

DCC023 JOC-D

MEDICAL TRIBUNAL OF NEW SOUTH WALES

CHAIRPERSON: BLANCH CJ OF DC

MEMBERS: MR R SMITH  
DR P McINERNEY  
DR B KOTZE

SECOND DAY: THURSDAY 2 FEBRUARY 2006

**IN RE DR BARRY CROSS AND THE MEDICAL PRACTICE ACT****SUPPRESSION ORDER IN RESPECT OF THE NAMES OF THE PATIENTS  
A TO M AND X****JUDGMENT**

HIS HONOUR: This is a complaint brought by the Health Care Complaints Commission in accordance with s 51(1) of the **Medical Practice Act** 1992. The complaint is in these terms,

"Dr Barry Phillip Cross of the Red and White Medical Centre, P O Box 1117, Coffs Harbour, 2450, New South Wales (the practitioner), being a medical practitioner registered under the Act, has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that the practitioner has engaged in conduct which demonstrates a lack of adequate knowledge, skill, judgment or care in the practice of medicine and/or engaged in improper or unethical conduct related to the practice of medicine."

The particulars of the complaint are, in respect of patient A:

1. The practitioner prescribed benzodiazepines, codeine compounds and Flunitrazepam to patient A on the dates and quantities set out in a schedule:

(a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;

(b) in quantities and for periods in excess of recognised

therapeutic standards of what is medically appropriate;

- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when prescribing such was contraindicated as patient A had a history of drug dependency.

Paragraph 2 in relation to patient A specifies in the complaint that the practitioner prescribed Flunitrazepam for the period exceeding two months without obtaining an authority to prescribe Flunitrazepam to patient A from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

Paragraph 3, the practitioner prescribed the drug Phentermine to patient A on the dates and in the quantities set out in the schedule attached and marked A:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) for a period in excess of recognised therapeutic standards of what is medically appropriate.

It might be convenient to deal with that complaint first because that complaint deals with a patient of Dr Cross's who was in her late fifties and it is asserted that the prescription of the drugs in that case far exceeded what was a reasonable prescription.

The background to the particular case is that the woman in question was undoubtedly a very difficult patient for any doctor to have in their practice. She had an extensive history dating from her childhood of abuse and

she had come to a point where she was living a very difficult life. She was in a relationship with a man who is patient C in respect of whom there is another complaint and we will deal with that in due course.

Patient A, however, had one son who had died and the death of that son had impacted severely upon her. She had a second son who apparently was a gifted footballer but who, during the relevant period, was living in a lifestyle she did not approve of and which involved him in having an affair with a mother and daughter at the same time.

It appears that throughout the various trials in this woman's life she had taken to the use of drugs in order to cope and she came to Dr Cross's practice and he saw her, he says, as often as three times a week, and very often she came into the practice and stayed talking to him for periods in excess of half an hour. He realised that she was a person who was very vulnerable and who needed treatment and he undertook to assist her insofar as he could. Unfortunately in doing that he came to the conclusion that the only way he could maintain her in the community, keep her alive with a reasonable degree of sanity, was to prescribe significant amounts of Panadeine Forte in particular. That got to the stage where he was essentially prescribing Panadeine Forte on request.

I should say that the sad tale of that woman's life came to an end when she committed suicide by drinking a bottle of whisky together with a significant number of Panadeine Forte tablets. I immediately say that there is

not the slightest suggestion that Dr Cross was in any way responsible for that and there is no connection between that woman's death and these proceedings apart from the fact that it became evident at the time of her death that she had been taking Panadeine Forte in significant quantities for a significant time.

To give some idea of the quantity of the medication, she was prescribed 8,280 Panadeine Forte tablets over a period of nineteen months in 2000 and 2001. That has been worked out as an average of 435 a month or fourteen a day.

In addition to the Panadeine Forte tablets she was prescribed different benzodiazepines and between 3 May 2001 and 6 September 2001 there were nine scripts for a total of 225 tablets of Flunitrazepam. She was also prescribed Nitrazepam, Temazepam and Diazepam in amounts indicating an excessive intake daily over a period of nineteen months.

Insofar as the assertion in the complaint that this was done without exercising responsible medical judgment and in quantities in excess of recognised therapeutic standards and when he ought to have known there was likely to be abuse and that it was done when she had a history of addiction, those assertions are admitted. There is no doubt that in those circumstances, insofar as patient A is concerned, the conduct of Dr Cross amounted to unsatisfactory professional conduct.

