THE MEDICAL TRIBUNAL
OF NEW SOUTH WALES
AT SYDNEY

Wednesday 4th April 2007

No. 40037 of 2005

BETWEEN

Health Care Complaints Commission

Complainant

Dr Steven Goodman

Respondent

Deputy Chair: Judge A M Ainslie-Wallace

Members: Dr G Yeo

Dr J Hely

Associate Professor Paul MacNeill

Orders and Reasons for Determination

Order:

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 names of the patients referred to in the proceedings.

Introduction:

The Health Care Complaints Commission (the '**HCCC**') alleges that the respondent, a medical practitioner, is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of *sections 36 and 37* of the *Medical Practice Act, 1992* 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) contravened the *Medical Practice Regulation 1998*; and/or

(iii) has engaged in improper or unethical conduct relating to the practice of medicine.

There are 178 particulars of the complaint.[1] The particulars relate to thirty patients not every particular is alleged in relation to each patient. The particulars are conveniently summarised in categories.

Prescribing

- The particulars in relation to each patient alleges that the respondent prescribed restricted substances and drugs of addiction[2] in quantities and on occasions when the practitioner knew or ought to have known that the patient was dependent or likely to become dependent on the restricted substances or drugs or addiction;
- when the practitioner knew or ought to have known that the patient was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances for the patient;
- when the practitioner knew or ought to have known that the patient was a participant in a methadone programme;
- without exercising adequate medical judgment as to whether the prescribing of restricted substances and/or drugs of addiction was appropriate in the circumstances and/or in accordance with recognised therapeutic standards;
- prescribed restricted substances in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances;
- that the respondent prescribed restricted substances in circumstances where the patient was neither present at the consultation nor was medically assessed or examined immediately prior to the prescription being issued;
- that the respondent contravened the *Poisons and Therapeutic Goods Act 1966* by recording a date other than the date of issue on prescriptions for restricted substances, by failing to record the name, strength and quantity of the substance prescribed, by prescribing a drug of addiction in quantities and/or for purposes not in accordance with recognised therapeutic standards of what is appropriate in the circumstances and by prescribing a drug of addiction for a patient whom the practitioner knew or ought to have known was an addict at the time.

Record Keeping.

> It is also alleged in relation to the thirty patients that the respondent failed to make contemporaneous entries in the patient's medical records, failed to record relevant information about diagnosis, opinion, treatment plan, particulars of medication prescribed, information given, the name of the practitioner as the person giving the treatment, sufficient and appropriate detail to allow another practitioner to continue the management of the patient and identify the practitioner as the person who made particular entries in the patient's record.

Each particular of each complaint was admitted and the respondent admitted that he was guilty of professional misconduct.

Background

1 The respondent graduated MB BS in 1975 and was first registered in December 1975. Following his registration he worked in hospitals in Australia and England. In 1981 he purchased a general practice in which he worked briefly. He then worked in a hospital Accident and Emergency Department.

2 From 1985 until 1999 the respondent worked part time at the Redfern Street Medical Centre, Redfern (the '**Redfern practice**') where he joined a friend from his university year, Dr Isaac Nadel. In 1987 another university colleague, Dr Christopher Roberts joined the Redfern practice. From October 1993 until January 1999, the respondent also worked part time at the Emerton Medical Centre.

3 The respondent said that when he first started to work in the Redfern practice it was a normal suburban general practice. He estimated that about 25% of his patients regularly requested benzodiazepines.[3] In about 1996 Dr Roberts introduced an approach to handling drug-seeking patients. Dr Roberts had developed a method of treating drug-addicted people based on the theory of co-dependency of addiction. The respondent said that it's primary contention was that it was pointless to restrict or control the use of drugs by addicts without attempting to change their behaviour or their inner feelings, which, according to

the theory, drove them to use drugs. He said that Dr Roberts proposed that the doctors at the practice prescribe the drugs requested by the addicts on condition that they attend Narcotics Anonymous (‘**NA**’). Dr Roberts believed that if they attended NA, the patients would start to heal and eventually would no longer feel the need to use drugs.

