

DCC003 SAF-K

MEDICAL TRIBUNAL OF NEW SOUTH WALES

CHAIRPERSON: BLANCH CJ OF DC

MEMBERS: DR D CHILD  
DR V SUTTON  
MS G ETTINGER

WEDNESDAY 8 FEBRUARY 2006

**IN RE DR SUSAN CATCHLOVE AND THE MEDICAL PRACTICE ACT**

**SUPPRESSION ORDER IN RESPECT OF THE NAMES OF PATIENTS**

**JUDGMENT**

CHAIRPERSON: This complaint is brought by the Health Care Complaints Commission in accordance with s 51(1) of the **Medical Practice Act 1992**.

The complaint is that Dr Susan Catchlove of 2/24 Young Street, Neutral Bay, 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.

There follows in the complaint particulars of the complaint and those particulars are in respect of twenty-four patients:

**PARTICULARS OF COMPLAINT**

**1. Patient A**

1. The practitioner prescribed the drugs Diazepam and Panadeine Forte 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) in quantities and for a period in excess of recognised therapeutic standards of what is medically appropriate;

(d) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused.

## **2. Patient B**

1. The practitioner prescribed the drugs Morphine and Diazepam to Patient B on the dates and in the quantities set out in the schedule attached and marked B;

(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 B had a history of drug dependency.

2. The practitioner prescribed Morphine for a period exceeding two months without obtaining an authority to prescribe Morphine to Patient B from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act** 1966.

3. The practitioner prescribed Morphine to the patient on a continuing basis for a condition that had not been confirmed by tests, examinations or other medical opinion/s and without seeking specialist consultation in relation to the patient's management.

## **3. Patient C**

1. The practitioner prescribed the drug Phentermine 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) for a period in excess of recognised therapeutic standards of what is medically appropriate.

## **4. Patient D**

1. The practitioner prescribed the drug Temazepam to Patient D on the dates and in the quantities set out in the schedule attached and marked D;

(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.

#### **5. Patient E**

1. The practitioner prescribed the drugs Temazepam and Diazepam to Patient E 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) 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.

#### **6. Patient F**

1. The practitioner prescribed the drugs Oxazepam and Diazepam 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 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 F had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient F from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

#### **7. Patient G**

1. The practitioner prescribed the drugs Flunitrazepam, Temazepam and Oxazepam 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 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 G had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient G from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

#### **8. Patient H**

1. The practitioner prescribed the drugs Oxazepam and Temazepam to Patient H on the dates and in the 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) in quantities and for a period that did not accord with recognised therapeutic standards of what was appropriate in the circumstances;

(d) when the practitioner knew or ought to have known that the drugs so prescribed were being or were likely to be abused;

(e) when such prescribing was contraindicated as Patient H had a history of drug dependency.

#### **9. Patient I**

1. The practitioner prescribed the drug Temazepam 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 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.

**10. Patient J**

1. The practitioner prescribed the drugs Flunitrazepam, Diazepam and Panadeine Forte 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 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 J had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient J from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

**11. Patient K**

1. The practitioner prescribed the drugs Temazepam and Diazepam 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 that did not accord with recognised therapeutic standards of what was appropriate in the circumstances.

**12. Patient L**

1. The practitioner prescribed drug Morphine 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) when such prescribing was contraindicated as Patient L had a history of drug dependency.

2. The practitioner prescribed Morphine without obtaining an authority to prescribe Morphine to Patient L from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

3. The practitioner prescribed Morphine to the patient on a continuing basis for a condition that had not been confirmed by tests, examinations or other medical opinion/s and without seeking specialist consultation in relation to the patient's management.

### **13. Patient M**

1. The practitioner prescribed the drugs Diazepam, Flunitrazepam and Nitrazepam 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 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 M had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient M from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

### **14. Patient N**

1. The practitioner prescribed the drug Flunitrazepam to Patient N on the dates and in the quantities set out in the schedule attached and marked N;

(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;

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient N from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

**15. Patient O**

1. The practitioner prescribed the drug Flunitrazepam to Patient O on the dates and in the quantities set out in the schedule attached and marked O;

(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.

**16. Patient P**

1. The practitioner prescribed the drugs Morphine and Diazepam to Patient P on the dates and in the quantities set out in the schedule attached and marked P;

(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 P had a history of drug dependency.

2. The practitioner prescribed Morphine for a period exceeding two months without obtaining an authority to prescribe Morphine to Patient P from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act** 1966.

3. The practitioner prescribed Morphine to the patient on a continuing basis for a condition that had not been confirmed by tests, examinations or other medical opinion/s and without seeking specialist consultation in relation to the patient's management.

**17. Patient Q**

1. The practitioner prescribed the drugs Flunitrazepam and Temazepam to Patient Q on the dates and in the quantities set out in the schedule attached and marked Q;

(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 Q had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient Q from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

#### **18. Patient R**

1. The practitioner prescribed the drugs Flunitrazepam and Nitrazepam to Patient R on the dates and in the quantities set out in the schedule attached and marked R;

(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 R had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient R from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

#### **19. Patient S**

1. The practitioner prescribed the drugs Flunitrazepam, Nitrazepam, Oxazepam and Temazepam to Patient S on the dates and in the quantities set out in the schedule attached and marked S;

(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 S had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient S from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

## 20. Patient T

1. The practitioner prescribed the drug Flunitrazepam to Patient T on the dates and in the quantities set out in the schedule attached and marked T;

(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 T had a history of drug dependency.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient T from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

## 21. Patient U

1. The practitioner prescribed the drugs Morphine and Panadeine Forte to Patient U on the dates and in the quantities set out in the schedule attached and marked U;

(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 U had a history of drug dependency.

