

**IN THE MEDICAL TRIBUNAL OF NEW SOUTH WALES**

**THE MEDICAL PRACTICE ACT 1992**

DEPUTY CHAIRMAN: HIS HONOUR JUDGE J C McGUIRE

MEMBERS: DR D CHILD

DR G YEO

DR C BERGLUND, PhD

**NO. 400020/04 – DR RAGHUBIR SINGH**

**REASONS FOR DETERMINATION**

**13<sup>th</sup> FEBRUARY, 2006**

**Nature of Complaint**

Pursuant to the Medical Practice Act 1992 (“the Act”), the Tribunal is enquiring into a complaint of the Commissioner, Health Care Complaints Commission (“the Complainant”) into professional conduct of Dr Raghbir Singh.

The Commissioner complains that Dr Raghbir Singh (“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 Section 36 and Section 37 of the Act in that he:

1. Between December 1999 and January 2002 on the dates shown in the schedule annexed hereto and marked with the letter A the Practitioner prescribed and/or supplied a drug of addiction, namely pethidine, for Patient A:
  - (a) without holding an authority issued under section 29 of the Poisons and Therapeutic Goods Act 1966 when Doctor Singh knew, or ought to have known patient A to be a drug dependent person,
  - (b) for a period exceeding recognised therapeutic standards of what is medically appropriate,
  - (c) for a period exceeding two months without having applied for and/or been given an authority under the Section 29 of the Poisons and Therapeutic Goods Act 1966,
  - (d) in quantities in excess of recognised therapeutic standards of what is medically appropriate,
  - (e) without exercising responsible medical judgment.
  
2. Between April 2001 and January 2002 on the dates shown on the schedule annexed hereto and marked with the letter “B” the practitioner authorised a pharmacist at the pharmacy recorded in Schedule B to dispense a drug of addiction, namely pethidine 100 mg/2 ml ampoules, to Patient A in circumstances where the practitioner knew that his prescription pads had been stolen and without properly determining that he had issued the prescription.
  
3. Between December 1999 and August 2001 on the dates shown in schedule A the practitioner failed to record the particulars of his prescribing of pethidine to Patient A, contrary to clause 84 of the *Poisons and Therapeutic Goods Regulation 1994* and/or failed to make a record of his consultation with Patient A, contrary to the requirements of the *Medical Practice Regulation 1998*.
  
4. During the period March 2001 and January 2002 on the dates and in the quantities shown in the schedule annexed hereto and marked with the letter “C” the Practitioner prescribed a drug of addiction, namely pethidine, for Patient B;
  - (a) for a period exceeding two months without having applied for and/or been given an authority under the Section 29 of the Poisons and Therapeutic Goods Act 1966,

- (b) in quantities in excess of recognised therapeutic standards of what is medically appropriate,
- (c) without exercising responsible medical judgment.

5. During March 2001 the Practitioner being the holder of an authority pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing thirty ampoules.
6. During July 2001 the Practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing ten ampoules.
7. During August 2001 the Practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing fifteen ampoules.
8. During September 2001 the practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing eleven ampoules.
9. During October 2001 the Practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing thirty-five ampoules.
10. During November 2001 the Practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules of pethidine per month to Patient B exceeded that authority by prescribing seventy ampoules.
11. During December 2001 the Practitioner being the holder of an authority issued pursuant to Section 29 of the *Poisons and Therapeutic Goods Act 1966* to prescribe six 100 mg ampoules

of pethidine per month to Patient B exceeded that authority by prescribing thirty ampoules.

12. During January 2002 the practitioner issued prescriptions for pethidine on the dates set out in Schedule C without holding an authority issued under section 29 of the Poisons and Therapeutic Goods Act 1966.
13. Between March 2001 and January 2002 the Practitioner failed to record the particulars of his prescribing of pethidine to Patient B on the dates shown in Schedule C, contrary to clause 84 of the *Poisons and Therapeutic Goods Regulation* 1994.
14. On 1 February 2002 the practitioner did not keep a separate register for drugs of addiction.

