

MEDICAL TRIBUNAL OF NEW SOUTH WALES

DEPUTY CHAIRPERSON. JUDGE WARD Q.C.
MEMBERS: DR N. VAN DUGTEREN
DR P. ARNOLD
Ms L. ADAMSON

IN THE MATTER OF A COMPLAINT BY A DELEGATE OF THE DIRECTOR-
GENERAL OF THE DEPARTMENT OF HEALTH.
AND MEDICAL PRACTITIONERS ACT 1938 S.32 (1).

IN RE DR DON NAI HSI HUANG.

6 AUGUST 1992.

DECISION

The complaint of the Delegate of the Director-General of Health against Dr Don Nai Hsi Huang (hereinafter called "the respondent") dated 12 June 1991 was (after amendment dated 2 October 1991) in the following terms:-

Don Nai Hsi Huang of 168 Cathedral Street, Woolloomooloo, N.S.W., ("the practitioner") being a medical practitioner registered under the Act has been guilty of professional misconduct within the meaning of Section 27(1)(a) of the Act in that:

- (A) he has demonstrated a lack of adequate knowledge, judgment and/or care in the practice of medicine; and/or
- (B) he has been guilty of other improper or unethical conduct relating to the practice of medicine.

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The particulars of the complaint as are follows :-

1. Dr Huang prescribed a benzodiazepine alone or in combination with one or more other benzodiazepines likely to produce dependence, on the dates to persons in quantities shown on the schedules annexed hereto and marked with the letters 'A' 'B' 'C' 'D' 'E' 'F' 'G' 'H' 'I' 'J' 'K' 'L' 'M' 'N' 'O' 'P' 'Q' 'R' 'S' 'T' 'U' 'V' 'W' 'X' 'Y' 'Z' 'AA' 'AB' 'AC' 'AE' 'AF' 'AG' 'AH' 'AI' 'AJ' 'AK' 'AL' 'AM' 'AN' 'AO' 'AP' 'AQ' 'AR' 'AS' 'AT' 'AU' 'AW' 'AX' 'AY' without exercising responsible medical judgement as to whether it was appropriate to issue such prescriptions when he knew or ought to have known that the drug or drugs were being or likely to be misused.
2. Dr Huang prescribed benzodiazepines alone or in such combination with another benzodiazepine on the dates and in the quantities shown in Schedules 'A' 'B' 'C' 'D' 'E' 'F' 'H' 'I' 'K' 'L' 'M' 'O' 'R' 'T' 'U' 'V' 'W' 'Y' 'AC' 'AF' 'AG' 'AJ' 'AK' 'AL' 'AM' 'AO' 'AR' 'AS' 'AT' 'AU' 'AW' and 'AY' in a quantity in excess of normal therapeutic standards.
3. Dr Huang prescribed a benzodiazepine alone or in combination with other benzodiazepines on the dates and in quantities shown in Schedules 'E' 'F' 'G' 'H' 'I' 'J' 'K' 'L' 'O' 'P' 'Q' 'R' 'S' 'T' 'W' 'Y' 'Z' 'AB' 'AC' 'AF' 'AG' 'AI' 'AJ' 'AK' 'AL' 'AO' 'AP' 'AQ' 'AR' 'AW' 'AX' on a continual basis for a period exceeding normal therapeutic standards so maintaining or inducing a dependence on that or those drugs.
4. Dr Huang prescribed a benzodiazepine alone or in combination with another benzodiazepine and or codeine on the dates and in quantities shown in the Schedules 'A' 'B' 'C' 'G' 'I' 'J' 'M' 'N' 'O' 'V' 'W' 'X' 'AC' 'AF' 'AG' 'AH' 'AL' 'AN' 'AW' 'AX' to persons he knew or ought to have known were addicts receiving treatment on a State methadone programme without proper consultation with the medical practitioner responsible for that person's therapy.
5. Dr Huang prescribed the drug codeine in the preparation Codral Forte or Panadeine Forte (in conjunction with a benzodiazepine) on the dates and in quantities shown in Schedules 'E' 'F' 'J' 'L' 'O' 'R' 'T' 'W' 'AB' 'AI' 'AK' 'AN' 'AO' 'AP' 'AR' 'AW' 'AX' for extensive periods without exercising responsible medical judgement as to whether it was appropriate to issue such prescriptions when he knew or ought to have known that the drug was being or likely to be misused.
6. Dr Huang did not maintain adequate medical records relating to the patients named in the schedules annexed hereto and marked with the letters 'A' 'B' 'C' 'D' 'E' 'F' 'G' 'H' 'I' 'J' 'K' 'L' 'M' 'N' 'O' 'P' 'Q' 'R' 'S' 'T' 'U' 'V' 'W' 'X' 'Y' 'Z' 'AA' 'AB' 'AC' 'AE' 'AF' 'AG' 'AH' 'AI' 'AJ' 'AK' 'AL' 'AM' 'AN' 'AO' 'AP' 'AQ' 'AR' 'AS' 'AT' 'AU' 'AW' 'AX'.

