

REVISED BY ASSOCIATE

MEDICAL TRIBUNAL OF NEW SOUTH WALES

DEPUTY CHAIRPERSON: JUDGE WALMSLEY SC

MEMBERS: DR D BRASH
DR E KOK
MS J HOUEN



FRIDAY 10 NOVEMBER 2006

IN RE DR BRENDAN O'SULLIVAN AND THE MEDICAL PRACTICE ACT

JUDGMENT:

DEPUTY CHAIRPERSON:

1. This application is concerned with a complaint about the prescribing of drugs by a consultant psychiatrist.
2. In *Spicer v New South Wales Medical Board and Ors* (unreported, Court of Appeal, 19 February 1981) Hope JA (Reynolds JA and Hutley JA agreeing) said this:
"In my opinion it is clear beyond argument that the proper handling and prescribing of drugs by medical practitioners are of the greatest importance to the community."
3. The question for the Tribunal to decide is whether Dr O'Sullivan, ('the Practitioner'), is guilty of what is known as 'unsatisfactory professional conduct' within the meaning of s 36 of the **Medical Practice Act** (the Act). The relevant subsection of s 36 is as follows:
"Meaning of Unsatisfactory Professional Conduct:

(1) For the purposes of this Act unsatisfactory professional conduct of a registered medical practitioner includes each of the following:

(a) Conduct Significantly Below Reasonable Standard

Any conduct that demonstrates that the knowledge, skill or judgment possessed or care exercised by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience."
4. S 36 of the Act contains a lengthy non-exhaustive definition of 'unsatisfactory professional conduct' but we take the Health Care Complaints Commission, (the Commission), to rely on 36(1)(a). Although in the course of earlier proceedings, it was submitted by the practitioner's former legal representatives that in order to be successful the Commission must prove each of the knowledge, skill, judgment and care to be significantly below the relevant standard, we reject that argument, which is plainly contrary to the meaning of the section and the way it is usually interpreted.
5. In general terms the more serious complaints about medical practitioners in NSW are referred to this Tribunal and the less serious ones to the New South Wales Medical Board.

6. When these complaints were made against Dr O'Sullivan they were first referred to the Board, which served a complaint dated 18 August 2004. The complaint was initially set down for hearing before the Board on 9th and 10 February 2005. According to records in evidence, on Dr O'Sullivan's application those dates were vacated, as his legal adviser was not going to be available to him. The hearing date was changed to the 18th and 19 May 2005.
7. On 9 March 2005, Dr O'Sullivan, through his then counsel, applied unsuccessfully to have the May dates vacated. On 7 April 2005 Dr O'Sullivan appealed under s 87 of the Act, against, among other things, the decision to refuse an adjournment. The filing of that appeal resulted in the vacation of the May dates.
8. On 7 June 2005, Dr O'Sullivan's then legal adviser applied on his behalf, to the Board, to have the complaints dealt with by this Tribunal rather than by the Board. That request was granted on 14 June 2005, the conduct committee of the Board so resolving pursuant to its powers under s 50 of the Act. Under s. 179 of the Act the inquiry before the Board was terminated on 24 August 2005.
9. The complaint we are to consider was filed on 29 September 2005. On three occasions since, the hearing was vacated at Dr O'Sullivan's request, each time due to the unavailability of his counsel.
10. When the date was last vacated, in August of this year, Dr O'Sullivan was made to understand that it was unlikely that the matter would be adjourned again on that ground and that on the new date if he had no counsel he would be expected to represent himself.
11. Dr O'Sullivan appeared for himself on Monday of this week when the hearing commenced. He applied for an adjournment but it was refused. Thus he represented himself throughout the hearing. He had, on several previous occasions, been directed to file and serve outlines of evidence he proposed to rely on. He did not comply with those directions. However, when ultimately he did seek to rely on or call evidence which had not previously been the subject of outlines served on the Commission, Mr Griffin for the Commission, very fairly did not object to his calling that evidence. In general terms at least we took it that the Commission in the course of the hearing was informed of the nature of evidence to be called, albeit in a somewhat truncated form.
12. The Commission's evidence consisted of four volumes of written material. Two of its witnesses were cross-examined. They were peer reviewers, consultant psychiatrists, Dr Andrews and Klug.
13. Dr O'Sullivan gave evidence and called witnesses.
14. Dr O'Sullivan graduated from the University of Sydney with bachelor degrees in science and medicine and an MA. He undertook three years training as a physician and then became a psychiatric registrar. He trained for five years in psychiatry. He became a Fellow of the College of Psychiatrists of Australia and New Zealand in 1988. In 1991, he was awarded the degree of Doctorate of Philosophy. Thereafter, for two years, he undertook post doctoral studies in Stockholm. He then returned to Australia and for many years conducted research in psychiatry at the University of Sydney and the Royal Prince Alfred Hospital.