4 The respondent said that the application of the theory meant that when people came seeking drugs, they were not questioned about why they were taking the drugs nor were they questioned in a way which would lead them to lie about the quantities of the drugs they were using. There was a contract to be agreed on which was that the patient would attend at least three NA meetings a week and, in return, the respondent would prescribe drugs as they asked.[4] The aim was to develop a therapeutic relationship with those patients through counselling them and with an insistence that they attend NA, would deal with the emotional problems which were said to underlie the drug taking behaviour.[5]

5 When he was asked how prescribing large amounts of benzodiazepines to patients was explained by the theory, the respondent said that artificially trying to control the quantities of drugs taken by the patients was not going to help them to heal because the substance abuse was a symptom of their problem not the cause.[6]

6 In pursuit of this treatment theory, the respondent (and the other two practitioners at the Redfern practice) prescribed vast quantities of drugs for their patients. By way of example, over a four-month period, Patient W [7] was given prescriptions for 6,400 tablets of benzodiazepines, averaging 75 tablets with each prescription. The prescriptions were given almost on a daily basis.

7 By 1997, after implementing this theory in the practice, 70-80% of the patients attending were drug addicts and by 1999 virtually the only people attending the practice were drug addicts.

8 From late 1998 the Pharmaceutical Services Branch of the Department of Health (the ‘**PSB**’) received a number of complaints about the presence of addicts in and around the Redfern practice and expressing concern about the level of drugs

being prescribed from that practice. Based on those complaints Mr Ken Thompson investigated the level and type of prescribing by the respondent. As part of the investigation Mr Thompson visited pharmacies in the Redfern area and collected the dispensing profiles from those pharmacies. The respondent was contacted and invited to attend an interview. An interview was held on 19th May 1999 in which the respondent declined to answer any questions.[8]

9 A *Section 66 Inquiry*[9] was held on 15th June 1999 and, at its conclusion, the respondent was ordered to relinquish his rights to prescribe or otherwise deal with *Schedule 4D* and *Schedule 8 Drugs*.

10 The visit to the respondent by the PSB in 1999 was not the first time the respondent had been spoken to about the level of his prescription of benzodiazepines.

11 In 1993 the respondent was visited by Ken Thompson of the PSB who expressed concern at the level of his prescribing of benzodiazepines to patients and that those patients were also receiving prescriptions from other doctors. At the time of the visit, Mr Thompson gave the respondent documents which outlined the risks of over-prescribing benzodiazepines and recommendations about to how to recognise and deal with patients who were "*drug seeking*"[10]. Although the front of the document referred to *Schedule 8* drugs, the respondent understood its warnings to include *Schedule 4D* drugs as well. The front page of this document referred to the provision of large amounts of drugs to addicted people and warned;

> *"Drugs obtained on such prescriptions DO NOT help addicts overcome their addiction, they only delay or disrupt proper treatment and add to the pool of illicit drugs traded and used by addicts."*

12 At this meeting Mr Thompson told the respondent about a general practitioner, Dr Huang, who had recently been de-registered for over-prescribing benzodiazepines for such patients.[11] At the end of the meeting, the respondent said that he understood the problem and promised that he would not over-prescribe again.

The Complaint

13 At the time of the investigation in 1999, the respondent estimated that there were between 600-800 patients attending the Redfern practice, virtually all of whom were drug addicts. He agreed that the group of thirty patients whose treatment comprise the particulars of the complaint was typical of the treatment he gave to the other patients at the practice although he felt that they fell into the worst category in terms of the quantities of drugs prescribed for them. He conceded that there were other patients not included in the complaint for whom drugs had been prescribed at the same level.[12]

14 The doctors at the Redfern practice kept one set of patient cards for each patient and each doctor worked different days, there was only one consulting room and no receptionist. No appointments were made. The respondent said that when he consulted with a patient, he would read the previous one or two notes on the card to inform himself of the treatment given to the patient in previous consultations.

Treatment Regime

15 In implementing the theory of treatment of patients, the respondent never referred any to a Drug and Alcohol expert for advice.[13] The respondent said that:

> *"Well we decided that we were the experts. We decided that we knew better."*[14]

16 The claim to expertise was slight. He conceded that he did not regard himself as having any particular expertise in the management of drug-addicted patients. He said that he was following the rationale outlined by Dr Roberts.[15] He did not understand the theory of co-dependency.

17 The respondent said that by giving the patients the drugs that they asked for, he and his colleagues at the Redfern practice were hoping to establish a therapeutic interaction with the patients by providing some form of treatment for them.[16]

18 The respondent never made any clinical assessment of whether or not the patient actually needed the drug prescribed, whether it was safe for the patient to use the

drug prescribed especially when the patient was using more than one type of drug.

