

**THE MEDICAL TRIBUNAL
OF NEW SOUTH WALES**

No: 40010 of 2008

HEALTH CARE COMPLAINTS COMMISSION

Complainant

DR PAUL AMEISEN

Respondent

**Complaint made under the Medical Practice Act 1992
and the Health Care Complaints Act 1993**

Medical Tribunal constituted under the Medical Practice Act 1992:

Deputy Chairperson, Judge Peter Johnstone

Dr Saw-Hooi Toh

Dr Vasco de Carvalho

Dr Maureen Gleeson

Hearing dates: 8, 9 and 10 December 2008

Date of Decision: 28 January 2009

REASONS FOR DECISION

The complaint

1. By a Complaint dated 28 March 2008 the Health Care Complaints Commission, following consultation with the New South Wales Medical Board, complained that the Respondent, Dr Paul Ameisen, a person registered under the *Medical Practice Act 1992*, has been guilty of unsatisfactory professional conduct and/or professional misconduct in that he has:

(i) demonstrated that the knowledge, skill or judgment possessed, or care exercised by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience; and/or

(ii) engaged in improper or unethical conduct relating to the practice of medicine; and/or

(iii) contravened the *Medical Practice Regulation*.

2. The Particulars of the Complaint specified the following matters, in summary:
 - The inappropriate and irresponsible prescription of certain drugs, including Pethidine, Alprazolam, Temazepam, Diazepam, Oxycodone, Codeine Phosphate, Clonazepam, and Flunitrazepam, for some 18 patients (A – R) between November 2004 and May 2005 (Particulars 1 – 18).
 - A failure to keep proper medical records in respect of the prescription of those drugs to those patients in contravention of the requirements of the applicable *Medical Practice Regulation* and the applicable *Poisons and Therapeutic Goods Regulation* (Particulars 20 - 22).
 - The provision of signed prescriptions for the drug Nilstat to a person who was not a registered medical practitioner, for completion and later issue by that person to patients.
3. The Respondent unequivocally admitted the conduct the subject of the complaint and conceded that his behaviour amounted to professional misconduct as a registered medical practitioner that was of a sufficiently serious nature to justify suspension or removal of his name from the Register: s 37 *Medical Practice Act 1992*. He submitted, however, that in all the circumstances the relevant public interest can be protected without deregistration or suspension, and asked this Tribunal to allow him to continue to practice medicine, albeit with conditions.
4. The Complainant's primary position is, however, that there should be an order for the deregistration of the Respondent doctor. It submitted that the seriousness and the aggravated nature of the misconduct, combined with a continuing absence of true insight into his behaviour, and the lack of genuine contrition, calls for his deregistration. Accordingly, the Respondent doctor is not currently fit to practice medicine.
5. The Medical Tribunal exercises its jurisdiction for the protection of the public and of the medical profession. This jurisdiction is protective rather than punitive, and deregistration is not an automatic outcome of professional misconduct even where that conduct is sufficiently serious to justify it: *HCCC v Karalasingham* [2007] NSWCA 267 at [67], particularly where significant steps have been undertaken, as in this case, by the medical practitioner to rehabilitate himself.
6. However, it is clear that deregistration may be required in serious cases of misconduct in order to adequately achieve those objectives by minimising the risk of recurrence, by deterring other practitioners from engaging in such conduct, and by maintaining public confidence in the profession.
7. The issue before this Tribunal is whether, given the Respondent's admission of professional misconduct, his candour, the substantial steps taken by way of re-education and to obtain and understanding of his misconduct, his blemish free record in the last three years and other ameliorating conduct, the Applicant has established, on the balance of probabilities according to the principles in *Briginshaw v Briginshaw*, that in all the circumstances deregistration is nevertheless justified, and if so, for what period.

