

MEDICAL TRIBUNAL OF NSW

Deputy Chairperson: Judge A. Balla

Members Dr Jennifer Kendrick
Emeritus Professor Walter Glover, AO
Dr Catherine Berglund, PhD

Matter no: 40015 of 2009

Applicant: Health Care Complaints Commission

Respondent: Dr Yuk-Fun Christina Port

Counsel for the Applicant: Ms Gail Furness

Counsel for the Respondent: Mr Mark Lynch

Judgment Date: 18 December 2009



PURSUANT TO CLAUSE 6 OF SCHEDULE 2 TO THE MEDICAL PRACTICE ACT 1992, THE TRIBUNAL HAS MADE A NON PUBLICATION ORDER IN RESPECT OF THE NAME OF ANY PATIENT OR ANY MATERIAL WHICH MAY IDENTIFY A PATIENT.

Dr Port was working as a general practitioner in Deniliquin when she wrote a number of prescriptions for Patient A between October 2000 and October 2004. The medication was prescribed as treatment for Patient A's depression. Dr Port admits Patient A had not consulted her on those occasions. All but the first of those prescriptions were written at the request of Patient A's wife. In June 2002 Dr Port became aware that Patient A's wife had not informed Patient A that the medication had been prescribed for him and that the wife was administering the medication to him in his coffee.

The particulars of the Complaint are admitted. In addition Dr Port has conceded that she has been guilty of unsatisfactory professional conduct and professional misconduct.

The Tribunal must determine the appropriate Order to protect the public.

Particulars of the Complaint

These particulars of the Complaint relate to entries on Patient A's records for the following dates:

- 11 October 2000 (Sinequan prescribed)
- 15 March 2002 (Aropax prescribed)
- 21 August 2002 (Zoloft prescribed)
- 18 June 2003 (Zoloft prescribed)
- 9 October 2003 (Aropax prescribed)
- 11 November 2003 (Aropax prescribed)
- 17 May 2004 (Zoloft prescribed)
- 8 October 2004 (Lithium prescribed)
- 16 October 2004 (Zoloft prescribed)

and the occasions on which the repeats permitted by the original prescription were filled.

Dr Port admits that on those occasions she issued prescriptions for Schedule Four medications being Sinequan, Paroxetine Hydrochloride (Aropax), Sertraline Hydrochloride (Zoloft) and Lithium Carbonate for Patient A:

- a. in each case except on 11 October 2000, at the request of and/or on the basis of information provided by Patient A's wife;
- b. in each case without having - consulted with Patient A, taken a medical history from Patient A, conducted appropriate preliminary examinations and tests, made a diagnosis, appropriately informed Patient A about his condition, the treatment options, the risks, the benefits and the possible complications or obtaining Patient A's consent;
- c. in each case without Patient A's knowledge; and
- d. in each case without having exercised responsible medical judgment as to whether it was appropriate to issue such prescriptions.

In each case other than the prescription written on 11 October 2000, Dr Port admits she gave the prescriptions to Patient A's wife believing that Patient A would take the prescribed medications.

In each case Dr Port admits she failed to appropriately monitor Patient A in respect of Patient A's treatment with the prescribed medications.

In each case Dr Port admits that she did not include in her treatment records sufficient information to allow another doctor to continue management of Patient A's case, that is that she had issued the prescriptions without a consultation and without Patient A's knowledge.

In each case Dr Port also admits that she issued prescriptions in a quantity or for a purpose not in accordance with the recognised therapeutic standards.

The admissions made by Dr Port relate to the following:

Date of Script	Date of Supply	Item Name	Type	Qty	Repeats
15.3.02	15.3.02	Aropax	Or	30	5
15.3.02	16.4.02	Aropax	Re	30	5
21.8.02	9.10.02	Zoloft	Or	28	5
21.8.02	17.10.02	Zoloft	Re	28	5
21.8.02	14.5.03	Zoloft	Re	28	5
21.8.02	4.6.03	Zoloft	Re	28	5
18.6.03	11.7.03	Zoloft	Or	28	5
18.6.03	25.7.03	Zoloft	Re	28	5

