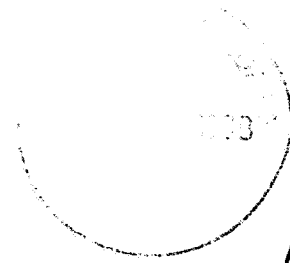


**IN THE MEDICAL TRIBUNAL
CONSTITUTED UNDER SECTION.
146 OF THE MEDICAL PRACTICE ACT 1992
No. 40021 of 1997**



IN THE MATTER OF a Complaint by

THE HEALTH CARE COMPLAINTS COMMISSION

against

ANTHONY EDWARD ZAHRA-NEWMAN

Deputy Chairperson Judge H L Cooper

Members Mr Berry
 Dr Ilbery
 Dr Gordon

Thursday 29 October, 1998

REASONS FOR DETERMINATION

This Tribunal is called upon to enquire into and determine complaints made by the Health Care Complaints Commission against Dr Zahra-Newman. The complaints are that he, being a Medical Practitioner registered under the Act, has been guilty of professional misconduct and/or unsatisfactory professional conduct within the meaning of Sections 36 & 37 of the Act, in that he:

- (a) has engaged in conduct which demonstrates lack of adequate knowledge, skill, judgment or care in the practice of medicine .and/or
- (b) has engaged in conduct relating to the practice of medicine that is improper or unethical.

The Complaint comprises some fourteen sets of misconduct, each set having a number of Paragraphs together with schedules.

Because of their voluminous nature, it is not proposed to repeat them at this stage. Suffice it to say that the allegations, in general terms, allege that the respondent irresponsibly prescribed drugs, including in some cases narcotic drugs, in the following general categories:

1. In quantities of excess recognised therapeutic standards of what is medically appropriate.

2. To patients whom he knew or should have known were addicts and/or where the drugs were likely to produce dependency.
3. In combination which were medically inappropriate.
4. In the case of several narcotic drugs, he prescribed the drugs on a long term basis, that is beyond two months, without an authority from the Department of Health as required by the Poisons Act or in quantities in excess of the Authorities which had issued in respect of the patients to the practitioner. The drugs included Morphine, Methadone, Pethidine, MS Contin, all of which are Schedule 8 drugs and in addition some Schedule 4 drugs such as Rohypnol, Nembudeine and Temazepam.

The respondent concedes in many respects that he did prescribe various drugs in quantities in excess of recognised therapeutical standards of what was medically appropriate. Furthermore, he ceased practising and at his request his name was removed from the Register in February, 1997.

The real issue for this Tribunal to determine is whether the respondent's conduct amounts to professional misconduct or merely to unsatisfactory professional conduct. The resolution of this issue requires a consideration of the evidence relating to each of the particulars in respect to each patient and looking at what the respondent did in the context of the over all medical history of the particular patient. It is proposed to take each of the particulars in turn.

PARTICULAR 1

Particular 1 is not in issue as it alleges that at all relevant times the respondent was a general practitioner.

PARTICULAR 2

This relates to Patient A. Paragraph (a) alleges:

"During the period 4 January, 1993 to 2 May 1994 the practitioner prescribed Temazepam capsules in quantities in excess of recognised therapeutic standards of what is medically appropriate."

According to schedule A to the Complaint, during this period the respondent prescribed a total of 5700 capsules of Temazepam otherwise known as Normison, a schedule 4 drug.

The respondent concedes that during this period he prescribed the capsules in quantities in excess of recognised therapeutic standards of what is medically appropriate but denies the prescriptions on 16/3/93, 31/5/93, 6/6/93, 23/7/93, 16/8/93,

26/11/93, 13/1/94, 21/2/94, and 27/2/94. These prescriptions are derived from computer print-outs prepared by various pharmacies. The respondent has no record of having prescribed these particular items and furthermore, the prescriptions themselves have not been located. There is evidence that it is possible for errors to arise in the computer print-outs because the respondent's name could be recorded automatically because he is the predominant prescriber for this particular patient whereas some other practitioner could have prescribed these items. Having regard to the over all history of the matter, and in particular in prescribing Temazepam to Patient A, this Tribunal is comfortably satisfied that these particular prescriptions were issued by the respondent.

Paragraph (b) alleges –

"During the period 19 January 1993 to 6 October, 1993, the practitioner prescribed Duromine in quantities in excess of recognised therapeutic standards of what is medically appropriate."

Schedule A shows that 30 Duromine tablets were prescribed on each of 19/1/93, 26/1/93, 4/2/93, 12/3/93, 15/3/93, 27/4/93, 7/7/93, 14/7/93, 3/8/93, 31/8/93 6/10/93. On 14/3/93, 90 tablets were prescribed.

The respondent concedes that he prescribed the Duromine, but disputes that it was in excess of recognised therapeutic standards.

He also disputes the prescriptions on 27/4/93, 7/7/93. The grounds are the same as mentioned as in relation to Temazepam, and for the same reasons, the Tribunal is satisfied on the balance of probabilities that he did so prescribe them.

Paragraph (c) alleges –

"During the period 2 May, 1994 - 21 June 1994 the practitioner prescribed Zanax tablets in excess of recognised therapeutic standards of what is medically appropriate."

Schedule A alleges that on 2 May, 1994, he prescribed 250 Zanax 1 mg X 6 repeats and on1994 500 Zanax by 1 mg.

The respondent concedes prescribing these amounts and concedes that they were in excess of recognised therapeutic standards.

Paragraph (d) alleges –

"During the period 4 January, 1993 to 20 June, 1994, the respondent prescribed drugs for Patient A when he knew or ought to have known:

- (i) that the patient was an addict and/or
- (ii) the drugs were likely to produce dependency in the patient.

The respondent concedes that he did prescribe these drugs and that at the time he knew or ought to have known that the patient was addicted to Temazepam. Paragraph (e) of this Particular alleges -

"During the period 4 January, 1993 to 20 June, 1994 the practitioner failed to exercise responsible medical judgment in his management and treatment of Patient A in that he:

- (i) inappropriately prescribed on a long term basis, Duromine to counteract the side effects of Temazepam.
- (ii) fail to consider and/or provide more appropriate treatment options.
- (iii) fail to reduce the dosage of Temazepam.

The respondent disputes the allegations other than that he agrees that he could have provided more appropriate treatment options.

In the course of his final address, Counsel for the complainant conceded that the evidence does not support the allegations that the Duromine was prescribed to counteract the effect of Temazepam.

It is not necessary to repeat Paragraph (f) as this allegation is not pressed.

Evidence was given by Dr Seidler on behalf of the Complainant that the quantities referred to above of the respective drugs were clearly in excess of good medical practice and that in his view, it was such that it would warrant the reprobation of his peers of good repute and standing.

Dr Seidler, however, was not fully appraised of the details of the background of the patient nor of the conditions with which she presented.

This patient was a married woman with children and was born on 2 October, 1952. Accordingly, at the time of the prescriptions, she was in her early forties. She had been a patient of the respondent since 1975. In mid 1986 he referred her to Professor Johnson of the Department of Psychiatry, Royal Prince Alfred Hospital. On 23 July, 1986, Professor Johnson reported with a history that the patient dated the onset of her illness to age 17 in 1969 when she was hospitalised at St John of God, following an overdose, her illness having been precipitated by a broken relationship. He goes on to say that there was post partum depression following the birth of her children in 1979, 1983 and 1984. Her symptoms as at mid 1986 started about one month before July, and was characterised by excessive crying, increased irritability, inability to cope, tired all the time, totally hopeless concerning the future and suicidal. There was insomnia, loss of appetite but no weight loss and clear suicidal ideation.

He felt that she had a severe depressive illness and in view of its severity he recommended hospitalisation in the affective disorders unit at that hospital.

On 30 March, 1987, Dr Williams, Psychiatrist, reported to the respondent of having seen her regularly. An insight into the type of patient she was appears in this report in this passage

"Since you have become semi-retired from medical practice, Wendy has transferred much of her dependency to Elizabeth and I, and barely a day goes by without her ringing up in distress, and having lengthy phone conversations. Her need is genuine enough, and she has certainly not rung up other than when she has really been in a mess. However, the dangers are also obvious enough - What will happen when AZN and WOW are both unavailable?"

"AZN" refers to the respondent and "WOW" refers to Dr. Williams.