15. He had rights of private practice in those positions, which in 2000 he exercised at the Royal Prince Alfred Medical Centre. His employer at that time was the South East Area Health Service. In mid 2000 he ceased employment with that body. The circumstances of his ceasing to be so employed became the subject of litigation in another jurisdiction which is, as yet, unresolved.
16. Dr O'Sullivan has the facility to communicate with people who are speech impaired and who are deaf. This is a rare and valuable facility in a psychiatrist.
17. Patient A became his private patient in the early 1990's. She has a borderline personality disorder and has been deaf since birth. After she came under his care she was also treated by a psychiatrist in the public health system called Dr Buhrich. This arrangement is known in medical circles as a shared care arrangement. Dr Buhrich would care for her when she was under the care of hospital authorities and Dr O'Sullivan when she was not.
18. For several years before October 2002 Patient A had been prescribed a drug which had the popular name of Rohypnol. Its generic name is flunitrazepam. It is also known as Hypnodorm. At that time its primary use was for the treatment of insomnia. Fortunately, there are now less addictive drugs available such as Stilnox to treat insomnia. Hypnodorm is a drug of addiction. It is a Schedule 8 drug. It is a member of the benzodiazapine group of drugs. It has marked sedative and hypnotic properties and has rapid onset of action. It has the disadvantages that patients who use it suffer overdoses and develop a physical dependence. It can impair memory, psychomotor performance and judgment. Patients with a long history of dependence on alcohol or other drugs are more likely to become dependent on it or intentionally to misuse it.
19. Patients who are prone to self harming commonly overdose on prescribed benzodiazapines. Hypnodorm was first listed as a drug of addiction in New South Wales in August 2000. This followed public concern about the harm its misuse was causing. Since then New South Wales Health Department approval has been required for its prescription to a drug dependent person. In all cases an authority is needed where prescribing exceeds two months.
20. For many years before October 2002 Patient A was prone to engage in acts of self harm, often by cutting or burning her own stomach and other parts of her body. Dr O'Sullivan told us that her stomach carries extensive scarring from these acts of self harm.
21. As at October 2002, Dr O'Sullivan, who continued to treat patient A as a private patient when she was not hospitalised - which she was from time to time - had a poor personal relationship with Dr Buhrich and another of his co-workers, the late Dr Beumont.
22. In October 2002, Dr Beumont apparently formed the view that Dr O'Sullivan was prescribing Hypnodorm inappropriately for patient A. He told Area Health Service employees, Drs Horvath and Storm and some others, of his concerns. Dr Horvath passed on those concerns to the Medical Board. In time, the complaint referred to above was made. The complaints originally made were more extensive than those which found their way to us in the amended complaint.
23. While there was a great deal of documentary material in evidence and we heard oral evidence over several days, the core of the case involves some prescriptions which Dr O'Sullivan wrote in October 2002.

