

not sighted and whose qualifications were never really given except that she was known to many patients, to act as a "social worker" for the purposes of taking a social history of the patients. Some of these "social histories" were seen. They did not impress as the kind of notes a responsible general practitioner would make. It is an abrogation of proper medical responsibility. Some patients ("over 500"; "4 or 5" of the nominated patients), had written on their cards, at or about the same time as the making of those social histories, words to the effect, that they did not want notes made of consultations. The respondent denied that he was responsible for such notations. He contradicted himself as to the effect of the notations, saying that he now only makes "minimal notes", although earlier he had said, "I have now indicated to all my patients that all notes must be thorough, otherwise I will cease to treat them".

The Tribunal viewed a number of hospital records of the nominated patients. They showed that extensive drug, social and medical histories had been given to and recorded by hospital staff, with no apparent reluctance on the part of the patient. They invariably informed the Tribunal of much more about the patients concerned than the notes or evidence of the respondent or, indeed, the patient's evidence given at the hearing. The Tribunal does not accept the respondent's evidence that his good memory excused him from note taking. The transcript is redolent of mistakes and contradictions made by him relative to drug, social or treatment history and of concessions that he did not know or remember particular facts relating to specific patients, even though he had months to prepare himself and had further opportunities to see many of the patients.

It was submitted on behalf of the respondent that :

a) it was not clear to what extent the records deviated from the norm bearing in mind that the respondent is a general practitioner,

(b) as the doctor had a general knowledge of the history of the patient, it was doubtful as to what further records were necessary,

(c) it was doubtful whether records for the respondent's type of practice would be lengthy,

(d) the handicap to locums was not applicable in this case as the respondent always used the same person, who had apparently coped and had made minimal notes also,

(e) the complaint was academic or theoretical, rather than practical, as there was no evidence that the lack of records have caused disadvantage to a patient.

The submissions are rejected. The Tribunal comments that hospital training and practice as a general practitioner (the type of practice which both medical members of the Tribunal have had for many years) would not permit acceptance of the propositions. The allegation that the type of practice required only such meagre records suggests rather that it was one for the supply of drugs upon demand. The complainant did not seek to prove that the lack of records led to disadvantageous results; the Complaint relates to medical practice, not as to whether the respondent has been medically negligent.

The evidence (as detailed) of the expert medical witnesses is accepted. The respondent's conduct is viewed seriously by the Tribunal due to:

- (a) the nature of the insufficiency of the records,
- (b) the respondent's arrogant attempt to justify himself and his record keeping,
- (c) his inadequate attempt to change his practice and
- (d) his belief that his present methods are satisfactory for his type of practice.

Particular 7(a)

The Tribunal finds all the placita of this Particular proved. Patients illustrative of the Particular, but not exclusively, are Patients V, X, Y, AJ, AN.

(i) The need to obtain a full medical history

The evidence of the medical witnesses called by the complainant was to the effect that there was a need at the initial consultation (in particular) to obtain a full medical history relating to patients presenting as drug addicts. This would include such things as previous ill health, any previous operations, allergies, or other concurrent medical attendances, particularly in a Methadone Programme. As Dr Marks said, "You need an extensive, dependable, solid, medical history". The respondent's patient cards and his case histories, made up for the Tribunal, are remarkably lacking in medical history. He gave some strange explanations for this such as, in relation to Patient D, "I asked him but there was no relevant medical history".; in relation to Patient F, "No significant medical history". His attitude was summed up in his evidence, "I think

drug addicts have only one problem, their drug dependence. They are quite healthy individuals .. and their only problem which causes them so much distress is the use of drugs". This was contrary to the evidence of Dr Drew who said he agreed that drug addicts, in particular, "often had serious underlying medical problems. It was also contrary to the experience of others recorded in an article in the Australian Prescriber Vol.5 No.3 p.62 (1981) "Narcotic Addiction and the General Practitioner".