He goes on to say "Her drug use worries me greatly and I appreciate that there is no easy solution." He further says:

"From my point of view, it is becoming increasingly clear what limitations there are on assisting Wendy individually and the couple together. At best I suspect we can only hope for a relatively minor improvement in the quality of life, and in the management of the period of decompensation. I will soldier on, on a regular weekly basis until it is abundantly obvious that we can get no further and then perhaps see if they will agree to see me together in a supportive way, perhaps once a month".

On 20 September, 1995, Dr Greenway, Psychiatrist, wrote to the respondent

"I think that we have a combination of substance abuse and panic disorder in someone who has a borderline personality. I think that we have to be careful about medicating her and also her expectations of us. I doubt if I will be able to establish the level of rapport that you have with this lady and certainly it does appear that (at the risk of sounding melodramatic) that there have been times when she had owed you her life."

In a letter appearing at pages 67 and following of Exhibit 1, the respondent sets out in considerable detail the history of this patient. He points out that in 1989, after prolonged and intensive counselling sessions from him, involving himself and her family, she voluntarily committed herself to the Jarra House refuge for women and children at Campsie where she voluntarily withdrew from all medications. Her drug use and hallucinations ceased after about 8 months. He goes on to say -

"Following her self-generated withdrawal, this brave lady achieved approximately 3 years in remission with complete absence from any tranquillising medications while bringing up three excellent, exemplary children and leading a happy family according to reports from the patient and

husband. However, approximately 3 years ago, (1991), the patient's borderline dysphoria returned to such a degree that she presented to local general practitioners, asking for relief for her dysphoria and was prescribed the Benzodiazepine Temazepam [Normison], a medication usually prescribed as a hypnotic for insomnia. By the time, the patient first saw me in 1991, she was taking between 30 to 100 Normison capsules daily. The patient was abusing alcohol to potentiate what relief she could obtain from these medication. After intensive counselling, by mid 1992, the patient gave me a firm commitment to cease all alcohol and I am pleased to report she has since maintained a complete abstinence from alcohol. However, multiple repeated attempts at gradual withdrawal of Temazepam was characterised by good initial progress, followed by over enthusiastic reduction to very low levels, followed by punishing halluciaosis, with rebound Temazepam levels. So it was a five steps forwards - six steps backwards process. In November, 1991, the patient revealed having severe panic attacks. These panic attacks were initially related to when she was driving over bridges but progressed to the point that they occurred whenever she was stressed, or when she was rushed. I contracted with the patient to revise and re-establish progressive muscle relaxation and cognitive thought blocking techniques, which commenced shortly thereafter. Results were mixed, complicated by her massive Benzodiazepiene requirements and both their immediate adverse affects as well as those that appeared on any dosage reductions."

In the same letter he details his attempt to wean her off the drugs with various difficulties arising. By June, 1993 she noticed a recurrence of lumps at the operation site where she had a left mastectomy for carcinoma of the left breast. This deteriorated the situation over the next few months to the point where her panic disorder increased in severity and frequency to a stage of frank agoraphobia where she was virtually housebound. As a result she reverted to taking up to 50 Temazepam tablets per day. The respondent started her on Alprazolam on 2 May, 1994 whereafter she ceased tranquillisers, alcohol and all other drug use other than those prescribed. Furthermore the respondent involved the whole of her family in his attempts to address the problems and complications of her tranquilliser use and maintained telephone contact with as many chemists as possible in the area of his surgery and her home to ensure that she did not obtain non-prescribed drugs.

The evidence clearly establishes that from time to time the respondent referred her to a number of psychiatrists, some of whom have already been mentioned. In addition there was Dr Bolinda. By'31 August, 1994, Dr Bolinda reported to the respondent following a joint consultation with the patient - "as discussed with you she has been reduced from high dosages of Xanax to current 16-20 mgs per day for severe

phobic anxiety state." He goes on to say that the patient has a severe phobic anxiety state and sudden withdrawal of Xanax is likely to lead to complications. "Therefore as discussed today, gradual withdrawal of about 1 mg a week over the next six months or so is likely to be more effective. If the panic attacks recur, the dose of Xanax may have to be increased".

PARTICULAR 3

Refers to Patient B.

Paragraph (a) alleges:

"During the period 17 June, 1989 to 17 September, 1989, the respondent prescribed Nembudeine tablets in quantities in excess of recognised therapeutic standards of what is medically appropriate."

Schedule B reveals that in that three month period, he prescribed a total of 13,027 tablets.

Paragraph (b) alleges:

"During the period 6 March, 1994 to 8 May, 1994, the respondent prescribed Rohypnol, Lexotan and Diazepam in quantities in excess of recognised therapeutic standards of what is medically appropriate."

This allegation is admitted by the respondent.

Schedule B reveals that 185 Rohypnol tablets, 60 Lexotan, and 50 Diazepam tablets were prescribed during this 2-month period.

Paragraph (c) alleges:

"During the period 17 June, 1989 to 8 May 1994, the respondent prescribed drugs for his patients when he knew or ought to have known:

- (i) that the patient was an addict and/or
- (ii) the drugs were likely to produce dependency in the patient."

The respondent concedes only the prescribing of the drugs.

Paragraph (d) alleges:

"During the period 17 June, 1989 to 8 May, 1994, the respondent failed to exercise responsible medical judgment in his management and treatment of Patient B in that he:

- (i) inappropriately prescribed on a long term basis, Nembudeine.
- (ii) failed to consider and/or provide appropriate treatment options.
- (iii) prescribed a combination of Codeine Linctus, Rohypnol, Mersyndol forte and Lexotan between 6 March, 1994 and 8 May 1994 when the patient was on Methadone.
- (iv) prescribed Ephedrine to counteract the effects of the Benzodiazepine drugs."

The respondent concedes paras.(i) and iii) and that he failed to provide more appropriate treatment options.

Paragraph (e) alleges that the respondent charged the prescriptions for Nembudeine tablets to his pharmacy account.

The respondent concedes this. Whilst at first sight this may raise suspicions of selling the drugs for a profit, this Tribunal is comfortably satisfied, having regard to the totality of the evidence much of which will be referred to later, that, in this particular case there is nothing sinister in the fact that the respondent charged the prescriptions for Nembudeine tablets to his pharmacy account. This Tribunal is satisfied that the respondent gave the tablets to the patient out of concern for the welfare of the patient and as an act of charity.

Dr Seidler, who was called on behalf of the complainant described the mixture of Methadone, Codeine Linctus, Rohypnol, Mersyndol forte and Lexotan as evidence of a gross dereliction of medical duty by the respondent. He pointed out that the patient was obviously an addict, had been on a Methadone programme and the combination of hypnotics and sedatives and compound analgesics, together with tranquillisers was a gross departure from good clinical practice in the treatment of addiction. In evidence, Dr Seidler pointed out that Nembudeine tablets were highly sought after in 1989 by addicts of all sorts as a way of reducing the pain of their withdrawal and that if a patient who had a history of drug dependency came in and requested a drug like Nembudeine in 1989, any practitioner would have a high incidence of suspicion that this patient was abusing that medication.

Patient B was born on 7 February, 1964 and so by the time of the matters complained of, was aged between 25 and 30.

He was introduced to the respondent by his sister, brother and mother. The whole family, going back to the grandmother, had a history of dependency problems on tranquillisers. The patient's brother had died of an overdose and they brought the patient to the respondent to see if he could do anything about the dependency problems.

The respondent referred the patient to Mr Stent, a behavioural psychologist who obtained a history that the patient's problems with drug abuse had started after the death of his father, four to five years earlier. In December, 1986, the respondent

noted that there had been trouble at Odyssey House' and that the patient had gone to Langton, Clinic and had also been referred to Narcotics Anonymous. In September, 1987, the respondent discussed with the patient the McKinnon unit for detoxification. As at 26 December, 1988, the patient had been seeing a Dr Gower, in South Australia and who had prescribed Nembudeine and Nembutal.

The evidence discloses that the respondent sought treatment for the patient from other sources. These included:

- August, 1988, Dr Roberts, Psychiatrist.
- March 1989, he had plans to go to Wisteria House.
- April, 1989, he recommended Westmount Hospital for medicated withdrawal.
- January, 1990 the patient was referred to a counsellor
- February, 1990 he was referred to Dr. Samag, psychiatrist.
- In August, 1990, it was noted that the patient had recently moved to South Australia and that a doctor in that state, would refer him for drug and alcohol dependency treatment.

