felt like a squeezing motion. In neither case did Dr. Jiaravuthisan explain to the patient what he was doing. There was a lack of sensitivity and respect for the patients. He was also abrupt and direct in communicating with his patients and he failed to ensure that patients understood and consented to his actions. His disrespect for the patients constituted unprofessional conduct. He admitted to having engaged in disgraceful, dishonourable or unprofessional conduct and to having failed to maintain the standard of practice. Like Dr. Roche, Dr. Jiaravuthisan was a seasoned, experienced physician who should

have known better. Although the misconduct is quite different, the lack of respect and sensitivity for patients underscores both cases. The Committee ordered that Dr. Jiaravuthisan be reprimanded and pay costs. He also had resigned prior to the hearing and entered into an undertaking with the College never to re-apply.

In *Re Dubins* (2016), Dr. Dubins admitted to having failed to maintain the standard of practice and to disgraceful, dishonourable or unprofessional conduct. Dr. Dubins had asked patients inappropriate sexual questions, used graphic and offensive sexual images with one patient and asked a patient to lower his pants all in the course of hypnotherapy. Dr. Dubins' office was also filled with garbage and dust and paint on the walls was peeling. Dr. Dubins had been cautioned in 1995 for conduct that included some that bore similarity to what was before the Committee in this case. Dr. Dubins' actions with a vulnerable patient showed a remarkable lack of judgment and respect. Dr. Roche's misconduct was similar in that aspect. In the *Dubins* case, the doctor also resigned and entered into an undertaking never to re-apply. The Committee ordered a reprimand and costs. It commented that the "immediate and permanent resignation of Dr. Dubins from the practice of medicine made it unnecessary to consider the imposition of an order of revocation, that otherwise may have been imposed."

In all three cases, the physicians' misconduct showed a remarkable lack of judgment, concern, respect and maintenance of boundaries in the care of patients with varying degrees of vulnerability. Those factors are all present in Dr. Roche's case.

Having regard to all the above factors, as well as the dispositions in the prior cases, the Committee was satisfied that the reprimand and the award of one day of costs was a suitable penalty in this case. The resignation of Dr. Roche and undertaking not to re-apply were key to the Committee in accepting the proposed penalty as appropriate, as revocation would have been warranted had she not done so

**Costs**

Regarding costs, the Committee found that given the serious findings of professional misconduct and incompetence, it is an appropriate case to require that Dr. Roche pay costs in the amount of \$5,500.00, pursuant to the tariff for one day of hearing.

**ORDER**

The Committee stated its findings in paragraphs 1 and 2 of its written Order of March 13, 2017. In that Order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Roche appear before the panel to be reprimanded; and
4. Dr. Roche pay costs to the College in the amount of \$5,500.00 within thirty (30) days of the date the Order becomes final.

At the conclusion of the hearing, Dr. Roche's counsel waived Dr. Roche's right to an appeal under subsection 70(1) of the Code on her behalf, and the Committee administered the public reprimand in Dr. Roche's absence.



**TEXT of PUBLIC REPRIMAND**  
**Delivered March 13, 2017**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. SUSAN LOUISE ROCHE**

Dr. Roche, the Committee finds that your behaviour is extremely troubling. It's fundamental to the practice of psychiatry towards patient boundaries, indeed, it's through our knowledge of psychiatric illness and treatment that we, the profession and the public, understand the concept and importance of boundary violations.

Dr. Roche, your breaching of boundaries was frankly egregious and almost incomprehensible to a reasonable physician and profoundly destructive of public trust. It was repeated, long standing, and involved multiple patients. In one particularly vulnerable patient, the violations constituted clear and serious abuse and harm to an extent that culminated in a relapse of a serious psychiatric problem.

Your failure to maintain the standard of practice extended well beyond the issue of boundary violations into areas of basic psychiatric documentation and therapy. Moreover, there is evidence that you abused the trust of the public purse for your own ends.

The Committee is saddened to see a long career in medicine being ended in this fashion. However, any feelings of sympathy are far outweighed by the profession's responsibility to protect patients and the public from the selfish, self-serving, disgraceful, and unprofessional behaviour that you exhibited.