

15 minutes. He regarded the respondent as a confidante. He had discussed with the respondent his dependence on Serepax and Mogodon and a treatment plan to get off Serepax, Mogodon and Methadone.

The respondent claimed that he was treating this patient for anxiety and insomnia, toothache and back pains since 1981 and then later he said that he was treating him for heroin addiction and alcoholism. The prescriptions remained the same.

The patient's evidence was in conflict with the claims of the respondent. He stated that he had not used heroin since he had been on Methadone and that he had never been treated by the respondent with tablets for alcoholism and the only treatment he had had from the respondent might well have been for his pancreas. The patient then claimed that he had stopped taking the Serepax and Mogodon "a few weeks ago" which had occurred after a discussion with the respondent "a couple of months ago". The Tribunal found this difficult to believe when a person had been a abuser of drugs for some 12 years.

Dr Seidler did not think that the patient, suffering from pancreatitis, should be treated with the combination of drugs prescribed and that if in fact Panadeine Forte was being given for "aches and pains in back and limbs" such long term prescription should have had the backing of an authority from the Department in order to prevent the patient getting the same drugs from other doctors.

The Tribunal found no evidence of any attempt by the respondent to monitor the drinking habits of this patient. He was unaware of his admittance to Langton Clinic and his

extensive criminal record. Although the respondent claimed that the patient had stopped drinking he couldn't recall when and he had made no reference to him in his written treatment plans as it was not considered to be critical. If he was substituting benzodiazepines for alcohol it is surprising that the same amount of benzodiazepines were prescribed over a very lengthy period of years.

PATIENT P

Particulars: 1,3,6 D.O.B. 16.12.1925

This patient gave evidence in the case for the respondent. The Schedules show, between 5.5.1989 and 12.4.1990, 32 prescriptions totalling 750 Oxazepam, 800 Nitrazepam tablets, always prescribed together. The patient cards recorded 41 visits of which 37 were merely date stamp entries except for any entry on 27 October, 1989, which was indecipherable except for a mention of bone and calcium and a few history notes in the years 1979 and 1980. The consultation dates during the relevant period were all out of order. There was in addition an authority from the Department of Health to prescribe Codeine Phosphate for this patient.

This patient was the mother of the *patient O*. She stated that she had been a patient of the respondent for some twelve years. The respondent said that he prescribed benzodiazepines for this patient because she was in "pain, couldn't sleep and worries". He then said that he prescribed the benzodiazepines for her insomnia and that he had never attempted to overcome her sleeplessness other than by prescribing them nor had he ever tried to stop the prescriptions. Although the patient

had said that she had had headaches "almost all my life" the respondent did not make any note of this as a medical problem of the patient.

The patient denied a claim of the respondent that she had told him that if he did not give her more Codeine she would get it through her son Greg. This patient claimed to have suffered from cystitis for many years and that the respondent had found the right medication to deal with the problem. She suffered from Osteoporis following a broken hip which has been a matter of investigation by several doctors, some of whom she has been sent to by the respondent, and she claimed that she had received benzodiazepines for many years prior to seeing the respondent but that she was not addicted to them. She claimed that the respondent had warned her about the proper use of her medication and that if she "got bombed off her face" she would be likely to fall and suffer injury.

Although the Tribunal feels that other forms of treatment could have been tried with this patient and the particulars have been proved, it would not come to a decision against the respondent on the basis of professional misconduct.

PATIENT R

Particulars: 1,2,3,5,6 D.O.B. 26.9.1960

This patient gave evidence in the case of the respondent. The Schedules show, during the relevant period, 87 prescriptions totalling 2175 Temazepam, 100 Nitrazepam, 2100 Diazepam and 1300 Panadeine Forte tablets, usually three prescribed at the same time. The patient cards tendered to the Tribunal only show 27 visits of which 17 were merely date stamp entries. The others

were merely the names or abbreviations of drugs except for an entry on 1.5.1987 "DD 15 years Rohypnol" with 6/12 crossed out and on 12.3.1990 "Clinical history needed before 1/6/90". The Medicare record showed that during the relevant period the patient had 81 consultations with the respondent and he was provided with 35 services by other Medicare providers. The respondent had an authority from the Department of Health to prescribe him Codeine Phosphate.

