

In 1995 the respondent was counselled by the Pharmaceutical Services Branch following an investigation which revealed that he prescribed Rohypnol in excess of quantities for long periods and to patients on methadone programmes.

A complaint was received by the HCCC on 2nd September 1999 from a patient's daughter in respect of treatment afforded to her mother prior to her mother's death. The cause of death according to an autopsy report was attributed to clomipramine toxicity combined with the effects of codeine, doxylamine and benzodiazepines with coronary artery atheroma listed as a significant condition contributing to the death. The complaint considered by the Tribunal arose from the complaint received by the HCCC on 2nd September 1999.

The first five particulars of the complaint concern patients A, B, C, D, and E. A non-publication order was made in respect of each of these patients.

Particular 1 concerns patient A. The particular complaint is that between November 1997 and May 1999 the practitioner prescribed to patient A, a patient who he knew had a dependence on alcohol and benzodiazepines and had attempted suicide on more than one occasion in the past, the tricyclic antidepressant drug clomipramine at a rate in excess of 7 tabs daily, in combination with the benzodiazepines nitrazepam at a rate of approximately three and a half tablets daily and diazepam at a rate in excess of 7 tabs daily, often on the basis of a telephone consultation with patient A only, without adequate face to face counselling, supervision or investigation.

Patient A had been a long-term patient at the practice at Jacques Street Bondi Junction. She was a patient who had consulted the practitioner's father. A schedule of the drugs prescribed throughout the period between November 97 and May 99 is behind tab 1 of exhibit A. The schedule shows that patient A was prescribed clomipramine monthly. The schedule shows that between February 1998 and May of 1999 the respondent prescribed various quantities of clomipramine of between 100 and 250 tablets per month.

Patient A died on the 19th May 1999. Dr Malouf, in a report dated 2 January 2000, considered the autopsy report and noted that the clomipramine and benzodiazepines were prescribed but the doxylamine and codeine were not necessarily prescribed.

The complaint made by patient A's daughter was that the respondent prescribed inappropriately to patient A, drugs which were found to have caused patient A's death. The Health Care Complaints Commission referred the complaint to the Pharmaceutical Services Branch. A report of the investigation by that branch signed by the Pharmaceutical Advisor and dated 29/12/99 is behind tab 4 of exhibit A.

The respondent informed the Pharmaceutical Services Branch Investigator, Peter Gilfedder, that he had seen patient A on the day before her death. The respondent informed Mr Gilfedder that patient A was in 'very good spirits'. He further said that patient A had agoraphobia which the respondent treated with Serepax. He said that patient A's de facto partner picked up any medication prescribed because he worked at a hotel in Bondi and that patient A did not like

going out without him. The respondent said that patient A would write out a shopping list of drugs and the respondent would prescribe them and give the scripts to the partner in exchange for signing a Medicare voucher for a consultation. He said he was patient A's General Practitioner for the last 15 years but he had not seen her for about six months.

In an interview with Peter Gilfedder on 6th December 1999 the respondent stated that patient A was seen by him on a weekly basis for many years but that towards the end of her life any consultations were conducted over the telephone. He agreed that he was not surprised that the amount of clomipramine prescribed would result in patient A taking on occasions more than 8 tablets a day over a long period. The respondent was aware that patient A had attempted suicide on at least two occasions. At the interview the respondent admitted that he was aware of the pharmaceutical guidelines regarding clomipramine and benzodiazepines and that he had not followed such guidelines but said he was in a difficult situation. He said that he knew that patient A was dependent on benzodiazepines and had been so for many years. He considered he was in a position to discharge her as a patient but he chose to continue to try and help her.

In the interview on 6th December 1999 the respondent stated that he was aware that patients on clomipramine must be kept under close surveillance. He said he believed he was keeping her under close surveillance to the best of his abilities. He said:-

‘She was a non compliant difficult patient and as I expressed previously my options were to either discharge her as a patient and tell her to find another General Practitioner, or to carry on,

which was in hindsight a dangerous and – and a fruitless roundabout’.