During the hearing the Tribunal indicated that it may lay a Complaint, pursuant to Schedule 4 of the Act, relating to the treatment practises of the respondent. The complainant sought and was allowed to add an additional particular, dated 21 January 1992, relating to treatment practise in the following terms :-

7. That the practitioner failed to exercise responsible medical judgement in his treatment of patients "A", "B", "C", "D", "F", "L", "M", "N", "Q", "T", "U", "V", "X", "Y", "Z", "AB", "AF", "AI", "AJ", and "AN", in that:

- (a) In respect of patients "A", "B", "C", "D", "F", "L", "M", "N", "T", "U", "V", "X", "AB", "AJ", "AN",
- i) the practitioner failed to obtain a full medical history,
 - ii) the practitioner failed to make an appropriate assessment of the patients' drug usage history including drugs used, quantity, frequency and pattern of usage, degree of dependence on drugs used and previous treatment obtained in respect of drug abuse,
 - iii) the practitioner failed to obtain an appropriate inter-personal, family and social history of the patient
 - iv) the practitioner failed to carry out any adequate physical examination of the patient,
 - v) the practitioner failed to examine the patient for any underlying physical problems associated with or exacerbated by the patients' drug use,
 - vi) the practitioner failed to refer the patient to specialist drug and alcohol clinics, practitioners or counsellors or obtain assistance from such clinics, practitioners or counsellors in his treatment of the patient,
 - vii) the practitioner failed to monitor or adequately monitor the continued drug use of the patient during the course of his treatment,
 - viii) the practitioner failed to make any assessment as to whether the treatment being provided by the practitioner was causing any harm to the patient,
 - ix) the practitioner failed to make any adequate assessment as to the effectiveness of the treatment being provided by the practitioner,

- x) the practitioner failed to make any assessment of alternative treatment options for the patient.
- (b) In respect of patients "M", "Q", "U", "X", "Z", and "AJ", the practitioner failed to refer such patients to a specialist psychiatrist for assessment, diagnosis, and treatment of the patients' apparent psychiatric disorders.
- (c) In respect of patients "A" and "V", the practitioner failed to take any adequate steps to ascertain whether the patients were pregnant during the course of the practitioner's treatment.
- (d) In respect of patient "Y", the practitioner failed to adequately monitor the diabetic condition of the patient.
- (e) In respect of patients "AF" and "AI", the practitioner failed to refer the patients to Pain Clinics, physiotherapy and/or orthopaedic care and failed to carry out investigative procedures such as radiography.

THE SCHEDULES.