In his initial report the respondent said that this patient was a homosexual Heroin addict for 15 years and a male prostitute for one year and now is HIV positive. He had been counselled about his dependency on Codeine Phosphate and when the authority expired it was no longer required. In his next report he said that he had put the patient on sickness benefits and discouraged him from prostitution. He had prescribed Temazepam and Diazepam for withdrawal anxiety and insomnia and Panadeine Forte for obscure pains. He stated that he had achieved a stable personality.

According to the patient he had only taken heroin on three or four occasions in his whole life. He also stated that he had made it clear to the respondent that he had a problem with Codeine by way of addiction which should have caused the respondent to question the "obscure abdominal pains" which the respondent claims he prescribed the drugs for. In fact the Albion Street Clinic had not been able to establish a diagnosis for those pains and eventually in March 1990 advised the respondent in a letter that it would be "unwise for him to receive analgesics that contained Aspirin or Paracetamol in significant quantities" and that it would be "unwise to have

it in the form of Panadeine Forte or Codral Forte". Thereafter the respondent did ease off the prescriptions of Panadeine Forte but did not stop them. He never attempted to establish the cause of the obscure abdominal pains or to refer the patient to a specialist or pain clinic.

Although the respondent knew that the patient went to the Albion Street Clinic, a specialist care unit for persons with HIV positive condition, he never knew what treatment he was receiving there or the counselling that he obtained for anxiety or whether he was prescribed any benzodiazepines. The respondent was unaware of any "fits" or "seizure" that the patient may have suffered and which required an attendance at hospital in 1990. The hospital notes referred to a four year heroin usage and noted intakes of drugs such as Valium and Codeine which the respondent was unaware of. The respondent never checked the patient's liver enzymes even though there was a liver test result shown in an exhibit which was so high as to preclude the use of Panadeine. These results had been given to the respondent according to the patient but this was denied by him.

There were many inconsistencies between the evidence of the patient and that of the respondent. The Tribunal is not able to accept the evidence of the respondent in its entirety. The patient said that the respondent only ever examined him physically once on the first occasion and, in respect of his liver, twice over a couple of years. Dr Seidler considered that the prescriptions for this patient constituted mismanagement and that compound analgesics were contra-indicated in liver disease. He strongly disapproved of the treatment.

PATIENT T

Particulars 1, 2, 3, 5, 6 and 7(a). D O B. 29.9.1954

The Schedules show 75 prescriptions during the relevant period totalling 1,675 Nitrazepam, 3,850 Diazepam and 2,500 Panadeine forte tablets. During the same period, although a Bondi resident, he obtained from several chemists in the Kings Cross area on the prescription of other doctors, 25 Oxazepam, 25 Temazepam, 1,525 Nitrazepam, 3,510 Diazepam, 1,250 Panadeine forte and 20 Codral forte tablets. The patient cards show only a couple of visits during the relevant period, although they cover visits from 1984 onwards and a separate group of cards for a period in 1988 and 1990. Many of these entries were date stamps, others were just a scribble of a drug or an abbreviation, except for entries in 1988 of "Duputyren's", "assaulted", "x-ray at St. Vincent's" and some mention of an "eye problem" in 1986. The Medicare records showed, during the relevant period, 85 attendances on the respondent and 335 services rendered by other providers.

When first seen by the respondent in November 1984 he was prescribed Valium and Doloxene. In October 1988 the respondent prescribed benzodiazepines because the patient was under "some distress". Even though there was no change in the stressful condition of the patient, there was a continuation of the prescription and, indeed an increase in the quantities, over the next two years, so that by April 1990 he had been prescribed up to 16 valium tablets a day by the respondent alone. Although the respondent had no notes of any dependency on heroin, he asserted that this patient was so dependent, although he did not know the quantities and he did not monitor his heroin use. He

asserted that he was essentially off drugs but "no drug addict stops completely".

The respondent suggested that he was treating him with the benzodiazepines because otherwise he would have resorted to harder drugs to seek comfort. He did not believe the patient was getting drugs anywhere else as he trusted him. When informed of the records of other attendances, he stated that it did not affect his thinking about his methods or give him any insight into any lack of control by him. The patient was prescribed drugs in periods of less than every five days. The respondent said he prescribed him Diazepam and Nitrazepam for his withdrawal anxiety and insomnia, Panadeine forte for body aches and pains from bike riding aggravating his Duputyrens contracture. When it was put to the respondent that that condition was not a painful condition, he asserted that the patient had "a pain threshold probably lower" than most. He made no attempts to follow up this patient when he suddenly ceased seeing him in August 1990 after seven visits during that month. Although he knew the patient's girlfriends, who were also patients, he did not have any information concerning the patient.