19 The respondent agreed that in relation to the patients in the complaint, very rarely were liver function tests ordered despite his concession that nearly all of the patients were suffering from Hepatitis C. The respondent said that benzodiazepines had no particular effect on the liver. He said that he: "*gave no thought*" to whether benzodiazepines would have an effect on a patient whose renal function was impaired through Hepatitis C. He did not know whether any of his patients was receiving treatment for Hepatitis C from another doctor.

20 The respondent said that once a particular benzodiazepine had been prescribed by Dr Roberts, he continued to prescribe in the same way.[17] He said that he looked at the previous notes because:

> "… *occasionally one may have prescribed less than what was asked for, if a lot was prescribed in the last day or two*".[18]

21 The respondent said that he never thought that the quantities of drugs that he was prescribing could kill his patients. He agreed that he knew that it could be dangerous. The respondent must have known that from reading the document, given to him in 1993 by the PSB investigator, which made it entirely clear that one of the consequences of prescribing drugs of addiction was overdose leading to death. It also warned that patients could inject tablets intended for oral use.

22 The respondent prescribed large doses of benzodiazepines to patients knowing that at the same time they were using heroin. The respondent said that he never paused to consider whether there was a risk to patients. He never looked at MIMS to see what risks were associated in prescribing large quantities of benzodiazepines.

23 The respondent prescribed Murelax, for a patient whom he knew was using heroin.[19] The respondent never considered whether there was a risk in prescribing this patient large quantities of benzodiazepines when he knew the patient was also using heroin and knew of none of the risks of prescribing Murelax in those quantities. In January 1999, a colleague prescribed Proladone (a

narcotic) suppositories for this patient. The respondent continued to prescribe that drug as well as the benzodiazepine. The respondent said that he never considered any risks to the patient's respiratory system from the prescription of those quantities or combinations of drugs. [20]

24 In no instance did the respondent notify any of the doctors administering Methadone to his patients to inform them that he was prescribing benzodiazepines for them. The respondent told the *Section 66 Inquiry* that he made no attempt to contact the Methadone providers because he did not think that: *"they were interested in or understood their patients"* and he and his colleagues at the Redfern Practice: *"did not encourage withdrawal programs as the patients complained they were too short".*[21] His evidence to the Tribunal was that he did not contact the Methadone providers because he knew that they would not approve of what he was doing.[22]

25 He said that he did not realise at the time that he was compromising his patients' health by giving them large quantities of benzodiazepines when they were using methadone. However he also conceded that the PSB investigator had told him in 1993 that but said that he:

> "*let that information slip from my mind*".[23]

26 The respondent knew that addicts could easily inject Temazepam when it was in capsule form.[24] He also knew that it came in tablet form. He did not prescribe the tablet form of the drug because he said that the patients would not accept temazepam in capsule form and referred to an outbreak of: "*chalk allergy*"[25]. This was a reference to the substance used to bind the drug when it is in tablet form, and which the Tribunal assumes from the evidence, makes it difficult to inject as opposed to the capsule form where the drug is easily withdrawn from the capsule for injecting. The respondent complied with the demands of these patients for prescriptions of Temazepam in capsule form knowing that they could inject it [26] and that it could cause damage to veins.[27]

27 When asked how this prescribing could fit within the theory of treatment being implemented, the respondent said that the patients were still advised to attend NA. [28]

28 The respondent exercised no clinical judgment and took no steps to safeguard his patients' health in any way during this period and well knew at the time that what he was doing was in no way consistent with the proper conduct of a medical practitioner.

Counselling

29 The respondent said that the theory of treatment allowed the free prescription of benzodiazepines at the request of the patient. He would insist that the patient only attend the Redfern practice so that they could be counselled and to stop them attending other doctors seeking the same drugs.

30 The difference between the way that the respondent prescribed from 1996 and in 1993 when he was visited by the PSB was counselling. The respondent said that after 1996 he was counselling and encouraging patients to attend NA and in that way attempting to help them overcome their emotional issues.[29] The patient notes made by the respondent show scant evidence of any counselling of patients.