The Schedules contained the dates of prescriptions written by the respondent for the 49 patients, nominated by the alphabetical letters A to AY inclusive and the number of tablets prescribed for the drugs, Oxazepam 30mg (Serepax), Temazepam 10mg (Normison), Nitrazepam 5mg (Mogodon), Diazepam 5mg (Valium), Flunitrazepam 2mg (Rohypnol), Codral Forte, Panedaine Forte, and Doloxene. The material had come from over 150000 prescriptions taken from Milson's Pharmacy and Rothman's Pharmacy, each at Bondi Beach, and Woolloomooloo Pharmacy at Woolloomooloo, covering the period between 1 May 1989 to 30 April 1990, less four weeks when the respondent was on leave. The number of patients, for whom benzodiazepine prescriptions written by the respondent were dispensed at those pharmacies during the 48 weeks totalled 1534. This number was culled down to 49, according to the Complainant's investigator "probably the worst cases", coming from a batch of 262 patients

(17.07% of total), for whom more than ten prescriptions were dispensed at the three pharmacies. It became obvious from the differences in the number of the prescriptions in the Schedules and the number of the consultations at which the same drugs were prescribed that more prescriptions were probably written for the nominated patients and dispensed at other pharmacies.

NATURE OF THE DRUGS

Tribunal accepts the composition, actions, and normal dosage for the listed drugs, as set forth in Mims Annual (1988). *The word tablet includes capsule in Appendix "A".* Hereafter is a brief summary of some of the relevant material:-

Serepax.

Composition. Oxazepam.

Actions. A benzodiazepine tranquilliser. Site of action is essentially in the limbic system of the Central Nervous System. For anxiety, tension, irritability, agitation, alcoholic withdrawal syndrome. Particularly useful for the elderly.

Dosage. Control of anxiety in patients with organic illness or emotional strain: 15mg three or four times daily. Patients with severe anxiety and exaggerated stress reactions: 15 to 30 mg three to four times daily.

Normison.

Composition. Temazepam

Actions. A benzodiazepine derivative of relatively short half-life with sedative hypnotic actions. Adjunctive therapy in the short term management of insomnia.

Dosage. Continuous use for more than 3 months is not recommended. In general, hypnotics should be prescribed for short periods only (2-4 weeks), unless patient is already reliant on regular hypnotic use. Recommended dosage is 10 to 30 mg, half an hour before retiring.

Mogodon.

Composition. Nitrazepam.

Actions. Induces sleep lasting 6 to 8 hours.

Dosage. 1 to 2 tablets (5 to 10mg). May be increased to 20 mg for inpatients.

Valium.

Composition. Diazepam.

Actions. Anxiolytic, sedative, muscle relaxant and anticonvulsant effects. Has an initial rapid distribution phase of half-life up to 3 hours, followed by a prolonged terminal elimination phase (half-life 20 to 48 hours). Do not prescribe in early pregnancy unless absolutely necessary.

Dosage. Usual adult dosage; 5 to 40 mg daily. Average dose for ambulatory patients : 2 mg three times daily or 5mg in the evening and 2 mg once or twice during the day. Hospital treatment of tension, excitation and motor unrest: 10 to 15 three times daily until the acute symptoms subside.

Rohypnol.

Composition. Flunitrazepam.

Actions. Sedative and hypnotic for severe insomnia.

Elimination half-life about 13 to 19 hours.

Dosage. Administer for a few nights only for most patients. Insomnia if recent onset: 0.5 to 1mg; of several weeks duration: 2mg. Severe chronic insomnia in patients with psychotic, neurotic or depressive conditions, sleep disturbances due to withdrawal therapy or pain: 3 to 4mg, increasing to 6 mg depending on tolerance and clinical response.

Codral Forte.

Composition. Aspirin 300 mg and Codeine Phosphate 6 mg.

Actions. Useful for the relief of severe types of pain, particularly that which does not respond to milder analgesics. The half-life of codeine is 2.5 to 3 hours

Dosage. Usual adult dose. 1 tablet, repeated as required with a maximum of 6 tablets in 24 hours.

Panadeine Forte.

Composition. Paracetamol 500 mg codeine phosphate 30 mg

Actions. Analgesic and antipyretic for relief of moderate to severe pain and fever.