Dr Seidler gave evidence against the prescription of Panadeine for the Duputyrens condition and he also considered the combination of Mogadon and Valium inappropriate.

PATIENT "U"

Particulars 1, 2, 6, 7(a) and 7(b). D O B. 26.7.1961

Between 9.10.1989 and 20.4.1990 the Schedules show 8

prescriptions totalling 175 Flunitrazepam and 400 Doloxene

tablets and records show that he also obtained 50 Doloxene tablets from a prescription dispensed at Kings Cross on the order of another doctor. The patient cards showed 12 visits between October 1989 and April 1990, six of the entries being merely date stamps and the others being a scrawl of a drug name. After the last entry 7 June 1990, there is written an entry "died on 8.6.90 did not fill script of Rohypnol". Otherwise there is no history of this patient recorded at all. During the period October 1989 to April 1990, Medicare records show that he saw the respondent on 14 occasions and 7 services were given by other providers.

The first "case history" provided by the respondent merely said the patient "was a heroin user for 11 years and a musician. He was quite unsuccessful in his career and would resort to drugs when he felt "down". He was prescribed Rohypnol and Doloxene for his habit. He died of heroin overdose on 8 June 1990". The respondent subsequently reported to the Tribunal, in his second "case history" that, having been informed of this patient's death, he checked with the chemist and learnt that a script for Rohypnol had not been collected. That script had been written on 21 May 1990. In fact there was a script written for Rohypnol and Doloxene by the respondent on 7 June 1990 according to the patient cards and the patient saw the respondent according to the Medicare records on 31 May 1990 and 7 June 1990.

The patient died on 8 June 1990, the pathologist's report showing that there was no opiate found in the body but there was alcohol and benzodiazepines. Although the respondent had used the word "overdose" in his "case history", when asked if it was in his view an unintentional overdose that

killed the patient, he said "I don't know what an overdose is". He had not seen any scars on the patient's wrist, which had been found on post mortem report. As far as he was concerned they were of no significance even if they were as a result of old attempts at suicide.

The records showed that there was a steady increase in the prescriptions for this patient, for example, between 21.3.1990 and 20.4.1990 there were prescriptions for 125 Rohypnol and 300 Doloxene tablets. It was obvious that the Schedules did not show prescriptions dispensed at all pharmacies.

Dr Seidler thought that the prescribing of Rohypnol and Doloxene for "his habit" to be totally inappropriate.

PATIENT "V"

Particulars 1, 2, 4, 6, 7(a), 7(c). D O B. 23...1959

This patient gave evidence in the case of the complainant.

The Schedules show 26 prescriptions during the relevant period for 300 Oxazepam, 800 Diazepam, 625 Flunitrazepam and 460 Codral forte tablets. The Medicare records show that she had 39 attendances upon the respondent and 131 services were given by other providers during the relevant period. Her patient record cards show 37 attendances, 19 of which were merely recorded as date stamps. The only history notes made were in records going back to 1984 "lost her script", "now into jewellery", "making ceramics", "report of path(?)". The other entries were merely scrawls of initials or names of the drugs prescribed.

Initially the respondent reported concerning this patient that she had seen him in 1984 with a history of

heroin dependency for three years and she was treated with Serapax, Rohypnol and Doloxene. He then reported that he had treated her "like a father treating a difficult child" and the drugs he gave her helped her worries and insomnia and her pains which include backaches and headaches. She had ceased to see him between 1986 and 1988. She had resumed again regularly as a patient from October 1988. Although the respondent claimed that he had asked this patient whether she was on Methadone, he made no reference to her being on a programme on which she went in September 1989. The respondent's evidence about his knowledge of the patient's previous Mandrax use and more recent use of cocaine was contradictory.

The patient claimed that she did not think that she had had Rohypnol prior to seeing the respondent. He claimed that she was already taking benzodiazepines when he first saw her. This patient had serious difficulties with her memory but she was viewed by the respondent as a perfectly normal lass as far as her brain goes, "perfectly". Although the patient had overdosed on heroin on at least eight occasions, the respondent misstated that he did not know of that fact.