### Orders Sought

The Commissioner seeks, pursuant to Section 64 of the Act, a finding that the Practitioner is guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his dealings with the two patients.

### Unsatisfactory Professional Conduct

Section 36 of the Act sets out the matters which constitute unsatisfactory professional conduct. It relevantly provides:

*Unsatisfactory professional misconduct of a registered medical practitioner include inter alia:*

- m) ***Other improper or unethical conduct***  
*Any other improper or unethical conduct relating to the practice or purported practice of medicine.*

## Professional Misconduct

Section 37 of the Act sets out the meaning of professional misconduct:

*“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”.*

The obligations of medical practitioners is encapsulated by Priestly J A in **Richter v Walton**, an unreported decision of the 15<sup>th</sup> July, 1993.

*“The degree of trust which patients necessarily give to their doctors may vary according to the condition which takes the patient to the doctor. Even in regard to the most commonplace medical matters, the trust of a patient placed in a doctor is considerable. In some cases, of which the present seems to be an example, the patient’s trust cannot help but be almost absolute. The doctor’s power in regard to the patient in such cases is also very great. I do not mean power in the abstract way but as a matter of fact; the extent of the power will vary according to the temperament of the patient, but the doctor with some patients and for limited periods, because of the relationship in which they are temporarily placed, is in a position to do whatever the doctor wants with the body of the patient. This is one of the reasons why doctors are subject to correspondingly great obligations and are expected to maintain high standards; all this being very much in the public interest.”*

## Onus and Standard of Proof

The standard of proof to be applied by the Tribunal is that referred to in **Rejfe v McElroy** (1995) 112 CLR 517 @ 521. That standard was applied in **Bannister v Walton** (1993) 30 NSWLR 699 where it was held that the requirement is that the Tribunal be *“comfortably satisfied on the balance of probabilities”*.

The Tribunal must have regard to the gravity and importance of the matters which it is deciding in accordance with the principles stated in **Briginshaw v Briginshaw** (1938) 60 CLR 336 @ 360 – 363. At pages 361 and 362 Sir Owen Dixon stated:

*“Except upon criminal issues to be proved by the Prosecution it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the Tribunal. But reasonable satisfaction is not a state of mind that is obtained or established independently of the nature or consequent of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question, whether the issue has been proved to the reasonable satisfaction of the Tribunal. In such matters “reasonable satisfaction” should not be proved by inexact proofs, indefinite testimony, or indirect inferences”.*

From the material contained in his Curriculum Vitae, it will be seen that the practitioner obtained his qualifications from universities in Glasgow and London. It appears as though he gained wide experience in various facets of medical practice including obstetrics, gynaecology and paediatrics.

He served as a medical registrar and psychiatric registrar in hospitals in Queensland and New South Wales.

Initially he commenced in general practice in Queensland in 1981 and thereafter engaged in general practice in that State and in New South Wales as a member of various group practices and clinics.

In 1997 to 2002 he was in general practice at Maxicare Family Clinic, Eaglevale. It was in that practice that he came into contact with Patients A and B.

From 2002 to date he has continued as a general practitioner in medical centres in the Western Suburbs of Sydney.

References from colleagues contain highly favourable opinions of his personal and professional behaviour and of his high moral standards, attitudes and qualities.

Dr Yvas described him as possessing good moral standards and during the time that he has served at the Ingleburn Medical Centre, Dr Yvas believed that he was practising ethically as well as professionally. He considered that the practitioner was a knowledgeable, bright and intelligent medical practitioner who was up to date in his knowledge of current medical practices.

The evidence before the Tribunal establishes the following matters:

### **PATIENT A**

Patient A was treated by the Practitioner between 31st October, 1999 and March, 2002.