History

8. Dr Ameisen, the Respondent, was born on 7 November 1948 and is now 60. After leaving school he studied medicine at the University of NSW, graduating MBBS in 1976 whereupon he registered as a medical practitioner. He completed his internship at St Vincent's Hospital and Liverpool Hospital where in 1977 he worked as a first year resident.
9. In 1978 he moved to Mudgee where apart from an extended overseas trip he worked as a general practitioner until 1992 at the Mudgee Medical Centre. He also worked as a VMO at the Mudgee District Hospital. His practice was a rural one, involving general practice, obstetrics, anaesthetics and emergency medicine. His exposure to patients with drug and alcohol addiction was limited. As a result of his overseas trip he developed an interest in other therapies including acupuncture, vitamin injection and nutritional therapy.
10. By 1992 his personal life had become complicated, with two young adopted babies, and the demands of a country professional practice involving long hours and home visits were such that he and his wife decided to relocate to Sydney.
11. Upon his return to Sydney in 1992, the Respondent went into a general practice at Bondi, with Dr Muller, until 1995. The Bondi practice was directed primarily towards natural therapies, including nutritional remedies, and acupuncture, but it also exposed him to large numbers of patients with drug and alcohol problems. It was in this period that he commenced the pattern of irresponsible and illegal prescribing of drugs to such patients, including drugs of addiction. He said he believed these were 'extreme cases needing extreme measures'. He claimed inexperience with such problems, an element of naïveté, or gullibility, and an absence of access to experienced advice and assistance. The Tribunal does not accept these explanations and viewed such attempts to minimise the seriousness of his conduct and his state of awareness as to the turpitude it involved, as indicative of continuing lack of insight.
12. After 3 years at Bondi the Respondent left that practice and worked solo in general practice at various locations in the eastern suburbs until 2002 when he joined a group practice at Edgecliff known as 'Your Health'. He then conducted his practice in that group for the next few years until it apparently collapsed.
13. The Respondent continued to treat drug dependent patients for whom he illegally and irresponsibly prescribed drugs, including drugs of addiction, and failed to keep proper records relating thereto, as particularised in the Complaint.
14. Since the collapse of the 'Your Health' group the Respondent has worked alone as a general practitioner in his own practice, where he provides, or makes available, a range of medical and general health services. In addition to the Edgecliff practice the Respondent maintained a clinic in Mudgee where he attends 2 days a month.

The 1995 investigation and warning

15. The Respondent first came to the attention of the Medical Board following complaints, in particular a letter dated 9 March 1995 sent by a doctor from the Drug Health Service in connection with one of his patients, [REDACTED] (Patient F), for whom he had been inappropriately and illegally prescribing narcotics and other drugs of addiction over a period of years. An investigation followed which revealed extensive improper prescription of such drugs in relation to a number of patients.
16. As a consequence of the investigation, The Respondent was interviewed at his surgery on 21 March 1995 by officers from the Department of Health during which the discoveries from the investigation were extensively discussed with him and he was given detailed advice and specific warnings about his prescribing of drugs. He was explicitly counselled about excessive prescribing, multiple prescribing, prescribing to known drug users, and the need to prescribe in accordance with recognised therapeutic standards. He was told in unequivocal terms that it was illegal to prescribe drugs of addiction for an addict or a patient he believed to be an addict without an authority from the Department, and that such authorities were legally binding as to the type of drug and the dosage specified.
17. The written report of that interview described the Respondent as being 'dismissive' of criticism at times during the interview. It was recommended that he be sent a letter formally reminding him of the various matters raised with him. Such a warning letter was then sent to him by the Director-General on 4 April 1995 together with a detailed pamphlet headed "Recognising and Handling Addicts" (Volume 1 Tab 8).
18. The warning letter of 4 April 1995 was salutary and unambiguous. Unfortunately, however, the dismissive attitude displayed during that interview continued, and in the view of this Tribunal persists even today. The letter was in these terms:

"I am writing to confirm advice given to you during a recent visit to your surgery by an officer of the Department of Health regarding your prescribing of drugs of addiction, benzodiazepines and anabolic steroids.

You will appreciate from this visit that the department is deeply concerned that addicts are able to obtain quantities of drugs of addiction...by persuading doctors to prescribe these drugs for them...addicts use a variety of approaches in attempting to obtain prescriptions for drugs of addiction...

You are reminded that, under Section 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. This does not prevent you from accepting addicts as patients or treating them without reference to the Department, provided that treatment does not involve the prescribing or administration of a drug of addiction (see attached list).