There were many discrepancies between the respondent's evidence and the patient's evidence, such as in relation to whether he knew she was pregnant, whether he did physical checks on her and whether he consulted her in relation to health matters. He never had any x-rays done nor did he refer the patient to specialist attention in respect to any of the alleged backaches. The patient said that she had been given drugs for "hanging out". The respondent conceded that some of the details in the "Case Histories" concerning this patient were

incorrect. There was a three months break in her attendances upon the respondent, when it appears that she had been detoxified at a Sydney private hospital in early 1991. As soon as she returned to consulting the respondent, he recommenced prescribing benzodiazepines. When asked about the hiatus in her attendances, the respondent said "I don't know what happened to her at this point of time ... she could have gone on holidays ... she probably told me she had been free from drugs for three months ... I don't know I can't recall now what happened at any time".

The patient stated that at no stage did the respondent ask her about seeing other doctors and in fact once he had told her that she should go and obtain her drugs elsewhere.

PATIENT "W"

Particulars 1, 2, 3, 4, 5, 6. D O B. 7.5.1952

This patient gave evidence in the case of the respondent.

The Schedules show 61 prescriptions totalling 3,025 oxazepam, 300 Nitrazepam and 1,100 Codral forte tablets during the relevant period. During this period, the patient cards produced showed 83 attendances of which 54 were merely date stamps and the remainder were scrawls of the initials or names of the drugs prescribed other than two which were to the effect, "owes \$27.00", "claims lost script". The date stamps on the cards were out of order. The Medicare records showed 95 attendances upon the respondent and 132 services rendered by other doctors during the period. This patient had been a Methadone Programme patient since 1985 on the records available to the Tribunal.

The respondent stated that he first saw him in 1980 and still continued to treat him. He initially reported,

"he has been using heroin for 15 years. Methadone has increased his weight tremendously and he weighed 110 kgm. He was drinking heavily to settle himself as Methadone made him "edgy". He needed Serapax for that purpose. He has been looking after his mother quite faithfully and Daryl is quite a sensible man". He later stated that the Serapax prescribed was to curb his drinking and the Codral forte was for toothaches, migraine and backache. He considered the results with this patient were only fair, but he was able to lead a useful life which was looking after horses for a friend in Terry Hills. He had not recorded any drug history because it was not significant, although he classified him as "heroin dependent". In one of his "case histories", he claimed that the patient's heroin use was "nil" as a result of his Methadone treatment. He stated that he prescribed the benzodiazepines for the patient's anxiety and "withdrawal". He was seeing him approximately twice a week during the relevant period. The respondent's evidence as to when he first saw the patient varied from 1980 to 1984 to 1987. Although he prescribed the Codral forte for toothache, he never had the tooth condition assessed, although he did say that he believed his patient went to the dental hospital.

He prescribed benzodiazepines even though he knew the patient was drinking. The respondent realised that drug addicts "top up" with benzodiazepines when they are on Methadone. He carried on prescribing in those circumstances because the Methadone treatment made them sleepless and edgy, because the dosage is often inadequate. He stated that he did not observe anything about the patient's arm on examination. Records show that the Methadone prescriber found "clearly a lot of collapsed

veins". This did not concern the respondent who considered that it was a finding common to "all my drug addicts which I do not note down". Dr Seidler considered that the Methadone prescriber should have been contacted, if the patient was "edgy", to try to adjust the situation with his Methadone dosage or by counselling rather than the prescription of benzodiazepines and Codral forte.

The patient in his evidence said that the respondent never treated him for any alcohol problem and that the respondent knew of his addiction to Serapax but, between them, they had decided that they would not treat that problem until "after I came off methadone". He had only been to a dental hospital on two occasions although he claimed that he had a very bad dental situation since 1987. He said that he had substantially stopped using heroin when he went to the respondent initially. He then had a Serapax addiction problem of which he told the respondent. The Serapax had helped him through a normal day living a "normal, sort of half productive day". He asserted that they did not give him a boost. He stated that he saw another doctor in addition to the respondent in order to obtain Serapax. The respondent never asked him if he was seeing other doctors. He asserted that he was only a social drinker and he had no problem with it. He said that he had wanted his blood pressure to be tested from time to time and that had happened. He said he might have to wait up to an hour to see the doctor but the time varied. He stated that the respondent "never demanded but he encouraged" him to do something about the situation he was in. He asserted that the respondent had taken up from 15 to 45 minutes for a consultation with him on a date, which the records before the

Tribunal showed to be one where the respondent saw 118 patients in the day.