Prior to consulting him she had attended other doctors in the practice at which he was a member. On a number of occasions these doctors had refused her requests for pethidine prescriptions.

She presented to him with a number of conditions including chronic renal pain, low back pain, a fractured pelvis and Hepatitis C.

On the first occasion he saw her he prescribed pethidine. Thereafter he prescribed or supplied pethidine on a regular basis, often several times a month.

It was the practitioner's evidence that he didn't realise that she was drug dependent until after he had attended her on some 10 –15 occasions.

There could be no doubt that Patient A presented as a difficult patient who proved uncooperative in many respects and who failed to accept treatment prescribed. In particular she refused to attend hospital as advised or to remain in hospital.

The practitioner referred her to appropriate specialists, a pain clinic and sought to have her admitted to several hospitals. Despite his efforts to have her treated and de-toxed, she substantially refused to cooperate and to follow his advice. Yet he continued to supply or facilitate her obtaining pethidine when it was obvious that she was pethidine dependent and in spite of his recognition that she required alternative and more effective treatment.

From time to time he refused to prescribe pethidine and threatened not to see her again, however despite such refusals and threats he would resume his practice of issuing prescriptions.

Indeed he prescribed or supplied pethidine at the same time that she was being treated by other doctors and when she was attending a pain clinic.

Seemingly he prescribed or supplied the drug to Patient A on some 64 occasions over a period of some 27 months.

The practitioner was well aware that Patient A had stolen prescription pads from his surgery. Further that in April, 2001 eight prescription pads were stolen from his surgery in the course of a burglary.

Between the 26<sup>th</sup> April, 2001 and the 21<sup>st</sup> January, 2002 the practitioner received some 20 telephone communications from 15 pharmacists to whom Patient A had presented prescriptions for pethidine.

The pharmacists sought confirmation from him that the scripts presented by Patient A were genuine and that it was in order for them to be dispensed.

In relation to most of the scripts queried by the pharmacists, he did not request a faxed copy or check on the issue date of the script before approving them to the pharmacist albeit that on occasions the pharmacist involved faxed a copy to him.

Seemingly he took no steps to verify the validity of most if not all the scripts which were queried.

It is patently obvious that the practitioner was well aware that he was facilitating the supply of pethidine to a pethidine addict upon her presenting a forged script to the pharmacist, a script which the practitioner well knew was a forgery.

The Tribunal is well aware that the practitioner was dealing with a drug dependent, non cooperative patient who would not and did not accept his advice. On occasions she would be in a distressed condition and in the throes of withdrawal.

The practitioner advanced as a reason for his prescribing of pethidine was his desire to stabilise Patient A. He also referred to her having sustained a variety of fractures and the fact that she was in pain.

Dr Bunker, Peer Reviewer, opined that he couldn't see the point of administering pethidine for the purpose of stabilising Patient A.

When asked to comment upon the practitioner's recorded reasons for prescribing or supplying pethidine, was that the Patient was in withdrawal, he stated that that was not an appropriate reason to prescribe or administer pethidine.

*Q. Why is that?*

*A. For a number of reasons. The first reasons are to do with the safety of administering narcotic analgesics in a situation where the patient is in a state of some chaos, psychologically and in regard to her living arrangements. Secondly, it's illogical from the point of view of the administration of a single injection of pethidine will only abort withdrawal symptoms for a period of three or four hours and I notice in many of the occasions when Dr Singh administered pethidine it was to forestall or ameliorate withdrawal symptoms when the patient was going to attend a clinical some time in the future. So it's illogical from that point of view. And thirdly, it would generally be held I believe, certainly held by me and I believe by my peers that it's inappropriate to supply drugs that people are dependent on whether they be narcotic analgesics or benzodiazepines or other drugs with the potential for addiction.*

Dr Bunker went on to say:.