31 At the *Section 66 Inquiry* the respondent claimed that he spent: "*significant time*" counselling his patients.[30] In cross-examination before the Tribunal, he conceded that he had not counselled every patient but said that he did: *"some counselling and encouraging … to go to NA and enquire about their progress there."*[31] When pressed he said that he would have counselled patients: *"half the time"*. He spent between 5-10 minutes with patients counselling them. When asked whether 5-10 minutes of counselling was: "*simply going through the motions"*, the respondent replied: *"well it became sort of standardised seeing many people a day with similar … consultations yes"*.[32]

32 The treatment theory was underpinned by the view that the patient's underlying problem was emotional. The respondent was asked whether he had made a

diagnosis of psychiatric illness in any patient. He said that in some patients he diagnosed depression and tried to have those patients take an anti-depressant. He added that the patients were reluctant to take the anti-depressant or they would not take it for very long. [33]

33 When **Patient I** asked the respondent for psychiatric help[34] on 23rd January 1999, he did not refer her for any assistance. His records made after that request, show no counselling. The respondent continued to prescribe large amounts of benzodiazepines for her. Equally when **Patient Z** (who later died by drug overdose) told the respondent on 13th February 1999 that she was having suicidal thoughts,[35] the respondent did not refer her for any specialist treatment.

34 When asked what counselling he had given **Patient B**, the respondent pointed to a notation: *"NA OK",* which he said indicated:

> *"I asked her, … I encouraged her to keep going, I may not mean much more than that"*[36]

35 According to the respondent, a fundamental basis for the prescription of benzodiazepine at the request of the patients was both an agreement to attend and an attendance at NA. The respondent did not know whether attendance at NA required abstinence from drugs and agreed that it was practically impossible to check whether or how many meetings a patient attended. All he could do was ask and assess what he was told to determine whether he believed them[37]. Given that the respondent also conceded that his patients were practised liars, it is difficult to understand how the respondent could have made a rational assessment of whether the patients were in fact attending NA.

36 In the course of implementing the theory of treatment, the practitioners did not require the patients to agree not to go to other doctors or not to use other drugs because the respondent said he did not think about it. He said that all a patient had to do to get a prescription was to say he or she had attended NA. [38]

37 In December 1998, the father of **Patient Q** rang the respondent and told him (according to the patient's notes) that Patient Q was injecting Normison (which was being prescribed by the respondent) and never went to NA. In a

subsequent entry in the notes, Dr Roberts challenged the patient who denied his father's claims. The respondent did not raise those matters with the patient who continued to receive prescriptions for Normison from the Redfern practice doctors.

Doctor Shoppers Programme

38 Through the Health Insurance Commission (**"HIC"**), practitioners were invited to participate in a *"Doctor Shoppers Program"*. This was aimed at monitoring the number of doctors attended by drug seeking patients and to reduce the amount of drugs received and the number of doctors attended by the patients. The rationale was to stop patients obtaining benzodiazepines or opiates from many different doctors and then selling them or swapping them for other drugs. As part of the program, patients were asked to enter into Voluntary Agreements in which they agreed that the details of drugs prescribed to them would be made available to the HIC. A number of the patients referred to in the Complaint had entered into Voluntary Agreements with the respondent and the other practitioners at the Redfern practice.

39 At regular intervals, the HIC provided a computer print out to the practice which showed the number of distinct prescribers for each patient, the numbers and types of drugs prescribed in the period and the daily average number of tablets prescribed for that patient.

40 The information received by the respondent from the HIC did little if anything to inform or change his prescribing.

41 The respondent was well aware of the rationale behind the Doctor Shopper Programme and the need to restrict the number of doctors and thus the number of prescription drugs available to addicted persons.[39]

42 **Patient A** was asked to sign a Voluntary Agreement in 1998 because the respondent suspected that he was a doctor shopper.[40] Six days later in October 1998 the respondent was notified that that patient had signed Voluntary Agreements with three other doctors, had 55 distinct prescribers and his average daily dose of benzodiazepine was 17 tablets. In November 1998 the respondent

was notified that the patient had entered into Voluntary Agreements with four other doctors, was seeing 51 prescribers and had an average daily dose of 15 tablets. [41]

43 Despite having this information, the respondent never confronted patient A about his behaviour nor did he change the rate at which he prescribed benzodiazepines for him. Dr Roberts noted that the patient had *"denied doctor shopping"*[42]. By July 1999 the information from HIC showed the Patient A had reduced the number of individual prescribers, to 36 from 51 but the average daily dose of benzodiazepines had doubled to 33 tablets.

44 To the extent that the practically unlimited prescription of drugs by the respondent was intended to encourage the addicted patients only to approach the Redfern practice for drugs, the HIC statistics are clear demonstration that it was a failure as it was in terms of encouraging patients to reduce their intake of drugs. In fact the respondent increased Patient A's intake of drugs over the period when he was bound by the Voluntary Agreement. [43]

45 In relation to Patient A the following is illustrative of the respondent's approach to patient care in this period[44];

> *Q …the incentive you were offering this patient not to doctor shop was to give him the drugs that he was getting elsewhere ?*
>
> *A Yes, and well and hopefully to have some interaction with him that would encourage him to go to NA so that eventually he would not feel the need to continue doing that.*

46 In fact, the respondent prescribed for Patient A, 25 Serepax and 50 Valium nearly every day. When the respondent was asked [45]whether he believed that Patient A had taken the 75 tablets himself in the preceding 24 hour period or whether he had obtained the drugs to sell on the street, the respondent said: *"I didn't ask myself that"*.