In his statement which is behind tab 1 of exhibit 1, the respondent stated that patient A was a very difficult patient to manage and he was mindful of the medication was receiving. He said patient A refused to undergo detoxification. He said his choice, he considered, was to continue to provide what appeared to be a maintenance drug regime which at the very least kept her reasonably stable, or to refuse to prescribe anything for her whatsoever. He considered that had he chosen the latter course patient A would have become a ‘doctor shopper’ with the likelihood that her death would have been hastened. The respondent stated that he chose the former option. He said that he only gave her one prescription of clomipramine per week and did not give her any repeat prescriptions.

Dr Ian Chung reviewed material regarding Dr Muller forwarded to him by the HCCC. In his report of 1st September 2004 Dr Chung stated that the respondent’s prescribing of clomipramine in the doses in which he did, need not per se, be abnormal. He said that the prescribing of clomipramine, in conjunction with benzodiazepines, need not always be unwarranted. Dr Chung’s concerns regarding the respondent’s prescribing practice are listed in his report of 1st September 2004.

In evidence before the Tribunal Dr Chung confirmed that his concerns regarding the respondent’s prescribing practices were as stated in his report of 1st September 2004. He, Dr Chung, considered that the management of patients such as patient A required a multidisciplinary team approach. He considered that it would be unlikely that patient A would comply with offers of referral whilst the respondent fulfilled her needs for the drugs she was dependent upon and in doses adequate for

those needs. He was also of the view that the drugs were supplied upon request and with little opposition or counselling by the respondent. He considered that counselling over the telephone could not replace face to face counselling with a difficult patient.

The conduct of the respondent in the case of patient A attracted the severe disapproval of Dr Cheung. He was of the opinion that the overall pattern of care by the respondent of patient A contained many areas of deficiencies.

The Tribunal is satisfied that particular 1 of the complaint has been established to the requisite degree of proof.

Particular 2 of the complaint concerns patient B.

Particular 2 of the complaint is that between January 1998 and November 1999 the practitioner prescribed flunitrazepam to patient B in excess of the normally recognised therapeutic standards of what was appropriate in the circumstances, when he knew that the patient was on a methadone programme, but without contacting his methadone prescriber and despite being counselled against such practices in 1995 by the Pharmaceutical Services Branch of the NSW Health Department.

The amount of flunitrazepam prescribed throughout the period referred to in particular 2 is listed on a schedule behind tab 1 of exhibit A. At the interview with Mr Gilfedder on 6th December 1999, the respondent stated that he prescribed flunitrazepam because patient B's Psychiatrist wrote letters 'saying that it was absolutely essential'. He stated he prescribed two each night but agreed he had prescribed at the rate of

three per day. He stated in the interview that patient B should have been on half a tablet at night 'if at all'.

In that interview the respondent said he was not aware that patient B was obtaining benzodiazepines elsewhere, although he was aware that since 1991 patient B was on a methadone programme and had been a heroin addict. He was not sure whether he had contacted patient B's methadone prescriber.

In his statement of 12 September 2005 the respondent stated that patient B had been a patient of his father's since 1986. He said he first saw patient B in September 1992. As at that time he was aware of patient B's methadone maintenance programme. He said he prescribed flunitrazepam (Rohypnol) because of the patient's chronic anxiety state associated with insomnia. He further stated that if he was to see a patient like patient B today he would refuse to prescribe Rohypnol or any other benzodiazepine.

Dr Chung, in his report of 1st September 2004, states that the respondent admitted that he permitted patient B to take a larger dose of the drug than was advised. Dr Chung stated that the management of patients such as patient B warrants great care and close supervision of the drug prescribed and their doses is essential. He also noted that in 1995 the respondent had been warned concerning his prescribing of benzodiazepines to patient B.