18.6.03	9.9.03	Zoloft	Re	28	5
18.6.03	1.10.03	Zoloft	Re	28	5
9.10.03	13.10.03	Aropax	Or	30	5
11.11.03	11.11.03	Aropax	Or	30	5
11.11.03	5.12.03	Aropax	Re	30	5
11.11.03	22.12.03	Aropax	Re	30	5
11.11.03	30.1.04	Aropax	Re	30	5
11.11.03	2.3.04	Aropax	Re	30	5
11.11.03	23.3.04	Aropax	Re	30	5
17.5.04	18.5.04	Zoloft	Or	30	5
17.5.04	30.6.04	Zoloft	Re	30	5
17.5.04	1.9.04	Zoloft	Re	30	5
8.10.04	8.10.04	Lithium Carbonate	Or	50	0
16.10.04	20.10.04	Zoloft	Or	30	5

Background

While Patient A had difficulty in recalling the precise date on which he first consulted Dr Port, the Tribunal is satisfied that she treated him for a cyst on 8 December 1994. On 15 December 1994 she noted in her records "*previous relationship – alcohol – she drinks more than him. Now relationship with ...*". The Tribunal does not accept the evidence from Dr Port that she either diagnosed or treated Patient A for depression in 1994.

There were two relevant consultations in 1995. On 1 November 1995 a locum at the practice prescribed Doxepin, an antidepressant. On 21 December 1995 Dr Port noted depression and alcohol and prescribed Aurorix a different antidepressant.

Dr Port offered the following explanations for her conduct:

- she knew that Patient A had taken antidepressants previously.
- she had initially prescribed the medication on the understanding that the wife would tell Patient A.

- Patient A's wife had been a patient of Dr Port for many years. She did not give evidence in these proceedings. Dr Port said that the wife had been concerned at Patient A's drinking habits and depression. On one occasion the wife was hysterical and was crying and screaming on the phone. She told Dr Port that Patient A had become very abusive and violent and she was worried about the children. On one occasion the wife had mentioned that she was worried about a gun (locked in a cabinet) which Patient A kept in the house.

Dr Port said she wrote the prescriptions to get Patient A under treatment because she was concerned for the wife and children. By creating a scene Patient A's wife had manipulated her into complying with her request.

Orders

Dr Port admits and the Tribunal finds that Dr Port is guilty both of unsatisfactory professional conduct within the meaning of Section 36 of the Medical Practice Act 1992 and guilty of professional misconduct within the meaning of Section 37 of the Medical Practice Act 1992.

The legislation makes it clear that the full range of disciplinary powers is available to this Tribunal on a finding of professional misconduct. The discretion of the Tribunal is at large and will depend upon the circumstances of the individual case.

The fact that Dr Port's conduct was sufficiently serious to justify suspension or removal from the register does not mean that her name must be removed. This course was urged on the Tribunal by the Health Care Complaints Commission.

The purpose of disciplinary proceedings is to maintain proper ethical and professional standards in protection of the community and also to protect the good standing and reputation of the profession. The object of protecting the public includes deterring the practitioner from repeating her misconduct and deterring others who might be tempted to behave in a similar way. Deregistration may be necessary to protect the public from the risk of recurrence of further professional misconduct, deter the practitioner from repeating the misconduct, deter others, maintain the standards of the profession and maintain public confidence in the profession. Even in cases of serious misconduct deregistration does not necessarily follow if at the time of the hearing present unfitness has not been demonstrated.

In deciding on the appropriate Orders the Tribunal has taken a number of matters into account.

Dr Port is not an inexperienced general practitioner. She qualified as a doctor in 1972. She started work in private practice as a general practitioner in Deniliquin in 1980. She had accordingly been practising in a rural setting with its pressures for over 20 years when the incidents the subject of the Complaint occurred. The Tribunal is satisfied that patients with issues with domestic violence and alcohol misuse would not be unusual in such a practice. She is now working a total of four days a week in Melbourne as a general practitioner in private practice, at the St Vincent's staff clinic and as a relieving obstetrician at the Royal Women's Hospital.

Dr Port admits she did not consult with Patient A before issuing any of the prescriptions. This means she did not take a medical history, conduct an examination or undertake or arrange for any tests. Accordingly Dr Port did not have primary material from which she could arrive at a diagnosis, decide whether the appropriate treatment was medication and, if so, make an informed decision about which of the available medications should be prescribed. Dr Port did not have the opportunity to ascertain whether Patient A had any risk factors which meant the medication she was proposing to prescribe was contra indicated. These are issues going directly to the health and safety of Patient A.