2. The practitioner prescribed Morphine for a period exceeding two months without obtaining an authority to prescribe Morphine to Patient U from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act** 1966.

3. The practitioner prescribed Morphine and a Codeine Phosphate compound, namely Panadeine Forte, to the patient on a continuing basis for a condition that had not been confirmed by tests, examinations or other medical opinion/s, and without seeking specialist consultation in relation to the patient's management.

## **22. Patient V**

1. The practitioner prescribed the drug Clonazepam to Patient V on 13 June and 24 December 2002 in the quantities set out in the schedule attached and marked V for the treatment of epilepsy without confirming a diagnosis of epilepsy by reference to appropriate test results, examinations or specialist opinions.

## **23. Patient W**

1. The practitioner prescribed the drugs Flunitrazepam, a Codeine Phosphate compound namely Panadeine Forte, and Tenuate to Patient W on the dates and in the quantities set out in the schedule attached and marked W;

(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.

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient W from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act** 1966.

## **23. Patient X**

1. The practitioner prescribed the drug Flunitrazepam to Patient X on the dates and in the quantities set out in the schedule attached and marked X;

(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;

2. The practitioner prescribed Flunitrazepam for a period exceeding two months without obtaining an authority to prescribe Flunitrazepam to Patient X from the New South Wales Health Department contrary to s 28 of the **Poisons and Therapeutic Goods Act 1966**.

**24.**

1. The practitioner failed to keep proper records of her treatment of Patients A to X in accordance with requirements of the **Medical Practice Regulation 1998**, as amended, in that she failed to record:

(a) information relevant to her diagnosis and treatment of the patients;

(b) the patients' medical history;

(c) the results of physical examinations performed;

(d) test results;

(e) plan of treatment for the patients;

(f) advice given to the patients.

2. The practitioner failed to make adequate records of the directions for use for the Schedule 4 and Schedule 8 drugs she prescribed to Patients A to X as set out in the attached schedules, contrary to the requirements of cll 40 and 84 respectively of the **Poisons and Therapeutic Goods Regulation 1994**, as amended.

There have also been provided schedules of prescriptions she has written out for the various patients and those schedules will be annexed to the judgment of the Tribunal so that the amount of prescribing can be seen in the judgment.

In general terms, the doctor was working as a sole practitioner at the beginning of the relevant period and then in a joint practice. Various people came to her surgery and in broad terms the allegation is that she

prescribed drugs inappropriately both as to the prescription of the drug itself, the quantity of the drug and also in circumstances where she had no authority to prescribe many of the drugs.

Her conduct in respect of all of these matters has been reviewed by Dr Ian M Chung, general practitioner, who was the peer reviewer in this case and his evidence, as tendered through his review dated 9 January 2004, was that in respect of compound codeine preparations there was a recognised standard and it was not to exceed the manufacturer's recommended dose of two tablets to a maximum of eight tablets in twenty-four hours. He said the continuous and consistent prescribing of codeine compounds in excess of two months may cause the development of tolerance and should be avoided.

His evidence in respect of benzodiazepines was that they should be used for short term alleviation of anxiety, drug detoxification and/or insomnia, on average the period of continuous usage should not exceed two months.

He further said in respect of those drugs care should be observed to avoid the development of tolerance leading to addiction and that the manufacturer's recommendation for doses of drugs to be used are for Valium, five to forty milligrams daily; for Serepax (Oxazepam) in severe anxiety syndromes, fifteen to thirty milligrams three to four times per day; for Mogadon (Nitrazepam), five to ten milligrams before retiring; for Normison (Temazepam), ten to thirty milligrams on retiring. He said Flunitrazepam is recommended in a dose of one to two

milligrams and requires an authority to be prescribed on the PBS.

In respect of opioid drugs including Morphine and pethidine his evidence was that Morphine injection is indicated for use in severe intractable pain in terminal cancer patients. The recommended dose in such patients is injections of five to twenty milligrams at four to six hourly intervals. Morphine tablets are restricted for use in cases of severe disabling pain not responding to non-narcotic analgesia. The dose is individual, but the recommended dose is in the order of forty to sixty milligrams per twenty-four hours.

In respect of the other group of drugs, Duromine and Tenuate, he said that the recommended dose for Duromine is no more than forty milligrams per day for no more than three months; and the recommended dose for Tenuate is no more than seventy-five milligrams per day for no more than three months.

It is then appropriate to look at the material in respect of the various patients. In respect of Patient A, Dr Chung said that he appeared to have been prescribed Diazepam five milligrams and Panadeine Forte long term and appeared to be prescribed Diazepam five milligrams at rates of up to eight per day. He appeared to be prescribed Panadeine Forte at rates of up to fourteen per day.

He expressed the view that that pattern of prescribing of drugs does not accord with accepted standards and that the doctor's conduct would attract his

severe criticism and strong disapproval and would attract similar disapproval of his peers of good repute and competence.

I should say that so far as Patient A and all the other patients, the doctor has not raised any denial of the basic allegations. In respect of Patient A it was put to her that she had prescribed 4940 Panadeine Forte tablets over a period of twenty-two months and her response to that was that he was using the Panadeine Forte for pain control.

Patient B, Dr Chung indicated, was on a methadone program in the past and was prescribed by the doctor Morphine in the form of 100 milligram tablets and Morphine mixture over a twelve month period without obtaining an authority under s 29 of the **Poisons and Therapeutic Goods Act** and he said the prescribing appeared to be on a regular basis, on average every five to seven days. This patient was also prescribed Diazepam over a long term.