θMay, 1991, the patient was being seen by Dr Potter, psychiatrist, who was reducing the Nembudeine regime.

- On 6 March, 1994 he was seeing a South Australian Psychiatrist, Dr Gorton, when it was noted that he was then on Lexotan, Rohypnol and Codeine Linctus. On 28 March, 1994 he saw Dr Byrne who put him on Methadone (105ml).

In January, 1995, the patient was referred by the respondent to Dr Byrne, who reported:

" He has proved us both wrong by detoxing himself of all Benzos about 3 weeks ago. This coincided with being transferred to Langton Clinic for Methadone dosing and dose reductions from a high of 160 mgs daily"

In evidence at P 186, the respondent said that he knew that Patient B had been a drug abuser from 1986 and that he was abusing Nembudeine in 1989 and that he came back from South Australia in 1994 on Methadone. The patient had remained addicted to narcotics for the duration that he was on the Methadone programme but the respondent could not recall the period over which he remained on that programme.

PARTICULAR 4

This relates to Patient C

Paragraph (a) alleges:

"During the period 23 March, 1993 to 28 May 1994, the respondent prescribed Rivotril tablets in quantities in excess of recognised therapeutic standards of what is medically appropriate."

Schedule C alleges that between 5 October, 1993 and 16 October, 1994, the respondent prescribed a total of 2500 Rivotril tablets.

However, the respondent disputes a number of the prescriptions for Rivotril, as well as for other items attributed to him in the Schedule, and concedes only the prescriptions of 200 each on 5/10/93, 13/12/93, 10/5/94, 17/5/94 and 16/10/94 making a total of 1000 Rivotril tablets during this period of approximately 12 months.

He argues that there is no confirmation of these prescriptions in the form of the prescriptions themselves and the only evidence supporting the existence of disputed prescriptions is evidence of the computer print-outs from the pharmacies. There is evidence in relation to at least 2 prescriptions for Panadeine Forte that, although the respondent was nominated on the print-out as the author of the prescription, examination of the original form of prescription shows that it was in fact prescribed by another practitioner. Having regard to the fact that those errors occurred in relation to this particular patient, this Tribunal is not comfortably satisfied on the balance of probabilities that a total of 2800 Rivotril tablets was in fact prescribed and is inclined to the view was substantially less.

Paragraph (b) alleges:

"During the period, 20 March, 1993 to 1 November, 1994, he prescribed drugs when he knew or ought to have known.

- i. the patient was an addict and/or
- ii. the drugs were likely to produce independency.

Even allowing for the fact that a number of the prescriptions set out in schedule C are in dispute, the respondent concedes that he did prescribe, when he knew or ought to have known that the patient was an addict to Rivotril and that the Rivotril was likely to produce dependency in the patient.

Paragraph (c) alleges:

"During the period 20 March, 1993 to 1 November, 1994, the respondent failed to exercise responsible medical judgment in his management and treatment of the patient in that he:

- (i) inappropriately prescribed on a long term basis the combination of drugs on the dates and in quantities shown in Schedule C.

(ii) failed to consider and/or provide appropriate treatment options.

The respondent concedes that he inappropriately prescribed on a long term basis Rivotril and also concedes that he failed to provide more appropriate treatment options.

Paragraph (d) alleges:

"During the period of 3 January, 1994 to 26 June, 1994, the respondent prescribed a drug of addiction, namely MS Contin for the patient for continuous therapeutic use for a period exceeding two months:

- (I) without obtaining an authority so to do from the Department of Health; and/or
- (ii) contrary to section 28 of the Poisons Act 1966."

The respondent concedes that he prescribed MS Contin for the patient without obtaining an authority from the Department of Health, but says that he was not required to do so.

Paragraph (e) alleges:

"During the period 3 July, 1994 to 25 July, 1994, the respondent prescribed a drug of addiction, namely Morphine (30 mg ampoules) for the patient in excess of the quantity specified in an authority under S.29 of the Poisons Act and without having applied for or having been given an authority from the Department of Health under S.29 for an increased quantity of Morphine."

This allegation is not admitted.

In his evidence, on behalf of the complainant, Dr Seidler testified that Rivotril falls into the category of highly sought after Benzodiazepines by drug users. It is sought after because it comes in packets of 200, whereas no other Benzodiazepine is marketed in such a large quantity and therefore, as he put it "you get more stone for your buck".

This patient's date of birth was 27th April, 1961. Accordingly at the dates mentioned in the complaint, he was 29 and 30 years of age.

Examination of the patient's file show that he was referred by the respondent by a number of other doctors and institutions. In September, 1993, he was seen by the pain clinic at Royal Prince Alfred Hospital. In December, 1993 the Hospital management reported "continue analgesia as prescribed by GP."

On 19 January, 1994 the Health Department issued an authority under the Poisons Act to prescribe Morphine Sulphate ampoules (30 mg at 5 ampoules per month). That authority was valid to 1 May 1994.

On 18 May, 1994 he attended Royal Prince Alfred Hospital.

On 17 July, 1994, the respondent wrote to Dr Galea regarding the medication prescribed and Dr Galea replied on 18 July critically of the prescription. Thereafter the respondent followed the guidance of Dr Galea.

On 28 September, 1994, the Palliative Care Unit of the Hospital wrote to the respondent - "for the time being, I feel it is appropriate for him to continue to be prescribed Anamorph."

He was seen by Dr. Galea at that Unit in September and on 23 November, 1994.

On 29 November, 1994, the Health Department gave authority under the Poisons Act to prescribe 20 tablets of Anamorph per month of 30 mg. That was a continuation of an authority granted on 26 October, 1993.

The file also contains a report from Mr Miller a clinical Neuropsychologist.

A note from Royal Prince Alfred Hospital of 8 May, 1995 states –

"[Patient C] has been able to cut his dose of Anamorph from 1 tab to $\frac{3}{4}$ of a tab on the days that he uses it. No great difficulty with current upper limit of 20 per month. He has appeared better cognitively with reduction in medication."

Under cross-examination, the respondent conceded that his prescription of Rivotril was inappropriate and that he should have taken him off that drug earlier. He was asked :

"Q. You thought it was responsible management to prescribe him Rivotril, which you did.

A. He was fitting at the time, he'd just had brain surgery, he needed an anti-epileptic.

Q. You believed it was responsible to prescribe Rivotril, which you did prescribe him?

A. At the time, yes, but then it went on too long. I t Obviously it was because the numbers became excessive and I should have cut it back earlier."

He further agreed that a prescription of 600 tablets in December and 400 in November of 1993 was excessive and should have been reduced. When asked the maximum he should have prescribed in his opinion, he said - "eight per day but the amount would' have to be determined in conjunction with blood tests."

In relation to the prescription of the Schedule 8 drug, MS Contin, the respondent said that that was a trial and he was seeing if the patient would respond to

that medication. He concedes that he prescribed that drug on 3 January, 1994, in February, 1994 and on 23 and 27 March, 1994 and again on 1, 10, 17, 24 and 29 May 1994 and on 5 and 25 June, 1994. He further agreed that this trial exceeded 2 months. He was then asked –

"Q. Do you agree that they were continuous therapeutic use?

A. I remember trialing them, we did not eventually settle on them. That's why I didn't put an application in. It was not meant for continuous use without applying. No, not in that sense, no.

Q. Was it for continuous therapeutic use in fact, bearing in mind the prescriptions you issued?

A. No I mean I was trying - he was on Morphine injections and I was trying him on the MS Contin along with the clinic to see if he would respond better to the oral medication rather than the injections.

Q. Do you say that meant you did not have to seek an authority from the Department of Health, is that what you believed at the time?

A. Yeah, I believe I would see if I intended to prescribe it then or continue to prescribe it, I would apply.

Q. After how long?

A. If we decided to continue with it.

Q. After how long?

A.. My understanding was, after two months.

Q. Why did you not apply, in the case of Mr [Patient C], in the case of MS Contin.

A. We stopped - We tried him twice, he kept breaking the tablets in half and he wasn't supposed to be doing that, he was taking V 2a tablet at the time."

The evidence establishes that, on the on the balance of probabilities the prescription was for one to two tablets per day.

At this stage it is convenient to consider the terms of S.28 of the Poisons Act. In its relevant parts, this section states:-

"A medical practitioner shall not prescribe for or supply to any person a drug of addiction for continuous therapeutic use by that person for a period exceeding two months unless he so prescribes or supplies that drug in accordance with an authority in respect of that person given to him by the Director General under S.29."