The failure to consult with Patient A means that Patient A did not know that he had been diagnosed with major depression and he was deprived of his right to give informed consent to the recommended treatment or to decide not to take the medication. He was not informed of the possible side effects so that, for example, he was not aware of the potential dangers in driving machinery which he regularly did in his work as a farmer. Dr Port was aware he was a farmer and routinely drove heavy machinery. Patient A was not aware he was taking the medication so he may have unknowingly taken other incompatible *"over the counter"* medication. If he had consulted another doctor he would not have been able to give that doctor an accurate history which could have impacted on that other doctor's diagnosis and the safety of any treatment provided by that doctor.

This was compounded by Dr Port's inadequate note keeping. Patient A's records do not disclose that she had been treating him without having seen him. Even Dr Port was unable to ascertain from her own notes, when she first wrote to the Health Care Complaints Commission, whether she had consulted with Patient A.

The type of medication was changed at the instigation of the wife. There is no evidence of the wife having medical, nursing or other qualifications. For example Dr Port said she had not repeated the prescription of Lithium because the wife had told her that it was not helping him. In addition while a certain dosage may have been intended by Dr Port, it was the wife and not Patient A who was in control of the dosage being administered. The evidence establishes that the wife, to the knowledge

of Dr Port, altered the dosage. When explaining the change in medication from Zoloft to Aropax, Dr Port said the wife had made the decision to increase the Zoloft "to 100" which the wife had concluded had not worked so at the wife's request she had changed the medication to Aropax.

It should have been apparent to Dr Port that it was unacceptable to treat the wife as a reliable historian on issues such as her husband's symptoms and his response to medication as there is no evidence of her having any relevant qualifications and she could not be considered impartial.

Further, the conduct occurred over a lengthy period. It is likely that from March 2002 to November 2004 Patient A was continually being medicated by his wife. His symptoms and progress were not being monitored by a medical practitioner. The changes in medication were not a response to Dr Port's observations of Patient A on examination or based on reliable information she had received from Patient A.

Lithium is an antipsychotic. MIMS online describes the uses/indications as manic depressive psychoses and schizo-affective illness. The publication confirms that pre-treatment physical examination and laboratory testing are required prior to therapy with Lithium and should be repeated at frequent intervals. The document discloses the risks to the health of the patient from the drug and the need for testing and monitoring. For example under the heading "*Check the following before use*" the publication says "*adequate renal function is essential .. thus a decision to initiate lithium therapy should be preceded by a thorough clinical examination and evaluation of each patient including laboratory determinations, ECG and a very careful assessment of renal function. Patients on lithium therapy should be maintained under careful clinical and laboratory control through out treatment..*"

There were significant risks to Patient A unknowingly being given Lithium without having been examined, without a proper diagnosis having been made, without the required tests having been undertaken and continuing on the medication without medical review. Dr Port's medical records disclose that Lithium was prescribed after Dr Port had a telephone conversation with the wife. The entry says "*His wife rang and was upset as ... is drinking and abusive, so she does not want to leave, but she wants him under control. I think he has had Lithium before. He will never wants to have blood tests for it too. Off Zoloft*".

Dr Port agreed when she gave evidence that at the time she had changed the medication to Lithium, she had not treated Patient A for depression for nearly 10 years and had relied solely on what his wife had told her as to his conduct and behaviour. She had suspected that Patient A might have an aggressive behaviour problem that would be similar to a manic phase. However she

agreed that Lithium should not have been prescribed until the manic depressive swings had been definitely established and the cause of the disease certain.

Dr Port said she was aware at the time that Patient A should have undergone blood tests before she prescribed Lithium. By way of explanation Dr Port said she had prescribed a small dose and expected the wife to contact her after a few days, inform her of Patient A's response and then organise a blood test. However, at the time of prescribing Lithium, Dr Port was already aware that Patient A's wife varied the doses Dr Port prescribed so there was at least a potential risk of side effects and even of Lithium toxicity. Dr Port did not put in place any strategy to monitor Patient A's progress while he was being given Lithium by his wife without his knowledge.

Further when the Health Care Complaints Commission became aware that Dr Port had prescribed medication without having seen Patient A, Dr Port did not initially volunteer the full circumstances surrounding her prescribing behaviour. While her first letter is internally contradictory, the Tribunal is satisfied that she exaggerated her contact with Patient A and exaggerated the extent to which she had determined him to be depressed and treated him for depression.