I should indicate here that Dr Chung's referral to the **Poisons and Therapeutic Goods Act** is a reference to s 29 of that Act. That Act says in s 28:

- "(1) A medical practitioner or nurse practitioner must not without the proper authority prescribe for or supply to any person a Type A drug of addiction;
- (2) A medical practitioner ... must not without the proper authority prescribe or supply a Type B drug of addiction;
  - (a) For continuous therapeutic use by a person for a period exceeding two months;
  - (b) For a period that together with any other period for which that drug or any

other Type B drug of addiction has been prescribed or supplied by the medical practitioner or nurse practitioner or has to the medical practitioner's or nurse practitioner's knowledge been prescribed or supplied by any other medical practitioner or nurse practitioner would result in that drug or that drug together with any other such drug being prescribed or supplied for continuous therapeutic use for a period exceeding two months."

There is no dispute in this case that the doctor had no authority to prescribe the drug and had not sought authority to prescribe any of the drugs where an authority was required.

Insofar as Patient B is concerned, Dr Chung noted that he had been treated with Morphine and Diazepam based simply on the patient saying that he had been on them since September 2001 for an AIDS related illness. He noted that the doctor had not questioned this any further, nor consulted with any other medical practitioner for confirmation.

In respect of this patient she had in fact been contacted in November 2001 and advised that the patient was a doctor shopper but, in spite of that, she continued to prescribe medication. He says she was aware that the patient was drug dependent and she did not apply for any authority in respect of that drug.

She admitted when she was interviewed in July 2003 that she continued to treat the patient with Morphine mixture and tablets and Diazepam even after being informed by the Health Insurance Commission of the patient's doctor shopping and she admitted that she had supplied prescriptions on a number of occasions where the patients

had advised the prescriptions were lost or stolen. In respect of this patient there were a number of entries where there were replacement prescriptions for lost medications and Dr Chung has noted nine such occasions.

He noted that the doctor had expressed in her notes some concern at the rate of prescribing but she continued to prescribe nonetheless. He also noted that the prescribing records were deficient in that they did not always indicate quantities and very rarely indicated any directions for use. He also noted that a number of entries read "scripts replaced", "repeat scripts", "re-prescribed" and "usual scripts repeated".

He expressed the view that he and his peers of good repute and competence would be severely critical of the doctor's conduct and would attract their severe disapproval.

In respect of Patient C, Dr Chung noted that she had been prescribed Duromine forty milligrams over a long period of time. He noted this was prescribed for weight control, but there is no note of the patient's weight and there was no note as to advice on diet plans. This patient apparently was a receptionist who worked for the doctor. She was questioned about the patient and said that the drug was prescribed as an appetite suppressant.

She accepted that pulmonary hypertension was one possible side effect if the drug were prescribed on a long term basis and she accepted that one of the noted side effects of long term usage could be gastrointestinal problems. In this case she continued to prescribe the

drug as indicated in the schedule over a long period of time in spite of the fact that there were notations on this patient's file that she was in fact suffering from gastrointestinal problems from time to time.

She admitted in evidence that she knew that long term use of the drug was not recommended, but in spite of that she did prescribe the drug for this patient on a long term basis.

In respect of Patient D, Dr Chung noted she had been prescribed Temazepam capsules long term. The doctor first saw him on 5 October 2001 and prescribed ten milligrams of Temazepam for insomnia. There was subsequently a replacement of a lost script.

In June 2002 the doctor was informed by a letter from the Health Insurance Commission that this patient was doctor shopping, but in spite of that letter she continued to prescribe Temazepam. There was a note that she warned the patient of overuse and Dr Chung came to the conclusion that he and peers of good repute and competence would severely disapprove of her prescribing conduct.

In cross-examination in respect of this patient the doctor admitted that she had received the doctor shopping letter and she acknowledged that long term prescription of this drug was not recommended. She was asked whether or not the receipt of the doctor shopping letter had raised loud warning bells and her answer was, "Yeah, but I think it raised the wrong warning bells at that point. Nowadays it would certainly raise the right warning bells".

She admitted that on the very day she received the

doctor shopping letter she prescribed ten milligrams of Temazepam to this patient. She was asked why she did not have any regard to the doctor shopping letter and her answer was, "I did give it regard, but I didn't give it the regard that I was meant to give it".

She admitted that there were seven separate prescriptions within twenty-six days for a total of 175 Temazepam tablets. She admitted that between 18 March 2002 and 7 July 2003 she prescribed 25,000 milligrams of Temazepam to this patient which worked out at about fifty milligrams per day.

She accepted that was far in excess of an accepted therapeutic dose. She accepted that she knew that this patient was abusing Temazepam. She said as to this patient:

"He was a very large man, very tall and wide. He was basically homeless and it's possible that he was taking that amount himself. It's also possible that he was selling some of that or, you know, using it as currency ..."

She was questioned about that and her answer was:

"I was half conscious. It's like part of me was - part of me thought, well, that's possible. Part of me thought poor guy".

She explained her conduct by saying that she was really trying to keep this patient in what she called a "holding pattern". She gave that evidence in respect of a number of patients and essentially what she meant was that she saw them as people with a very significant problem who were not motivated to do anything about it and she was concerned simply to keep them alive in the community.

In respect of this patient, she acknowledged that

shortly before she was seen by Mr Szwarcberg she knew that her prescribing rights in respect of many of these drugs were going to be withdrawn and she would not be able to prescribe any longer. And in respect of this Patient D, she then tried to put in place medication and a regime that would allow him to ameliorate his addiction without harm to him.

It is clear from what she said that she knew that what she was doing was wrong and steps would be taken to prevent her from continuing to do it.