24. We shall turn to consider the individual parts of the particulars. Part 1 of the particulars says this:
- “During 2002 the Practitioner inappropriately described Patient A a Schedule 8 drug flunitrazepam in the quantities and on or before the drug dispensing dates shown in the Schedule marked annexure A without proper and sufficient clinical indications for doing so and in circumstances where the practitioner knew or ought to have known that continued prescription of flunitrazepam put the patient at risk of becoming dependant on the drug.”*
25. It is Dr O’Sullivan’s evidence and his case, that from time to time, from 2000 onwards, although by no means continuously, he did prescribe Hypnodorm for Patient A. Further, he concedes that he prescribed the drug to Patient A on 20 March 2002, 20 September 2002, 17 October 2002 and 24 October 2002, as alleged in the complaint.
26. All of the prescriptions were in evidence. The prescription dated 20 March 2002 was for sixty tablets, that is thirty with a repeat of thirty, and the dose prescribed was one tablet per day. Thus the maximum period which could be covered by that prescription was two months.
27. The MIMS recommended dose at that time was one to two tablets per day. In cross-examination of Dr Andrews, the peer reviewer called on behalf of the Commission, he conceded that the MIMS recommended dose was a recommendation only. We took him to concede that there might be cases where more than two would be appropriate.
28. A prescription for a Schedule 8 drug must be filled within six months of the prescription’s date (see clause 89(1) of the **Poisons and Therapeutic Goods Regulations** 1994). Otherwise, it cannot be used.
29. For reasons not apparent to us the patient did not have the prescription of 20 March made up within six months. She did however have part of it made up in October 2002. We infer that that was due to an error on the part of the pharmacist. There is no evidence that Dr O’Sullivan knew in October 2002 that that prescription had not been filled within the six month period. Indeed, the Commission did not urge a contrary view.
30. So although it was referred to in the Complaint, we do not see the prescription of 20 March as being a highly critical issue. The ones we saw as critical were those on the other dates which were listed in the annexure to the complaint and in particular those of 17 and 24th October 2002.
31. Dr O’Sullivan submitted in relation to part 1 of the complaint, or at least we took him to submit, that there were proper and sufficient clinical indications for his prescribing flunitrazepam for Patient A. Secondly, we took him to say that the patient was, before 2002, from time to time at least, dependent on the drug. Accordingly, the Tribunal has taken the argument to be that if she was already dependent it could not be said, as asserted in this part of the complaint, that he knew or ought to have known that she was at risk of becoming dependent.
32. Dr O’Sullivan said he only prescribed flunitrazepam where dependence on it was already a problem and only then with the aim of reducing the dose very slowly over time and in circumstances where he had tried other methods to wean her off the drug such as by using what is known as a Valium taper or some alternative hypnotic drugs and in circumstances where she could not be accepted for admission for a formal detoxification. He said Patient A was a patient of that kind. She had failed at Valium tapers. There were no

alternative drugs. She was not a patient who was accepted for admission for a formal detoxification.