This witness was not impressive and his evidence could not be considered reliable.

PATIENT "X"

Particulars 1, 6, 7(a), 7(b). D O B. 2.1.1962

The Schedules show nine prescriptions totalling 225 oxazepam, 225 Temazepam, 50 Flunitrazepam and 180 Codral forte tablets were dispensed between 18.1.1990 and 27.4.1990. On all occasions three types of those tablets were given at the same time, except twice, when there were four different types given. The patient cards recorded 9 visits upon the respondent of which 5 merely are shown with a date stamp and the others with the scribble of drugs prescribed. This number accords with Medicare records. The patient received services from three other providers during that short period. The only history recorded on the cards has been done by the respondent's locum during his holiday in early January 1990. That record is that she was "HIV positive and on a Methadone Programme". She apparently attended the surgery because her boyfriend had been a patient. He was not a drug addict but saw the respondent because of an old Potts fracture which gave him "quite a lot of pain".

The respondent stated that she was depressed and anxious and unable to sleep because of her HIV status. She had been addicted to heroin for five years. She had been on a Methadone Programme since 1986. The respondent said of her, "I practically offered her what she asked, just to make sure she did not have to work the streets". He agreed that it was controversial to treat people suffering from depression, as this patient did, with benzodiazepines. Then he said he was not treating her for depression only. He was treating her. He did not refer the patient to specialist care for her depression. He was unaware that she had her depression treated at Albion Street

Clinic or as to any treatment that she received at Kirketon Clinic or that she had been admitted to Jarrah House for detoxification in 1990 for among other things her benzodiazepine dependency as well as barbiturates. He did not consider that essential history because "I provide a form of detox".

Dr Seidler considered that this was a case where the Methadone prescriber should have been contacted as benzodiazepine abuse is associated with disinhibited behaviour, which is particularly dangerous in a HIV positive patient who has a drug addiction. She should have been receiving specialist counselling available for persons with HIV condition.

PATIENT "Y"

Particulars 1, 2, 3, 6, 7(d). D O B. 9.11.1949

The Schedules show some 44 prescriptions totalling 425 oxazepam, 225 Temazepam and 875 Nitrazepam tablets between May 1989 and 24 April 1990. The patient cards show 30 consultations, 17 of which are merely date stamps during the relevant period, whereas the Medicare records show some 96 attendances and 10 services by other providers during that period. The only history or other details recorded, other than the specification of scribble for a drug, is "All treatment under repatriation. green prescription" and "Dr Burns suggested check his electrolytes" and "Dr Burns will send copy of letter". The respondent said the patient was a TPI for alcoholism for over 20 years and had cirrhosis, pancreatitis and spinal degeneration. His plan was to curb his drinking and to tend to the pain from his spine. He had authorities to prescribe Codeine Phosphate and he gave him oxazepam for alcoholism and nitrazepam for sleep. He had first

prescribed him benzodiazepines in December 1983 because of a sciatica attack and had continued from then. He said he continued the prescriptions for benzodiazepines because this patient "wanted to stop drinking". He then stated that the patient had "come off" drink in 1988, then he said 1986 or so, then he said "nobody stops drinking absolutely" and, then he said he did not prescribe benzodiazepines to alcoholics who do not want to stop. If they wanted to stop he would help them along. Until they want to stop, he would prescribe benzodiazepines. He denied that there were forms of treatment for pain other than Codeine Phosphate. He had never organised any physiotherapy or other forms of treatment at pain clinics, other than to refer him to St. Vincent's Hospital Diabetic Clinic. The patient had recently gone to the North Coast. He did not know how often he checked the electrolytes after October 1989 or whether he had tried to contact the patient when Dr Burns had asked him to obtain them.

He said that he could not recall if the patient had diabetes although he said he sent him to a clinic, which, he said, found that he had no diabetes. He had to alter this evidence when it was pointed out to him that the hospital had reported that he had it and it should be controlled by diet. He stated that he just assumed that the patient was being followed up by the diabetic clinic because he would prefer his patients to have those facilities, even though he asserted that he could manage simple diabetes. He could not recall doing any blood tests and he did not record them. He said he would not prescribe benzodiazepines to somebody who just refused to reduce his alcohol.