This lack of concern about his patients' medical histories, if they were drug addicts or alcoholics or persons seeking benzodiazepines was shown by his almost invariable prescription of benzodiazepines, as requested, on the first visit. It is of little surprise therefore that few told the respondent about their hospitalisations and that, as appears from hospital records, they never referred to him as their local medical officer.

Particular 7(a).

(ii) Need to make an appropriate assessment of a patient's 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

Evidence was given by Dr R. Fisher and Dr Seidler, in some detail, as to the above need for a treating doctor and Dr Marks stated:

"one needs a very extensive history. That would go into both the drug history, both in terms of length of use, why that use first started, the dosage that had been taken over the period, how that had varied, what management had been undertaken by other practitioners, before you as a doctor saw the patients ...".

The National Campaign Against Drug Abuse Monograph advised that an assessment of illicit drug user should include:-

1. quantity, frequency and patterning of drug usage including a profile of drug usage for all known substances as well as the substance of major abuse.
2. Extent and severity of previous drug problems which would include responses to previous treatment and self initiated periods of recovery.
3. The degree of dependence on the main drug being used which would include an assessment of drug tolerance, severity of withdrawal phenomena and craving or urges to take alcohol or drugs.

The only attempt (occasionally made) of drug assessment of a patient by the respondent, as appears on his patient cards, was to make an entry such as "DD 10 years", meaning drug dependent 10 years. In his "case histories", when he did deal with this matter, the history was extremely limited and very often wrong. He claimed that it made no difference if they had been dabbling with a drug for five or ten years. He sought to overcome the futility of trying to establish details by stating that most drug users use whatever they can afford or is available from time to time. Although it became clear from the records and evidence from some of the patients that they had histories of dependencies on other drugs such as barbiturates, amphetamines, cocaine and LSD, quite often the respondent was apparently unaware of this usage. This did not concern him, because his attitude was,

"all are polydrug abusers, no drug addict is a pure drug addict. They will experiment and try, those that are hooked on heroin and LSD, I note that becomes their primary drug of abuse. If they are just dabblers, once in 6 months, that is not significant. People will use any drug on a weekend, they will use coke, they will sniff glue, they are not significant ...".

The respondent alleged that virtually all his patients were benzodiazepine users when they first consulted him. He didn't make a note of that on his patient cards. His attitude was "the actual dosage they use is unimportant because most of the time it is false .... they steal from their friends, the actual dosage is not important". He seemed to be unconcerned about previous treatment received by patients, as exemplified by his comment when he learnt of his unawareness of Patient X having been detoxified in a clinic shortly prior to seeing him. He said, "A drug addict, an alcoholic, goes in and out of detox three or four times a year ...". This lack of concern was further demonstrated by his saying concerning Patient V, who hadn't seen him at one stage for three months, "when she saw me again it was (Patient V) again and she needed the drugs. She was still drug - she still had the drug dependent personality - and therefore I wanted to reduce her exposure to harm".

Particular 7(a).

(iii) The need to obtain an appropriate interpersonal, family and social history of the patient

The medical witnesses called by the complainant supported the need for this type of history and Dr Marks stated, "one would also need to go into the family background, the social background to try and determine what were the circumstances that had originally started, on this abuse ...". The Monograph of the National Campaign Against Drug Abuse states that the assessment of the patient should include, "family relationships and family drug history". The respondent's patient notes failed to show any of this type of history for his patients

and even the "case histories", made up for the Tribunal from his recollection, generally showed a poor knowledge. The respondent summarised his attitude as follows:

"How long they use drugs, for what purpose they use drugs, I have found that the pattern is quite similar. I only note the unusual feature where I have somebody from a very good family like (Patient AA). Her father is a Reverend and she started using drugs ... for the general addicts the history is nearly always the same, they have been using drugs for years and years and years".

Illustrative is the case of Patient AA who asserted (inter alia) that she had been sexually abused by her mother as a child and had been raped on three occasions prior to seeing the respondent. The respondent was unaware of that alleged history.

Particular 7(a).

(iv) and (v) The need to adequately physically examine patients and the need to examine patients for any underlying physical problems associated with or exacerbated by the patient's drug use.