There is a further assertion that there were prescriptions of Flunitrazepam for a period exceeding two months without obtaining authority. That assertion is

also admitted but there is an explanation. The explanation made is that Flunitrazepam was previously available under a different section of the regulations but it then became classified in a different way which required specific approval to prescribe it after a certain period. Dr Cross says that he did not become aware of that change in the regulations and ultimately he said he did not become aware of that until September 2001. When he did become aware of it he says he sought the necessary authority to prescribe and his explanation is that this was an oversight.

It is submitted on behalf of the Health Care Complaints Commission that the change in the regulations relating to allowing the prescription of Flunitrazepam was widely circulated in the profession and that Dr Cross should have become aware of it at the time that it occurred. There is a further criticism made of Dr Cross's evidence on the basis that Dr Cross initially suggested that he became aware of the change in April but it was pointed out to him that he did not make the application until September. When that was pointed out to him he changed his evidence to say that he was mistaken in saying he had become aware of it in April, he had only become aware of it immediately before he made the application. We are invited not to believe him in respect of that.

Our conclusion about that is that we do accept what Dr Cross says about that issue. There is no doubt from the rest of the material, some of which we will refer to later, to indicate that his recordkeeping was poor and

that his management of his practice left a lot to be desired, and there is no reason, in our view, not to accept the fact that he became aware of the change in the regulations in September and that immediately after that he sought to obtain the necessary approval. The letter seeking that approval has been tendered.

The other assertions in respect of patient A, namely that he prescribed Phentermine without exercising responsible medical judgment and for a period in excess of recognised therapeutic standards is also admitted.

A schedule of all of the prescriptions in respect of patient A has been tendered before this Tribunal.

Insofar as patient B is concerned, the complaint is that:

1. On 18 October 2000 the practitioner:
  - (a) prescribed twenty-five Flunitrazepam for patient B and failed to make a record of his treatment of and prescribing for patient B contrary to the requirements of cl 84 of the **Poisons and Therapeutic Goods Regulation** 1994 and Schedule 2 of the **Medical Practice Regulation** 1998.

There was a further complaint in respect of patient B which has now been withdrawn. The first aspect of the complaint which I have read out is accepted by Dr Cross and in the Tribunal's opinion appropriately accepted by him, and we find that complaint established.

While dealing with that matter I should note that it arose in these circumstances, that patient B does not exist. There was a handwritten prescription in the name

of Robert B - and I use the letter B instead of the name - and it appears clear that what occurred was that Dr Cross made a mistake and the prescription should have been for Wayne B. I stop to mention that aspect of the case only on the basis that it raises the curious fact that although all the doctor's other prescriptions that have been tendered were computer generated prescriptions this one was handwritten and he was at a loss to explain why that was so.

The complaint in respect of patient B has more significance when one looks at the complaint in respect patient C, patient C is the person who was living in a relationship with patient A. And the complaint in respect of patient C is:

1. The practitioner prescribed codeine compounds (Panadeine Forte) to patient C on the dates and in the quantities set out in the schedule attached and marked C:
  - (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
  - (b) in quantities and for a period in excess of recognised therapeutic standards of what is medically appropriate.
2. The practitioner failed to make a record of his treatment of and prescribing of patient C contrary to the requirements of Schedule 2 of the **Medical Practice Regulation** 1998; or in the alternative to particulars 1 and 2 above.
3. The practitioner improperly wrote prescriptions for

the drugs listed in Schedule C in patient C's name and in so doing caused or permitted patient A to obtain the drugs from pharmacists by knowingly false representations as to the name and address of the persons to whom the drugs were purportedly intended.

These assertions in respect of patient C have formed the major part of the hearing before us and these assertions need to be looked at carefully.

In short, the assertion is that patient C accompanied patient A to Dr Cross's surgery on a number of occasions and that Dr Cross wrote out prescriptions for patient C. The highest allegation against him is that he did that deliberately so that patient A could have access to the medication.

The medication provided to patient C is set out in annexure C which has been tendered and that indicates some seventeen prescriptions from 19 February 2001 and includes, for example, the prescription of 1,380 Panadeine Forte tablets plus some Aropax and Nitrazepam and Flunitrazepam and Temazepam.