However, if you consider that you cannot successfully manage an addict, or a person whom you suspect may be an addict you should refer the patient or one of the addict management facilities set out in the attached Notes for Medical Practitioners.

Trafficking in prescriptions and drugs dispensed on prescriptions obtained in this way has become a major problem. Your co-operation in declining to prescribe a drug of addiction for an addict without authority will help overcome this problem.

The officer has reported that you appear to have prescribed a drug of addiction outside the terms of an authority issued to you by the Department in respect of some patients in your care. Authorities to prescribe drugs of addiction are issued by the Department on the recommendation of the Medical Committee following due consideration of the patient's medical condition and the information supplied by the applicant prescriber. The terms of any such authority must be strictly adhered to and not only is it an offence to prescribe outside the specified terms, but excess prescribing might well lead to therapeutic addiction.

Should you wish to vary the terms of the authority, a further application, supported by clinical information should be forwarded to this Department.

Finally you are reminded of the need to ensure that any substance that you prescribe should be in a quantity and for a purpose which is in accordance with the recognised therapeutic standards of what is medically appropriate in the circumstances. This is particularly important with drugs liable to abuse such as benzodiazepines, analgesics and anabolic androgenic steroids. Failure to comply with those standards may lead to the initiation of disciplinary proceedings."

19. The Tribunal found the response of the Respondent to the interview and warning letter of 1995 entirely inadequate and indicative of a continuing lack of insight on his part. It is unable to accept, for example, his evidence that he thought the visit amounted to 'a guide and a bit of advice' such that he 'didn't realise that my job would be at stake' (T 20.32 and following):

"I think that when I had the visit in 95, I saw it as a guide and a bit of advice from the experts in the field and didn't realise that my job would be at stake or that the matter was as serious as it now, I see, it was. Because it was the first time I had, I was in the situation, I thought well, it was a very friendly meeting, there was no mention that, you know, there'd be any punitive part to it or anything, and I thought well this has pulled me up, this made me realise that in this new environment, I've got to be extra careful and tighten up, and I did tighten up severely. But as you well know, there's a ten-year period between those two visits, and even though I pulled up very tight for a year or two, with the pressure of patients and I had a bit of a reputation as a reasonable doctor in Sydney and I built that up over the years, and patients soon learn, you know, if someone is a bit kind, maybe gets a little bit closer to his patients, maybe gives them a peck on the cheek and a hug on the way out, to some of their older female patients, perhaps, yeah, it was a friendly, warm practice, and perhaps I got a little bit too close to these patients that I should have been more vigilant with."

20. The Respondent not only ignored the warning; he openly flouted it, and continued to over-prescribe, issue multiple prescriptions and to breach the terms of authorities issued by the Department. Contrary to his evidence of 'tightening-up', he made but token and temporary efforts to change his conduct, particularly when, with the effluxion of time, there was no formal follow-up or ongoing supervision by the Department and he thought he was no longer under scrutiny.
21. His continuing disdain for compliance is apparent in much of his evidence and may be seen in stark relief in some of the correspondence.
22. In a letter dated 8 May 2000 to the Respondent in relation to [REDACTED] (Patient G), Dr Alex Wodak, a drug and alcohol specialist at St Vincent's Clinic, complained about the unrestrained pethidine injections the patient was receiving and recommended reduction and alternative treatment to avoid an increasing the need for pethidine and the emergence of 'significant drug seeking behaviour'. The advice went unheeded.

23. In a letter dated 26 February 2002 to the Respondent in relation to [REDACTED] (Patient F), who had been the subject of a specific warning to the Respondent in the 1995 interview, Dr James Bell, an experienced drug and alcohol specialist from the Langton Centre, raised concerns about the patient's use of pethidine and 'the absolute need for limits to be placed on her access to this drug'. But rather than limit her access, the Respondent increased it, in direct opposition to the specialist advice and contrary to the Departmental authority relating to the patient.

24. The evidence relating to Ms [REDACTED] sometime boyfriend, [REDACTED] (Patient L) was also indicative of the Respondent's continuing disdain for compliance (T 121.25ff). The following exchange is illustrative:

"Q. In giving the pethidine to Mr [REDACTED] you must have been concerned that he may well be providing it to his girlfriend, Ms [REDACTED] because you knew she was pethidine dependent?