*Q. Are you able to indicate to what extent he exceeded those standards?*

*A. At that stage of this patient and this doctor's journey together it was very apparent that this patient had a significant problem with pethidine addiction and administering pethidine was clearly not working. It was inappropriate to administer or prescribe any pethidine at that stage.*

*Q. From 2001, what about earlier than that, given that the doctor first prescribed in October 1999 and then continued until about 2000, 2001 and January 2002.*

*A. Well I've already said that I think that I think there was a delayed recognition that dependence was a problem. Certainly once dependence was confirmed, which to my recollection in Dr Singh's mind was in March 2000, there should have been no prescribing after that, unless it was in a context of a negotiated and supervised management plan with the input of an appropriate drug health specialist or paying specialist.*

In his opinion the practitioner didn't exhibit appropriate medical care and clinical judgement and was moderately critical of the practitioner's prescribing and clinical practice.

Dr Bunker was also critical of the practitioner's lack of documentation relating to the supply of cumulatively significant amounts of pethidine.

The Tribunal is firmly of the opinion that for the practitioner to supply such substantial amounts of pethidine on so many occasions was entirely

inappropriate medical practice and demonstrated a lack of responsible medical judgement.

Leaving aside the practitioner's possible belief that pethidine should have been prescribed for the reasons he advanced, there was simply no question of the patient presenting to him in a condition indicating that she needed to be stabilised or was in withdrawal or in any other condition suggesting that pethidine was appropriate, when he approved of her obtaining the drug from pharmacists, pursuant to prescriptions which were not issued by him and which he knew to be forged.

Simply put, she had not attended upon him prior to him facilitating her receiving the drug and accordingly, he was in no position to determine whether she was in pain, whether she required stabilising, whether she was in withdrawal or whatever.

On multiple occasions he deliberately facilitated her obtaining the drug whilst completely oblivious to her condition, albeit that on occasions the pharmacist described her state. He aided her to obtain a drug of addiction in the clear knowledge that she was using a forged prescription, on a stolen prescription form.

He simply did not know what she would do with the pethidine – whether she would self administer or whether she would sell or distribute the drug to others. There is no evidence that Patient A did improperly dispose of the drug however there was a clear potential for diversion.

There was of course no record as to why he approved the dispensing of such prescriptions.

His conduct demonstrated a lack of responsible medical judgment and, in the firm opinion of the tribunal, he was acting unethically and in clear breach of his obligations as a medical practitioner.

The most charitable description which could be applied to the practitioner is that he proved to be a totally unimpressive witness. He was evasive and persistently avoided answering questions which were capable of a simple and direct response.

There can be no doubt whatsoever that 15 pharmacists telephoned the practitioner seeking to verify scripts which they obviously believed to be forged, yet with one exception, he claimed to have no memory of having spoken to the pharmacists.

His completely incredible accounts as to those calls and explanations as to the pharmacists' communications with him caused the Tribunal to conclude that he has little, if any, insight as to the impropriety of his conduct in facilitating Patient A illegally obtaining a drug of addiction on so many occasions. He further showed little insight into his failure to maintain proper records.

When questioned as to faxed prescriptions forwarded to him he asserted that they had been intercepted by some unidentified person at his surgery. He further suggested that phone calls were not put through to him.

With regard to telephone calls described by some pharmacists, he claimed that he couldn't recall them or on the occasion he did speak to a

pharmacist, he indicated that the script being queried was not his. This claim is contrary to the account of the pharmacists.

In relation to a call from a pharmacist as to a forged script dated 1/10/01, he claimed that he couldn't remember the call although the pharmacist stated that he confirmed it was appropriate to dispense it.

That call was significant for several reasons:

- (1) He approved dispensing a script dated 1/10/01 which he knew to be forged;
- (2) He did so after he had been specifically told by an officer of the Pharmaceutical Services Board (PSB) on 14/9/01 not to dispense scripts for Patient A;
- (3) He proffered the patently absurd suggestion that calls from pharmacists were being intercepted and somebody else masquerading as him, was approving the scripts - somebody who apparently sounded like him.