In respect of Patient E, Dr Chung noted the prescription of twenty milligram capsules of Temazepam and five milligrams of Diazepam on a long term basis. The Temazepam twenty milligrams he noted were prescribed at rates of from two to four per day. The doctor explained that patient was being treated for alcoholism and anxiety.

She accepted the patient was overusing the medications and when it was put to her that this was a result of over-prescribing she said:

"You could see it that way, but it is like you say to them this is what is meant to be and if you don't give another lot when they have used those ones up, then what happens is they run around in a panic and can't sleep".

He noted that the first entry in the prescribing records dated October 2001 was, "Friend gave him Valium last night and felt normal plus sleep", and that appeared to be the basis for prescribing more Valium. There was also then in this case a replacement of a lost pills script.

She gave evidence in cross-examination that this

patient was seeing a psychiatrist on and off but she did not speak to the psychiatrist about any of the medication that she was prescribing. She knew he had cataract surgery, but she did not make any inquiry as to whether there was another GP involved or why this patient was seeing her in respect of these prescriptions and not seeing any other practitioner.

In respect of Patient F, Dr Chung noted that he had been on a methadone program and the doctor prescribed Flunitrazepam to him without the relevant authority under the **Poisons Act**. He noted that the prescriptions for Flunitrazepam were for quantities of ninety and that doses prescribed were four at bedtime. He also noted the regular prescription of Oxazepam and/or Diazepam as set out in the schedule.

He noted that the doctor had admitted that she was aware this patient had alcohol and benzodiazepine dependencies. She was aware she had been taking eight Flunitrazepam per day in the past and that she was prescribing four to six at bedtime because this was the dose the patient said she was taking. Her explanation for prescribing quantities of ninety was that it was less expensive and there was a note that there had been some discussion about withdrawal.

Dr Chung again expressed the view that he and his peers of good repute would regard this conduct with severe disapproval.

In respect of Patient G, Dr Chung notes the patient was on the methadone program and appears to have been

prescribed Temazepam capsules at an escalating rate from January 2003. He noted that the average prescription from January to June 2003 was three per day although the rate varied from one per day up to six per day. The doctor had admitted to changing this patient's medication from ten milligrams of Temazepam to twenty milligrams of Temazepam capsules.

It was noted that the doctor had prescribed this medication when she first saw him in 2001 and the prescription was made without any further inquiry of the patient or without referral to any other medical practitioner or any body to check whether this person was simply shopping around for medication.

The schedule indicates a significant number of prescriptions and again this patient's records indicate prescriptions when a script was lost. She did make a note in his records that he was warned about overuse but after that warning excessive prescriptions continued throughout June 2003.

She knew, she said in cross-examination, that her prescribing was inappropriate and wrong but she said that she knew this at one level and repeated the statement that she had made a number of times throughout the course of these proceedings that part of her mind understood one aspect of the matter, but the other part of her mind did not. She accepted that the prescription in respect of Patient G was three and a half times the recommended dose but she said the patient had a high tolerance.

In respect of Patient H, Dr Chung noted he was on the

methadone program and that he was prescribed twenty milligram capsules of Temazepam. He noted the schedule indicated that the prescribing had been at rates of three per day up to twenty-five per day and he expressed the view that this rate of prescribing was regarded by him and would be regarded by his peers of good repute and competence as attracting disapproval.

In cross-examination the doctor said this patient was schizophrenic and it was hard to get a story from him and she prescribed drugs without obtaining a history. She said she was trying to find out about him, she would not do that sort of prescribing now, but she also said that she accepted his word that he was not on a methadone program and she made no further inquiry about that and she kept him on drugs being prescribed by her until 30 June 2003 which is shortly before she ceased prescribing.

In respect of Patient I, Dr Chung notes the patient was on the methadone program and was prescribed twenty milligram Temazepam capsules regularly at rates of three per day, six per day and up to eight per day. He noted that the doctor indicated this patient lived on the street and that she was prescribing Temazepam for him to sleep.

Dr Chung noted that the records did not indicate any treatment plan and virtually no clinical observations or measurements. There were also in this case entries which indicated repeat prescriptions because of supposedly lost scripts or lost tablets.

Again, in July 2003 just before her interview with Mr Szwarcberg she prescribed Valium again indicating her belief that she was about to lose her prescribing powers and that was because of the method of prescribing in this case.

Dr Chung also said that he and he would expect all his peers of good repute and conduct to regard this prescription history as attracting his and their severe disapproval.

In respect of Patient J he was prescribed Temazepam capsules regularly on a long term basis. He was prescribed Flunitrazepam without authority and was prescribed Diazepam regularly and on a long term basis. He noted the doctor admitted that this patient was drug dependent.

There was a letter from the Health Insurance Commission indicating that the patient had seen twelve doctors in a two month period and that letter was seen by the doctor. She indicated that she prescribed the variety of drugs "to keep him off hard drugs and to try to keep him from having withdrawal".

In this case too there were a number of replacement scripts for supposedly lost or stolen scripts or drugs. In one case there was a prescription for Valium and Hypnodorm prescribed twice in the one day because he lost the scripts.

The doctor was aware this patient had a drug dependency problem. She did warn him about his overuse, but having issued that warning she continued to prescribe

medication for him.

In cross-examination she said that she told him to go to a clinic, but two years later she was still prescribing Flunitrazepam for him. She said she would not have done that if he had been on a methadone program. She said she did not check to see whether he was.

She agreed that he was a person who very often lost scripts and she agreed she should have been more careful about re-prescribing. She agreed that after receiving the doctor shopping letter she did not do anything to check whether he was seeing other doctors and she continued to prescribe as before.