A. Correct. If they had always been there together I think this realisation would have come much faster, but every time I came, she was away for a month in Newcastle. Eventually she was living in Newcastle and they were in the process of breaking up. Just about every time I saw him, he was there alone and there would be a call, you know, two days later from [REDACTED] 'I'm coming back to Sydney in a week and, you know, I'll need blah blah, and my authority says blah blah and you know. And then it was that sort of situation. I had the feeling that they were broken up or almost broken up. And towards the end I started to get suss, but really though, they were fighting, they weren't helping each other, they were fighting each other.

Q. But it took you the space of 104 pethidine ampoules to become, to reach that stage?

A. I think, you know, I had the misconception that for two months I can treat him. I didn't realise he was drug seeking right up front. He was working, he was normal. About three months along of his treatment, he got busted from marijuana and then I suddenly realised drug culture, smoking, maybe there's some issues there, maybe he's a drug seeker. He presented like a normal person at first and I saw no signs of any drug addiction or drug seeking, he wasn't asking for Valium and sleeping pills and other, you know, like the usual story. Don't want to bother you, doctor, just a script. He came, he had a full examination. He was complaining of asthma and we dealt with his asthma somewhat and then he seized up with his back. And I thought, okay, and then a week later there was another attack and then there was another one."

25. The evidence overwhelmingly established that the Respondent had, at this period, a total disregard for the legal requirements, or for specialist opinion. The Tribunal is satisfied that he was simply supplying drugs on demand to drug seeking patients, and was knowingly aware that his conduct was contributing to and aggravating their addiction. Of more concern, however, is his continuing lack of insight. This was apparent from the totality of the cross-examination. The following passage is illustrative:

" Q. Could I take you to volume three, which I think is still in front of you, the thick volume, tab six the first tab which relates to [REDACTED] page 52, page 52 is an example of an application for an approval under section 29, its got across the top New South Wales Department of Health Poisons and Therapeutic Goods Act, form one, that's the form you used to have to fill out to seek an approval wasn't it? A. That's amazingly interesting, yes I can see it in front of me.....

Q. And you filled this form out did you? A. That's me and its my signature.

Q. And about half way down the page above the signature it has a part that you have to fill out it says I consider this patient and then you have got a circle around "is not" a drug dependent person with a tick. You agree that that is what it shows? A. That's what it shows.

Q. And do you consider that that was a truthful statement at the time that you made that?

A. Someone has five pethidines per month - -

Q. Sorry, you are not answering the question. Do you consider that that's an accurate statement at the time, and truthful?

A. I will explain it, a drug dependent person is seeking drugs every day. There were periods when she would come in and then you wouldn't see her for five days, I haven't had a vomited attack and I have had no problem, and my mother as well, we thought there was a genetic link, and they use to come together. Then they would come five days in a row and request pethidine, and this is why she had a request for five per month, can you understand that, you can use five in one day to cover a person with acute pain around the clock, so this is the scarcest amount of pethidine per month that you could possibly order on anybody, it would hold you for three hours five times during that month, this is why when I visited them two months ago they were about 400 that medication, oral, 120 ms contin VD twice a day, I have never heard of such a dose, on that they were happy and they weren't screaming and they weren't ringing me 16 times a day and not vomiting on my floor.

Q. I take it doctor that you do consider that to have been an honest and truthful statement, is that right? A. At that time I thought she was not drug dependent, yes, at that time. That changed.....

Q. If we go back to the schedule of prescribing for this particular patient, which commences at page 18 of the complaint document, you had been treating her since at least February 2002 on a very regular basis with a wide range of drugs, haven't you; yes? A. Yes.

Q. You must, I suggest to you, have either believed or at least been suspicious that she was a drug-dependent person? A. I agree.

Q. Why then in that document, the application under section 28, why did you tick the box that said you consider her not to be a drug-dependent person?

