

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Dean Carey Leduc, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names and any information that could disclose the identity of patients 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. Leduc,  
2018 ONCPSD 59**

**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. DEAN CAREY LEDUC**

**PANEL MEMBERS:**  
**DR. M. DAVIE (CHAIR)**  
**MR. M. KANJI**  
**DR. A. TURNER**  
**MR. P. GIROUX**  
**DR. C. CLAPPERTON**

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

**MS L. CADER**

**COUNSEL FOR DR. LEDUC:**

**MR. D. DOW**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MS J. MCALEER**

**PUBLICATION BAN**

**Hearing Date:** September 17, 2018  
**Decision Date:** September 17, 2018  
**Release of Reasons Date:** November 15, 2018

## **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 September 17, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct (the “Order”). The Order set out the Committee’s penalty and costs decision with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Dean Carey Leduc 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;
2. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession; and
3. under paragraph 1(1)33 of Ontario Regulation 856/93 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 THE ALLEGATIONS**

Dr. Leduc admitted allegations 2 and 3 in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession, and 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. Counsel for the College withdrew the allegation that he had engaged in sexual abuse of a patient.

## THE FACTS

The following facts were set out in the Agreed Statement of Facts and Admission, which was filed as an exhibit at the hearing:

### Background

1. Dr. Leduc is a 54 year-old general practitioner, with a practice in a town in Ontario. At all material times, Dr. Leduc practised in a clinic setting that also operates as a walk-in clinic with 12 physicians.
2. Patient A became a patient of Dr. Leduc in or around 1998, when she was a teenager. Between approximately September 2003 and September 2013, Patient A saw Dr. Leduc for a variety of physical issues, including pain associated with ankle and humerus fractures and a dislocating shoulder, for which she eventually received disability insurance. Patient A also saw Dr. Leduc for a range of psychiatric issues, including an eating disorder, depression, anxiety, addiction to alcohol, addiction to narcotics and benzodiazepines, chronic pain and PTSD.
3. After receiving information in September 2013, the College conducted an investigation into allegations regarding Dr. Leduc's conduct and clinical care with respect to Patient A.

### Standard of Practice with Respect to Patient A

4. In the course of the investigation, the College retained Dr. Jeffrey Sloan to review Dr. Leduc's care of Patient A, including his prescribing of narcotics and related substances, and to provide an opinion with respect to this care.
5. Dr. Sloan opined, in part, as follows:  
*Dr. Leduc's care of this patient demonstrates a significant lack of knowledge regarding safe prescribing habits for narcotics and benzodiazepines.*

*Dr. Leduc's care of this patient demonstrates a significant lack of skill in managing this patient's numerous aberrant behaviors.*

*Dr. Leduc's care of this patient demonstrates a staggering lack of judgment in his continuing prescriptions of medications to this patient while being aware of the risk of addiction and harm to this patient.*

*Finally, while I cannot say with certainty that Dr. Leduc's clinical practice, behaviour, or conduct expose or are likely to expose other patients to harm or injury, there are a number of indicators that raise concern.*

A copy of Dr. Sloan's report dated July 10, 2015 is attached to the Agreed Statement of Facts and Admissions at Tab 1.

### **Boundary Violations with respect to Patient A**

6. In July 2011, Patient A experienced a traumatic personal event and confided in Dr. Leduc. After discussing the events in some detail, and providing counselling, Dr. Leduc hugged Patient A in his office. Over the next two years, Dr. Leduc and Patient A would often hug at the end of an appointment.
7. In June 2012, criminal proceedings regarding the events of July 2011 took place. During the proceedings, Dr. Leduc called Patient A from his cell phone and asked if she wanted to meet and talk. They arranged a time and place to meet and, once they had met, they went to a restaurant. Despite his knowledge that Patient A struggled with alcohol addiction, and the fact that she was on Demerol and benzodiazepines that he had prescribed to her, Dr. Leduc did not object to Patient A ordering wine, which he paid for in addition to her meal.
8. Dr. Leduc disclosed personal information to Patient A during their discussion and, at the end of the encounter, Dr. Leduc drove Patient A home.
9. Patient A continued to see Dr. Leduc after June 22, 2012 for regular follow up care and for supportive counselling. At this time, Dr. Leduc was prescribing Patient A large doses of

Demerol by tablet and by injection, as well as benzodiazepines. In early September 2012, Patient A experienced further physical trauma and, as a result of her injuries, Dr. Leduc assisted with her application to the Ministry of Community and Social Services for disability coverage.