33. We took him to submit also that since his care of her was shared with others, he had hoped that there would be increased involvement in her treatment by the Community Health Service with home visits and monitoring of medication and other treatment and by his telling employees of that service that there was a need for her to be hospitalised.
34. He said further that in relation to the scripts he issued on 17th and 24 October 2002 he gave her a script on the 17th, which on the 24th she said she had lost and he then replaced. He said that when he replaced it he rang the pharmacy where she usually went to see if the previous one had been dispensed. He said he also spoke with the Glebe Community Health Centre requesting that she be given some supervision. He said he also took account of the risks which were presented by the drug as against the potential benefits to her in her continuing with it. He said he took account of the fact that there were, clinically, apparently, abrupt withdrawal symptoms and he had a good knowledge of her history, in particular her long history of self harming and self defeating behaviour. He saw the drug as necessary to manage her withdrawal state, despite its addictive properties.
35. Peer reviewer, Dr Andrews, a consultant psychiatrist, even accepting, (which he did not), that Dr O'Sullivan was trying to wean the patient off the drug said this,
"To my mind prescribing flunitrazepam for chronic insomnia is akin to prescribing pethidine for chronic pain."
36. We pause to say that that report was given at a time when he did not have the complete history of the patient and assumed she was given it for chronic insomnia. He went on:
"Likewise prescribing flunitrazepam for flunitrazepam addiction is akin to prescribing Pethidine for Pethidine addiction. I can find no entries in his records giving reasons for the choice of this drug or even what the indications were for a benzodiazepine and only rarely does he record the doses and amounts prescribed. In my opinion Dr O'Sullivan's prescribing of flunitrazepam in this case, without convincing clinical reasons and without clinical documentation and particularly over such a long period of time is a departure from the minimum acceptable standard of practice and I am mildly disapproving of this departure. I believe that this departure would invite the disapproval of the general body of my colleagues.
...
Of much more concern to me is the fact that Dr O'Sullivan prescribed this drug to a patient who was actively and repeatedly self harming, that he prescribed it twice in rapid succession following admissions of his patient to hospital for self harm, and especially that he prescribed in this high risk situation in large quantities. On the second occasion he prescribed ninety tablets only two days after discharge from hospital for an overdose on the same drug."
37. We pause to say that, again, he was, in our view, incorrect in assuming that there had been an overdose on the drug. Rather, she was hospitalised for other reasons. We simply point out that those were views expressed at an early stage when not all of the facts were known to him.
38. The other peer reviewer, Dr Klug, also a consultant psychiatrist, did not comment specifically on whether the drug was appropriate in the absence of unsuccessful attempts of Valium and other tapers and he did not address that either when he was called to give evidence.

39. The Tribunal can see readily why in a patient who is not already addicted to the drug, prescribing flunitrazepam on the dates and in the quantities in annexure A should not have been given in quantities in which it was prescribed, especially on the 17th and 24 October. But we are satisfied that she was already dependent by 2002 and had been to a greater or lesser extent for several years before. Thus we are not persuaded that Dr O'Sullivan in 2002, when he prescribed the drug, knew or ought to have known that she would become addicted, since she was already addicted.
40. In the course of argument this morning and on several occasions during the course of the hearing, we have expressed some doubt to counsel for the Commission, Mr Griffin, as to whether that part of the complaint could be made out. Today Mr Griffin submitted that we ought read part 1 of the complaint in a disjunctive way. There are two parts to it: first, that he dispensed the drugs without proper and sufficient clinical indications, and secondly, that he did so in circumstances where he knew or ought to have known she would become dependant. Prescribing the drug without proper and sufficient clinical indications covers, to a very large extent, the same ground covered by the second part of the complaint. So we see potential for some duplicity in that part of the complaint if read disjunctively. The view we have reached therefore is that that part of the complaint is not made out because Patient A was dependent in the first place.
41. We turn now to part 2 of the Particulars which is as follows:
- “(a) The Practitioner inappropriately prescribed Patient A sixty flunitrazepam tablets on 17 October 2002 and ninety tablets on 24 October 2002 in circumstances where Patient A was engaging in self harming behaviour at the relevant time.*
- (b) The quantities of medications prescribed were excessive and not clinically justified.*
- (c) Patient A had been admitted to hospital for a possible flunitrazepam overdose on 19 October 2002.*
- (d) Even if the Practitioner was not aware that Patient A had been admitted to hospital for a possible flunitrazepam overdose on 19 October 2002 he should have considered the possibility that Patient A was abusing the medication.”*
42. Mr Griffin for the Commission conceded that only circumstances (a) and (b) could apply to the action of prescribing the drug on 17 October but submitted that all of (a) to (d) inclusive applied to the act of prescribing on 24 October 2002. He conceded, additionally, that if (c) applied, then (d) probably did not.
43. Dr O'Sullivan conceded that as at 17 October, to his knowledge, his patient was engaged in self harming behaviour. Indeed he said that her self harming behaviour was chronic. But as we have noted, Dr O'Sullivan said the quantities prescribed were clinically justified.
44. Both Drs Andrews and Klug were critical of his prescribing as he did on those days.
45. Dr O'Sullivan said that Patient A came to him on 24 October and said she had lost the script he gave her on the 17th. He conceded that when he wrote the prescription on the 24th, he knew that she was engaging in self harming behaviour and had been admitted to

hospital for what was described as a ‘possible overdose’, although she probably had not been admitted for an overdose.