There is little point in detailing all of his entirely unsatisfactory accounts of the calls described by the pharmacists.

He did however make some concessions and agreed that he did not check whether or not he had written a script.

*Q. And you were not certain whether or not you had written a script is that right?*

*A. I should have checked. In retrospect, I should have checked and I did not check.*

- Q. And you invariably, when you received a telephone call, said to the pharmacist "Dispense the script" didn't you?*
- A. Most likely.*
- Q. And you did so knowing that Patient A had stolen prescription pads from your surgery that's right?*
- A. That's correct.*
- Q. And knowing that she had in the past, forged scripts for pethidine on those stolen pads, that's right doctor?*
- A. I was aware of it.*
- Q. Doctor, can I ask you why you would tell a pharmacist to dispense a script in circumstances where you knew there was a real likelihood of it having been forged and you were not certain whether or not you had written a script?*
- A. There would be the pressure of work at the time. The people waiting in the waiting room and in a hurry, most likely I would have done that.*

The Tribunal simply didn't accept that in general the Practitioner made any genuine attempt to give a truthful account of what passed between the pharmacists and himself.

On 11/4/01 Peter Gilfedden of the Investigations Unit of the PSB attended on the practitioner and informed him that he could not prescribe any drug of addiction to a drug dependent person without authority. The practitioner claimed that he hadn't know this and had thought that he could prescribe without authority for two months even to an addict.

On 23/8/01 Ian Anderson of the Department of Health also attended upon the practitioner and advised him that under the provisions of Section 28 of the Poisons and Therapeutic Goods Act he could not prescribe or

administer any drugs of addiction to a person who he believed to be an addict without the prior approval of the department.

Three weeks later on 14/9/01 he was spoken to by Kenneth Thompson, the Pharmaceutical Adviser from the Department of Health who told the practitioner that if he issued a prescription for any drug of addiction to Patient A without the prior approval of the Department, he would be in breach of the Poisons and Therapeutic Goods Act. He reminded the practitioner that he had already been advised of the position and told him not to issue another prescription for a drug of addiction for Patient A.

The practitioner simply treated with contumely and contempt these advices and directions in that he continued to facilitate pethidine being dispensed, pursuant to forged prescriptions. This was not simply a case of inappropriate prescribing. His actions arguably involved a deliberate flouting of the law with regard to facilitating the provision of a drug of addiction, to a person he knew to be an addict.

There is clear evidence in relation to both Patient A and Patient B that the practitioner failed to make and keep appropriate medical records. Through his counsel he admits the conduct particularised.

The practitioner did seek in evidence to provide some account with regard to his failure to record consultations however his version of events was not considered to be sensible or reliable. On numerous occasions he made no entry of a consultation and on some 16 occasions there was an entry as to a consultation, but no reference to the prescription of pethidine.

On the assumption that consultation occurred and it was associated with the prescribing of pethidine, for which there was no entry in the clinical notes, Dr Bunker was critical of the practitioner's conduct. He was also critical of the situation where a pethidine prescription was written and there was no record of any consultation. He referred to a large volume of such unsatisfactory incidents of medical record keeping and prescribing over a prolonged period of time.

Dr Bunker went on to say "It is a reasonable basic expectation that the prescription of any medication of any type is recorded in the clinical notes with an indication as to the purpose of the prescription ... the requirement to clearly document those prescriptions in the case of Schedule 8 Narcotic Goods is even greater, so I am severely critical of the absence of documentation over a long period of time."

The practitioner did not have a Drug Register in his possession when visited by a PSB officer.

In commenting upon this, Dr Bunker stated "It's a clearly described and widely known requirement for doctors to keep a separate register for Schedule Eight drugs, should they choose to keep those drugs on surgery premises. I would be critical of either not keeping a book or not keeping such a book up-to-date. I would be critical of that."