This need is supported by the evidence of the medical witnesses called in the complainant's case and has support from Dr Drew and Dr Marks. The latter stated:

"Certainly one should undertake a clinical examination of various things apart from just the ordinary straight forward, common clinical examination ..., for example, I would want to know whether there was any evidence of liver enlargement, because many of those people would be abusing alcohol as well as the heroins. One might expect to find some evidence of liver damage. One would certainly look at the arms to see whether they were actually mainlining the drugs, how recently they were mainlining it, whether there was evidence of infections, that type of thing...".

Dr Seidler stated:

"I would generally physically examine all patients that I see with addiction, looking particularly at the arms for evidence of slashed wrists, intravenous drug use in the

veins of the arm and in the backs of the hands. ...I would take their blood pressure, examine their chest. They very often had chronic, infective processes going on. They often have bronchitis, so I listen to their chest, listen to their hearts, examine their abdomens ... for evidence of hepatitis or chronic liver disease, evidence of constipation from narcotic usage and stigmata of other diseases ... I would physically examine patients on my programme at the outset of their programme and probably two-monthly thereafter".

The respondent's initial solicitor in seeking a report from Dr Drew advised him in a letter, "Little to no physical examination of the patient was carried out by Dr Huang on most occasions on which he was consulted by the patients...". Patients N, G, V and AW, in evidence, said that they had never had physical examinations other than occasional blood pressure tests or limited examinations and that evidence did not excite any cross-examination by the respondent's counsel. The patient cards showed virtually no results of physical examination. Towards the latter portion of the lengthy hearing, when patients were called in the respondent's case, statements were tendered. Some of these alleged that the respondent had physically examined the makers and there was particular mention that their livers were examined. The Tribunal does not accept a good deal of this evidence as, by and large, those patients seemed to say anything, which they felt might support the respondent's continued practice.

Particular 7(a).

(6) The need to refer patients to specialist drug and alcohol clinics, practitioners or councillors or obtain assistance from such clinics in his treatment of the patients

The medical witnesses called in the complainant's case supported this need and Dr Drew made mention

of the number of alternatives, such as drug and alcohol units attached to hospitals, drug and alcohol clinics, Methadone prescribers and psychiatrists available for the treatment of drug dependent people in Sydney. Patients N and G gave evidence that it was never suggested to them that they should go to a drug and alcohol unit nor were any other options presented to them. Patient V gave similar evidence.

The respondent, through his counsel, initially suggested that there was no point in sending the type of patient that he was treating to a drug and alcohol clinic, as they would not go. Later he said he had referred patients to a drug and rehabilitation centre. When pressed, he was only able to suggest names of seven patients so referred; they were patients during the years 1980 to 1982. He then stated that he had attempted to refer a few patients to a Methadone Programme, but he could not remember who they were. Patient AC had, in fact, been referred for Methadone treatment. The Tribunal accepts that this was after the patient had requested it and had asked the respondent to write a referral for him.

Particular 7(a).

(vii) The need to monitor or adequately monitor the continued drug use of the patient during the course of the treatment

Whatever treatment is being given to a drug addict, it is a medical practitioner's responsibility to continue close monitoring of the drug usage of the patient during the treatment. As Dr Drew said, "It is very easy to add additional drugs to what is happening and thereby increase harm" and "If he is not attempting to assess that he is really helping the patient

in terms of minimising harm, then he is simply being a drug dealer and that is to my mind illegal and improper".

The respondent's lack of monitoring of the patient's drug use is not only shown by a complete absence of records relative to it, but is consistent with his statement that, "in terms of drug addicts the number of times they use for a particular period of time is not important". He was unable to tell the dates on which any of the 48 patients had had their last "hit" or had not had any heroin since any particular date. He took the view that, "patients of mine dabble all the time" and "I find that most heroin addicts do dabble. They use once or twice a fortnight". He further said "No drug addicts stop drugs completely. They will use whenever they have the chance, whenever there is an opportunity ...".