A Mr Thompson of the Pharmaceutical Services Branch had visited the respondent on 7th September 1995. On that date the respondent had advised him that patient B had been a patient of his for a little while and

had bad back problems which had resulted in sleep deprivation. The respondent told Mr Thompson that it was actually patient B who had bought up the possible use of Rohypnol.

The respondent considered that he had prescribed Rohypnol within accepted parameters. Mr Thompson agreed with this statement of the respondent but then showed to the respondent a printout of Rohypnol dispensed for patient B which showed that at least six or more other medical practitioners were then currently prescribing Rohypnol for patient B. When so informed, the respondent became very angry and stated that he would never ever see patient B again.

Mr Thompson told Dr Muller that the other medical practitioners had expressed the same sentiment but at least one medical practitioner had to take charge of patient B's medical treatment, even if it only amounted to encouraging patient B to go for detoxification and referring him to a pain clinic for proper assessment of his pain.

Following the visit by Mr Thompson on 7th September 1995 the Director General of the Department of Health, by letter dated 1 November 1995, wrote to Dr Muller advising that a variety of approaches are made by some people in attempts to obtain prescriptions for benzodiazepines and that trafficking in prescriptions and drugs dispensed by prescriptions had become a major problem. A copy of the Guidelines for the Rational Use of Benzodiazepines issued by the Royal Australian College of General Practitioners was enclosed with the letter of 21 November 1995. The respondent has acknowledged receipt of such guidelines.

The respondent has acknowledged and agrees that his prescription of Rohypnol for patient B was contrary to the guidelines forwarded to him and was inappropriate.

The respondent agreed that he did not discuss his prescribing of Rohypnol for patient B with the methadone prescriber. He also agreed that he did not refer patient B to a pain clinic for proper assessment of his pain as suggested by Mr Thompson in 1995.

The Tribunal is satisfied that particular 2 has been established to the requisite degree of proof.

Particular 3 of the complaint is that between November 1997 and November 1999 the practitioner prescribed benzodiazepines and paracetamol containing compounds to patient C in excess of the normally recognised therapeutic standards of what was appropriate in the circumstances despite having a radiologists' report dated 26/7/94 noting liver damage and a pathology report dated 26/7/95 stating that liver damage may be the result of ethanol or drug therapy.

The schedule of drugs prescribed by the respondent for patient C is behind tab 1 of exhibit A. The radiology report of 22nd December 1994 is part of the documents behind tab 22 of exhibit A. Also contained in the documents behind tab 22 is a report of Dr DJ Byrnes dated 3 March 1994 which states that he, Dr Byrnes, saw patient C as she had recently been troubled by giddiness and morning vomiting. Dr Byrnes described patient C as a very pleasant lady who also happened to be an extremely heavy drinker. He was of the opinion that patient C had alcoholic gastritis and cerebellar degeneration.

In his statement of 12 September 05 the respondent stated that patient C was a long-standing patient who was difficult to manage. He stated that in the period referred to in the particular [November 1997 to November 1999] patient C, he considered, was a reformed alcoholic. The respondent also stated that patient C was a chronic cigarette smoker who had been taking Serepax for 25 years and also receiving paracetamol and Panadeine Forte for a shoulder injury.

The respondent stated that he did not initially prescribe Serepax for patient C. He continued to prescribe Serepax for an anxiety state which he considered was due to domestic violence. He prescribed paracetamol and Panadeine Forte for pain as a result of severe osteoarthritis and the shoulder injury.

The respondent has admitted that he prescribed benzodiazepines and Panadeine Forte over a long term. Dr Chung, in his report of 1st September 2004, states that both benzodiazepines and Panadeine Forte can interact with alcohol. He considered that the combination of benzodiazepines and Panadeine Forte in the doses made available by the respondent's prescribing was capable of causing serious harm. He also considered that paracetamol was not advisable for a patient with liver damage. The general circumstances of the respondent's care attracted his disapproval.