Dosage. 1 to 2 capsule (maximum 6) a day.

Doloxene.

Composition. Doloxene

Actions. Is a mild analgesic related to the narcotic analgesic methadone; it is not as potent. Combined with aspirin it produces greater analgesia.

Dosage 1 capsule four hourly for pain.

The Tribunal accepts Dr Bell's explanation of the nature and effect of the drugs listed in the Schedules to the Complaint. The benzodiazepines, being the drugs ending in "azepam", all acted on the same receptor and produce essentially

the same effects although the potency varied. For example, 30mg of Oxazepam (Serepax) was approximately equivalent to 5mg of Diazepam (Valium) and to 5gm of Nitrazepam (Mogadon), Temazepam (Normison) 10mg slightly lower than Oxazepam 30mg and Flunitrazepam (Rohypnol) 2mg was of slightly greater potency. The more important difference was their absorption, metabolism and excretion. There were important clinical differences between long and short acting benzodiazepines. Withdrawal from short acting benzodiazepines tended to be more severe and more difficult to accomplish. Withdrawal from long acting benzodiazepines appeared to be milder, if a little more prolonged. Short acting benzodiazepines were recommended in the treatment of insomnia so that the effects of the drug did not last beyond the period of sleep. Long acting benzodiazepines provided more stability and less fluctuations between intoxication and withdrawal when used on a maintenance basis and being taken by day and by night. It was not appropriate to maintain patients long term on short acting drugs, particularly as treatment of dependence. The regular use of reasonably high doses (more than six tablets daily), either long or short acting, is likely to be associated with the developments of neuroadaption and the risk of withdrawal symptoms on cessation of the drug. Usually the withdrawal symptoms will be mild and not medically dangerous, although withdrawal from high doses of short acting benzodiazepines can be associated with severe symptoms, including seizures. The possible effects of inappropriate use of benzodiazepines is referred to, in detail, later.

Codral forte and Panedeine both comprise 30mg of codeine phosphate, in combination with aspirin and paracetamol

respectively. They are analgesics and suitable for use in treatment of pain as the codeine is metabolized in the body to morphine. As an opiate they were capable of producing physical dependence and withdrawal symptoms. Doloxene (dextropropoxyphene) is a weak opioid with mild analgesic activity. Cessation after long use can be associated with a withdrawal state. It can be used to attenuate the severity of withdrawal from other opioids.

Insomnia and anxiety are common indicators for benzodiazepine therapy. Diagnostic assessment should be given of the medical and psychiatric problems which induce the conditions. In the first instance, treatment should, if possible, be by use of non pharmacological methods such as counselling and advice on overcoming the causes. Martindale 29th Edn. p.706 states that benzodiazepines may be considered appropriate treatment, if the anxiety or insomnia does not respond to the non pharmacological approaches and is "disabling, severe, or subjecting the patient to extreme or unacceptable distress". For insomnia, benzodiazepines should be used only intermittently in the short term up to two weeks. Their efficacy after a further four weeks is a matter of considerable doubt. Dr Drew said "their sedative effect or hypnotic effect will wear off very quickly and one will end up in a worse situation than you start off with". Dr Eric Fisher said "the evidence is that they lose their effect after six weeks and I believe that patients do not get any benefit whatsoever and in fact may become much worse ... the perpetuation of the drug produces more illness than if they never had the drug". For insomnia, it is preferable to use the shorter acting benzodiazepines such as Temazepam and Oxazepam. For severe anxiety the use of benzodiazepines may be considered appropriate

for short term use in combination with relaxation therapy and other psychotherapy but prescriptions should not last more than four weeks. Dr Drew stated that they should be used for "two or three weeks at the most, if one can possibly get away with it". Dr Bell said, "there is very good evidence that long term benzodiazepines are not particularly efficacious in the treatment of anxiety". Benzodiazepines have no action in treating depression and they exacerbate that condition. They may cause deterioration in schizophrenic patients.