She said she was aware he was using more than the prescribed amount. It was put to her that it appears that he was using fifty tablets in fourteen days and her answer was that he may have lost some of them or someone might have taken them. She agreed that during June she had prescribed 500 Flunitrazepam and she said in her words, "I was a very soft touch - I was manipulated".

She said she misinterpreted the doctor shopping letters. She did not take them as a warning about the fact that she should treat these patients with caution and make inquiries. She misinterpreted them in the sense that she said that she took them as an indicator that she should keep prescribing and be the only prescriber.

She last prescribed Flunitrazepam for this patient on 28 June 2002 because she knew the scheduling of the drug was about to change. She gave him ninety tablets. She was aware that she would require an authority in the

future to prescribe Flunitrazepam tablets. It should be noted that in spite of that knowledge she did continue to prescribe Flunitrazepam after she knew she was required to have an authority to do so.

Again, Dr Chung says that he and he would expect all doctors of good repute, competence and conduct would regard the doctor's practices of prescription with severe disapproval.

In respect of Patient K, Dr Chung said that he was prescribed Temazepam regularly and long term. He was also prescribed Diazepam regularly and long term. He was prescribed Diazepam five milligrams at the rate of up to ten per day and Temazepam ten milligrams at the rate of up to five per day.

In cross-examination she agreed that this level of prescribing was far in excess of accepted norms and Dr Chung again said that he and he would expect his peers of good repute and conduct would regard this level of prescription as attracting severe disapproval.

In respect of Patient L, the patient was on a methadone program and he was prescribed Morphine tablets for more than twelve months without the appropriate authority. The doctor said she was treating him for chronic back pain. She said she was not aware he was drug dependent. She agreed she should have applied for an authority.

It appears that she began prescribing Morphine for him simply because he came into her surgery and said he was on a program of MS Contin which is Morphine and she

did not check that that was the case. She prescribed medication of 100 milligrams at intervals of less than ten days. She warned him about the abuse of the drug and on a number of occasions she provided extra prescriptions to allow extra medication to be available to the patient.

She said this patient did not exhibit signs of addiction. She said he worked on a prawning trawler and needed the medication for his back. It was submitted that she must have known he had become addicted to the Morphine after such a long period. She said she did not know he was an addict at first, but she knew he had been taking Morphine before.

She accepted she should have made more detailed records in respect of the patient and that at the end she said in cross-examination that she accepted that he was an addict because he had been taking the Morphine for such a period of time and she knew that she should get an authority. She said in respect of that, "I was not trying to break the law".

She agreed that from 26 August 2002 to 6 June 2003 she gave him twenty tablets a week. She did say that he never seemed impaired and she was treating him for pain.

A submission has been made on her behalf that the records do indicate that she made an effort to get him off the Morphine and it is true that the schedule of the drugs prescribed for this patient indicates that in April 2002 to May 2002 there was a reduction in the dosage from 100 milligrams to sixty milligrams. It went back up again to 100 milligrams on 23 May. It came down again in July

and August but from 26 August it remained at 100 milligrams so that whatever effort was made was short term and seems to have been abandoned in late August until immediately prior to the interview with Mr Szwarcberg.

Again, that history of prescribing would indicate she knew that what she was doing was not something that was acceptable to other medical practitioners. Dr Chung again notes that the method and level of prescribing in respect of this patient would attract the severe disapproval of himself and his peers of good repute, conduct and competence.

In respect of Patient M, Dr Chung noted the patient was on the methadone program and was prescribed Flunitrazepam tablets without the relevant authority. He was also prescribed benzodiazepines continuously and over a long term. Dr Chung noted the patient was a doctor shopper.

In cross-examination the doctor said that the patient came in and said he was in intense pain. She did not ask who his surgeon was or other GP was. She agrees she should have been more suspicious when he came in simply asking for medication.

She said she did refer this patient to a psychiatrist, Dr Gutkin, and she received a letter from Dr Gutkin in reply. The letter from Dr Gutkin after thanking her for referring the patient said:

"As you well know he is addicted to Hypnodorm, Valium, Mogadon as well as taking methadone eighty mils per day. He admits to doctor shopping and using illicit Hypnodorm about six times a day".

That information was information that the doctor said she had not been able to get from this patient but Dr Gutkin seems to have had no trouble obtaining it at all. Of some perhaps greater significance is that Dr Gutkin then went on to say:

"Today I have given him one prescription for Valium to take at a dose of ten milligrams five time a day on the understanding that he ceases all other benzodiazepines. He will continue the methadone".

Almost as soon as the doctor received that letter she saw Patient M again, she saw him on 6 February 2003 and she prescribed fifty Diazepam and fifty Nitrazepam tablets. That prescribing was directly in the face of the letter from Dr Gutkin which clearly indicates that he had taken over the management of drug prescribing for this patient.

The doctor explained that by saying that she was prescribing the drugs she prescribed because they were weaker benzodiazepines and they were to assist in him coming off drugs. She made no clinical notes that day in respect of that and she said that the patient had decided not to go back to Dr Gutkin and she did not record that. She said she did not check with Dr Gutkin about that.

She said that the letter did alert her to the fact that this patient was a doctor shopper, but she accepted his word that he was not at that stage and that was not what he was doing in coming to her. There was a note in her records in respect of this that she had no Health Department authority, but she did keep on prescribing.

Again in respect of this patient, Dr Chung expressed

the view that he and his peers regarded the level of prescription as attracting their severe disapproval.

In respect of Patient N, Dr Chung noted that he had been prescribed Flunitrazepam tablets for more than two months without an authority. He noted the prescriptions were from one tablet to four tablets at bedtime. He noted Flunitrazepam was prescribed at 120 tablets a time on most occasions and that the Flunitrazepam was at a rate of up to eight tablets a day.