The respondent agrees that the continued prescribing of benzodiazepines and Panadeine Forte over such a long period was inappropriate. He also agreed that the Radiologist's report of 26 July

1994 noted liver damage and that the pathology report dated 26/7/95 stated that liver damage might be the result of ethanol or drug therapy.

The respondent said that with hindsight he should have entered into and enforced a contractual arrangement whereby he would stop seeing her if she continued using benzodiazepines. He was of the opinion that if he done so the patient would have become a 'doctor shopper' for that class of drug. That opinion was reinforced by the report of Dr James Bell, Director of the Langton Clinic. Dr Bell saw patient C in October of 1998 and advised patient C to avoid taking benzodiazepines during the day and over time to reduce her nocturnal sedation. Dr Bell concluded his report by stating, 'I am not sure whether this advice is helpful'.

Dr Chung agreed in his evidence before the Tribunal that in the period up to 1999 'doctor shopping' was a real and prevalent problem.

The Tribunal is satisfied that the complainant has established particular 3 of the complaint to the requisite degree of proof.

Particular 4 of the complaint is that between February 1998 and January 2000 the practitioner prescribed benzodiazepines and drugs of addiction to patient D without maintaining adequate clinical records documenting the treatment when the practitioner knew that patient D had a past history of heavy alcohol abuse.

In the interview with Mr Gilfedder the respondent said that he had prescribed pethidine for pain for patient D after amputation of a toe of patient D on 27th February 1998. He said he knew that he did not have authority to prescribe the pethidine for long periods. He also said that

he prescribed diazepam for anxiety. The schedule of drugs prescribed for patient D is behind tab 1 of exhibit A.

In his statement of 12 September 2005 the respondent states that patient D had been a patient since at least 1990. The respondent states that patient D had a history of alcohol abuse. He states that patient D suffered from unstable insulin dependent diabetes and with severe peripheral neuropathy and peripheral vascular disease. An amputation of patient D's left second toe occurred on 3 October 1997 and an amputation of his right third toe occurred on 27th February 1998.

The respondent states that patient D was extremely non compliant of medical advice and suffered from anxiety and pain as a consequence of his medical conditions and their complications. The respondent agrees that his clinical records were not in accordance with the requisite standard. The report of Mr Gilfedder of 29th December 1999 states that the respondent kept no drug register to account for drugs of addiction.

The Tribunal is satisfied that the complainant has established particular 4 of the complaint to the requisite degree of proof.

Particular 5 is that between May 1996 and November 1999 the practitioner prescribed benzodiazepines contrary to the normally recognised therapeutic standards of what was appropriate in the circumstances when the practitioner knew that patient E had previously been addicted to heroin and was likely to abuse these drugs.

The respondent has stated that in his statement of 12 September 2005 that patient E first attended his practice in August 1995 with a history of

insomnia and anxiety. He states that he prescribed benzodiazepines for her because patient E had maintained that it was her best way of detoxifying from heroin.

The respondent stated, with the benefit of hindsight, that he would now send such a patient to a methadone clinic or a drug and alcohol specialist.

The respondent, at the interview with Mr Gilfedder, agreed that the prescribing for patient E of benzodiazepines since 1996 for withdrawal from heroin was inappropriate.

Dr Chung, in his report of 1st September 2004, states that there is no record that the respondent made any proper attempt to treat the patient's addiction in a recognised manner or to bring about successful referral to an appropriate person or agency for her addiction.

In evidence before the Tribunal Dr Chung said that it was a general understanding amongst all competent Doctors that one has to be circumspect in the way in which potential addictive drugs are prescribed to a patient who has demonstrated addictive behaviours in the past. In a subsequent report of the 24th September 2005 Dr Chung stated that the fact that the respondent had engaged in inadequate practices for an extended period did not erase the possible harm from such conduct. The Tribunal is satisfied that the complainant has established particular 5 of the complaint to the requisite degree of proof.

Particular 6 is that for at least two years prior to 6 December 1999 the practitioner failed to maintain a drug register for drugs of addiction

contrary to clause 113 of the Poisons and Therapeutic Goods Regulation 1994.