10. In late September, Dr. Leduc contacted Patient A again and offered to meet outside the office to talk. They met at a coffee shop during the day and talked for about one hour. At the end of the encounter they walked to Dr. Leduc's car and he drove Patient A home. Between June and September 2012, Dr. Leduc called Patient A on a few occasions from his cell phone.
11. Patient A continued to see Dr. Leduc after the encounter in late September for regular follow up care, including her pain and mood medications, and for supportive counselling. In the spring of 2013, Dr. Leduc and Patient A met for a third time outside of his office. On this occasion, they met outside Patient A's apartment and walked from there to a restaurant, where Dr. Leduc again paid for Patient A's lunch and alcoholic drink.
12. Dr. Leduc hugged Patient A and/or they exchanged kisses on the cheek during one or more than one of the three out of office encounters.
13. Dr. Leduc recognizes that his conduct was inappropriate conduct for a physician towards his patient and that it breached physician-patient boundaries, especially in the context of Patient A's vulnerabilities. Dr. Leduc knew that Patient A had very few people she trusted or could turn to for support and, during this time, she endured significant physical and emotional trauma.

## **PART II —ADMISSION**

14. Dr. Leduc admits the facts in paragraph 1 to 13 and admits that, based on these facts, he engaged in professional misconduct, in that:

- I. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), he failed to maintain the standard of practice of the profession; and
- II. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), he 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.

## **FINDING**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Leduc's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and 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.

## **AGREED STATEMENT OF FACTS ON PENALTY**

The following facts were set out in the Agreed Statement of Facts on Penalty, which was filed as an exhibit at the hearing:

### **Registrar's Investigation**

1. In July 2015, the College received Dr. Jeffrey Sloan's report regarding Dr. Leduc's prescribing to Patient A. As a result of the concerns raised in that report, the Inquiries, Complaints and Reports Committee (ICRC) approved an appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code in order to conduct a broader investigation into Dr. Leduc's prescribing practices.

2. The College retained Dr. Rae Lake to provide an opinion with respect to Dr. Leduc's standard of care, including his prescribing of narcotics and benzodiazepines. Dr. Lake reviewed 10 patient charts and also conducted an interview with Dr. Leduc. During the interview Dr. Leduc advised that after receiving notice of the public complaint he completed the three-part Safe Opioid Prescribing program at the University of Toronto. He completed the program in January 2014.
3. In his initial report, dated September 27, 2016, Dr. Lake only reviewed and opined on the prescribing and care provided by Dr. Leduc to the 10 patients *after* January 2014. After receiving his report, the College asked Dr. Lake to provide an addendum with respect to the standard of care provided by Dr. Leduc *before* he took the Safe Opioid Prescribing program and made changes to his practice. In his addendum, dated February 21, 2017, Dr. Lake found that the care provided by Dr. Leduc prior to January 2014 did not meet the standard of practice of the profession in 6/10 charts; displayed a lack of knowledge, skill or judgment in 7/10 charts; and that in 5/10 charts his clinical practice exposed those patients to harm or injury. Dr. Lake's reports, dated September 27, 2016 and February 21, 2017 are attached at Tab 1 and Tab 2 [to the Agreed Statement of Facts on Penalty], respectively.

### **Relevant Remediation and Education**

4. At the conclusion of the Registrar's Investigation, the ICRC reviewed and considered the material and ordered Dr. Leduc to participate in a Specified Continuing Education and Remediation Program (SCERP). The Decision and Reasons of the ICRC is attached at Tab 3 [to the Agreed Statement of Facts on Penalty]. The SCERP required Dr. Leduc to, among other things, practice under the guidance of a clinical supervisor for a period of six months. It also required him to re-take all three webinars and the workshop that comprise the Safe Opioid Prescribing program at the University of Toronto. Dr. Leduc registered in and successfully completed the three-part series from March to May 2018, and completed the workshop component in June 2018.
5. The clinical supervision component of the SCERP required biweekly meetings with the



supervisor for two months and monthly meetings for four months. Dr. Leduc's clinical supervisor, Dr. Paul Lyons, conducted the supervision between December 2017 and May 2018, and provided a total of eight (8) reports to the College's Compliance Case Manager. These eight reports, dated December 15, 2017, January 5, 14, 26, February 24, April 1, 28, and May 25, 2018, are attached at Tab 4 [to the Agreed Statement of Facts on Penalty].