Likewise, he failed to monitor the effect of his treatment or what benefit it might have been having. He didn't monitor the use of benzodiazepines to any appreciable extent. In relation to Patient L, when asked if he had monitored the amount of benzodiazepines he was taking, he said that he did not and he did not consider that he should have. His attitude was expressed, at one stage, as, "the actual dosage of benzodiazepines they use is unimportant". He said, "I find it impossible to monitor patients in a GP context". He went on to assert that the only way he could monitor patients was by attending upon chemists close to him, from time to time, to enquire whether the patients were doctor shopping. The respondent did not test any patient's urine, a practice stated to be necessary by Dr Eric Fisher and Dr Seidler and regularly

practised under video surveillance by the latter in the Kings Cross area with similar patients.

Particular 7(a).

(viii) The need for the practitioner to make an assessment as to whether the treatment being provided by the practitioner was causing any harm to the patient.

As the respondent did not attempt to adequately monitor the drug use of his patients, it was impossible for him to know whether he was simply supplementing their drug intake or "feeding the habit" or whether he was, in fact, minimising harm by substituting a less dangerous drug for an illegal one. He does not seem to have acquired any knowledge of overdoses or fits suffered by some of his patients and seemed to be satisfied with a general statement, such as, "heroin overdose would occur, I would say, about once every three months in the average heroin addict". He seemed to have an attitude concerning the monitoring of benzodiazepine use that, so long as a patient did not present at surgery "totally bombed out", he was willing to continue to prescribe to the patient. On another occasion, he said, "abuse is appearing in my surgery intoxicated, in the state where I suspect that they are not taking care of themselves". In relation to Patient V, for instance, he said, "you can't monitor memory", when he was asked if he had monitored her memory to see if she was experiencing any memory loss from the use of benzodiazepines.

Particular 7(a).

(ix) The need to make an adequate assessment as to the effectiveness of the treatment being provided by the practitioner.

Constant assessment is necessary to decide whether the treatment is being effective in order to justify its continuance. Dr Drew stated that, if you were not attempting to assess whether the patient is really being helped, the prescriber simply becomes a drug dealer. Dr Bell was quite adamant that, "in maintenance prescribing, it is essential to be evaluating the effectiveness of such prescribing by documenting patients' progress". The respondent's attitude seemed to be that, if a patient didn't come back to him, that patient no longer needed treatment. He considered that as the only measure as to whether his treatment was successful or not. If the patient continued to come for treatment, he was content because he was helping the patient to cope with his life and to stay alive. His contentment was ill founded if one considered the fuller knowledge of some of the patient's lives as revealed in the hospital records.

Particular 7(a).

(x) The need to make an assessment or alternative treatment options for the patients.

The evidence of the medical witnesses called in the complainant's case and that of Dr Drew was that treatment options available to the patients should have been assessed by the respondent and fully canvassed with each of the patients and that the respondent had demonstrated a serious limitation in that regard. There is virtually no evidence of any attempt on the

respondent's part to sit down with a patient and attempt to have that patient consider the suitability of treatment other than the prescription of benzodiazepines. It is true that he did protest that he did in the latter part of his evidence, but the fact that he virtually always prescribed on the first visit and often three benzodiazepines at the same time, gave the lie to his protestations. He clearly downgraded the Methadone Programme and drug and alcohol clinics and did not send patients to pain clinics.

Particular 7(b)

The Tribunal finds this Particular proved.

Many of the respondent's patients had serious psychiatric illnesses. The respondent said, "All my patients have reactive depression". In relation to patients having suicidal thoughts, he stated, "most of my patients do at one stage". He also stated that, "I find that most drug addicts have a (sexual) abuse history, if you question long enough". Having these views, the respondent did not refer the patients to specialist psychiatrists. Rather, he embarked on his own course of benzodiazepine treatment. Despite being asked, the respondent was unable to produce to the Tribunal any authority that benzodiazepines can or should be used for persons with depression. His attempt to do so was a failure.