The respondent agrees he, for at least two years prior to 6 December 1999, failed to maintain a drug register for drugs of addiction contrary to clause 113 of the Poisons and Therapeutic Goods Regulation 1994. The respondent also admitted that he failed to maintain a drug register contrary to the regulation in the interview with Mr Gilfedder.

The Tribunal is satisfied that the complainant has established particular 6 of the complaint to the requisite degree of proof.

Particular 7 is that for at least two years prior to 6 December 1999 the practitioner failed to enter the required details of the receipt and administration of the drug of addiction Pethidine in a drug register contrary to requirements of clause 114 of the Poisons and Therapeutic Goods Regulation 1994.

The respondent admits that he failed to enter the required details of the receipt and administration of the drug of addiction pethidine in a drug register contrary to the requirements of the regulation. In an interview with Mr Gilfedder on 6th December 1999 he also admitted that he had failed to abide by the requirements of the Law in regard to entering details of the receipt and administration of drugs of addiction.

The Tribunal is satisfied that the complainant has established particular 7 of the complaint to the requisite degree of proof.

Particular 8 of the complaint is that for between January 1998 and December 1999 the practitioner failed to record in the patient notes sufficient details of his prescribing of the drug of addiction pethidine to patients D, F and G as required by clause 84 other than the Poisons and Therapeutic Goods Regulation 1994.

The respondent admits that between January 1998 and December 1999 he failed to record in the patient notes sufficient details of his prescribing of the drug of addiction pethidine to patients D, F and G.

The Tribunal is satisfied that his failure to record such details was required by clause 84 of the Poisons and Therapeutic Goods Regulation 1994.

The Tribunal is satisfied that the complainant has established particular 8 of the complaint to the requisite degree of proof.

Particular 9 is that from November 1997 to May 1999 in relation to patient A and December 1999 in relation to patients B, E and D the practitioner failed to record in his patient notes the full details of his prescribing of prescribed restricted substances as required by clause 40 of the Poisons and Therapeutic Goods Regulation 1994.

The respondent admits that his patient notes in relation to patients A, B, D, and E were deficient and were not in accord with what was required by clause 40 of the Poisons and Therapeutic Goods Regulation 1994. The respondent also admitted in his interview with Mr Gilfedder on 6th December 1999 that he had failed to comply with relevant regulations in relation to recording full details of prescribed restricted substances.

The Tribunal is satisfied that the complainant has established particular 9 of the complaint to the requisite degree of proof.

Particular 10 of the complaint is that the practitioner contravened section 36(1)(b) of the Medical Practice Act 1992 in that he failed to maintain proper records of his treatment of patients A to G in accordance with the provisions of clauses 13 to 17 and Schedule 2 of the Medical Practice Regulation 1998.

The respondent admits that he contravened section 36(1)(b) of the Medical Practice Act 1992. The practitioner also admitted in his interview with Mr Gilfedder that he failed to keep appropriate records of his treatment of patients A to G.

The Tribunal is satisfied that the complainant has established particular 10 of the complaint to the requisite degree of proof.

The Tribunal has considered the quality of the acts of the respondent claimed to demonstrate a lack of adequate knowledge, judgment or care in the practice of medicine and said to constitute improper and/or unethical conduct related to the practice of medicine. The degree of seriousness of the acts upon which the complaint relies, if found proved to the requisite stated of proof, is to be considered in determining whether unsatisfactory professional conduct amounts to professional misconduct.

The Tribunal has also taken into account what was stated in *Pillai v Messiter* [1989] 16NSWLR 197 that professional misconduct includes

such a departure from accepted standards as to portray indifference and an abuse of the privileges which accompany registration as a Medical Practitioner.

The conduct of the respondent in relation to patients A, B, C, D and E attracted the severe disapproval of Dr Chung.