THE PATIENTS.

The 49 patients were of varying ages, all over 21 years old and of both sexes. They were often described as social misfits or derelicts; they included drug (mainly heroin) addicts, prostitutes, alcoholics; most were unemployed and on social service benefits. Evidence was given by 21 of the nominated patients, a somewhat new development in Tribunal hearings concerning a doctor's prescribing conduct with drug addicts. It exposed patients to lengthy questioning about their medical histories as their aid was sought in an attempt to prove that they viewed the respondent as a "good doctor". It has been the experience of Tribunal members that patients, called by a medical practitioner to give evidence in an inquiry, will praise their doctor, a fortiori, if the doctor is satisfying their wishes by fulfilling their requests over a lengthy period.

In search of the listed patients, a legal officer employed by the Department of Health, called at twenty one of the addresses in the Bondi, Woolloomooloo and inner city area listed in the respondent's patient cards. Some addresses did

not exist, some patients had moved, some patients were not known at the addresses and no one answered at other addresses. Three patients were found at their addresses, while contact was made with another two by finding their parents' addresses through hospital records.

In proof of the respondent's practising methods, the complainant called the five listed patients found by the legal officer. The patient card for one of the five patients namely, patient Mr R had details of visits not made by him and prescriptions not issued to him. It was obvious from his evidence that the information had been recorded on the incorrect card, that of Patient AH, although the ages of the two patients with the same name were disparate. Mr R, had been a temporary patient during the absence of his usual doctor for a genuine complaint and not seeking the drugs concerned in the Complaint. The remaining four patients, G, N, V, AW were addicts of heroin and other drugs. Their evidence was, of course, not completely reliable due to the effect of drugs on their memories. They all gave an impression of seeking to be accurate and certainly they were not shown to be biased against the respondent. A few of them were still patients of the respondent and occasionally appeared to be embarrassed giving evidence in his presence.

The respondent called seventeen of the listed patients to give evidence, being Patients A, C, E, F, I, L, O, P, R, W, AA, AC, AF, AG, AP, AS, AT. The circumstances surrounding the preparation of their early statements was subject to cross examination referred to later. The statements prepared for the hearing focussed too closely on denials of specific matters upon which the respondent had been cross-examined. Their evidence was

assessed by the Tribunal as biassed, obviously intended to support the retention of a "treatment" regime favourable to their drug addiction or dependence. It was frequently in conflict with their written statements. It frequently bore the usual indefiniteness and unreliability of testimony of drug addicts.

In Appendix "A", to be considered as part of the decision, there is set forth a short analysis of the evidence relating to patients and some of the respondent's and the Tribunal's observations. This material has been compiled from evidence of patients, two statements ("case histories") compiled by the respondent, his oral evidence and records exhibited to the Tribunal. These records consisted of Department of Health records of patients on a Methadone Programme, computer print out details of medical attendances of the patients upon the respondent and similar records of attendances upon other providers during the relevant period supplied by the Health Insurance Commission (Medicare), the summaries of prescriptions (and the actual written prescriptions) contained in the Schedules to the Complaint, a summary of prescriptions written by other medical practitioners for the nominated patients and dispensed at the three pharmacies from which the respondent's prescriptions were collected, patient cards kept by the respondent for the relevant period and sometimes for extended periods before and after that period, hospital records of 15 patients (in respect of 3 patients, from two hospitals). Dr Seidler was asked questions concerning the treatment of most of the patients, while other doctors were asked questions concerning some of them.

Because the patients tended to fall into categories and showed some similarities, the analysis in Appendix

"A" is of the first and last seven and the middle ten of the alphabetically listed patients and those who gave evidence. Sometimes the respondent's comments generally about his treatment appears in the summaries, as do some of the specified material relied upon by the Tribunal in coming to its findings. Generally, the Tribunal has sought to refer to some of the patient details in relation to each Particular of the Complaints. The Tribunal has been cognisant of and has taken into account the material contained in Appendix "A".