46. In those circumstances, we ask ourselves were the quantities excessive and not clinically justified? As we note, both Drs Andrews and Klug say they were not justified. Dr O’Sullivan says they were. It was not in issue but that if it was appropriate on either day to prescribe the drug, 30 tablets could have been prescribed rather than 60 and 90.

47. Dr O’Sullivan gave evidence in defence of his position and he was cross-examined. At pages 256 to 257, this question and this answer were given:

“Q. Doctor, upon reflection as you sit here today if you were in the same circumstance would you have made the same decision to issue that quantity Hypnodorm on 24 October?”

A. It’s a really good question and I think the honest answer is maybe I would have given her 30 and told her deliver them directly to the community health team and for the community health team to ring me back or for her to SMS on her mobile because she was deaf and confirm with me that that was true. To be honest, I don’t know what more I would have done or what different I would have done but I believe I took all reasonable measures on re-prescribing that script. On ringing the local chemist to ensure that as of the morning of the 24th it hadn’t been filled, of giving her a repeat of script, of ringing the community team, of communicating directly what my concerns were, of telling them what her medications were. The thing is that Mr Griffin because it’s not in the notes it doesn’t mean it wasn’t said. Not everything that is said is in the notes and I made it quite clear of my concerns.”

48. The Practitioner’s evidence about the events at about that time had some difficulties as we see it, and we say something about them. In his letter of 13 November 2002 to Professor Fearnside and Dr Samuels in response to a request for a response to an early version of the complaint, Dr O’Sullivan said this:

“On the appointments of 17/10/02 and 24/10/02 she reported to me that she had lost her Hypnodorm script in the preparations to move house. I believed her the first occasion but on the second occasion I was naturally suspicious. It is important to note that at no previous time had she sought additional scripts. This was new but I then refused to give her any further script.”

49. He told us, however, he recalled that there was only one occasion, not two, when she said she had lost her script, that being on 24 October. He did concede his memory for those events would have been better in November 2002 than now.

50. There were other matters which we noted. The script given on the 24th he said was to replace that of the 17th. However it was for ninety tablets, whereas the one on the earlier occasion was for sixty. Additionally, Dr O’Sullivan told us that although the one of 24 October said that the patient was to take one per day, in fact he intended that she take three per day. In effect, his instructions to Patient A were different from what was written on the prescription. He said to us that he expected that in any event she would only ever have thirty prescribed at a time and that that was the practice that he was familiar with at the pharmacy at which she normally had the medication dispensed.

51. Before us Dr O’Sullivan maintained that both the prescriptions on the 17th and the 24th were appropriate in all the circumstances. Whilst drawing attention to what Dr O’Sullivan said about these events some years ago, the view we take is that it is not necessary for us to resolve the apparent variations in recollection. The fact remains that Dr O’Sullivan

concedes that he issued the prescriptions on the 17th and the 24th, but maintains they were both appropriate in the circumstances.

52. Bearing in mind that (a) on both the 17th and 24 October he knew that she was dependent on the drug (b) she had been admitted to hospital recently for self harm (c) he could, just as easily, have given thirty, rather than sixty or ninety, (d) what we are satisfied was his own knowledge at the time that the drug had its dangers (e) the requirements of s 29 and (f) the peer views, the Tribunal is of the view that this part of the complaint is established on the balance of probabilities.

53. We turn to part 3 of the Particulars which is as follows,

“The Practitioner prescribed flunitrazepam to Patient A for a period exceeding two months without having applied for or been given an authority under s 29 of the Poisons and Therapeutic Goods Act 1966 in breach of s 28 of the Poisons and Therapeutic Goods Act 1966.”