## **PATIENT B**

There is no real issue as to the complaints and particulars with regard to Patient B.

Dr Singh grossly exceeded the limits imposed by his authority to prescribe pethidine on numerous occasions.

This involved no minor transgression as he systematically and deliberately ignored or defied his obligations under the Poisons and Therapeutic Goods Act.

He was contemptuous of his obligations to keep appropriate records and to maintain a drugs register.

Reference has been made to the unsatisfactory nature of the practitioner's evidence however it is to his credit that he made substantial admissions as to the matters complained of and concessions made by his counsel on his behalf.

Mr Harrison SC stated in his address "For relevant purposes, the conduct that is put against him is accepted, admitted as having occurred".

The practitioner was subject to an enquiry by a Medical Board pursuant to Section 66 of the Medical Practice Act 1992 on the 15<sup>th</sup> March, 2002. That Board had the power to suspend him for a period not exceeding 8 weeks or to impose conditions relating to the practitioner's practising medicine.

The evidence placed before the Board contained some but not all of the material placed before this Tribunal. Significantly, it did not have available to it the evidence of Dr Bunker nor the evidence of the practitioner as adduced under cross examination before this Tribunal.

On 27<sup>th</sup> March, 2002 the Medical Board imposed the following conditions on the practitioner's practice of medicine.

- 1) Not to possess, supply, administer or prescribe any Schedule 8 drugs.
- 2) To attend the Pharmaceutical Services Branch and surrender his Schedule 8 drug authority. The Board must approve any application for a change in his Schedule 8 authority.
- 3) To work only in a group practice (group may be defined as at least 3 practitioners), with one other practitioner always on site.
- 4) To work only when another registered medical practitioner who is aware of Dr Singh's employment-related conditions is also on site – Dr Singh's conditions do not permit him to work any other time.
- 5) To provide the Board with a copy of these employment-related conditions signed by the registered medical practitioners referred to in condition (d) above before he commences work.
- 6) To not undertake solo general practice work.
- 7) To seek Board approval prior to changing the nature or place of practice.
- 8) Dr Singh is to nominate a supervisor, to be approved by the Board, to monitor and review Dr Singh's clinical practice and

compliance with conditions in accordance with Level 2 Supervision of the Board's Guidelines. That is, the supervision is to be indirect but on the premises. The supervisor is to be provided with copy of the Board's Guidelines for Supervision. The cost of the supervision is to be borne by Dr Singh. Dr Singh and the supervisor are to:

- a) Meet on a fortnightly basis;
  - b) Meetings must address case review, record review, workload and clinical outcomes;
  - c) At each meeting, the supervisor is required to complete a record of matters discussed at the meeting in a format prescribed by the Board;
  - d) The supervisor is required to forward to the Board, initially on a monthly basis, the meeting records and a report in a format prescribed by the Board;
  - e) The supervisor is required to inform the Board immediately if there is any concern in relation to Dr Singh's compliance with the supervision requirements, compliance with other conditions of registration, clinical performance, health, or if the supervisor relationship ceases. Dr Singh authorises the supervisor to provide such information to the Board.
- 9) Dr Singh is to provide the Board with written evidence of his continuing professional development and maintenance of vocational competence relevant to his current or proposed employment. Initially such reports to the Board are to be forwarded by Dr Singh at six monthly intervals.

- 10) Conditions 1) and 2) take effect immediately. Conditions 3) to 9) take effect from close of business on Thursday 28 March 2002.

This Tribunal is comfortably satisfied that the complaints and particulars in relation to Patients A and B have been established (Particular 14 was withdrawn) and that his conduct constituted professional misconduct within the meaning of S.37 of the Act. The question arises as to what orders are appropriate.