6. Dr. Leduc has completed all aspects of the SCERP with the exception of the reassessment. The reassessment was directed to occur approximately six months following the completion of the remediation.

### **Boundaries Course**

7. Dr. Leduc enrolled in and successfully completed a boundaries course at the Schulich School of Medicine at the University of Western Ontario on March 21 to 22, 2014. The evaluation of his participation in the course, as well as two post-course evaluations, completed by the facilitator, is attached to this Agreed Statement of Facts at Tab 5 [to the Agreed Statement of Facts on Penalty].

### **PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for Dr. Leduc made a joint submission as to an appropriate penalty and costs order. The jointly proposed penalty includes a suspension of Dr. Leduc's certificate of registration for a period of six months, a reprimand, and costs payable to the College in the amount of \$16,012 to reflect the cost of a one-day hearing as well as late cancellation costs.

The Committee accepted the joint submission, finding that the penalty represented an appropriate order in the matter. The reasons of the Committee follow.

## **General Principles**

There are several principles to be considered when determining an appropriate penalty. These include public protection, general and specific deterrence, the need to maintain public confidence in the integrity of the profession and the College's ability to govern the profession in the public interest, and the rehabilitation of the member to the extent possible, where appropriate.

The Committee is also aware of the legal principle that a joint submission on penalty should be accepted, unless to do so would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. The Committee gave serious consideration to the proposed penalty in light of the applicable legal principles.

## **Nature of the Misconduct**

Dr. Leduc failed to maintain the standard of practice of the profession in a number of ways. Of most concern was the prescription of high doses of opiates in combination with benzodiazepines to Patient A.

Dr. Sloan, the expert who provided an opinion in this case, noted that Dr. Leduc's care demonstrated a significant lack of knowledge regarding the safe prescribing habits for narcotics and benzodiazepines. Dr. Sloan concluded that Dr. Leduc showed a lack of judgment in continuing to prescribe medications to the patient, while being aware of the risk of addiction and harm to the patient. For example, Dr. Sloan noted that following an ankle fracture in 2007, Dr. Leduc prescribed 120 Percocet tablets over fifteen days and then prescribed over 1300 tablets over the next four months before he began to taper the patient's medication.

Dr. Sloan also noted that the patient attended a detox center in Florida and was successful in getting off of Percocet. On her return, she received regular prescriptions of benzodiazepines and antidepressant medications from Dr. Leduc over the following months.

Despite addiction treatment, Dr. Leduc provided regular injections of Demerol to the patient and prescriptions for Demerol tablets in 2012 following a complaint of a dislocating shoulder. Following a fracture of Patient A's humerus, Dr. Leduc prescribed increasingly large doses of Demerol and over a two-month period a few months after the fracture, she received a total of 722 tablets of Demerol. She was receiving prescriptions of Diazepam 5 mg and admitted using alcohol as well. Even when Patient A suffered a seizure which prompted treatment in an emergency department and it was identified that Demerol was the likely cause of the seizure, Dr. Leduc continued to prescribe it. The foregoing is a short summary of some of the prescribing irregularities upon which Dr. Sloan based his opinion, which highlights the nature of Dr. Leduc's failure to maintain the standard of practice in the realm of narcotic and controlled drug prescriptions with Patient A.

In a further evaluation of Dr. Leduc's practice, there were concerns raised with respect to his prescribing of narcotics and benzodiazepines to other patients as well.

Dr. Leduc also engaged in boundary violations with Patient A. He hugged and/or exchanged kisses on the cheek on one or more office visits. He met her outside the office, shared meals on two occasions and coffee on another occasion, and he divulged his own personal information to her. Dr. Leduc also called her a few times from his cell phone. These were clear boundary crossings and Dr. Leduc should have known better than to establish this type of relationship with such a vulnerable patient.