54. Section 28 says:

“ A medical practitioner shall not prescribe for or supply to,

(a) any person, a drug of addiction that may be prescribed or supplied in accordance with para C (for continuous therapeutic use by that person) for a period exceeding two months or for a period which together with any other period for which he or she had prescribed or supplied by any other medical practitioner would result in that drug, or that drug together with any other such drug being prescribed for continuous therapeutic use by that person for a period exceeding two months;

(b) any person who in the medical practitioner’s opinion is a drug dependent person, any drug of addiction not being a drug of addiction that may be prescribed or supplied in accordance with para C; or

(c) any person any drug of addiction prescribed for the purpose of this paragraph unless the medical practitioner so prescribes or supplies that drug in accordance with an authority in respect of that person given to the medical practitioner by the Director General under s 29.”

55. In support of his argument that there was no continuous period of prescribing for more than two months, Dr O’Sullivan relied on an argument in an affidavit sworn by his former solicitor, Mr Duong, on 6 October 2005. We have considered the contents of that document as he asked us to do. As will be apparent from our reasons below, while the argument in that affidavit does dispose of some of the arguments on which the Commission might have wished to rely, it does not by any means defeat all of them. We do not consider it appropriate that we look at the March prescription for the purposes of the Commission’s argument as it does not support a continuous period of more than two months.

56. When prescriptions given later in the year (other than the ones on 17th and 24 October), are put together there are gaps. Further, none of them individually is for a period which, on its face, would have exceeded two months.

57. Nice arguments do arise where there are gaps between prescriptions and as to whether, with relatively small gaps of a few days or a few weeks, it could be said that a period of

more than two months is, in fact, continuous. In the course of argument counsel referred us (and we referred counsel) to decisions where this issue had previously been the subject of consideration.

58. Ultimately, whilst not necessarily abandoning other arguments, we took Mr Griffin to put forward as the strong point of the Commission's case on this issue, the prescription of 24 October. On the face of that prescription, it was for ninety tablets to be taken at the rate of one per day. Thus it seems to the Tribunal that the Commission has established to the requisite degree of proof, that on that day at the very latest Dr O'Sullivan was under an obligation to seek approval before prescribing the drugs. We make that finding notwithstanding the evidence of Dr O'Sullivan that he had an intention that the patient should take more than one per day which, if so, would have had the effect of reducing the period. The fact is that he prescribed the drug for 90 and, on the face of the prescription, it says the rate is one per day. We are satisfied that the Commission's case is made out very clearly on that part of the complaint.
59. Dr O'Sullivan submitted that if that part of the complaint were proved it is, in any event, a technical one, or alternatively a trivial one, and not such as to warrant a finding of unsatisfactory professional conduct. We will come to consider that in a moment.
60. We should at this stage say something about some issues which arose in the course of the hearing. Dr O'Sullivan was highly critical of several doctors who he maintained had made complaints about him to the Medical Board with improper motives, their motives in short being to secure his de-registration to thwart efforts he was making in another jurisdiction to seek reinstatement in his former position as Senior Staff Specialist and Associate Professor. He said further that the peer review reports of Drs Andrews and Klug were based on a number of false premises and that his ability to defend these proceedings was hampered because incorrect assumptions were made initially by those present at a section 66 inquiry and by reason of incorrect information being given to reviewers and others at an early stage, there being, what he described on several occasions, as a 'domino effect', which had adverse consequences for him. However, we do not consider there is any substance in these arguments. As we have reminded Dr O'Sullivan during the course of the hearing, our jurisdiction is to hear the evidence concerning the amended complaint only and decide only what flows from the findings that we make. That those who initiated the complaint may have done so through ill-will or otherwise does not detract from the fact that a complaint was made and supported by a substantial and credible body of evidence, much of it documentary. There was no application made for a stay of the proceedings. We should add that in any event as it was not necessary to decide whether the complaint was motivated by ill-will, we have not done so.
61. As to there having been erroneous assumptions made by peer reviewers and parties to a section 66 inquiry that, in our view, is an unremarkable matter. It is commonplace for not all facts to be available to reviewers and to those present at an early section 66 inquiry. In the end the Commission relied only on matters which were before us and did not try to make out or prove matters which could not be made out before us.
62. One matter in particular we mention is that it was said in one of the early letters of complaint that there was more than one patient involved. However, before us, the Commission only relied on evidence concerning one patient.