In cross-examination the doctor said that she often gave doses in excess of the recommended doses because of people's different tolerances to drugs and Dr Chung again categorised this conduct as attracting his and his peers' severe disapproval.

Patient O, he noted, was prescribed 200 Flunitrazepam tablets which would be about a three month supply without obtaining any authority to do so and he noted a further 210 tablets were prescribed in December 2002. The doctor admitted that she knew he had been taking Flunitrazepam for quite some time before seeing her, but she made no further inquiry about that and she did not refer the patient for any other specialist opinion. She was not able to explain why she prescribed 200 tablets at a time and she also prescribed Rohypnol, Hypnodorm mainly in quantities of 100.

Again Dr Chung observed there was no treatment plan noted in the clinical notes. Apparently this patient was being treated for a sleep problem and there was no referral to a sleep clinic and the doctor did not regard

the patient as being addicted but simply as having a sleep problem. She accepted that the script issued on 11 December was in breach of the Act because she had no authority.

In respect of this patient, Dr Chung says he and his peers would severely disapprove of this conduct.

In respect of Patient P, the patient had been on a methadone program and another doctor held an authority for prescribing. Doctor Catchlove prescribed for him 100 milligram tablets of Morphine for more than two months without an authority.

In cross-examination the doctor said that he first appeared on 4 December 2002 suffering from chronic pain. He told her that he had other doctors but he wanted her to prescribe MS Contin which is Morphine. She did that. She said she did not call any of the other doctors or consult with anyone else about the prescription.

She said there was some confusion at a pharmacy about this case because the patient's father was also being prescribed medication and there was some communication with the authorities about it, but she thought that had been as a result of that mix-up.

She said she assumed his pain management and she did that by prescribing Morphine and she accepted that she had no authority to do that and she should have got such an authority.

Again Dr Chung expresses the view that he and his peers regard this conduct with severe disapproval.

In respect of Patient Q, he was on a methadone

program. He was prescribed Temazepam capsules of twenty milligrams over a long term. He was prescribed Flunitrazepam tablets in December 2002 without authority and the rates of prescribing of the Temazepam twenty milligrams was up to sixteen per day.

In cross-examination the doctor said that she was unaware that if he had been on a methadone program he would have had a doctor to prescribe the methadone. She described this man as someone who she understood was on parole having served a sentence for an offence of violence. She said he was a very intimidating person and she had very great difficulty in dealing with him. She felt threatened by him and she gave in to his demands in circumstances where she accepts that she prescribed in an inappropriate fashion.

Dr Chung says in respect of Patient Q that he and his peers would regard this treatment as warranting severe disapproval.

Patient R, Dr Chung notes, was on a methadone program. The doctor prescribed Flunitrazepam regularly for twelve months without an authority. The prescriptions were for 120 tablets on at least eleven occasions and ninety and sixty on one occasion each. The directions for use were two to four at bedtime.

The information appears to indicate to Dr Chung that she was prescribed at a rate of six tablets a day, seven tablets a day, nine tablets a day and twelve tablets a day. He noted that she was prescribing Nitrazepam concurrently with Flunitrazepam. He noted that the

doctor's records indicated she was aware this patient was dependent on medications but was surprised to hear that the person was a doctor shopper.

Patient S is related to Patient R and the same pattern of prescribing was repeated. Again, this patient was on a methadone program and again large numbers of Flunitrazepam tablets were prescribed as set out in the schedules.

The doctor made no demur about that when giving evidence and Dr Chung says that he and his peers would regard the method of prescribing for both Patient R and Patient S as attracting their severe disapproval.

Patient T, Dr Chung noted, was on the methadone program and he noted that the doctor prescribed Flunitrazepam regularly without an authority and that on five occasions towards the end of 2002 the prescriptions were for 120 tablets each time. He noted the rate of prescribing ranged between six tablets a day to fifteen tablets a day and averaged out at ten tablets a day. The doctor said she prescribed at that level to stop the patient using heroin and she did that because the patient said that it helped with overcoming her need to go back on the streets. The doctor was aware the patient was on a methadone program and did not contact her methadone prescriber.

She agreed that she had been manipulated and in cross-examination she said that this patient would put on a scene and she would simply give in to her.

Dr Chung says that he and his peers would regard this

method of prescribing as attracting their severe disapproval.

Patient U was noted by Dr Chung as having been on a methadone program in the past and she was prescribed 100 milligram Morphine tablets regularly for at least twelve months without any authority. Again he assessed that conduct as attracting his severe disapproval.

Patient V, there were notes about prescriptions of Kapanol which again is Morphine. The doctor said in cross-examination she did not contact the doctors because the doctors she knew of in this case were surgeons. She simply prescribed as a method of pain management.

Again Dr Chung said her conduct attracted his severe disapproval.

Patient W was prescribed Flunitrazepam tablets 210 at a time for well over twelve months and that was done without authority. He noted the prescribing there was for a period of eleven months at an average rate of five tablets per day. He noted she had also prescribed 100 Tenuate tablets at a time for well in excess of twelve months.

The doctor in cross-examination accepted that this method of prescribing was well in excess of acceptable rates and Dr Chung says it is conduct that both he and his peers would regard with severe disapproval.

Patient X, Dr Chung notes, was prescribed Flunitrazepam tablets ninety at a time continuously for well over twelve months without the relevant authority. He noted at least twelve times when the prescription had

been for ninety tablets and he noted that the prescription rate over a six month period was an average of five tablets per day.