### ***Aggravating Factors***

The Committee found that the prescriptions of narcotics and controlled drugs to Patient A was alarming and showed a staggering lack of judgment on the part of Dr. Leduc and caused harm to this patient. The harm caused to the patient and the particular vulnerability of this patient are aggravating factors. This was also not an isolated incident. Dr. Leduc's prescribing deficiencies extended to others in his practice. This is also an aggravating factor.

Compounding the prescribing irregularities was the fact that Dr. Leduc was engaging in boundary violations by seeing this vulnerable patient outside of the office and hugging and exchanging kisses on the cheek.

### ***Mitigating Factors***

It is to Dr. Leduc's credit that he took steps to remediate his failings as soon as he was notified of the complaint against him. He successfully completed the University of Toronto course in Safe Opioid Prescribing in 2014 and again in 2018.

Dr. Leduc complied with the SCERP remediation recommended for him as well as completed the Boundaries course.

Dr. Leduc admitted the allegations and agreed to a joint submission on penalty; in doing so, he has spared the need for witnesses to testify and saved costs and time of a contested hearing.

### **Case Law**

The Committee is satisfied that the penalty proposed is reasonable and in keeping with the disposition of similar cases based on the case law that was submitted for consideration.

In *CPSO v. Parikh* (2012), the physician engaged in serious boundary violations by giving the patient hugs, engaging in cell phone contact with her, and giving her large sums of money to help with her financial difficulties. The penalty for failing to maintain appropriate boundaries in this case included a reprimand, a suspension of Dr. Parikh's certificate of registration for two months, as well as the requirement to complete appropriate courses. Dr. Parikh was ordered to pay hearing costs to the College.

In *CPSO v. Bingham* (2018), the physician engaged in sexually inappropriate behaviour with a vulnerable younger patient in the context of a GP psychotherapy practice. He hugged her with full body contact, walked with her, and kissed her on the cheek. The Committee accepted the

plea of no contest and made a finding of professional misconduct on the basis that Dr. Bingham engaged in the sexual abuse of a patient and that he 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. Dr. Bingham voluntarily resigned his membership with the College and agreed to never apply or re-apply to practise medicine again. Had he not done so, the Committee indicated that it would have revoked his certificate of registration. Seventeen years previously, the Discipline Committee had found, on the basis of an Agreed Statement of Facts, that Dr. Bingham had committed an act of professional misconduct in that he committed 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 facts in that case were that Patient 1 was in her late twenties when she received psychotherapy from Dr. Bingham. After one of her sessions, Dr. Bingham hugged Patient 1 as she was leaving his office. During her final session with Dr. Bingham, Dr. Bingham gave her a kiss on her lips. At that time his certificate of registration was suspended for 6 months, 3 months of which was suspended upon completion of conditions. This case was arguably more serious than Dr. Leduc's case as there was a history of misconduct and a finding of sexual abuse on the 2018 allegations.

In *CPSO v. Ghali* (2016), the physician hugged and kissed the patient at the end of the appointment. The College had alleged professional misconduct on the basis of sexual abuse of a patient and on the basis that Dr. Ghali had 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. Dr. Ghali admitted the second allegation and the College withdrew the allegation of sexual abuse. The Committee accepted the parties' joint submission on penalty and Dr. Ghali's certificate of registration was suspended for three months. The Committee also ordered a reprimand, the imposition of terms, conditions, and limitations on his certificate of registration and ordered him to pay hearing costs to the College.

*CPSO v. Gutman* (2011) is analogous to the current case, in that the findings involved failure to maintain the standard of practice of the profession in addition to boundary violations that

involved hugging a female patient and the physician sharing details of his personal life with her. The case proceeded on the basis of an Agreed Statement of Facts and Admission. Dr. Gutman admitted that he failed to maintain the standard of practice of the profession, and that he had 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 College withdrew the allegations of conduct unbecoming, sexual abuse and incompetence. The parties made a joint proposal on penalty which was accepted by the Committee. Dr. Gutman's penalty included a suspension of his certificate of registration for four months, the requirement to complete courses, and the imposition of terms, conditions and limitations on his certificate of registration, including those related to his addiction. Dr. Gutman was ordered to pay hearing costs to the College.