MS Contin is and was, at the relevant time, a drug of addiction.

This Tribunal is comfortably satisfied on the balance of probabilities that the respondent did prescribe MS Contin (60 mg) at 20 tablets per time on 3/1/94, 25/1/94, 26/1/94, 13/2/94, 21/2/94, 28/2/94, 22/3/94, 27/3/94, 1/5/94, 10/5/94, 17/5/94, 24/5/94, 29/5/94, 5/6/94, 26/6/94 and 12/7/94.

On the basis that the patient was to take two per day, these prescriptions indicate the prescribing of a drug of addiction for continuous therapeutic use for a period from 3 January 1994 up until at least the week following 26 June 1994. This is clearly a period in excess of two months.

It may well be that the respondent was using the MS Contin as a trial only. Nonetheless it was a trial of a drug of addiction for therapeutic purposes. That trial for therapeutic purposes exceeded two months and the respondent failed to obtain the authority of the Department of Health as provided by law.

It is conceded by the respondent that he had the authority of the Department to prescribe Morphine, 30 mg ampoules, at the rate of 5 per month. He also conceded that he increased that in July, 1994 to 15 per month. When this was put to the respondent he responded - "yes, but once again, I have not prescribed the tablets to him for several months - the injections, for several months. There was no intention to continue prescribing at that level."

This of course completely misses the point. The obligation upon the respondent was not to exceed 5 ampoules per month. Over that month he in fact exceeded this authority three-fold.

This patient had organic reasons for his serious levels of pain and was seen by a number of other doctors in the years leading up to the period specified in the complaint. The records show that the respondent attempted to have other specialists treat him.

- In January, 1990, the respondent referred him to Dr Besser and Dr Teychenne, Neurologists.
- In May, 1990, he referred him to Professor Klineberg, a Faciomaxillary surgeon specialising in facial pain.
- In June, 1990 he referred him to Dr Reichardt, Psychiatrist, asking him to review the patient and advise and manage him in relation to Methadone.
- In November, 1990, he referred him to Dr Wolfendon, Neurologist asking him to review the patient in relation to his need for narcotic analgesia.

- In December, 1990, Dr Wolfendon referred the patient back to Dr Besser.
- In May, 1991 the Respondent wrote to the Department of Housing setting out the list of problems causing him pain at that time in order to assist the patient to obtain better housing.
- In September, 1991, the patient saw Dr Best, the Registrar of Faciomaxillary surgery.
- In December, 1991 he had physiotherapy.
- The respondent's first reference to prescribing Rivotril to the patient was on 17 March, 1992. This was for tempero-mandibular joint dysfunction and was chosen as it was also an anti-epileptic complications from his brain surgery such as fitting.
- Dr Besser of the pain clinic at the Prince of Wales Hospital saw him on 17 June 1992 and told him that there was nothing to worry about.
- In October, 1992, the patient passed out at the bus stop on the way to the pain clinic.
- In November, 1992 he had an appointment at the drug and alcohol unit at the hospital.
- In April, 1993 he was trialed with a TENS machine which gave no relief.
- In August, 1993 he saw the Pain Clinic and was to continue with the Clinic Psychiatrist.
- In September, 1993 Dr Hovis said that the patient had had a TMJ block and indicated that narcotics should be no problem.
- In October, 1993, he saw the pain clinic which expressed no concern at the intake of morphine by the patient. The respondent tried to stop Rivotril but a week later the patient had a tremor so he recommenced it.

In December, 1993, he was seeing Dr Ditton and also was referred to the Prince Alfred Hospital Neurologist. He also saw Dr Bousfield and Dr Gelea. By March of 1995 Dr Gelea had recommended switching back to MS Contin as being preferable to Anamorph. The final entry on 14 May, 1995 notes that the patient had ceased Rivotril completely and was actively reducing his Benzodiazepines.

PARTICULAR 5

The refers to patient D. Paragraph (a) alleges:-

"During the period 19 January, 1993 to 1 May, 1995, the respondent prescribed a combination of drugs for this patient when he knew or ought to have known:

- (i) that the patient was an addict and/or
- (ii) that the drug was likely to produce dependence.

The respondent concedes some of the prescriptions set out in Schedule D but disputes most of the prescriptions for Panadiene or Codral Forte on the grounds that there is no prescription signed by him and no record in his notes of such prescriptions. These alleged prescriptions are derived from computer print-outs from pharmacies.

Paragraph (b) of this Particular alleges:

- "During the period 19 January, 1993 to 1 May, 1995, the respondent failed to exercise responsible medical judgement in his management and treatment of the patient in that he:

- (i) inappropriately prescribed on a long term basis, Methadone on the dates and quantities shown in Schedule D.

Sub-paragraphs(ii) and (iii) are no longer pressed.

Paragraph (c) of this Particular alleges:

"During the period 20 September, 1993 to 27 July, 1994, the practitioner prescribed drugs of addiction, namely Methadone and Morphine for this patient for a continuous therapeutic use for a period of two months:

- (i) without obtaining an authority in respect of the patient to so prescribe drugs of addiction from the NSW Department of Health and
- (ii) in breach of Section 28 of the Poisons Act.

The respondent had the authority of the Department of Health to prescribe 5 ampoules of Morphine per month up to 1 June, 1994.

Schedule D reveals that during the above period he prescribed in May, 1994 a total of 10 ampoules and in July, 1994 a total of 15 ampoules. These prescriptions were clearly in breach of the terms of the authority which he had.

In addition, he prescribed Methadone, 20 tablets (10g) on 29/9/93, 30/9/93, 13/10/93, 27/10/93, 9/11/93, 7/12/93, 19/12/93, 20/12/93, 11/1/94, 14/2/94, 14/3/94, 27/3/94, 29/3/94, 18/4/94, 27/7/94, 18/10/94, 1/11/94.

Under Section 28 of the Poisons Act, a Medical Practitioner shall not prescribe for or supply a drug of addiction to any person who is in his opinion an addict of any drug of addiction, unless, in accordance with an authority given by the Director General.

No such authority was obtained.

In evidence, the respondent agreed that he held an authority to prescribe 5 Morphine ampoules per month up to 1 June, 1994. He also knew the patient's narcotic history namely that she had been on a Methadone programme, at least between January and April of 1987. He agreed that he prescribed for this patient, Methadone, without an authority and gave as his reason –

"She herself was concerned about being on the injections [for Morphine] although they gave her relief, and when we eventually decided to come off them. I had prescribed some. I attempted to prescribe Methadone tablets to reduce the injections."

The respondent added that the patient had a huge area of her head, which was denuded of skin, constant ulcers, osteomyelitis and was in constant pain and that is why she was getting Morphine.

When asked whether he thought it was appropriate to prescribe Methadone to this patient, 'when she had formerly been a narcotics addict and on the Methadone programme, he replied:

"Yes. In her case, she was a very responsible person, yes. She had a husband with her that was also involved in all the consultations. She was fine lady."

The respondent also said that the Methadone was a trial following discussions with Dr Glare.

The respondent described the prescriptions of Methadone as sporadic and not continuous. The respondent was asked.:

- Q. Did it not occur to you Doctor, that some time, in the period of September, 1993 through till April, 1994, that you had been prescribing Methadone for those months without an authority?
- A. When Miss Lawrence put them together I admit I was surprised at the number, however, looking at them in the Schedule, it was sporadic. That's the best I can say.

This patient was in her late forties, lived in a long term relationship with a partner and held a job during most of the time.

Examination of the patient's records reveal that the prescription of drugs was not the only treatment given by the respondent. The respondent referred her to a large number of specialists including the Pain Clinic, a Plastic Surgeon, Orthopaedic surgeons, a Neurologist, Rheumatologists, and Physicians. None of these specialists were able to relieve her severe pain by means of attacking the cause.

PARTICULAR 6

This relates to Patient E. Paragraph (a) alleges:

"During the period 24 January, 1991 to November 1992, the respondent prescribed Pethidine in quantities in excess of recognised therapeutic standards of what is medically appropriate."

The respondent does not dispute this.

Paragraph (b) of this Particular alleges -

"During the period 24 January, 1991 to 19 November, 1992, the respondent prescribed Pethidine when he knew or ought to have known:

- (i) that the patient was an addict and/or
- (ii) the drug was likely to produce dependency in the patient.