While Dr Port did not suggest that the explanations she offered justified her behaviour the Tribunal does not in any event consider those explanations satisfactory or plausible.

Dr Port said she took into account that Patient A had taken antidepressants previously. However, as set out above, the evidence establishes this was on two occasions seven weeks apart in 1995 ie six years before the pattern of prescribing commenced in 2002. On one of those occasions it was a locum and not Dr Port who had seen Patient A. Dr Port did agree this was a grossly insufficient basis for prescribing antidepressants.

Next, Dr Port said that she had initially prescribed the medication on the understanding that the wife would tell Patient A. However on 26 June 2002 the wife told her that Patient A was not aware he was taking Zoloft and Temaze and she was giving it to him in his coffee. Dr Port said that she was surprised and had reinforced to the wife that Patient A should be told. Dr Port said she knew and trusted the wife and accordingly accepted the wife's assurance that she would tell Patient A. Dr Port did not take any steps herself to ensure that Patient A was subsequently told.

Next, Dr Port said she was open to being manipulated by the wife because she was under a lot of pressure both at work and from the wife. However she only gave evidence of one occasion on which in a telephone conversation the wife was hysterical so that she became concerned for the safety of the family.

The Tribunal does not accept that “pressure” explains Dr Port’s conduct. This was not an isolated incident in which Dr Port responded inappropriately to pressure from a patient. There were a number of prescriptions written over two and a half years at the request of the wife when Dr Port was aware that she had not consulted with Patient A. Later Dr Port became aware that the wife was giving Patient A the medication without his knowledge. Even then Dr Port did not contact Patient A herself to tell him or to ask him to attend for a consultation. The Tribunal does not accept that either work pressures or pressure from the wife provide an explanation for Dr Port’s continuing conduct over this period.

As noted in the peer review provided by Dr Menogue *‘Dr Port might have had concerns for the welfare of ... [the] children [of the wife of Patient A] and such concerns are appropriate, however such an emotion does not justify the prescription of medication for depression on numerous occasions without ever having seen the patient.’*

Counsel for Dr Port submitted that Dr Port’s concession that her behaviour amounted to unsatisfactory professional conduct and professional misconduct was plainly demonstrative of serious and well established insight into her wrongdoing. Her contrition was demonstrated by those concessions which potentially exposed her to deregistration. It was extremely unlikely, it was submitted, that she would repeat such behaviour given that insight, the impact of these proceedings and the changes to her professional life which have reduced the work pressures.

Contrition is an important consideration in determining the appropriate Orders to be made. So is the risk of repetition of the behaviour. However the Tribunal does not accept that Dr Port’s concessions and the other matters relied on show that there has been a genuine change in Dr Port’s standards, values or insight so as to reduce the risk of recurrence.

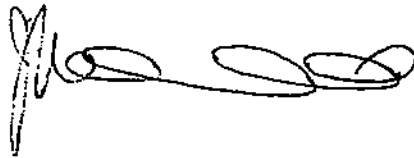
Dr Port relies on support from three referees. While they speak highly of her clinical skills and integrity the Tribunal has found them of little assistance in determining the appropriate protective Order. Dr Antoniadis, a medical psychotherapist who saw Dr Port twice in August 2009 concluded that Dr Port now understood the severity of the boundary violations involved, appeared deeply regretful and had gained an understanding of the assertiveness required to maintain boundaries. The Tribunal did not find the opinion helpful because Dr Antoniadis was not given an accurate history and undertook very little treatment. The Tribunal accepts the submission made by counsel for the Health Care Complaints Commission that Dr Port had consulted Dr Antoniadis and had recently applied to be enrolled in an ethics course in the second semester of 2010 at Monash University for the purpose of these proceedings.

The Tribunal is satisfied that the gravity of the conduct is sufficiently serious for the removal of Dr Port from the Register to be the only Order which would reflect the need to maintain proper ethical and professional standards, to protect the public and to protect the good standing and reputation of the profession. The Tribunal will order that she not apply to be registered for a period of three years from the date of the Orders.

Orders

1. Dr Port's name be removed from the Register of Medical Practitioners.
2. Dr Port is not permitted to apply for her name to be restored to the Register of Medical Practitioners until 18 December 2012.
3. Dr Port to pay the costs of the Health Care Complaints Commission.

Dr. Jennifer Kendrick
Member

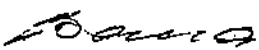


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A Balla DCJ.
Deputy Chair