THE RESPONDENT'S BACKGROUND.

The respondent was registered as a medical practitioner in the State of New South Wales on 1 January 1971. He was born in Singapore of Chinese parents, graduating in medicine from Singapore University in 1970. He came to Australia in 1971. He spent two years in residency at Newcastle and Sutherland Hospitals before returning to Singapore to practise medicine in a large general practice. He asserted, in an written statement, that the head of the practice believed that benzodiazepines were the best method of treating patients addicted to drugs or alcohol, because they alleviated worry and stress, the two main reasons for addicts not being able to fit into society. This statement came well after the respondent had given written statements, nominating other reasons, in seeking to justify his prescribing. He had initially written to the Complaints Unit saying, "I may have started practice without any experience of drug-addicted people". He later explained that the experience was with drugs "in the sense of alcohol and substance abuse", but not heroin. His statement about the "head of the

practice" is not accepted. He returned to Australia in 1979. He has, since then practised as a sole general practitioner at Woolloomooloo and Bondi. It was stated that at any time he had over 1500 patients and that 60% of them were heroin addicts. The percentage of alcoholic or benzodiazepine patients was not ascertained. He kept patient cards; referrals and reports were kept separately. He employed a receptionist and he personally operated a computer for Medicare accounting. His official surgery hours, during the period of the complaint, were between 8.30am-11.00am, 3.30pm-5.30pm on Monday to Friday at Woolloomooloo and between 12.00 noon-2.45pm, 7.30pm-9.00pm on Monday to Friday at Bondi Beach.

BACKGROUND TO THE COMPLAINTS.

It is convenient to set forth some of the actions of the Department of Health and the history of the respondent's contact with it. His Counsel submitted that "the Complaint's Unit (sic) has over the years failed to discourage him in his prescribing habits" and, "in the absence of adverse action, he was entitled to assume that his prescription practices were in order" and, "the absence of official regulations has placed Dr Huang and those other doctors who are liberal in their benzodiazepine prescriptions in an impossible position". These submissions are not entirely accurate; they are irrelevant in this case; a medical practitioner has the right to prescribe drugs so long as it is appropriate treatment for a patient; the final action of the Complainant did not seem to alter the respondent's practices as he continued to assert the propriety of his conduct. The Tribunal does not accept as excusatory the

respondent's assertion in his statement of 14 December 1991 that "prior to these proceedings I had no warning that my prescriptions of benzodiazepines were objected to by the Department" or that he was entitled to assume that his prescribing habits were acceptable, merely because he had not had a visit from its officers since late 1985. The Tribunal does not accept his statement that, "If at any time, had I been told that the Department objected to the prescriptions of benzodiazepines to any class of patients, I could have and would have complied with any suggestions or directives". Evidence showed that he has sought to justify the propriety of his prescribing treatment and that it has continued unabated since action was taken by the Department.

For some years the Department of Health has issued to medical practitioners a "Guide to the Poisons Act and Regulations for Medical Practitioners and Dentists", being a summary of certain provisions relating to the supply of substances for therapeutic use on medical prescription. It refers to the Poisons List and its Schedules. It sets forth provisions regulating the prescription of Schedule Eight (Drugs of Addiction) drugs, which included Codeine Phosphate, and advice and warning as to the conduct of addicts in seeking to obtain drugs and of Schedule Four (Restricted Substances) drugs, being substances, which in the public interest, should be supplied only upon written prescription of (inter alia) a medical practitioner. Schedule Four contains an Appendix D in which are listed "restricted substances, which may be abused and which are liable to cause dependence"; these substances included the benzodiazepines, Oxazepam, Temazepam, Nitrazepam, Diazepam, and

Flunitrazepam. Only doctors and (inter alia) a person for whom a prescription has been written by a medical practitioner are allowed to be in possession of such drugs. Certain matter had to be written on the label of a container of such substances, if supplied for more than three day's treatment. These included the patient's and prescriber's names and adequate directions for use.