The doctor in cross-examination said that the Tenuate tablets were given to assist with a weight problem and she agreed that her note taking was deficient in the sense that it did not show that she had taken the blood pressure of the patient which is a precaution when prescribing Tenuate, but she said she did in fact do that.

Again Dr Chung indicates that this level of prescribing attracts his severe disapproval and would attract the severe disapproval of his peers of good repute and competence.

As I have indicated, none of those assertions of fact are denied by the doctor. There is some variation of interpretation but essentially all of those matters are accepted and in those circumstances it is quite properly accepted by the doctor that the conduct amounts to unsatisfactory professional conduct within the meaning of that term in s 36 of the **Medical Practice Act** which defines unsatisfactory professional conduct as:

"Any conduct that demonstrates a lack of adequate knowledge, skill, judgment or care by the practitioner in the practice of medicine".

The definition of unsatisfactory professional conduct is also satisfied by the contravention of any act or regulations. It is perfectly clear that there is an abundance of evidence that overwhelmingly establishes at least that there was unsatisfactory professional conduct within the meaning of s 36.

The next question is whether or not the conduct amounts to professional misconduct under s 37 which defines the misconduct as being:

"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".

HIS HONOUR: The definition in the Act of misconduct has been the subject of some interpretation. In the case of **Qidwai v Brown** 1984 1 NSWLR 100 Priestley JA said:

"Whether the conduct was in such breach of standards accepted by the medical profession in this State and would reasonably incur the strong reprobation of fellow practitioners of good repute and competence".

In the case of **Pillai v Messiter** which is reported in 1989 16 NSWLR 197, at page 200 Justice Kirby who was then the President of the Court of Appeal said 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".

In respect of statutory requirements relating to the use of drugs of addiction, in the case of **Spicer v New South Wales Medical Board and Others**, Court of Appeal, unreported 19 February 1981, it was said:

"Strict adherence to the statutory requirements relating to the use of drugs of addiction is required by medical practitioners. It is clear beyond argument that the proper handling and prescribing of drugs by medical practitioners are of the greatest importance to the community. If a medical practitioner handles or carries out that very great responsibility in a way which is reckless and which shows a

disregard for the law, it cannot be said he is fit at such time to be a medical practitioner".

It comes then to consider how the conduct of the doctor here compares with that definition or those definitions of misconduct. I note in particular the fact that she was aware of the need to have an authority in respect of the prescription of some of this medication and in spite of being aware of the need to have the authorisation she proceeded on a significant number of occasions to prescribe these medications.

Her explanation of this was that part of her mind was aware of the need for the authorisation, but somehow she became confused. She thought that if she wrote out the scripts and they were taken to a pharmacist, if she had no authority then the scripts would not be filled. But she kept writing out the scripts and the scripts did keep being filled and she did continue to know that she did not have any authority to write out the scripts and she made no effort to obtain the authorisation.

That is quite a serious breach of the provisions of the law relating to drugs of addiction and in my view would constitute misconduct in itself. However in addition to that she not only wrote out the scripts without authority, but she wrote out scripts for amounts of drugs that were significantly in excess of the recommended dosages. Not only that, she knew that that was the case and she continued to do that over a period of time.

In addition to that, there were the doctor shopping warning letters that were sent to her. She estimated

about thirty over a period of a number of years. I have adverted to some of those letters that were sent to her in individual cases which have been referred to here. She appears to have completely ignored those letters. She has explained that on the basis that she took them as being an invitation to her to take over the sole prescribing for the patients. She did that without any inquiry of any other practitioner or any other government authority that could have assisted her with that. It is quite an unreasonable and dare I say irrational interpretation of those letters that she has put forward.

In addition to that, there was the evidence tendered from Bruce Battye of the New South Wales Health Department and he gave evidence in his statement that in early January 1994 he detected a quantity of prescriptions issued by the doctor to a patient who was known to the department.

He went to the doctor's consulting rooms and spoke to her and showed her a number of prescriptions which she had issued. He asked her why she had not applied for an authority and she said she had no forms. He asked her if she knew the restrictions that applied to the prescribing of drugs of addiction under the **Poisons Act**. She then agreed she did not know of the restrictions that applied.

He then detailed the restrictions that applied and he also explained to her that it was not just a case of prescribing without an authority but importantly the apparent rate of prescribing which appeared to be of the order of thirty Percodan per day which was far in excess

of the recommended maximum dose.

After the visit a letter was sent to the doctor dated 25 January 1994 by the Director General confirming the advice given during the visit by Mr Battye and that letter said:

"You are reminded that under s 28 of the **Poisons Act** it is an offence to prescribe or supply a drug of addiction for a person whom you believe to be an addict or to supply a drug of addiction to any other patient for a period exceeding two months unless you have an authority from the department to prescribe that drug for that person".

The letter went on to say:

"Furthermore, you are reminded that you should prescribe for or supply to any person for use by that person any substance listed in the Poisons List for Therapeutic Use in a quantity or for a purpose not in accordance with recognised therapeutic standards of what is medically appropriate in the circumstances".

The Director General asked for an acknowledgment of receipt of that letter and the doctor did in fact send a handwritten acknowledgment to that effect dated 26 April 1994 saying:

"This note is to comply with your telephone request to acknowledge receipt of a letter of 25 January '94 concerning over-prescribing ..."

It went on to say, "These matters were addressed with a visit from your doctor and the whole problem rectified". What that illustrates, of course, is that both the need for an authority and the need not to over-prescribe were forcibly brought to her attention by the New South Wales Health Department, the Pharmaceutical Services Branch at that time and she acknowledged it all.