The evidence of medical witnesses was that benzodiazepine use is counter-indicated in a depressed patient. Dr Bradshaw, in an article, had stated, "benzodiazepines are generally not helpful in depression, and may exacerbate the condition". The National Health and Medical Research Council

guidelines state, "benzodiazepines have no action in treating depression and may exacerbate the condition". Martindale (29th Edition) is strongly critical of the use of benzodiazepines in depression, stating that there is "a lack of evidence of any anti-depressant effective". Dr Seidler gave evidence that the patients M, Q, U, X, Z and AJ, referred to in this particular, — should have been referred to a specialist psychiatrist for treatment of their psychiatric conditions.

Particular 7(c)

The Tribunal finds the Particular proved.

Dr Seidler gave evidence that benzodiazepines should not be prescribed to pregnant women at all and particularly in the first trimester, when there is an association, he believed, with foetal abnormalities. He often inquired whether a female patient was pregnant before prescribing benzodiazepines and when their last menstrual period was and, in the process of their initial blood test, he included a pregnancy test to exclude pregnancy. He had found that heroin addiction made periods irregular. Dr Drew considered it to be an omission not to make an effort to establish whether the patient was pregnant, before prescribing benzodiazepines. Dr Marks stated that he would want to make sure that the patient was not pregnant and failure to pay attention to trying to determine, whether they were or not, would be a lack of medical care. He further stated "I would not prescribe benzos during pregnancies". The National Guidelines for the Prevention and Management of Benzodiazepine Dependence and Mims refer to the possible serious consequences to an unborn child of prescribing benzodiazepines during pregnancy.

Dr Szirt stated that he saw no problem with prescribing benzodiazepines in pregnancy and he wouldn't suggest or encourage users of the drugs to reduce their use or stop it during pregnancy. He did acknowledge that there were risks "that regular benzodiazepine use towards the end of pregnancy and perinatally is known to cause CNS depression in neonates, especially in the premature newborn. This may manifest as hypothermia, hypotonia and respiratory depression and is sometimes referred to as the floppy infant syndrome. He did not consider this, however, a problem in 1992 because, "the moment the baby is no longer inside the mother, it is no longer getting the benzodiazepine and very rapidly gets rid of them and it has got no problems". Martindale states that Diazepam concentrations are found to be very high even on the twelfth day after birth.

The Tribunal finds it difficult to accept the evidence of this witness in its entirety. He demonstrated over zealous support for the respondent in the witness box and his evidence was not only contrary to all the other evidence in the hearing but also contrary to advice given by him, in a letter, he wrote to the respondent concerning Patient AP's pregnancy in 1986. In that letter he mentioned the fact that the patient was "taking quite large doses of Serepax and I have suggested she should gradually cut it down through the pregnancy and hopefully in the last few weeks she will 'not require any'".

Particular 7(d)

The Tribunal finds the Particular proved.

Patient Y was diagnosed as being a diabetic at the St. Vincent's Hospital endocrinology unit in 1985. The

respondent had a letter advising him of that assessment in his files. He gave confusing evidence about this patient. At one stage he said, "I would not have checked his glucose levels because he wasn't a diabetic". He then stated "I cannot recall that he has diabetes, I have done a diagnosis, I sent him to a diabetic clinic, he came back with a history that they found that he had no diabetes". He did eventually accept that the patient did have diabetes and he agreed that he had never checked his sugar or glucose levels. He gave as an excuse for not monitoring his diabetic condition, "I assumed that he was being followed up by the diabetic clinic". However, he later admitted that he knew that the patient had ceased to go to the St. Vincent's Hospital. This failure to monitor the diabetic condition was a serious failure, because the respondent was prescribing for him large doses of benzodiazepines and codeine. Dr Seidler, whose evidence the Tribunal accepts, gave evidence that the taking of large doses of benzodiazepines and painkillers by a diabetic can interfere with glucose tolerance.

Particular 7(e)

The Tribunal finds the Particular proved.

The respondent had prescribed benzodiazepines and codeine for back pain for Patient AF for about five years in respect to a compressed fracture of his spine sustained six years before. Throughout those years he had never carried out any investigatory procedures such as x-rays, nor had he referred the patient for investigation by a specialist or arranged any physiotherapy or referral to a pain clinic. Dr Seidler gave evidence that within two years of the particular injury that

patient's spine should have been completely healed and if he was continuing to get pain then an x-ray report should have been obtained and an orthopaedic consultation arranged.