The substantial factual dispute in the case is simply that patient C was called to give evidence in these proceedings and he denied flatly that he had ever been into Dr Cross's surgery. He denied that he had obtained prescriptions that are set out in that schedule which comes from the records of Dr Cross.

One important function this Tribunal must carry out is to determine who is to be accepted in respect of this conflict of evidence because Dr Cross gives evidence that

certainly patient C did come to the surgery and did receive these prescriptions. He said that patient C received them for pain emanating from a broken arm or wrist which, when he saw him, was in plaster.

As to that conflict of evidence, the Health Care Complaints Commission submits that patient C should be accepted. It is pointed out that there are no separate records in Dr Cross's practice for patient C. He is mentioned from time to time in the records of patient A.

Dr Cross thought he had some separate notes in respect of patient C but he accepts that no such notes exist. It is pointed out that he did not charge patient C for any of these ministrations and it is pointed out that Dr Cross has had some problem with his recollection about various times and various incidents.

As to the last submission it has to be observed that he was a general practitioner conducting a practice where he saw fifty to sixty people a day and he was being cross-examined about people he saw and his observations of them in 2001 and 2002. It is obviously unrealistic to expect people to be too precise in their recollections about those circumstances.

In considering the various matters that have to be considered about this we have taken into account firstly the fact that patient C was not an impressive witness. It is of course difficult to make decisions based on demeanour but insofar as it can be of assistance patient C was not impressive.

It should also be noted that in one of the records of .02/02/06

the notes of Dr Cross he made a note of the pension number and Medicare number of patient C. He gave evidence that patient C produced those documents to him and he copied those particulars out. Patient C denied that. Patient C said that he had given the cards to patient A to take to the practice so that it would facilitate her getting the extra tablets.

It appears to us that the evidence given by Dr Cross is more likely to be correct. That is particularly so when we take into account the evidence of patient C that he said he was concerned at the level of drug prescription by Dr Cross and was concerned for the welfare of patient A. Obviously that is very much at odds with his assertion that he was providing her with assistance in obtaining extra medication.

The other matter that is relevant in considering that issue is the fact that it is abundantly clear that patient A was in a situation where she could go to see Dr Cross and obtain a prescription for Panadeine Forte and other drugs whenever she wanted to. He has admitted that he had given them to her basically on demand, that being the only way he could see to maintain her in the community on a reasonable basis. There was no need for anyone else to go and obtain drugs on her behalf.

Patient C also admitted that after the death of patient A he had some animosity towards Dr Cross. He said that had now passed but her daughter still blamed Dr Cross for the demise of patient A. It is perfectly clear there has been some degree of ill feeling.

Dr Cross, on the other hand, in our view was quite straightforward in giving his evidence. He has frankly accepted the mistakes that he has made and as I have said previously he was obviously very concerned about patient A although admitting now, as should be admitted, that he made all the wrong decisions about prescription of drugs for her over a long period of time. In our view, on the question as to whether patient C or Dr Cross should be accepted on this issue, we have concluded that Dr Cross's account should be accepted and patient C's account should be rejected.

On that basis, insofar as patient C is concerned, Dr Cross admits the assertion in 3.1 and 3.2 that he prescribed medication without exercising reasonable medical judgment and for periods in excess of therapeutic standards and that he failed to make a record of his treatment as asserted in the complaint three, para 1 and para 2. Paragraph 3 is the paragraph asserting that he allowed patient A to obtain drugs by prescribing for patient C, and we find that that complaint has not been made out.

I should observe that the doctor, in respect of patient C, did remember clearly one instance where patient C came to the surgery, and that was the incident where he pulled his cards out for identification. He asserted there were other occasions when patient C came to the surgery with patient A.

He was cross-examined about that and could not identify precisely which occasions they were. That is not

surprising after such a length of time, but he does assert there were other occasions than that one occasion when patient C was there. He accepts that there were occasions when he wrote out the prescription for patient C when patient C was not present and clearly that was an entirely inappropriate thing to do.

The fourth complaint through to complaint number thirteen deal with other patients and all of the assertions in respect of those other matters are admitted.

In respect of patient D the assertion is that he prescribed benzodiazepines in the quantity set out in the schedule marked D:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for a period in excess of recognised therapeutic standards of what was appropriate in the circumstances;
- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient D had a history of drug dependency.

The schedule in annexure D indicates eighteen prescriptions of Oxazepam and Diazepam between 2 June 2001 and 1 May 2002.