The respondent concedes the prescribing of Pethidine.

Paragraph (c) alleges:

"During the period 24 September, 1991 to 19 November, 1992, the respondent failed to exercise reasonable medical judgement in his management and treatment of the patient in that he -

- (i) inappropriately prescribed on a long term basis, Pethidine, for the treatment of chronic pain.
- (ii) failed to consider and/or provide more appropriate treatment options.

For reasons which will appear later, the allegation of failure to consider and provide more appropriate treatment options is not established.

Paragraph (d) alleges:

"During the period 5 January, 1992 to 16 March, 1992, the respondent prescribed a drug of addiction, namely Pethidine, in quantities in excess of the quantity specified in an authority issued under Section 29 of the Poisons Act and without having applied or having been given an authority from the Department of Health for an increased quantity of Pethidine."

This patient, who was in her late forties, had developed a tumour in her pituitary. It grew and-despite repeated surgery and radiotherapy it kept growing until it involved nerves three, four and six of her face. It wrapped itself around her left carotid artery and invaded the centre of her brain. This caused her a lot of pain. To relieve this pain she required opiates on a long term basis.

When the respondent first saw this patient, she already had this condition and had had surgery for it and was suffering from a lot of pain with migraines, sinusitis

and a considerable amount of documented illness. At that stage, she was receiving Pethidine occasionally from other doctors for bad pain exacerbation. She consistently consulted Professor Caterson who was her Endocrinologist. He expressed the view to the respondent that she should continue with intermittent Pethidine. The respondent referred her to the Pain Clinic but because of the nature of the tumour, they referred her back to Professor Caterson. The respondent discussed his dosage of Pethidine with Professor Caterson and also Dr White, a vascular surgeon. These specialists did not approve of the amount of Pethidine tablets prescribed when they reached higher levels but the respondent spoke to them because he was worried about the high levels and he wanted to bring her down to some control. The respondent was of the opinion that the patient was addicted to Pethidine because she was receiving it regularly.

At one stage she had a balloon placed in her stomach for weight control which caused her Considerable pain. To relieve this pain the respondent gave her an intravenous injection of morphine which was contrary to his normal practice. This relieved the pain instantly and that is when the problem began because the patient wanted to have further injections. The respondent said that he felt responsible because, if he had the foresight, he would not have given that injection.

A report from Dr Caterson to the respondent dated 19 January, 1990, confirms that this patient's problem had been, as usual, her continuing headache and nerve pain symptoms on occasions when she touches her hands and feet. A C.T. scan showed that the tumour had spread and was growing down the sphenoid. He also said that he prescribed her some Pethidine to carry her over the Christmas period, although he was hopeful that radiotherapy would be effective.

In a further letter of 22 July, 1991, Dr Caterson acknowledged that the patient was taking 12 to 20 Pethidine tablets per day and Pethidine injections and that he had written a further prescription for Pethidine.

In a further letter, dated 22 August, 1991, Dr Caterson said -
"I gave her another script for Pethidine and this is the third since you have been away. I look forward to you returning and taking over her pain management once more. I think we just need to encourage [the patient]."

Thus this Tribunal is comfortably satisfied that whilst the respondent's high prescriptions of Pethidine were inappropriate, the continued use of it was something

which was known to the patient's treating specialist and at least acquiesced to the extent of twelve to twenty Pethidine tablets per day.

The records also show that from 1977 onwards, the respondent was referring the patient to a large number of specialists as well as the Pain Clinic and the Drug and Alcohol Unit.

On 4 March, 1992, Dr White, Psychiatrist, wrote referring to the pressure of advice from the respondent and others on the patient to be admitted to hospital. On 1 April, 1992 he wrote referring to the patient's unbearable pain in her left leg. On 3 April, 1992, central Sydney Area Palliative Care Service wrote to the respondent noting that the patient was unlikely to accept help from Drug and Alcohol at Royal Prince Alfred Hospital and suggested Dr Woad at St Vincent's Hospital. As at 28 October, 1992, the patient was on Methadone but off everything. On 3 September, 1993, Dr Caterson wrote saying that the patient could now manage with Anodyne.

The respondent conceded that he had an authority from the Department of Health to prescribe 300 Pethidine tablets (50 mg) per month plus 14 Pethidine ampoules (100 mg) per week.

He also agreed that in January, 1992, he prescribed 600 Pethidine tablets (50 mg) for the patient, and in February, 1992, 1900 50 mg tablets and in March, 1992, 1200 50mg tablets of Pethidine. He gave as his reason that, after giving her the intravenous injection, she started going around to other doctors and hassled him to give her intravenous analgesia because it gave her instant relief. He was trying to get her back into control by increasing the tablets temporarily as an inducement not to go shopping around to doctors for injections. He was increasing the tablets but reducing the injections because he wanted to get her off the injections. He conceded that he was authorised to give her injections and had advice from specialists that injections were appropriate. He felt, however, that they were destabilising her. When asked whether the quantities in which he prescribed Pethidine were appropriate for her treatment, he replied -

"In retrospect no, but at the time that is the approach I took. In retrospect that was wrong."

He went on to say that she was a very unusual patient. She had a lot of pain and he gave her increased quantities which he should not have done. However, given

the circumstances of this patient, he felt that what he did was not in excess of recognised therapeutic standards at the time.

He also agreed that he should have handled her in other ways. He tried to refer her to the pain clinic at Prince Alfred Hospital but there were problems there. He was handed her by his colleagues and that is how he came to deal with her the way he did. He said that today he definitely would not take that approach and agreed that the amounts prescribed were in excess of recognised therapeutic standards of what was medically appropriate for that patient. He also pointed out that the patient was already dependent on drugs at the time he first saw her. He had tried to get her into the pain clinic at Prince Alfred Hospital but they referred her to the Drug and Alcohol Unit where she claimed she was treated badly. They called her a junkie and did not believe that she had a tumour. The respondent checked the patient's claims with Professor Caterson who himself checked it and found her complaints justified.

When the doctors treating her finally got her put on Methadone, Pethidine was stopped and she remained on Methadone.

When asked why he did not seek an increase in the authority for the amount of Pethidine he was prescribing beyond the 300 a month already authorised, he said

"I had no intention of maintaining it. If we had to maintain it, then I would have put an application in but I did not think that dosage could be".

He added

"I was probably too close to the case at the time, and as I said, I didn't intend to continue prescribing it.

PARTICULAR 7

This relates to Patient F. Paragraph (a) alleges:

"During the period 28 October, 1992 to 24 January, 1994, the respondent prescribed Rohypnol in quantities in excess of therapeutic standards of what is medically appropriate."

Paragraph (b) alleges that during the same period, the respondent prescribed Rohypnol in quantities when he knew or ought to have known:

- (i) that the patient was an addict and/or
- (ii) the drug was likely to produce dependency in the patient.

Paragraph (c) alleges - that during the same period, the respondent failed to exercise responsible medical judgment in his management and treatment of the patient in that he

- (i) inappropriately prescribed on a long term basis, Rohypnol.;
- (ii) failed to consider and/or provide more appropriate treatment options
- (iii) prescribed Catovit to counteract the effects of the large doses of Rohypnol.

In effect, this Particular alleges that over a period of some 456 days, the respondent prescribed a total of 450 Rohypnol tablets. The respondent prescribed 100 Catovit tablets on one occasion only, namely on 25 October, 1993.

Dr Seidler, when giving evidence on behalf of the complainant, expressed very serious reservations about the appropriateness of prescribing' Rohypnol. He said -

"More particularly, in that these were not private prescriptions for a very expensive medication and considering this patient from the notes, was staying at the Edward Egar Lodge, a hostel for homeless men, one must wonder how the patient obtained the necessary finance to obtain the necessary medication."

He went on to say that Rohypnol retails on the street for \$8 per tablet, so there is a huge black market for the medication. It is known as a Rambo because it makes people feel invincible and is highly prized by the homeless population who have had drug dependence problems in the past.

However, when one comes to look at the medical history of this particular patient, Dr Seidler's misgivings appear unfounded.

This patient was born on 10 July, 1955 and so at the relevant time was 27-29. He was one who wanted to do something with his life. He had been largely living a drug-orientated lifestyle. He wanted to study Librarianship at Sydney University. In order to achieve this, the respondent encouraged him to move into the Matthew Talbot Centre for homeless men where he was given a semi-permanent room for some three or four years. The patient, whilst working part time as a cleaner, put himself through the Librarianship course at Sydney University and completed it and is now working in that field on a permanent basis.