Patient AI was prescribed Panadeine Forte for four years for pain allegedly arising from a broken leg treated at Royal Prince Alfred Hospital in August 1987. The patient was never referred back to the hospital or to a physiotherapist or a specialist medical practitioner. The respondent stated that the patient had refused a suggestion that he do so. He had not had the leg x-rayed because "there is no indication for an x-ray". The hospital notes had made a mention of osteomyelitis. When asked about this condition the respondent initially stated "I don't know ... I am not sure". Then he stated that he remembered that the patient had chronic osteomyelitis and that he failed to detect and make a diagnosis himself of it. He remembered it because he remembered that he had to give a certificate about it. He agreed that he never did anything about his leg such as having it x-rayed but he was providing "support for him through a difficult time of his life". He didn't consider the condition of osteomyelitis as life endangering unless there was gangrene"; a conclusion he was prepared to come to because he had spent three months in Newcastle under an orthopaedic surgeon years before. Although he had said that the patient had refused to see any doctor or go to hospital he eventually stated that he thought that the osteomyelitis was being well taken care of by a hospital and that he was being well managed by a specialist so that it was not so much a concern for him. He didn't make any contact with the hospital as to the treatment being given even though he knew that "osteomyelitis would not occur in a patient who was well on

the way to recovery". The respondent stated in fact that the patient had referred himself to the hospital about his condition of osteomyelitis.

#### CREDIBILITY OF THE RESPONDENT

The Tribunal does not find that the respondent was a reliable witness. It finds that he gave incorrect, biased and sometimes untruthful evidence where his interest were at stake, that he showed inventiveness when he sought to explain his treatment plans, that he sought to justify himself as a primary consideration and he showed opportunism when it came to obtaining evidence from his patients in an attempt to cover up his own inadequacies. He sought unsuccessfully to show a remarkable capacity for recalling details without any assistance from any contemporaneous records. When it came to his explanations of what he may have been doing at any time by way of treatment or in pursuance of a treatment regime, more often than not, he dealt with such matters on a general basis according to his categorisation of the witness, although he protested throughout that his practice was one of eyeball to eyeball and individual treatment.

His unreliability in relation to the details concerning patients was highlighted by comparison between his evidence and hospital records, Medicare information, Methadone records and patients' evidence.

The respondent's opportunism relative to his patients' evidence is demonstrated by his shifting attitude concerning his patients throughout the proceedings. In an early statement to the Tribunal, the respondent said that the patients he treated were "a whole ... of Sydney subculture of deprived

people ... prostitutes, drag queens, alcoholics, gays, AIDS infected people". The patients involved in the Schedules were described as "beyond hope" and "as being the worst that any doctors could have". In his early evidence he commented about the four patients called in the complainant's case, that their evidence was not true because "those patients were so traumatised by appearing in court they would say anything ... I would expect them to say what they were asked to say ... these were very very socially disaffected people". In questioning other witnesses concerning those patients, the respondent's counsel used such phrases as "misfits in society" and "all extreme social misfits". Very little of the evidence of patients called in the complainant's case was questioned in cross examination although their truthfulness was sought to be "smeared" by reference to their drug usage and social position in life.

The respondent, although having said that he considered that 90% of his patients were unreliable and traumatised by drugs, obtained statements from some of his patients in July 1991. This was done under a pretence that his patient cards were missing because they had been taken by the Health Department. In fact the Health Department had the cards for one day only and that was in July 1990. When his attention was directed to that time frame, his response was, "What's wrong with taking about 12 months to write a statement?". The evidence of patients A, AS, AW, C, CE, L and R is contradictory of the respondent's assertion, "I never asked them for statements". The respondent asserted that a notice he put in his surgery concerning the "charges" against him in June 1991 (that is, the Complaint) had in late December 1991 and early January 1992 led