In respect of patient E the complaint is that the practitioner prescribed benzodiazepines to patient E or on the dates and in the quantities set out in the schedule

attached and marked E:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (c) when such prescribing was contraindicated as patient E had a history of drug dependency.

The schedule indicates twelve lots of prescriptions between 17 November 2001 and 18 June 2002 for Oxazepam and Diazepam. On most of those occasions 100 tablets were prescribed.

In respect of patient F the complaint is that the practitioner prescribed benzodiazepines and codeine compounds to patient F on the dates and in the quantities set out in the schedule attached and marked F:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for periods in excess of recognised therapeutic standards of what is medically appropriate;
- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient F had a history of drug dependency.

The schedule in respect of patient F includes

twenty-eight lots of prescriptions between 2 July 2001 and 25 March 2002, mostly of 100 tablets relating to Diazepam and Panadeine Forte.

Patient G, complaint number seven, is that the practitioner prescribed benzodiazepines to patient G on the dates and in the quantities set out in the schedule attached and marked G:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for periods in excess of recognised therapeutic standards of what is medically appropriate;

The schedule in respect of patient G indicates twenty-five lots of prescriptions between 22 July 2001 and 30 April 2002, and they are for prescriptions of Diazepam, mostly for 100 tablets.

In respect of patient H, complaint number eight is that the practitioner prescribed benzodiazepines and codeine compounds to patient H on dates and in quantities set out in the schedule attached and marked H:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (c) when such prescribing was contraindicated as patient H had a history of drug dependency.

The schedule in respect of patient H indicates nine prescriptions from January 2002 to May 2002 for Panadeine, Nitrazepam, Oxazepam in quantities sometimes of 100 tablets otherwise mainly of twenty-five.

Complaint number nine in respect of patient I is that the practitioner prescribed benzodiazepines to patient I on the dates and in the quantities set out in the schedule attached and marked I:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for a period in excess of recognised therapeutic standards of what is medically appropriate;
- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient H had a history of drug dependency.

The annexure which is Schedule I relates to seventeen prescriptions of Oxazepam, largely of 100 tables.

Complaint number ten in respect of patient J is that the practitioner prescribed benzodiazepines and Codeine compounds to patient J on the dates and in the quantities set out in the schedule attached and marked J:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for periods in excess of recognised

therapeutic standards of what was appropriate in the circumstances;

- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient I had a history of drug dependency.

The schedule in respect of patient J relates to twenty-eight prescriptions from 6 June 2001 to December 2001 relating to Temazepam, Panadeine Forte and Oxazepam, mainly of 100 tables in each prescription.

The complaint number eleven relates to patient K, and it is that the practitioner prescribed benzodiazepines to patient K on the dates and in the quantities set out in the schedule attached and marked K:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for a period in excess of recognised therapeutic standards of what was appropriate;
- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient K had a history of drug dependency.

The schedule in respect of patient K relates to twenty-two prescriptions between July 2001 and May 2002. They relate to Oxazepam, largely of twenty to twenty-five

tablets but on some occasions for 100.

Complaint twelve relates to patient L and is that the practitioner prescribed benzodiazepines to patient L on the dates and in the quantities set out in the schedule attached and marked L:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for a period that did not accord with recognised therapeutic standards of what was appropriate in the circumstances;
- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient L had a history of drug dependency.

Annexure L relates to fourteen prescriptions issued between July 2001 and June 2002 for Oxazepam, mainly of 100 tables each.

Complaint number thirteen relates to patient M and is that the practitioner prescribed benzodiazepines and codeine compounds to patient M on the dates and in the quantities set out in the schedule attached and marked M:

- (a) without exercising responsible medical judgment as to whether it was appropriate to issue such prescriptions;
- (b) in quantities and for a period that did not accord with recognised therapeutic standards of what was appropriate in the circumstances;

- (c) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;
- (d) when such prescribing was contraindicated as patient M had a history of drug dependency.

The schedule relating to patient M relates to sixty-seven prescriptions from 15 June 2001 to 20 June 2002. It is for largely Diazepam and Panadeine Forte but there are other prescriptions for Tramal and the prescriptions are for varying amounts between 120 down to fifty or sixty tablets at a time.