To assist in allowing him to study and maintain part-time employment, the respondent wrote a number of letters to employers actual and prospective. During the period concerned, the respondent counselled the patient and encouraged him to continue with his studies. The patient was low on funds and his main usage was to

abuse Amphetamine. If he could get a good night's sleep, the patient could wake up in the morning and go to work and do his studies. He was taking medication, including 1 -1½ Rohypnol tablets at night and that saw him through.

The respondent saw him once a month and he progressed well and he stopped medication. The patient had come from a background where he wanted to make a life for himself and his self esteem was low. The respondent was working on that and was happy to see the patient succeeding at University and the job.

The patient also had severe bipolar affective disorder (manic depressive psychosis). By 1991, he had been seen by Dr Reichhardt, a Psychiatrist.

The respondent knew that the patient was on a Methadone programme at the time he treated him, because he had referred him to Dr Reichhardt for that treatment. He also was aware that Rohypnol was a drug which could be abused. However, in this particular case, he felt that the patient needed something to get him to sleep so that he could pursue his studies and part time work. Rohypnol did that. The respondent felt it unlikely that the patient was abusing the drug or selling it, because he seemed to be taking it at monthly intervals and was managing with his studies and part time work as a cleaner. Under these circumstances the respondent did not agree that his prescribing was inappropriate notwithstanding the patient's prior history of substance abuse.

PARTICULAR 8

This relates to Patient G. Paragraph (a) alleges:

"During the period 11 June, 1989 to 6 June, 1981, the respondent prescribed Nembudeine in quantities in excess of recognised therapeutic standards of what is medically appropriate.

Schedule G shows that from 11 June, 1989 to 3 September, 1989 the respondent prescribed either 200 or 250 tablets at a time. In 1991, he reduced his prescriptions to either 50 or 75 tablets at a time.

The respondent concedes the prescriptions of Nembudeine and that they were in excess of required therapeutic standards of what is medically appropriate.

Paragraph (b) alleges:

"During the period 11 June, 1989 to 2 May, 1993, the respondent prescribed Methadone, Nembudeine, and Pethidine when he knew or ought to have known :-

- (i) that the patient was an addict and/or
- (ii) the drug was likely to produce dependency in the patient.

The respondent concedes that during this period he prescribed these drugs and that he did know at the time that the patient was addicted to Nembudeine.

Paragraph (c) alleges:

"During the period 11 June, 1989 to 2 May 1993, the respondent failed to exercise responsible medical judgment in his management and treatment of patient G in that he

- (i) inappropriately prescribed on a long-term basis, the combination of drugs shown in annexure G and
- (ii) failed to consider and/or provide more appropriate treatment options.

The respondent concedes that he inappropriately prescribed on a long term basis the combination of drugs alleged. He said that he did consider more appropriate options but agrees that more appropriate options for treatment should have been provided.

Paragraph (d) alleges;

"During the period 30 July, 1992 and 2 May, 1993, the respondent prescribed a drug of addiction, namely Pethidine to patient G for continuous therapeutic use for a period exceeding 2 months.

- (i) without obtaining an authority in respect of the patient so to prescribe from the NSW Department of health and/or
- (ii) contrary to S.28 of the Poisons Act.

Schedule G shows that the respondent prescribed 100 Pethidine (50 mg) on 30 July, 1992 and 50 such tablets on 14 September, 15 October, 18 October and 7 December of 1992. On 6 January, 1993 he prescribed 100 tablets and then 50 tablets on each of 2nd, 4th April and 2nd May 1993.

For the period from 30 July, 1992, to 7 December, 1992, the prescriptions are approximately equivalent to one tablet per day which would constitute prescriptions for continuous therapeutic use for a period exceeding two months. There is then a break until 6 January, 1993 from which point the prescriptions are much less and would appear to constitute continuous therapeutic use for a lesser period than one per day. Accordingly in respect of the period July to December, 1992, this Tribunal is satisfied that the respondent was in breach of S.28 (a) of the Poisons Act.

This patient was born on 21 July, 1945 and so at the relevant time was into her late forties. She was a transsexual having undergone the relevant surgery. She also had considerable back pains and psychiatric problems. From the Schedule of prescriptions (G), it does appear that the respondent's attempts to reduce the amount prescribed to her was unsuccessful. The respondent stated that he was working with her to reduce them. He also explained that he prescribed Methadone because she had back pain. She had put on prodigious weight and had severe lumbosacral problems. This was prescribed after the patient had ceased the use of Nembudeine. He commenced her on Pethidine in July, 1992 because he felt that it was a partial antagonist to narcotics as people who have any predilection to addiction tend not to like Pethidine. He also pointed out that narcotic addiction was never a question with this patient but he put her on Pethidine to make sure that it remained that way.

The medical records show that the respondent referred this patient to a number of specialists as far back as 1978 when there is a letter from Dr Anthony Hordern, Psychiatrist. In November, 1978 there is a report from Dr Greenway and a further one in April, 1980. The respondent had referred the patient to Dr Hassle, a Rheumatologist in October, 1981 and in June, 1992 to Dr Robertson.

PARTICULAR 9

This relates to Patient H. Paragraph (a) alleges:

"During the period of 30 September, 1991 to 15 November, 1993 and in May, 1994, the respondent prescribed Morphine and MS Contin for patient H in quantities in excess of recognised therapeutic standards of what is medically appropriate."

The respondent concedes prescribing these drugs and concedes that they would be normally in excess of recognised therapeutic standards but says that in the peculiar circumstances of this patient, they were appropriate.

Paragraph (b) alleges:

"During the period 3 September, 1991 to 15 November, 1993 and in May, 1994, he prescribed Morphine and MS Contin for patient H when he knew or ought to have known:-

- (i) that the patient was an addict and/or
- (ii) the drug was likely to produce dependency in the patient.

The respondent concedes prescribing the drugs but says that she was already an addict to Morphine prior to his seeing her.

Paragraph (c) alleges:

"During the period May, 1994 the respondent prescribed drugs of addiction, namely, Morphine and MS Contin for Patient H in excess of the quantity specified in an authority issued under S.29 of the Poisons Act and without having applied or having been given an authority for increased quantities of those drugs."

The respondent concedes prescribing the drugs.

The respondent first met this patient in 1975 shortly following her initial motor vehicle accident that led to over twenty operations on her right talus, eventual amputation and development of an extremely severe case of phantom limb pain. That this was such a severe case of pain is corroborated by Dr Jones of the South Sydney Rehabilitation Centre. After 1975 he lost contact with her until she was referred to him in about 1985 with extreme difficulty in coping with the severity of nerve storm pains. She was already receiving approximately double the amount of injection that was authorised. She was suffering from stump ulceration, bilateral shoulder osteoarthritis, severe left knee osteoarthritis, panic attacks and increasingly severe angina and left ventricular cardiac failure. On top of this, she had had carcinoma of the rectum which appeared to have resolved.

The patient's records show that in March of 1985 Dr Bartrop, Psychiatrist, wrote to Dr Biggs, the patient's former general practitioner noting that he would speak to Dr Morgan of the pain management unit at Royal, North Shore Hospital. Dr Teychenne, Neurologist, wrote to the respondent indicating that he had also been involved.

On 22 April, 1985 the respondent received an authority to prescribe Pethidine, 100 mg and Morphine 30 mg ampoules.

In August, 1986 Dr Willis, Psychiatrist noted that the patient was taking 15 mg of Morphine every second night to sleep and that she had intense pain.

By letter dated 20 February, 1994, Dr McDonald of the Drug and Alcohol Department of Royal Prince Alfred Hospital noted that opioids were going to be a lifetime necessity for this patient.

The evidence satisfies this Tribunal that the respondent prescribed Morphine to relieve the patient's pain and attempted to try to reduce the quantities needed in the face of multiple deteriorating illnesses and continuing phantom limb pain. He referred her to specialists at the Royal Prince Alfred Hospital Pain Clinic who concurred with

her need for narcotics on a long term basis. It was they who suggested trying to wean her off the injected Morphine to the oral long-acting Morphine and this met with mixed success.

Under these circumstances this Tribunal is not satisfied on the balance of probabilities that the respondent prescribed the drugs alleged in excess of recognised therapeutic standards or inappropriately.