63. The Commission proceeded before us only on what it could prove, so Dr O'Sullivan, as we see it, could not possibly have been prejudiced in any way by any false or incorrect assumptions having been relied on initially. Further, we should say that over the five days of the hearing before us we formed the view that Dr O'Sullivan conducted his own case with some skill, and Mr Griffin for the Commission (and no doubt on instructions) did not seek to take advantage of any unduly technical points. We consider that he presented the case for the Commission in an objective and fair way.
64. Dr O'Sullivan in the course of his case tendered a report from consultant psychiatrist, Dr Durrell. He withdrew it at the end of his case when Dr Durrell was unavailable for cross-examination. Today, before Mr Griffin commenced his submissions, Dr O'Sullivan expressed concerns that he might have been unfair to himself or caused himself prejudice by acceding too readily to a suggestion which came from the Deputy Chairman that he ought withdraw the report of Dr Durrell, given he was unavailable yesterday for cross-examination. Ultimately, Mr Griffin withdraw any objection the Commission had to the tendering of Dr Durrell's report in the absence of Dr Durrell for cross-examination. He submitted to us that the views expressed by Dr Durrell ought be accepted by us subject to weight. It was in that light and in that context that we accepted the report.
65. The report, in any event, was largely a summary of the history and, itself, was based on some false assumptions, for example, whether Dr O'Sullivan was ever informed that patient A had been hospitalised in September and October 2002. This was a live issue in correspondence and, at times, during the course of the hearing but ultimately was not an issue as we took Dr O'Sullivan to concede that he was informed at relevant times that Patient A was in hospital in September and October 2002. Dr Durrell, when giving his report, assumed that he had not been told. Dr O'Sullivan explained to us that in saying that he had not been told, he was saying that he had not been told by his fellow carer, Dr Buhrich. Appropriate conduct, we took him to say, dictated that Dr Buhrich ought to have drawn his attention to the fact that the patient they jointly shared was, at the relevant times, an inpatient. As it happens, he was told that she was hospitalised, not by Dr Buhrich but by a doctor, who was then a registrar, Dr Foi.
66. Dr Durrell gives support for Dr O'Sullivan on the third part of the complaint. That is, he says that in the psychiatric profession the failure to seek approval as required by s 28 was not one of the more significant matters. We have taken account of what he says. Having in mind what all of the psychiatric witnesses have had to say about the breach of the section and having in mind the matters proved in parts 2 and 3 of the complaint, we are of the view that the conduct of Dr O'Sullivan does amount to unsatisfactory professional conduct and we find that in the circumstances as proved his conduct did amount to unsatisfactory professional conduct.
67. We have considered what penalty would be appropriate, particularly given Patient A was obviously hard to manage and given Dr O'Sullivan's submission that the s 28 breach was what was described as technical and trivial. The view that we have reached is that it is appropriate that Dr O'Sullivan be reprimanded. We are persuaded that having been subjected to the complaint and all associated matters that he has had to endure over the last few years it is unlikely that he will again engage in inappropriate drug prescribing.
68. In making the findings that we have made we have found them in the *Briginshaw v Briginshaw* (1938) 60 CLR 336 sense.