47 **Patient M** entered into a Voluntary Agreement. The respondent wrote an entry in his notes for 14th November 1997 *"In the 3 months to 20 September 51 scripts mainly benzos averaging 14 tablets per day and 20 different prescribers"*. Despite this, the respondent continued to prescribe on demand for Patient M and prescribe the

drugs he requested, Murelax. In the light of information from the HIC, the claim by Patient M to be going to NA four times each week, was as counsel for the HCCC put, *"either… a lie or it was doing him no good"*[46].

48 **Patient CC.** The respondent knew her to be a doctor shopper and a heroin addict who was on the methadone programme. On 18th August 1998 the respondent was visited by a representative of the HIC who told him that the patient had been identified in 1996 as having 172 consultations with 55 doctors and that between July 1997 and October 1997 she had 67 visits with 22 doctors with an average daily dose of tablets of 16. In the following audit period while under the care of the respondent and while she was bound by a Voluntary Agreement with him, her daily dose had decreased by 1 tablet. The respondent was told that some 200 prescriptions had been issued to this patient by him. The respondent said that he would discuss the matter with the patient. There is no note in the respondent's records that he did.

49 That information and the visit by the representative of the HIC did nothing to change the respondent's prescribing practice.

50 By November 1998, the patient was attending daily for a prescription of 25 Murelax tablets. At this time the respondent noted that she might be selling the tablets. [47]

51 For each patient in the Complaint for whom there was a Voluntary Agreement, there was a similar pattern; while there may have been a decrease in the number of distinct prescribers, the daily dose of drugs increased, their health did not improve and the management of the patients did not change.

Prescribing

52 In many, many instances the respondent wrote post-dated prescriptions for the patients. The respondent said that he gave post-dated prescriptions when the surgery was to be closed so that the patients would not have to go without their tablets during a break. He then said;

I think that was the start of it and then patients sort of asked for them because they said they were going up to Woy Woy for the weekend."

53 As to whether it was appropriate to write post dated prescriptions, the respondent said;

> *"Although I had an idea that it was not permitted to post date scripts, again once you start doing something you – it sort of gets easier the next time and after (a) while you don't think about it".* [48]

54 The respondent said that writing post dated prescriptions met the patient's convenience and his because he said that when the practice became very busy it helped if the patient did not come back every day for a prescription. [49]

55 The respondent also wrote prescriptions for patients when he had not seen the patient. On two occasions the respondent gave a prescription for Murelax intended for patient N to his girlfriend (also a patient of the practice, Patient CC in the complaint) for whom he was also prescribing Murelax. The respondent said that he did not think it was a problem at the time. When it was suggested to him that he would have had no way of knowing whether patient N ever received the prescription, said that he did not give it sufficient thought.

Case studies

56 It is illustrative of the course of conduct engaged in by the respondent, to examine the treatment of a handful of the patients referred to in the complaint.

57 **Patient N**: the respondent knew that Patient N was using heroin. On 2nd February 1999 Patient M's girlfriend (Patient CC) told the respondent that Patient M had used heroin on the weekend.

58 The respondent did not ask the patient about his use of heroin when he next saw him.[50] The respondent said that at that time he thought that his patients used benzodiazepines so that they would not have to buy heroin because that is what they had told him.

59 By the time that the respondent stopped prescribing for Patient N, he was receiving daily prescriptions from either the respondent or the other practitioners at Redfern including post dated prescriptions.

60 **Patient A**. The HIC printout for him shows that he was using diazepam which neither the respondent nor the other doctors in the Redfern practice prescribed. There was no note of this in the patient's file. Professor Bell[51] commented that the pattern of prescribing for this patient showed escalating doses to what he described as *"massive"* levels. In December 1998 the respondent prescribed 300 Serepax and 200 Panadeine Forte tablets for this patient and in April 1999 he was prescribed 1,325 benzodiazepines and 340 codeine tablets.

61 Despite a note in June 1998 that *"this guy lies"*, the respondent continued to prescribe for him and, presumably accepted his assurances that he was attending NA.