A. I thought she would become a dependent person sooner or later, but at that time she still had three and four days where she wasn't seeking treatment and that is definitive of not a drug addict. Drug addicts cannot just suddenly get rid of their addiction for four or five days and require nothing. That confused me and on those grounds I thought she's not an addict, I don't think she's an addict; she should be, but she's not. How is she getting four and five days free of medication and not asking for it? Medically that's impossible, I've never seen it, and the specialist never saw it. Eventually she became addicted, and now she's on an enormous - like a terminal cancer patient, oral treatment. If I was given that initially, I would not have had a problem."

The 2005 investigation and the Complaint

26. Against this background, it came as no surprise, at least to the Tribunal, that the Respondent again became the subject of a second investigation in 2005 regarding his prescribing of drugs, leading to the Complaint the subject of these proceedings.

27. Having regard to the Respondent's unqualified admission of the Complaint and the particulars it is not necessary to review the specifics of his misconduct in detail. However, some aspect of the investigation and its outcome, and the subsequent interview of the Respondent by the Departmental investigator, provide important background to subsequent developments, and are relevant to the question of whether the Respondent has developed true insight and understanding in relation to the nature and consequences of his actions, and the extent to which the candour he professes, and relies on in these proceedings to avoid deregistration, is genuine.

28. The investigation was carried out by The Pharmaceutical Adviser – Inspections and Investigations of the Pharmaceutical Services Branch of NSW Health, Alex Gavrilovic. He prepared a detailed report dated 23 August 2005, with an Addendum dated 8 September 2005 (Folder 1, Tabs 1 and 2) with various detailed attachments (Tabs 3 – 10).

29. As part of the investigation, the Respondent was interviewed by Mr Gavrilovic and Mr Bruce Battye, the Principal Pharmaceutical Advise, at his Edgecliff rooms on 5 August 2005 (see transcript at Tab 5). During the course of that interview the Respondent was asked whether he agreed his prescribing practices were actually contributing to the dependency of patients. In reply, he said:

“You know, I guess from your point of view I am but from my point of view I feel I am doing the same as I was 15 years ago, keeping them going, keeping their anxiety at bay and keeping them asleep, you know, when they should be sleeping. I haven’t escalated and I haven’t changed and I have tried with acupuncture and manipulations to sort of decrease their use but they are just the person that you know they are on the extreme of the population...”

30. The key to the true attitude of the Respondent was, in the Tribunal’s view, revealed when he said this in that interview:

“...they buy heroin and sell half of it as well. I mean they are not legal people. I am in charge of their health and I have kept them alive. These sort of people, from my experience, now I know the orthodoxy disagrees with me and I don’t know if I should be putting this on tape but my feeling is that in every occasion I have said to the person, look, I can’t write any more scripts for you, I am sorry, it’s too much you know you are escalating. When people escalate I pull out but if they have a regular weekly or two-weekly or four-weekly script and there is no escalation over 10 years I am sort of obliged to continue it somehow. I don’t know why. I guess you get a bond with those people, you deal with their other health matters, not just their drugs one, and you feel responsible for their anxieties and their insomnias and the rest of it. Their Methadone doctor is not, he is just excited about their Methadone and their addiction. He is not treating their general health. I am.”

31. When cross-examined, the Respondent sought to distance his present self from this expression of indifference for orthodoxy (T 150.16):

“Q. What you were saying here in that answer was that you were prepared, even though you knew it was excessive prescribing, to give people their regular script just because that’s what they were getting? A. This was me then. When I read this, I can’t believe that it came out of my mouth.

Q. And you knew that that was contrary to what you refer to as the orthodox, didn’t you?

A. Under the pressure of questioning this came out. It’s not really what I felt deep inside my heart. I did say it. I did say, but under pressure and at the end of the day and after a torrid two-hour session sometimes things come out that you might (not) entirely mean.

DEPUTY CHAIRPERSON

Q. Is that what’s happened here in the witness box too?

A. No, not at all. The last triennium I think I’ve been as regular as a person can be. I’ve been at odds with myself every day to do the right thing and the education that I’ve done has helped me. I didn’t have the benefit of that then, unfortunately. I’d been warned, I was guided, I was counselled and I didn’t listen enough and I do admit to it. It was me then; that was another person.