As I have said, in respect of all of those patients the practitioner has admitted the substance of the complaint. There was some ambiguity in the pleadings where it appeared that where it was asserted he knew there was a drug dependency he denied that. That was on the basis of his understanding that what was being asserted was that there was a dependency on Methadone. But there is, in fact, no dispute about the fact that in all of these cases where it is asserted that the patient was drug dependant he knew that was the case.

Consequently, in light of those admissions, the Tribunal is satisfied that all of those aspects of the complaint are in fact established.

Complaint number fourteen is that the practitioner failed to keep proper records of his treatment of patients A and D in accordance with the requirements of the **Medical Practice Regulation** 1998 as amended, and that complaint is also admitted and the Tribunal finds it

established.

One issue that now arises is as to the classification of the matters in the complaint. The failings of the practitioner can be classified as unsatisfactory professional conduct under s 36 of the **Medical Practice Act** 1992 or it could be classified under s 27 as professional misconduct. Professional misconduct is defined by s 37 in this way:

"For the purposes of this Act professional misconduct of a registered medical practitioner means unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the register."

In determining the classification a useful test is that set out by Kirby J, then the President of the Court of Appeal, in **Pillai v Messiter** (2) (1989) 16 NSWLR 197 at 200. And what his Honour there said was this:

"But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as although not deliberate to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."

The Health Care Complaints Commission has made the submission that the evidence in this case would justify this Tribunal in coming to the conclusion that the conduct here was misconduct under s 37 rather than unsatisfactory professional conduct under s 36.

In particular, it is pointed out quite forcefully that in 1987 Dr Cross was spoken to about prescribing to drug addicts and he was presented with material from the

Health Commission of New South Wales which has been tendered before this Tribunal and marked exhibit E. That material deals with what drugs are restricted as prescribed drugs of addiction. It includes forms to apply for authority to prescribe drugs and it provides a guide to the poisons regulations and significantly it also provides a guide for recognising and handling drug addicts.

It is appropriate to classify Dr Cross's conduct in these matters as dealing with people who had significant drug problems and who could be manipulative as it is recognised drug addicts can be when going to see medical practitioners in an attempt to inveigle from them drugs to satisfy their own problems. There is a useful guide in that material to the type of conduct to be expected from drug addicts and it is for that reason the submission made by the Health Care Complaints Commission has some degree of force behind it.

The submission states that he was given a warning and given guidelines and there were two visits from the Pharmaceutical Services Branch in 1987 and 1989. So it is certainly true that there had been warnings given in 1987 and 1989 and that Dr Cross had been provided with relevant information.

The somewhat difficult question is whether or not the conduct of Dr Cross meets the test that I have enunciated and whether it passes beyond mere professional incompetence and deficiencies in practice such that it could be categorised as either deliberate or done with

indifference. I do not believe there is any material to support a finding that it was done deliberately. The question is whether the material establishes that it was done in a way which could be categorised as with indifference.

As I have already analysed the situation with patient A I do not believe his conduct with patient A could be categorised as being indifferent. Indeed, so far as patient A is concerned, the Tribunal is satisfied that in a misguided way he believed he was acting in her best interests in attempting to keep her alive and living in a reasonable state in the community.

Because of the findings we make in respect of patient C, that evidence does not add to any other evidence as to indifference. The real question is whether, taking all the material together, it could lead to a finding of indifference as opposed to incompetence.

On this question the material presented by the peer reviewer, Dr Hunter, is of some significance. He certainly criticised the practices of Dr Cross but when he was dealing with the question of what Dr Cross's motivation was he said:

"I gained the impression that Dr Cross feels very sorry for his patients, is easily manipulated by them for example when they say they have lost scripts, and believes that his prescribing of drugs of addiction will maintain the status quo and not cause any harm. I believe he prefers to avoid any confrontation with his patients."

There has been an up to date report from Dr Hunter dated 24 January 2006 and in that report, although

Dr Hunter does not address that question of motivation at the time, he does note that there has been a change in Dr Cross's behaviour and an acceptance of the need for change.

We think that what Dr Hunter, the peer reviewer, said about that is probably the explanation for the behaviour of Dr Cross and that he was too gullible in dealing with drug addicts and was not prepared to engage in confrontation with them in the circumstances, and his belief was that he was not doing them any harm, in the words of Dr Hunter, that he was maintaining the status quo. If that be our assessment of the situation then it would be impossible to come to the conclusion that the conduct of Dr Cross was misconduct as opposed to unsatisfactory professional conduct.