Dr Seidler was unaware that benzodiazepines could lead to any decrease in alcoholic consumption. He believed it made irrational behaviour far worse.

PATIENT "Z"

Particulars in 1, 3, 6, 7(c). D O B. 5.11.1952

The Schedules show 42 prescriptions totalling 25 oxazepam, 950 nitrazepam, 1,225 diazepam and 420 Panadeine forte tablets within the relevant period. The patient cards showed 49 visits of which 8 only had a date stamp and, except for three short notes which were indecipherable, the rest merely recorded the initials or a scribble of a drug name. The Medicare records showed some 82 visits to the respondent and 63 services rendered by other providers during the relevant period.

The respondent, initially, reported in the "case history" that this patient was "a paranoid schizophrenic", who was constantly plagued by voices and obscure illness. He would upset other patients with his boisterous behaviour and the police had to be called a few times. He was barred from the surgery finally in exasperation. The respondent said his treatment of this patient "was mainly to relieve him of whatever he complained of and he had been my patient since November 1988. His request for Diazepam and Nitrazepam were reasonable as he was living in Mathew Talbot Hospital for homeless men. He never recorded that the patient was an alcoholic. He alleged that the patient's complaint was one of sleeplessness. He was actually prescribed Largactil, Disipal and Serenace by St. Vincent's Hospital. Although he acknowledged that there were dangers of benzodiazepines potentiating the central nervous system if

prescribed in combination with anti-depressants, he nevertheless did so. He never arranged for him to have a consultation with a psychiatrist. The respondent did not suggest to him that he go to Caritas but decided to bar him.

Dr Seidler considered that it was totally inappropriate to prescribe benzodiazepines for a chronic schizophrenic and that he should have been prescribed major tranquillisers and put the patient under the care of a psychiatrist. There did not seem to be anything in the history of the patient justifying the prescriptions for Panadeine forte.

PATIENT "AA"

Particulars 1 and 6. D O B. 21.3.1971

This patient gave evidence in the case of the respondent. The Schedules show 37 prescriptions totalling 275 Oxazepam, 425 Temazepam, 750 Diazepam, 20 Panadeine forte and 1,250 Doloxene tablets during the relevant period. The patient cards record 56 visits with the respondent during the relevant period, 27 of which merely had date stamp entries and the remainder a scrawl as to the name of drug. There were no other histories. The Medicare records showed some 67 attendances by the respondent and 10 services given by other providers during the relevant period.

The respondent said in his "case history" of this patient, "teenage heroin addiction for two years, under age prostitution. Poor interpersonal relationship with an older man David Gee another patient an artist and a volatile personality". His plan was to keep her off heroin and prostitution by ego strengthening counsel to improve her self esteem and reconcile her with her father. Doloxene was used as an opiate substitute,

Oxazepam initially to continue her use but later Diazepam to wean her off Oxazepam and gradual reduction in Temazepam usage. She had moved her address some nine times in three years. He thought that she had become more stable.

Although he asserted that he knew this patient well he was unaware of many facts concerning her such as, that in January 1989 she had been admitted into Royal Prince Alfred Hospital in a coma, that she alleged that she had suffered three rapes. He stated in his written submission to the Tribunal that this patient was only being seen once a month or so, yet up to date records showed that he had been seeing her on at least three of four occasions during the months of August and December 1991. She had been hospitalised in November 1989 at 14 weeks pregnancy. He was unaware of her further admission to hospital in August 1991 with abdominal pain when she was taking large amounts of Valium and doloxene. It was reported that she had fittted from Valium in the past. Besides the respondent's evidence about this patient being unreliable, she was an unreliable witness. She gave three different accounts of when she last used heroin, namely November 1990, April 1991 and January 1991 and she stated that she could not "remember dates, times, places, addresses or things" and yet she sought to specify the length of the first visit upon the respondent. She stated that the respondent left to her as to how many Doloxene tablets she took. She denied some of the history concerning herself which the respondent asserted, particularly in relation to her mother. The respondent was unaware of her alcohol usage. She asserted that she got a boost from Doloxene and her history would suggest that she only used