32. The Tribunal found these protestations unconvincing.

33. The Investigation Report concluded (57 – 61) that the Respondent:

- Knowingly continued to prescribe benzodiazepines to dependent persons without prior consultation with their methadone prescriber in doses and quantities that were excessive;
- Issued prescriptions for drugs of addiction including pethidine injections at high doses, at brief intervals, over an extended period of time to patients who were dependent and for whom he held no authority, or for whom another doctor held the authority;
- Knew some of his patients were sharing their prescribed benzodiazepines with their partners;
- Prescribed drugs of addiction and benzodiazepines to patients without a therapeutic plan, and prescribed such drugs at excessive levels with the potential to cause dependency;
- Provided prescriptions with forward dates and approved the issue of prescriptions for restricted substances on his behalf by an unauthorised person;
- Failed to properly maintain a drug register as required by the *Poisons and Therapeutic Goods Regulation*.

34. The report went on to recommend withdrawal of the Respondent's authority to issue prescriptions for or to supply or possess drugs of addiction and other restricted substances. It also recommended the report be forwarded to the Health Care Complaints Commission and the NSW Medical Board for appropriate action. The Respondent relinquished his authority to prescribe specific drugs (Schedule 8 and Schedule 4D drugs) including drugs of addiction and benzodiazepines. He has practiced since without that capacity and has no longer treated addicted patients in the same way as he did previously. He states that he has improved his administrative practices and now complies with the regulatory requirements.

35. A peer report was obtained on behalf of the Complainant from Dr Ian Chung (Volume 1, Tab 1) dated 19 May 2008. In his Summary (Page 20) the doctor relevantly commented:

"A primary concern is that Dr Ameisen had been investigated before and he was interviewed and warned about his conduct both verbally and in writing. He had been provided information as to proper prescribing and the requirements of the Poisons Act. Therefore his conduct in 2005 must be considered in the light of this prior investigation and the subsequent attempt to instruct, guide and warn Dr Ameisen...

The failure...to alter his conduct following the first investigation into his conduct and his repetition of the same conduct suggests:

- a flagrant disregard of official advice and warnings...;
- a disregard of the serious nature of his conduct;
- the safety of his patients and the risk to their health and their life;
- Inadequacy of clinical knowledge in the area being treated viz. Addiction medicine;
- failure to be aware of his clinical inadequacies;
- his disregard of his responsibility to know and observe the Laws governing his practice of his profession;
- a lack of knowledge or a disregard of, the clinical guidelines, manufacturer's recommendations, regulatory requirements and/or the safe prescribing of the drugs he prescribed to his patients;
- an inability to learn or to change behaviour (emphasis added)."

36. Dr Chung was severely critical of the Respondent's overall pattern of conduct and in his opinion his conduct would attract the very severe disapproval of his peers of good repute and conduct of a similar level of knowledge and experience as the Respondent.

37. The Complainant also qualified Dr John Ellard to provide an independent review. His report (Volume 4, Tab 24) dated 31 January 2007 records the following opinions:

"My comment on the health care provided by Dr Ameisen based on all the material in my possession – a large amount – is that the standard of clinical practice was significantly below the level to be anticipated from a general practitioner of equivalent experience and responsibility...

In my opinion the information at my disposal raises the question of what my peers of good standing would believe. I believe that my peers of good standing would share the view that I have given you.

I consider as well that his standard practice would meet the definition of "unsatisfactory professional conduct" as described in the Medical Practice Act 1992 and I believe that an appropriate Tribunal should determine the question for it is very important."

38. The Tribunal noted these opinions from two such respected and eminent practitioners.

The Respondent's submissions

39. The Respondent's position essentially is that he is a different person today from the person he was in 2005, and that since the investigation and interview in 2005 he has fully recognised and now understands the enormity of his conduct. He says that his disavowal of his misconduct is genuine and made with true insight, and is not mere words. In short, he contended that he has undergone a metamorphosis.

40. In his Statement signed on 19 September 2008 the Respondent said:

"18. I accept that I should have made the required changes earlier, particularly after the PSB wrote to me in 1995. Initially I did try and make a number of changes to my practice. I reduced the number of addicted patients I was seeing and I did not try to detox them myself anymore which is what I had been doing. I did, however, continue treating some patients by prescribing benzodiazepines.