Accordingly we do not find there was professional misconduct, but we do find, for the reasons given, that there was unsatisfactory professional conduct within the meaning of s 36.

#### LUNCHEON ADJOURNMENT

HIS HONOUR: We have heard submissions about the fine, does anyone want to say anything more about - I know that from the doctor's point of view orders one, two and three are opposed. Do you want to say anything more about it, Mr Beckett?

BECKETT: No, I don't think so.

HIS HONOUR: In respect of the matter that is order number seven, it says in compliance with Schedule 2 the matter that we are concerned about is that the audit include specifically - they want some guarantee that the order will specifically include the prescription of Panadeine Forte. Now I am not sure what is - when you say compliance with Schedule 2 of the Medical Practice Act Regulation, what is that--

BECKETT: That's with respect - yesterday I handed a copy of the schedule which relates to note taking primarily.

HIS HONOUR: So if we wanted something--

BECKETT: Specifically about Panadeine Forte I think it would need to be included.

HIS HONOUR: To mention that in particular.

BECKETT: Yes, I think so.

HIS HONOUR: Do you have a problem with that?

BOZIC: I don't have a problem with it. Dr Cross certainly doesn't have a problem with it. He tells me that he is able to print out, on a monthly basis, how much Panadeine Forte he's prescribed in that month so that that information is available. And if that was the sort of thing that the Tribunal wanted monitored there could certainly be a condition - amongst any others of course - but Dr Cross could certainly comply with a condition that he provide information to whoever the appropriate person or body is about how much Panadeine he has prescribed again in respect of how many patients.

HIS HONOUR: What I had in mind was to say at the end of that, that audit should include a monitoring of the degree of Panadeine Forte prescriptions.

BOZIC: Well we're certainly content and can comply with that.

HIS HONOUR: Having considered the findings that we have made and the submissions made as to any orders, the orders that we make are these:

1. That Dr Cross is not to possess, prescribe, handle or administer Schedule 4 Appendix D drugs.
2. That he is to submit to a random audit of his medical records by a person or persons nominated by the board to monitor compliance with Schedule 2 of the **Medical Practice Act Regulations** 2002 within three months from 1 February 2006 and subsequently as required by the board. Dr Cross is to authorise the said person or persons to prepare a report on his or her or their findings and to provide that report to the board.

Dr Cross is to meet all the costs associated with the audits and any subsequent reports, and any such audit should include a monitoring of the level of his prescription of Panadeine Forte.

3. Dr Cross should enrol and complete all units in an external course entitled "Issues in general practice prescribing" offered by Monash University no later than January 2008. The cost of the course is to be borne by Dr Cross.
4. Dr Cross is to nominate a supervisor within the next twenty-one days to be approved by the board to monitor and review his clinical practice and compliance with any conditions in accordance with level three supervision of the board's guidelines. Where the supervision is indirect the supervisor may work on the separate premises and the supervision meetings are to be held at Dr Cross's practice premises. The supervisor is to be provided with a copy of the board's guidelines for supervision and a copy of this decision. The cost of the supervision is to be borne by Dr Cross. Dr Cross and the supervisor are to:
  - (a) meet on a quarterly basis for at least two hours;
  - (b) meetings must address case review including medical records, patient overall care and prescribing;
  - (c) at each meeting the supervisor is required to complete a record of matters discussed at the

meeting in a format that is approved by the board;

- (d) the supervisor is required to forward to the board, initially on a quarterly basis, a report in a format approved by the board;
- (e) the supervisor is required to inform the board immediately if there is any concern in relation to Dr Cross's compliance with the supervision requirements, compliance with other conditions of registration and clinical performance or if the supervisor relationship ceases. Dr Cross is to authorise the supervisor to provide such information to the board.

- 5. The Medical Board or its committee may, at its discretion, terminate or vary the conditions at its discretion.
- 6. We order the doctor to pay the costs of the Health Care Complaints Commission in respect of the proceedings.

I can indicate that we have considered other submissions, particularly as to the imposition of a fine, and have concluded that it would not be appropriate in the circumstances.

Those are the orders that I propose on behalf of the board.

Mr. SMITH: I agree.

DR McINERNEY: Yes, I agree.

DR KOTZE: I agree.

HIS HONOUR: That will be the judgment and the orders of

the Tribunal once it has been reduced to writing and signed by the members of the board.

In conclusion, can I thank you gentlemen for your sensible and economic conduct of the case, it has been much appreciated.

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