Dr McDonald was critical of the respondent in allowing the patient to self inject. The respondent explained that she was already self-injecting when he saw her in about 1985 and he pointed out that whilst it was easy for a specialist to make this comment, it was another thing to achieve it.

In relation to the allegation in Paragraph (c), the respondent disputes that in May, 1994 he prescribed 120 Morphine Sulphate 30 mg ampoules and MS Contin 60 mg ampoules. The only evidence supporting such a prescription is from a computer print-out. There is no prescription in existence verifying this allegation nor is there any record in the respondent's notes.

In the view of the fact that these are the only two such alleged prescriptions for such a large amount this Tribunal is not comfortably satisfied on the balance of probabilities that the prescriptions alleged to have been given in May, 1994 were written by the respondent.

PARTICULAR 10

This relates to patient I. In his final address, counsel for the complainant conceded that the evidence does not establish this Particular of complaint. Accordingly it is not set out here.

PARTICULAR 11.

This relates to seven patients referred to as J, K, L. M. N. O and P and alleges in paragraph (a):

"During the period 24 July, 1991 to 1 August, 1994, the respondent prescribed drugs of addiction to these patients for continuous therapeutic use for a period exceeding two months;

- (i) without obtaining an authority in respect of the patient so to prescribe drugs of addiction from the NSW Department of Health and/or
- (ii) contrary to S.28 of the Poisons Act.
- (iii) when he knew or ought to have known that the patients had been or were on a Methadone programme.

Patient J.

In relation to patient J, Schedule J alleges that the respondent prescribed Pethidine, 50 mg tablets on the following dates:

8 February, 1993	-	20
8 March, 1993	100	
23 March, 1993		100
13 April, 1993	50	

This would appear to be a prescription of Pethidine for continuous therapeutic use from the 8th of February to 13 April, 1993, a continuous period in excess of 2 months.

The same Schedule also reveals prescription of the same tablets on the following dates:

1 May, 1994		100
10 May, 1994	100	
18 July, 1994	25	

This Tribunal is not satisfied on the balance of probabilities that this constitutes continuous therapeutic use for a period of 2 months.

The respondent concedes that he was aware that patient J had attended the Langton Clinic for Methadone and was resumed on that programme on 30 August, 1993. This of course is subsequent to the first of the two periods mentioned above.

The records show that on 7 November, 1989 the respondent applied for authority to prescribe Pethidine 50 mg, not over 6 tablets per day for L4/5 disc protrusion. On 3 February, 1992 he referred the patient for Methadone blockade maintenance programme. On 23 March, 1992 the respondent wrote that the patient was suffering from chronic indolent and symptomatic Hepatitis C. He referred him to a specialist to manage this condition.

On 29 March, 1993 Dr Bentivoglio, Orthopaedic surgeon, reported on the existence of low back pain and the presence of foot drop.

On 12 August, 1993, Dr Willis wrote to Dr Slivoratnam to see the patient with the view to Methadone maintenance adding that he had been on Heroin for the past three weeks after the death of his father.

This patient was a psychiatric nurse in his late forties who had sustained a back injury when lifting a heavy patient and had undergone surgery. He told the

respondent that he needed the medication so that he could continue with his nursing career.

When asked why he did not apply for authority in 1992/1993 to prescribe Pethidine, the respondent replied that he did not intend to prescribe it on a long term basis and he was not sure whether he was aware, at the time of the prescription that the patient was addicted to a drug of addiction.

Although the prescriptions in 1994 does not amount to continuous therapeutic use for a period of two months, Pethidine was nonetheless prescribed to a patient whom the respondent then knew to be an addict to a drug of addiction. His knowledge came from the fact that he was on a Methadone programme. Accordingly the prescription in 1994 constitutes a breach of S.28 (b) of the Poisons Act.

Patients K and L

In this final address counsel for the complainant conceded that the evidence did not establish the matter particularised.

Patient M

The allegation here is the respondent prescribed Methadone (10 mg tablets), 20 at a time on 15 September 1991, 29 January, 1992, 9 September, 1992, 15 December, 1992, 12 December, 1993, 5 July, 1993, and 3 April, 1994. None of these prescriptions could be said to constitute a prescription for continuous therapeutic use for a period exceeding two months. However, in this case the respondent was aware, by reason of a letter from Dr Dalton dated 26 August, 1990, that patient M was on a Methadone programme and, therefore, that she was addicted to a drug of addiction. Consequently he was obligated by S.28 (b) of the Poisons Act to obtain the authority of the Department of Health before so prescribing. He did not do so.

Patient M was born on 10 October, 1953 and so was in her late 30's at the time referred to in the complaint. She had been involved in a motor vehicle accident in December, 1988 suffering severe damage to both legs one of which was left deformed.

The respondent's medical records contain a number of reports from other doctors, including specialists, regarding her physical condition.

On 26 August, 1990, the respondent referred the patient to Dr Dalton for Methadone blockade treatment. On 15 December, 1992 he wrote that the patient had difficulties dealing with substance disorders. On 15 March, 1993 he referred her to Dr

Tooth, an Orthopaedic specialist. On 29 March, 1994 he wrote, "Over the past years introduced Marijuana. ... She found the use of Marijuana helped to blunt the severity of her pains." The respondent said that when he last saw patient M she still needed surgery on her leg which was horribly deformed. "It was pointing out in the other direction and she was still having a lot of pain. "When queried about his prescription of Methadone, the respondent said -

"Once again I gave the patient the benefit of the doubt. She was in a lot of pain. She was in a bike smash and her leg was pointing the other way and she had multiple surgery. I gave her the benefit of the doubt. I shouldn't have."

Patients N and O

In his final address, counsel for the complainant indicated that these particulars are not pressed. Accordingly they are not repeated.

Patient P

The particulars of prescription for Methadone included in Schedule J in relation to this patient, do not show prescriptions for continuous therapeutic use of Methadone for a period exceeding two months. Rather they show prescriptions for therapeutic use for a period of about a month to a month and a half in late 1991, March, 1992 and again in about mid 1994.

This patient was born on 11 November, 1962 and so was in her early 30's at the time of the treatment.

On 1 December, 1991 the respondent wrote a referral notice describing the patient as one having a difficult time giving up Heroin. The file also contains relaxation charts and instructions and also "Lists of This Weeks Goals" which the respondent was using in his counselling of the patient towards the goal of relieving her of her addiction. She was the victim of a rape and the extent of her internal turmoil can be seen in her note of 8 June, 1992:

"Basically since the rape I am confused by Counsellor and Legal System - don't know what to do, who to see. They all send me to each other. RPA and Kirkton Centre."

This Tribunal is comfortably satisfied that the respondent well knew that the patient was addicted to a drug of addiction at the time that he prescribed the Methadone tablets. Accordingly his failure to obtain an authority from the

Department of Health before so doing, brings him in breach of S.28 (b) of the Poisons Act.

PARTICULAR 12

This alleges that the respondent failed to maintain a Register of drugs of addiction contrary to the regulations under the Poisons Act. The respondent concedes this but it is to be noted that after he was interviewed in about September, 1994, he rectified this default and by November, of that year his records and register were described as being in order.

PARTICULARS 13 AND 14

In his final address, counsel for the respondent conceded that these particulars were not pressed.

AN OVERVIEW OF THE RESPONDENT'S CONDUCT

When one looks at the volume and nature of the drugs prescribed by the respondent in isolation, one can be forgiven for becoming highly suspicious that his prescribing practices were indicative of something other than the legitimate therapeutic treatment of his patients. However, an examination of the medical history of each of the patients referred to earlier, indicates that there is no basis whatsoever for this suspicion. Each of the foregoing patients had severe problems. In many of them the problems were intractable, Most of the patients had severe organic disabilities giving rise to severe pain.

In none of the above cases was the respondent's treatment limited to the mere prescription of drugs. He spent a considerable amount of time with each of them trying to wean them off drugs by means of counselling. In addition he referred them to others for specialised treatment. All too often the response was merely to refer the patient back to him for continuation of day to day management.

The respondent treated these patients with a drug prescribing regime which he developed in the belief that he was doing them some good. but in reality he could have been doing them harm.

The respondent graduated in Medicine at Sydney University in 1972. From 1975 to 1980 he practised with Dr Berenson as a general practitioner in Leichhardt. In 1980 he commenced a new practice in Marion Street, Leichhardt and some of his former patients followed him.