However, that is not the only communication with her

from the Health Department. There was a further statement tendered by Kim Dolan who said that she received a telephone call in December 2002 from a pharmacist at Darlinghurst who apparently thought that the doctor was inappropriately prescribing Hypnodorm which is another name for Flunitrazepam. She telephoned Dr Catchlove at 10.50am on 24 December 2002 and counselled her about the fact that she should not be prescribing any medication on request of patients. She said:

"It also appears that most of the patients to whom she was prescribing Hypnodorm were already on the methadone program and as such another medical practitioner would already hold an authority to prescribe a drug of addiction to them and therefore she should not prescribe for them as well".

This witness statement also goes on to detail the fact of advice to the doctor that if she was unsure of the patient's current status she should call Pharmaceutical Services and check. It also says that if she did prescribe a drug, it must be in a quantity and for a purpose that accords with the normal therapeutic standard. She was also advised that she could not prescribe a Schedule Eight drug to a known drug dependent person without prior authority.

The file note by Ms Dolan from which she made that statement and which is attached to that letter indicated that she basically told her "to pull her head in" and then outlined the various advices that were given.

Now, again, that is a further warning and advice that was given to the doctor that would have been of assistance to her in December 2002. The doctor has given evidence

that she has no recollection of it. That is surprising because one would think that a telephone call to a doctor from the Pharmaceutical Services Branch of that kind might stay in her mind. But accepting that she has forgotten it, she most certainly totally ignored it.

When all of those matters are put together in my view they very clearly and abundantly prove that the conduct in question here was misconduct in accordance with the definition in the Act. The fact of a finding that it is misconduct does not necessarily mean there should be a suspension or deregistration and it is necessary to consider the various submissions that have been made in this case about what should be the order of the Tribunal once the Tribunal has concluded as I do that it was misconduct.

It is pointed out that the doctor has been practising for more than forty years and that she is currently continuing in practice and has been now for over two years without any right to prescribe drugs of addiction and she apparently has been operating as a general practitioner for that period of time without further criticism.

A further subjective matter that has to be taken into account is that she is now sixty-seven years of age and if she is deregistered in it would be very difficult for her to resume medical practice. She would need to prove that she was fit to resume practice and a deregistration might result in her being forced to leave the profession at this stage. That is a sad prospect for someone like this doctor who has been in practice for such a long time.

She apparently has accumulated no assets and went through bankruptcy at about the stage that these complaints relate to. She is entirely dependent on her income as a doctor to live and it would be, as I said, a very sad situation for her to lose her practising rights.

The submission has been made that the Tribunal should view this on the basis that none of this was done for profit. Some material has been tendered which indicates that the doctor's salary has been reduced since she stopped this sort of practice. On the other hand, to my mind the material which in fact was tendered by the doctor and which grounded a submission by the Health Care Complaints Commission does not establish that she was doing this for profit. It appears much more to be the case that she just behaved in a completely reckless and foolish fashion in respect of drug addicts who are well known to be manipulative and sometimes overbearing and forceful in their attempts to get drugs. I think in this case that is the probable explanation of how she came into this situation. Certainly on the material produced she was bulk billing and not making a significant income from this.

There is also to be taken into account her references and the references she has put before the Tribunal speak quite highly of her. There is a reference from Dr Holliday dated 6 December 2005 and he says that she has taken the disciplinary action seriously and she is an experienced and essential member of his practice which, according to the doctor has noted on his letterhead,

consists of four doctors. There is also a reference from Dr Oliver who says that this doctor has been his and his family's general practitioner for about fifteen years and he says:

"I have no hesitation in providing my support to Dr Catchlove as being a highly competent and responsible general practitioner dedicated to the ethics and mission of her profession".

There is also a reference from Dr Wilson who says, "This doctor enjoys a strong reputation and loyalty amongst her patients", and he says she is a valuable member of the medical workforce in her area.

All of those matters need to be taken into account. On the other hand, what the Tribunal is dealing with here is a period when the doctor behaved in what can only be categorised as quite a reckless and foolish way. She had a very cavalier attitude to prescribing for patients who came to the practice. The notes indicate that she tended to accept them at face value when she should have, as any reasonable medical practitioner would have, made some further inquiries to ensure that they were not drug addicts who were doctor shopping. In respect of many of these people she made no attempt or no serious attempt to find alternative treatments and there was no checking of most of their histories.

The fact that she significantly prescribed without authority over a period of time is a serious matter and in accordance with the authorities must be dealt with as a serious matter. The fact that she significantly over-prescribed knowing that she was significantly

over-prescribing is another matter that is serious and both of those matters are compounded by the fact that she did this in spite of warnings that had been given to her in the ways that I have indicated.

She has been criticised for not having read the **Poisons Act**. I do not regard that as being a valid criticism, but it is a valid criticism that she did not know what the relevant provisions of the **Poisons Act** were and she has admitted knowing enough of the provisions of the Act to know that she was breaching them.

And the other matter that, in my view, calls for very careful consideration is the case where she was obviously aware of the level of her prescribing and that her patients could be selling them or giving them to other people. In spite of being aware of all of that, she continued to prescribe at the same rate.

In my view all of that demonstrates a completely reckless indifference to her obligations as a doctor. In my view the orders which would be appropriate for the Tribunal to make are that her name be removed from the register of medical practitioners; secondly, that pursuant to s 64(3) an application for review of that order may not be made until two years have elapsed from today; thirdly, that the respondent pay the costs of the Health Care Complaints Commission to be agreed or assessed by the Tribunal; four, I have made an order of non-disclosure of the names of all the patients and the exhibits can be returned after twenty-eight days. The members of the Tribunal all being agreed, that will be the

DCC003 SAF-L

order of the Tribunal.

oOo