Dr Chung in his report of the 1st September 2004 stated that the respondent's failure to record full details of drugs of addiction and/or prescribed restricted substances contrary to the law attracted his severe disapproval and/or his severe criticism. He further stated that the conduct of the respondent would attract the severe disapproval of his peers of good repute and conduct.

Dr Wodak in his report of 9th September 2005 stated that in regard to patient A he was sure that the respondent was not proud of writing prescriptions repeatedly without reviewing the patient or of having 'losing track' of how many scripts he had written for patient A. He did not consider that he was deserving of severe penalty for his conduct. He himself was unaware of any authoritative guideline as of the time of the complaint or since that explicitly and unambiguously condemned such prescribing with clear advice about maximum acceptable prescribing levels.

As to patient B, Dr Wodak stated that unfortunately many patients in methadone maintenance treatment in NSW today still managed to obtain benzodiazepines relatively easily. He considered that clear and unambiguous and explicit guidelines in this area were still non-existent and certainly did not exist as at the time that Dr Muller treated patient B.

Dr Wodak agreed that ideal treatment in relation to patient B did not occur. He considered that the quantities of benzodiazepines prescribed by the respondent for patient B were modest.

Dr Wodak would far prefer that all General Practitioners in New South Wales would discuss the prescription of benzodiazepines with Doctors prescribing methadone but was of the opinion that if every General Practitioner in Sydney who had prescribed similar quantities of benzodiazepines to methadone patients were to be deregistered there would be few doctors left.

This evidence of the opinion of Dr Wodak was allowed into evidence not as to truth of the fact but as to the degree of seriousness of the conduct of the respondent.

Dr Wodak was also of the opinion that if every General Practitioner in Sydney had prescribed similar quantities of oxazepam to an alcohol dependent patient as the respondent did were to be deregistered there would be few doctors left. Again this evidence of the opinion of Dr Wodak was allowed into evidence not as to truth of the fact but as to the degree of seriousness of the conduct of the respondent.

Dr Wodak was also of the opinion that even if the Radiologists' report was correct there were not unacceptable quantities of paracetamol prescribed to patient C.

As to patient D, Dr Wodak considered that patient D was an insulin dependent diabetic with an amputation. He considered that the respondent did well to maintain his prescription of oxycodone and

pethidine ampoules to this level. Dr Wodak also considered that if the respondent failed to keep adequate notes for patient D he deserved to be criticised but he did not consider it was a major offence.

As to patient E, Dr Wodak did not consider that the amounts or doses prescribed by the respondent were excessive. He also stated that clear guidelines on prescribing benzodiazepines to heroin dependent patients did not exist at the time referred to in the particulars of the complaint and do not exist as at the present time.

Dr Wodak considered that the management of the cases referred to in particulars 1 to 5 of the complaint were less than optimal management but that the standard of management overall was adequate. He certainly did not seek to excuse the conduct of the respondent overall.

Dr Chung disagreed with the opinion of Dr Wodak that the circumstances referred to by the respondent mitigated his conduct. In evidence the respondent stated that he found himself in a difficult position. The respondent found himself in a position of dealing with older patients he had inherited particularly from his father who had commenced the patients on benzodiazepines.

In his evidence before the Tribunal Dr Chung said that the conduct of the respondent did not fit in with the very worst category of case. He said if you were to take the normal distribution curve, and you cut off the 20% of the worst case and 20% of the best case, the respondent's conduct would fit into the middle of that curve. As to where precisely it fits into that curve requires the wisdom and the judgment of the Tribunal.

The Tribunal has considered all the evidence adduced. The Tribunal is satisfied that the particulars of complaint which it has found proved demonstrate a lack of adequate knowledge, skill, judgment and care in the practice of medicine by the respondent and show that the respondent has engaged in conduct relating to the practice of medicine that is improper or unethical.

The Tribunal is satisfied that the respondent is guilty of unsatisfactory professional conduct. The Tribunal is not satisfied that the unsatisfactory professional conduct of the respondent is of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the register.