His evidence was that whilst all of the patients specified in the Complaints were patients to whom he prescribed Opiate medications, this was not a typical sample of his patients. He said that, on average, he saw fifteen to twenty patients per day of whom three to five were taking addictive medications. About half of his patients were psychiatric.

He concentrated on counselling patients and enjoyed this type of work and prepared a number of sheets covering such matters as relaxation training, stress management, drug addiction and had them printed out and provided them to patients.

The respondent gave evidence that when the Complainant wrote to him he was disturbed by the fact that the allegations came to be made. He added:-

"On standing back and looking at my prescribing practice, I believe that I became too close to the patients and too involved with their problems. In many cases I persisted in prescribing addictive medications for too long. I prescribed analgesics when I should not have. The reason was simply that my judgment was adversely affected by my personal desire to help the patients get over their problems. Many of the patients had underlying personality disorders. I failed to recognise, as was pointed out to me later, that personality disorders cannot be effectively treated while patients have high drug levels. "

This Tribunal accepts this explanation, supported as it is by further evidence referred to later. It does appear that the patients were referred to the respondent because he treated them with sympathy and spent a lot of time with them as well as giving them prescriptions for drugs. In many respects his errors arose because he embarked upon the treatment of difficult patients when he lacked the specialised training and expertise so to do. The tragedy for the respondent is that he did not then realise the deficiencies in his own knowledge and expertise.

Because of the difficulties arising out of the Complaints, the respondent became depressed to the extent where he sought psychiatric assistance from Dr. John Woodford. Furthermore, he disposed of his practice and in February, 1997 surrendered his registration as a medical practitioner. Since then he has worked in his own business which involves selling to medical practitioners specialised computer programmes for use in their practices. He testified that he has no present intention to resume medical practice.

Dr Greenway in a reference dated 3 August, 1995 says that he had had professional contact with the respondent since 1978 and goes on to say

"Dr Zahra-Newman's referrals were not infrequently of difficult patients for whom I felt I could do little. Dr Newman would continue to treat and had a tendency to become enmeshed with these patients on occasions. I suspect that at times his clinical judgment was clouded by a need to succeed and not give up on patient,. I am not implying by this an improper relationship, but rather that Dr Newman found it difficult to "let go" and to say "no" when required. This is perhaps a reflection of an inability to admit failure or to let go rather than evidence of carelessness."

In a letter dated 1 August, 1995, Mr George Stent, clinical psychologist states that he shared consulting rooms with the respondent between 1981 and 1988. He says that many patients regarded the respondent as "the only one who understands". He goes on to say:

"I believe that ultimately his tolerance and understanding resulted in developing a patient population which could only be described as incredibly demanding and manipulative.

"I must admit that Tony's patience with chronic psychological conditions exceeded my own tolerance. I found that the patients who were referred to me by Tony were by far the most demanding patients I had to deal with. I was in awe of his apparent ability to manage a practice where such patients were the majority rather than isolated cases.

"These observations of Tony are made in the knowledge that his clinical methods are the subject of Departmental scrutiny. As a psychologist, my observation of Tony's clinical approach was that he was insightful and indefatigable. It is regretful that at times he has been unable to emotionally distance himself for the pain of his patients and their desire for short term gratification. His is a case of compassion clouding judgment regarding accepted methods of clinical practice."

Dr Charles Ovadia gave a reference dated 25 July, 1995 in which he says:

"I can state that Dr Zahra-Newman has a case load of patients who are very difficult for other GPs to deal with; patients who suffer from chronic pain syndromes, chronic rheumatological syndrome, drug dependence, personality disorders, manic depressive disorders. These patients and their families are so difficult and so time consuming that I have seen them refused treatment elsewhere. Dr Zahra-Newman seems to be able to grant them a lot of time and patience and with good results."

These references add further support to the evidence of the respondent himself.

As mentioned earlier, the respondent came under the care of Dr John Woodford, a Psychiatrist who has had considerable experience with treating medical practitioners. He first, saw the respondent on 26 May, 1995 when he was extremely

distressed and indeed depressed. Dr Woodford has continued to see the respondent on a regular basis ever since. In his report of 22 July, 1996 Dr Woodford says of the respondent:

"He perceives more clearly, in retrospect, the problems which had been going on in his patient management. This understanding was being assisted by his participation in a Masters Degree in psychological medicine."

In evidence, Dr Woodford said that over the last three years that he has known the respondent they have talked quite a bit about his practice and the respondent demonstrated that he has a greater understanding now of the problems that he encountered in the management of his patients. He also stated that from a psychological point of view the respondent is fit to practice medicine.

He was asked whether it would be appropriate to impose a condition upon the respondent's re-registration that, for some period, he not prescribe Schedule 8 medications. Dr Woodford replied

"I would not have thought so. I would have thought that education is always better. I don't believe that Dr Zahra-Newman has abused any substance himself, and I think it has been only his unwise prescribing that has been the problem, and I think that education is better suited to the situation apart from restriction."

This Tribunal is also impressed by the fact that the respondent came to a realisation of the lack of appropriateness in his prescribing practices and sought treatment from Woodford and has maintained that treatment and in addition has sought his own removal from the Register in early 1997. This is not the case of a practitioner who says everyone is out of step except him. This is a case of a practitioner who realises he was out of step and took the appropriate action to try to rectify the matter.

At the outset of these reasons it was pointed out that the real issue was whether the respondent had been guilty of professional misconduct or merely unsatisfactory professional conduct.

This Tribunal is comfortably satisfied on the balance of probabilities, having examined the respondent's prescribing practices in the context of the particular patients that his conduct amounts to unsatisfactory professional conduct.

CONSEQUENTIAL ORDERS.

Under S.40 of the Medical Practice Act, a complaint about a registered medical practitioner may be made and dealt with even though the practitioner has ceased to be registered.

S.61(2) of the Medical Practice Act provides

"If the person is not registered, an order or direction can still be given under this section but has effect only so as to prevent the person being registered unless the order is complied with or to require the conditions concerned to be imposed when the person is registered, as appropriate."

As mentioned earlier, this Tribunal is satisfied that the respondent was guilty of unsatisfactory professional conduct in that his conduct demonstrated a lack of adequate judgment in the practice of medicine. Accordingly this Tribunal does not view the respondent as one who should not be registered should he seek to do so. Despite his good intentions he made major errors of judgment in prescribing massive amounts of drugs of various types.

The question now to be considered by this Tribunal is what conditions, if any, are to be imposed should the respondent seek to become registered as a medical practitioner. In answering this question the Tribunal acts not to punish a practitioner but to protect the community.

It is the view of this Tribunal that there are two areas of unsatisfactory conduct which need to be addressed.

The first is the respondent's prescribing of drugs of addiction either without first having obtained the authority of the Department of Health as provided in S.28 of the Poisons Act or excess of an authority so given.

As part of the protection of the community it is open to this Tribunal to impose a financial impost upon the respondent which will act as a deterrent not only to him but also to others who may be like minded. This Tribunal considers it proper that the message be sent out to all medical practitioners that prescription of drugs of addition without the appropriate authority cannot be tolerated. Accordingly the Tribunal imposes a fine upon the respondent of \$1000. A higher fine, although warranted, has not been imposed because the respondent is also being ordered to pay the Complainant's costs.

The second area to be addressed is the respondent's lack of judgment as demonstrated in his prescribing practices. This Tribunal accepts the view of Dr. Woodforde that this is best met by appropriate education. The respondent needs to understand the rational use of drugs in pain relief.

The finding of this Tribunal is that the respondent should not be re-registered until he has undergone education in the Pharmaceutical Services Board's Course in prescribing practices on a one to one basis at his own cost. The Tribunal also orders the respondent to pay the complainant's costs of the hearing.

FORMAL ORDERS

- The Orders of this Tribunal are as follows:

The respondent is not to be registered as a medical practitioner unless and until he has complied with the following orders:

1. He pays a fine of One thousand dollars (\$1,000) to the New South Wales Medical Board on or before 30 June, 1999.
2. He produce to the Registrar of the New South Wales Medical Board satisfactory evidence that he has satisfied the Director of the Pharmaceutical Services Branch (or the Director's nominee) by assessment to be arranged by the respondent at his own costs, that he (the respondent) has a full and proper knowledge of prescribing practices and requirements particularly relating to Rohypnol and Schedule 8 drugs.
3. He has paid, or made arrangements to the satisfaction of the Health Care Complaints Commission for the payment of, the costs of the Complainant of these proceedings.