A Medical Tribunal hearing is not a criminal proceeding and the Tribunal is not concerned with questions of punishment, penalty and retribution. This Tribunal's sole concern is to make orders which are designed to protect the community. In the exercise of its power it is charged with making appropriate orders to maintain the standards of the medical profession and to maintain the confidence of the community in the profession.

It is essential in exercising its function that the Tribunal make orders which will deter other medical practitioners from similar behaviour to that demonstrated by the practitioner.

Orders which will give a clear signal to the profession that the conduct giving rise to the imposition of such orders is unacceptable in a medical practitioner.

The practitioner's misconduct was blatant. This is not the case of a single fall from grace but of repeated transgressions.

As stated, he demonstrated a lack of insight in the course of his evidence. Serious consideration was given to the question of the practitioner's de-registration however having regard to the fact that the conduct complained of occurred some years ago and that he has apparently complied with the conditions imposed by the Medical Board over the past several years, the Tribunal considers orders short of de-registration are appropriate for the protection of the community.

It is to be noted that the HCCC did not submit that orders involving suspension or de-registration were called for.

Nevertheless, this Tribunal regards the practitioner's conduct as attracting orders not only involving the imposition of conditions upon his medical practice but requiring the issue of a reprimand and a fine approaching the maximum available.

The orders of the Tribunal are:

- 1) That the practitioner be reprimanded;
- 2) That he be fined \$26,000;
- 3) That he pay the costs of the HCCC of and incidental to these proceedings;
- 4) That the following conditions be imposed on his registration:
  - i. Not to possess, supply, administer or prescribe any Schedule 8 drugs.
  - ii. To attend the Pharmaceutical Services Branch and surrender his Schedule 8 drug authority. The Board must

approve any application for a change in his Schedule 8 authority.

- iii. To work only in a group practice (group may be defined as at least 3 practitioners), with one other practitioner always on site.
- iv. To work only when another registered medical practitioner who is aware of Dr Singh's employment-related conditions is also on site – Dr Singh's conditions do not permit him to work any other time.
- v. To provide the Board with a copy of these employment-related conditions signed by the registered medical practitioners referred to in condition (d) above before he commences work.
- vi. To not undertake solo general practice work
- vii. To seek Board approval prior to changing the nature or place of practice.
- viii. Dr Singh is to nominate a supervisor, to be approved by the Board, to monitor and review Dr Singh's clinical practice and compliance with conditions in accordance with Level 2 Supervision of the Board's Guidelines. That is, the supervision is to be indirect but on the premises. The supervisor is to be provided with a copy of the Board's Guidelines for Supervision. The cost of the supervision is to be borne by Dr Singh. Dr Singh and the supervisor are to:
  - a. Meet on a fortnightly basis;
  - b. Meetings must address case review, record review, workload and clinical outcomes;

- c. At each meeting, the supervisor is required to complete a record of matters discussed at the meeting in a format prescribed by the Board;
  - d. The supervisor is required to forward to the Board, initially on a monthly basis, the meeting records and a report in a format prescribed by the Board;
  - e. The supervisor is required to inform the Board immediately if there is any concern in relation to Dr Singh's compliance with the supervision requirements, compliance with other conditions of registration, clinical performance, health, or if the supervisor relationship ceases. Dr Singh authorises the supervisor to provide such information to the Board.
- ix. Dr Singh is to provide the Board with written evidence of his continuing professional development and maintenance of vocational competence relevant to his current or proposed employment. Initially such reports to the Board are to be forwarded by Dr Singh at six monthly intervals.
- 4) The Tribunal orders that the NSW Medical Board have the professional performance of Dr Singh assessed in accordance with part 5A of the Medical Practice Act with particular reference to the maintenance of his patient medical records.

\_(Signed)\_\_\_\_\_

JUDGE J C McGUIRE

\_(Signed)\_\_\_\_\_

DR D CHILD

\_(Signed)\_\_\_\_\_

DR G YEO

\_(Signed)\_\_\_\_\_

DR C BERGLUND, PhD