19. It was not until the interview with officers of the Pharmaceutical Services Branch in 2005, that I finally took proper stock of the situation. I understand now that my knowledge and understanding of the legal requirements and the medical standards for treating, and prescribing for, drug dependent patients was seriously deficient. At the time, while I thought I had a plan for them, I did not document the plan nor did I adhere to the plan. I did not have a proper appreciation of how to handle drug dependent patients, or how to make them understand that if they were non-compliant it was my responsibility to either get them to comply or send them elsewhere.

21. Although I have changed my practice and no longer treat addicted patients in the same way, my level of knowledge in how to deal with that particular type of patient has been greatly increased and I believe that I understand them much better than I did previously."

41. His statement went on to summarise some of the steps taken in the attempt to gain insight and understanding:

"20. I relinquished my authority to prescribe Schedule 8 and Schedule 4D drugs, and, after a period of adjustment, learnt to manage a practice successfully without recourse to them. In order to properly understand how to treat drug seeking and/or dependent patients, and to further my clinical education, I have done the following:

- (i) Completed the Monash University courses Issues in *General Practice Prescribing*,
- (ii) I have attended counselling sessions with Dr Scidler,
- (iii) Completed 10 supervised sessions with Dr Gary Swift, relating to treatment and management of drug and alcohol patients;
- (iv) I have continued with my professional development in the QA and CPD program. I have pursued my interest in holistic medicine and alternative and natural therapies;
- (v) I have done five geriatric sessions at St Vincent's Hospital with Dr Nick Brennan.

21. Although I have changed my practice and no longer treat addicted patients in the same way, my level of knowledge in how to deal with that particular type of patient has been greatly increased and I believe that I understand them much better than I did previously."

42. Dr Scidler provided a report dated 16 November 2008 in which he expressed the view that the Respondent had obtained some insight:

"Since early 2006, I have seen Dr Ameisen on approximately 10 occasions for counselling and guidance regarding his current difficulties. In that time he has successfully completed an online course through Monash University on how to treat patients with addictions...Dr Ameisen has attended sessions, at my suggestion, with Dr Gary Swift at Clinic 36, where he sits in and observes an experienced addiction specialist treating opioid dependent patients in a concentrated clinical situation. Dr Ameisen has reported to me that since doing this his understanding of the full implications of prescribing opioid preparations and benzodiazepines for patients suffering with addiction, has increased exponentially.

In my discussions with Dr Ameisen he has demonstrated that he now clearly understands the slippery slope of prescribing to demanding and manipulative patients with addiction. I believe he understands what is involved in responsible prescribing benzodiazepines and prescription opioids...

I note that Dr Ameisen works as a solo practitioner...I would suggest if possible that he worked in a group practice. This would considerably assist him in making more informed clinical judgments in the future...It would be my recommendation, considering his past prescription however that he no longer prescribes benzodiazepines or opioids to any of his patients. This would provide him and the community with that level of security, that the transgressions of the past would not be repeated."

43. Following cross-examination of the Respondent, however, the Tribunal did not share the views of Dr Scidler. Whilst it accepts that the Respondent has made significant attempts to obtain understanding and insight, it was unable to accept his continuing professions of ingenuousness or that he yet fully appreciates the significance of his wrongdoing. In the end the Tribunal was convinced that he has not established himself as a different man: *Ex parte Tziniolis; re the Medical Practitioners Act (1966)* 67 SR 448 at 461.