Acknowledging receipt of the "Guide" and a letter, dated 21 July 1980, the respondent thanked the Department for having sent it at his request, made "in order to deter 'street' addicts from frequenting my surgeries". The letter (inter alia) reminded the respondent of the "variety of approaches" of addicts and that they "present with painful symptoms of organic illness and injury". It pointed out that "trafficking in prescriptions and drugs dispensed on prescriptions obtained...has become a major problem" and sought his co-operation. The letter had followed an interview on 16 July 1980 with officers of the Pharmaceutical Services Section as to excessive prescriptions of Mandrax (later put out of circulation in 1982) and Schedule Eight drugs, Physeptone and Percodan.

On 19 February 1981, officers of the Pharmaceutical Benefits Division of the Department of Health spoke to the respondent concerning his excessive prescribing of two hypnotic barbiturate drugs, Tuinal and Seconal. Officers took no action after the respondent asserted the need for certain addicts, "genuinely seeking help", to have them for sleep. When the fact of "doctor shopping" was mentioned to him, he stated that, "if any patient he was treating went to another doctor and obtained additional supplies, that other doctor was at fault".

Following a complaint, he was interviewed on 18 October 1982, about prescribing Serapax to a schizophrenic patient and Nembudeine tablets to another patient who had "conned" him. Although he knew that one of the patients had been treated by another doctor, he "did not feel obliged to tell the doctor what he had prescribed". He was advised, apparently, that prescription of benzodiazepines may allay a patient's discomfort while withdrawing from drugs of addiction.

On 23 June 1983, following a complaint of overdosing by a person with Valium, Mogadon and Tryptanol, he was interviewed concerning his prescriptions of those drugs for the patient. He was then warned that "he should prescribe with caution and a sense of responsibility and exercise professional judgment". He was also told that "the Medical Tribunal had held that the repeated supply of drugs on prescription without any attempt to ascertain the underlying cause of the complaint and treating same was misconduct in a professional respect". Enquiries made of a few pharmacies at that time indicated that the respondent's prescribing of narcotics, barbiturates and Nembudeine was within limits to be expected in a general practice. Further monitoring of prescriptions, by discussions with pharmacists, suggested that the respondent's prescribing of benzodiazepines up till August 1985 had been reduced.

In September and November 1985 there was media comment about the respondent's prescribing of drugs. During a small survey in Woolloomoolloo and Bondi pharmacies in September and October 1985, it was found that, of 2629 prescription written by the respondent, 1422 (54%) were for one or more benzodiazepines. The percentage for other doctors

prescriptions was about 8%. At an interview on 4 December 1985, the respondent asserted to officers that he was prescribing for persons with drug dependence. He discussed the philosophy "governing his prescribing of tranquillisers, hypnotics and analgesics to drug dependent persons" and his views of a "band - aid therapy for a social problem". This included the use of benzodiazepines as a drug of choice for heroin withdrawal and the use of Serepax, Rohypnol and Valium to "cut the edge off" drug intake and the use of strong analgesics for pain associated with withdrawal or as a substitute for heroin. He also asserted that he had not received any guidelines from the Department for prescribing of benzodiazepines. A complaint of professional misconduct, suggested by the officers, was not pursued. The respondent was told that his prescribing would be monitored.

In 1989, following further complaints about the respondent's prescribing, a "more thorough investigation" was carried out. This led to the making of the present complaints. Throughout, the respondent reiterated, he "would follow guidelines" or he "applied the rules of the Health Department". He was advised that the Department did not give doctors guidelines for prescribing to individual patients and he should keep within normal standards and the Regulations. In evidence, whilst still maintaining that position, he accepted that, as the medical practitioner, the responsibility for prescribing properly and with care was his, be there guidelines or not.

QUALIFICATIONS OF MEDICAL WITNESSES.

The complainant called as medical witnesses Dr R.R.Fisher, Dr Eric Fisher, Dr J.R.Bell, Dr R Seidler and Dr