In *CPSO v. Matheson* (2017), Dr. Matheson admitted that he failed to maintain the standard of practice of the profession and in that he 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 with respect to the manner and circumstances of his opioid prescribing and in failing to comply with the College's Out of Hospital Premises requirements. The College withdrew the allegation of incompetence, the allegation of disgraceful, dishonourable and unprofessional conduct in respect of prescribing opioids after agreeing not to do so, and the allegation of disgraceful, dishonourable and unprofessional conduct in failing to respond to the Out of Hospital Premises program as requested. The matter proceeded on the basis of an Agreed Statement of Facts and Admission and a joint proposal on penalty. The Committee accepted the joint proposal and ordered a four-month suspension, a reprimand, and the imposition of terms, conditions and limitations on his certificate of registration. Dr. Matheson was also ordered to pay hearing costs to the College.

In *CPSO v. Haines* (2014), the physician failed to maintain the standard of practice of the profession in his prescribing of opioids and benzodiazepines. The case proceeded on the basis of an Agreed Statement of Facts and Admission and a joint proposal on penalty. The Committee noted in that case that upon hearing of the College's investigations, Dr. Haines took the initiative to update his medical knowledge and prescribing practices, which was considered a significant

mitigating factor. Dr. Haines received no suspension of his certificate of registration, but the Committee ordered the imposition of terms, conditions and limitations on his certificate of registration, including ongoing assessment of his practice, as well as a reprimand and hearing costs payable to the College.

## **Conclusion**

Given the foregoing, the Committee is of the view that the proposed penalty for Dr. Leduc is in line with the orders imposed in previous cases of a similar nature. A reprimand allows the Committee to express to Dr. Leduc the seriousness with which his boundary violations and failure to maintain the standard of practice of the profession are viewed by the profession and should serve as a specific deterrent to Dr. Leduc, denouncing his misconduct.

The suspension of Dr. Leduc's certificate of registration for six months provides specific deterrence and general deterrence to the profession. Boundary violations are to be taken seriously and will not be tolerated. Maintaining standards of practice of the profession is also important, and physicians are expected to be current with guidelines around opioid prescribing. This is fundamental to maintain the integrity of the profession and public confidence in light of the current opioid crisis.

## **Costs**

Costs of \$16,012.00 reflect the costs of a one-day hearing as well as the late cancellation costs associated with three physician panel members. This is an appropriate cost order based on the circumstances of this case.

## **ORDER**

The Committee stated its finding of professional misconduct in paragraphs 1 and 2 of its Order of September 17, 2018. In that Order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Leduc attend before the panel to be reprimanded.
4. the Registrar suspend Dr. Leduc's certificate of registration for a period of six (6) months, effective immediately.
5. Dr. Leduc pay to the College costs in the amount of \$16,012.00, within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Leduc waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.



**TEXT of PUBLIC REPRIMAND**  
**Delivered September 17, 2018**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. DEAN CAREY LEDUC**

Dr. Leduc:

The Panel is extremely disappointed that you find yourself here, at discipline, for such egregious, repeated boundary violations with long-term Patient A.

In addition to your boundary violations with Patient A, you failed to maintain the standard of practice with your prescribing. Your Demerol prescriptions for Patient A went from 30 tablets a month to 30 tablets a week and ultimately culminated to 30 tablets a day. When Patient A presented to the ER with a seizure, you acknowledged that it was likely medication related, but you prescribed more in large doses. Even after she received specific addiction treatment, you continued prescribing opioids, along with benzodiazepines and anti-depressants.

The Panel is perplexed that you sought contact with this patient outside the office setting, by having meals and personal discussions. It is just not clear to the Panel how you felt such boundary violations were going to be helpful to this patient. As a professional, one must always put one's patient's needs above their own. If you were in need of someone to share your personal information with, you should not have chosen this very vulnerable patient, or any patient for that matter. You clearly contributed to her problems.

We acknowledge that you have displayed some insight and taken responsibility. This is supported by the supervisor's positive reports and your boundaries and prescribing courses. We expect that you will continue to do so.