44. Dr Allnutt, a respected Forensic Psychiatrist, was also qualified on behalf of the Respondent. He provided a report dated 6 October 2008 in which he expressed guarded support. He concluded by saying:

“Determining whether or not an individual has adequate insight or not in these circumstances is in my view ultimately a matter for the Medical Tribunal through the application of their professional and clinical knowledge. Ultimately I do not believe that that full insight into what motivates any individual’s behaviour is achievable. Overall in my opinion, your client does manifest reasonable insight into his conduct based on the information he provided to me... Whether or not his insight is adequate enough, is a matter for the Tribunal based on their assessment of this issue”

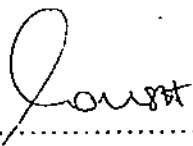
45. In the result, The Tribunal had the benefit of a significant amount of material not available to Dr Allnutt, and in particular had the benefit of seeing and assessing the Respondent under cross-examination when, as previously indicated, he did not acquit himself well. In the words of Dr Allnutt, the Tribunal’s view, ultimately, is that the Respondent has not obtained a ‘deep appreciation and emotional connection’ with his wrongdoing and there is no ‘cognitive understanding’ of it, such that he is really ‘just saying what people want to hear’ (T 46.29).
46. Detailed submissions were made on behalf of the Respondent as to why deregistration was not required in this case, both in writing and orally before the Tribunal. These included a submission that the Tribunal could be comfortably satisfied that the acknowledgement of wrongdoing by the Respondent was genuine and that it stemmed from the efforts he has made to understand, at both a theoretical and a practical level, the proper principles and standards (Paragraph 14). The efforts made and steps taken to ‘re-educate and rehabilitate’ himself were detailed and stressed (Paragraphs 18 – 30). Reliance was also placed on several character references provided in support of the Respondent. Counsel pointed to the last three years of problem free practice (Paragraphs 31 – 33) and submitted that the Respondent has demonstrated his fitness for practice (T 174.45 and 179.8 - 15), such that a reprimand, a fine and the imposition of conditions on his ability to practice would be adequate to achieve the objectives of the Tribunal’s protective jurisdiction.
47. In the view of the Tribunal, however, the gravity of the misconduct was so serious that an order for deregistration is required. The objectives of protection of the public and the maintenance of public confidence in the medical profession can, in the Tribunal’s view, only be adequately achieved by such an order. The Applicant has established, on the balance of probabilities according to the principles in *Briginshaw v Briginshaw*, that in all the circumstances deregistration is justified.
48. The Tribunal finds that the Respondent’s conduct amounted to serious professional misconduct deserving of significant disapprobation. It is comfortably satisfied that he has displayed a marked impairment in his clinical judgment and competence to practice, and that his present fitness to practice was not established.
49. The Tribunal finds that the Respondent’s misconduct in his illegal and inappropriate prescription of drugs included a willingness to knowingly dispense drugs of addiction on demand to patients, including drug dependent patients, or to patients who became drug-dependent as a result of his conduct.

50. The seriousness of his conduct was aggravated by the extent of the mis-prescribing and the very long period of time over which it extended. It was exacerbated by his callous disregard for the warning given to him in 1995.
51. The Tribunal is also comfortably satisfied that the Respondent has not yet obtained a sufficient degree of true insight and understanding of the misconduct such that he should be allowed to continue to practice, even with the type of restrictions contemplated. It follows that the Tribunal could not be satisfied that the restrictions contemplated would be sufficient to protect the public. In particular, the Tribunal remains seriously concerned by the nature of the Respondent's continuing self-exculpatory attitude.
52. Having regard to all these matters, the Tribunal considered that the only appropriate order should be deregistration with a significant period restricting his ability to make an application for restoration of his name to the Register.
53. The Tribunal also considers that the Respondent should pay the Complainant's costs of these proceedings, on the ordinary basis as defined in the *Civil Procedure Act 2005*.

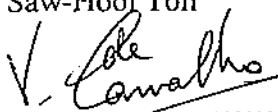
Statement of Decision

54. For these reasons the Tribunal orders:

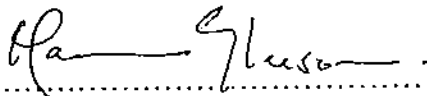
1. The Respondent's name is removed from the Register of Medical Practitioners.
2. The Respondent is not permitted to apply for the restoration of his name to that Register for a period of 18 months from today.
3. The Respondent is to pay the Complainant's costs of these proceedings, on the ordinary basis.



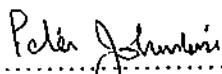
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Dr Saw-Hooj Toh



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Dr Vasco de Carvalho



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Dr Maureen Gleeson



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Deputy Chairperson, Judge Peter Johnstone