69. In the course of argument this morning Mr Griffin submitted to us a document called 'proposed orders' which set out the Commission's position. Bearing in mind the submissions put to us by Mr Griffin and by Dr O'Sullivan we think it appropriate to make all of the orders in that document.
70. Accordingly, the Tribunal orders that the respondent be reprimanded, that the respondent comply and be involved regularly with the MOPS continuing medical education program of the Royal Australian and New Zealand College of Psychiatrists as determined by that college; and he should report such participation to the Board in the schedule of continuing medical education provided at annual renewal of registration; that the respondent participates regularly in a peer review group and he should report on his participation in a peer review group to the Medical Board when requested to do so by the Board; four, that the Medical Board is the appropriate review body in relation to orders 2 and 3 for the purposes of ss 92 and 93 of the Medical Practice Act.
71. We pause in relation to the question of costs.
72. Although we have found only two of the three parts of the complaint made out, given that in our view there has been no significant additional time taken by reason of the one part that was not made out, our view is that the respondent should pay the costs of the complainant.
73. We have not called on you Dr O'Sullivan but if there is anything you want to say to us about that you are entitled to say something to us about the costs. It does happen in cases where part of a complaint is not made out that a percentage of the costs is not ordered to be paid. But for the reason announced I do not see that the case has been made any longer by that and I think it entirely appropriate in the circumstances in which this complaint was first laid, given the difficulties of locating relevant medical records and the difficulties of reading your own records Dr O'Sullivan I regard it as a reasonable matter for the Commission to put all three parts in the complaint as it did and so for those reasons, unless there is something you want to put to me, Doctor?
74. All right well then we order the respondent pay the complainant's costs of proceedings

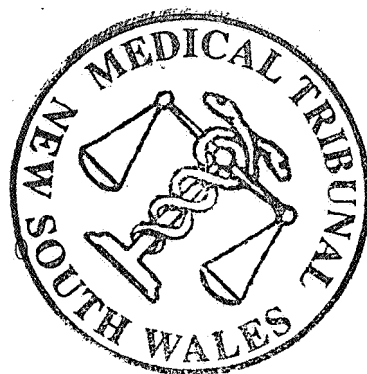


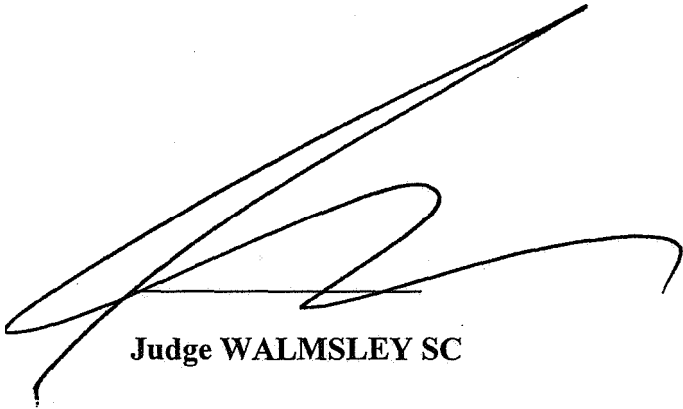
FINDINGS:

The practitioner is guilty of unsatisfactory professional conduct.

ORDERS:

1. That the Respondent be reprimanded
2. That the Respondent comply and be involved regularly with the MOPS continuing Medical Education program of the Royal and Australian and New Zealand College of Psychiatrists as determined by that College and he should report such participation to the Board in the schedule of continuing medical education provided at annual renewal of registration.
3. That the Respondent participates regularly in a peer review group and he should report on his participation in the peer review group to the Medical Board when requested to do so by the Board.
4. That the Medical Board is the appropriate review body in relation to orders 2 and 3 for the purposes of s.92 and 93 of the Medical Practice Act.
5. The Respondent pay the Complainant's costs of the proceedings
6. Leave granted to the HCCC to approach through my associate if no agreement made on costs
7. Dr O'Sullivan to pay costs on application to set aside summons re Mr Dix, Dr Wilhelm, Prof. Fearnside, Dr Tadros, Dr Samuels and Dr Horvath
8. Drs Reid, Storm and Cook to pay Dr O'Sullivan's costs re application to set aside summons.

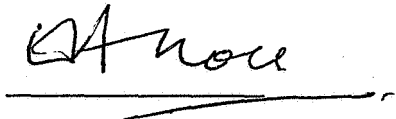




Judge WALMSLEY SC



Dr David BRASH



Dr Esther KOK



Ms Jennifer HOUEN