The Tribunal considers that the particulars of complaint as proved by the complainant are serious breaches by the respondent and represent improper and unethical conduct in the practice of medicine.

The Tribunal has taken into account that since of the complaint by the daughter of patient A, the respondent has voluntarily surrendered his authority to prescribe schedule 8 and schedule 4D drugs.

The respondent has also ceased practice as a solo General Practitioner. In July 2001 he commenced practice at the Bondi Junction Medical Centre. No complaints have been made to the HCCC in relation to his practice of medicine since he commenced practice at the Medical Centre.

The delay that has occurred between the commission of the acts upon which the complainant relies and the complaint of 1st April 2005 is also a

matter which the Tribunal has taken into account in considering any penalty in relation to the unsatisfactory professional conduct which the Tribunal has found proved.

Orders

The orders which the Tribunal considers are appropriate are:

The practitioner, Dr Robert Joseph Muller, is found guilty of unsatisfactory professional conduct.

- A. The practitioner is reprimanded.
- B. The practitioner's continued registration is subject to the following conditions:
 - 1. Schedule 8 and Schedule 4D drug authorities remain withdrawn.
 - 2. Any future changes in his authority with respect to schedule 4D and schedule 8 prescribing rights must address any defects in his prescribing and be in accordance with the protocols established by the Medical Board.
 - 3. Any application by the practitioner to the Pharmaceutical Services Branch of the NSW Department of Health for the variation and/or lifting of the restrictions on his rights in relation to schedule 8 and schedule 4D drugs be made only in consultation with the Medical Board.
 - 4. To work only when another registered medical practitioner is always on site and not at any other time.
 - 5. Not to undertake solo general practice work.

6. Within fourteen days of these orders to provide the Board with a copy of his conditions signed by or on behalf of his employer and signed by the senior practitioner with whom he works.
7. To seek Board approval prior to changing the nature or place of practice.
8. To provide the Board, within seven days of commencing work in any future approved practice or employment, with a copy of his employment conditions signed by or on behalf of his employer and signed by the senior practitioner with whom he works.
9. To undertake and satisfactorily complete all components of the Clinical Communication Program (CCP) presented by the Cognitive Institute of General Practitioners.

Phase 1: Preparation and Goal Setting – to occur in the six weeks prior to phase 2.

Phase 2: Attend and participate in all sessions of the three-day residential workshop to be held in Brisbane, Queensland.

Phase 3: implementation and Mentoring.

To supply the Medical Board with the following:

- (a) Copy of letter from the Cognitive Institute confirming registration,
- (b) Copy of Cognitive Institute Phase 1 and Workshop Progress Statements within one week of receipt,

(c) Copy of Cognitive Institute Certificate detailing successful completion or otherwise of all program components within one week of receipt.

The practitioner is responsible for any costs incurred in participating in the CCP.

This course is to be completed within 6 months of the making of these Orders.

10. Within six months of this decision, and subsequently as required by the Medical Board, to submit to a random audit of his medical records, by a person or persons nominated by the Medical Board, to monitor compliance with the standards required by the Medical Practice Act Regulation 2003, in particular Part 3 'Records' and Schedule 2 'Records relating to patients'. Dr Muller is to authorise the said person or persons to prepare a report on their findings for submission to the Board and is to meet all costs associated with the audits and any subsequent report or reports.

11. Within the next 12 months to attend a Board-nominated General Practitioner on four occasions. Discussions should include but not be limited to record keeping, prescribing and boundaries that apply between patients and a practitioner. Dr Muller is to authorise the Board-nominated General Practitioner report to the Medical

Board. Dr Muller to meet all costs associated with the meetings and any subsequent report or reports.

12. The Medical Board may review these conditions.

C. The Respondent is to pay the Complaint's costs in this matter.

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Dated: Monday 14th November 2005

Judge AF Puckeridge QC
Deputy Chairperson

Dr R. Gordon
Member

Dr J. Hely
Member

Associate Professor P. McNeill
Member