62 The respondent prescribed 50 Valium and 25 Serepax tablets every day for this patient, but did not ask himself whether the patient had in fact taken those tablets himself in the preceding 24 hours.[52]

63 **Patient B** like a number of the respondent's patients was on the Methadone programme. [53]

64 Patient B told the respondent that she suffered from insomnia. It is apparent from his evidence that he did not believe that because he said that it was *"symptom of her problem, or she just said that"* [54].

65 On 11th December 1998 the respondent gave her two prescriptions for Temazepam (Temaze), one of those prescriptions was post dated to 13th December 1998. On 3rd and 25th March 1999, the respondent wrote prescriptions for two benzodiazepines on the same day – Temaze and Murelax. Again, in April 1999, the respondent wrote two prescriptions for benzodiazepines on the same day and also gave the patient a post-dated prescription. The effect of writing those prescriptions was to give the patient access to 65 benzodiazepines tablets in the space of two days. The respondent's notes show that the patient attended

in the morning and was given a prescription for 25 Temaze. She returned in the afternoon and told the respondent that her wallet had been stolen and he wrote a second prescription for 15 tablets.

66 He knew at the time that he wrote those two prescriptions that addicted patients often claimed to have been robbed or to have lost their tablets or prescriptions in order to get another prescription.

67 His only justification for writing post dated prescriptions was to say that the patient lived in Wollongong and she would not need to come up to the surgery so often.[55]

68 The respondent agreed that there was no therapeutic reason to do that but it was part of the rationale for treatment if the patient went to NA. Although the patient claimed to suffer from insomnia, he did not examine for the cause of it. He said that the first time she attended the practice and said she suffered from insomnia, they treated her as an addict so that she did not have to pretend that she suffered from insomnia. Instead he offered her counselling.

69 **Patient E** was a patient for whom the respondent prescribed benzodiazepines and opiates together. No authority was sought for the prescription of the *Schedule 8* drugs. In February 1999, the respondent prescribed two opiates – Proladone and MS Contin and benzodiazepines for the patient.

70 **Patient H**: The respondent (and the other doctors in the Redfern practice) prescribed Valium, Serepax and Temazepam for this patient. On 16th June 1998 he told the respondent that he was selling his prescriptions.[56] The respondent said that he refused to issue him with a prescription on that day but thereafter continued to give him the prescriptions for which he asked.

71 This patient received 25 Temaze and 25 Serepax every second day from the practice. By May 1999 he was receiving prescriptions every day and also receiving post dated prescriptions. In January 1999 the patient received 1,050 benzodiazepine tablets, February 975 and in March 1,125 tablets.

72 **Patient I:** The respondent knew that this patient was epileptic. She was also on the Methadone programme. The respondent never monitored her condition nor did he know whether another doctor was monitoring it.[57] He did not even make a note of any anti-seizure medication she was taking. In March and April 1999 she was prescribed 1,600 and 1,650 benzodiazepine tablets. The respondent wrote twelve post dated prescriptions for her in April 1999.

73 He knew that there were risks to her of using benzodiazepines when she was on the Methadone programme and was an epileptic. He did nothing to avoid those risks.

74 On 23rd January 1999, the patient said to the respondent that she needed psychiatric help. He did nothing at all in response to that comment. He could offer no explanation why he did not refer her for treatment nor counsel her.

75 **Patient P**: It is clear from this patient's notes that he was injecting both temazepam and methadone. In fact the respondent's note in September 1997 queried whether that the patient was using the veins in his penis to inject drugs. [58] It is clear from the notes that the respondent knew that the patient was taking drugs intravenously, from time to time. [59] In this knowledge, the respondent continued to prescribe temazepam for this patient in capsule rather than tablet form.

76 During the time he was a patient of the respondent, Patient P received increasing doses of benzodiazepines. Between January and April 1999, he received a total of 3,225 tablets of benzodiazepine. The respondent wrote seven post dated prescriptions in seven weeks.

77 **Patient W** received 6,400 benzodiazepine tablets between January and April 1999; averaging about 50 tablets per day. He was on methadone and, according to the notes had been released from prison in December 1998. Professor Bell said that this patient could not have had a habitual intake of benzodiazepines of this magnitude within a month of being released from prison. He regarded the pattern of prescribing for this patient as *"giving the patient a habit"*.

78 **Patient Q** was on methadone. The patient was frequently prescribed temazepam by the doctors at the Redfern practice. On 11th December 1998 he told the respondent that he had been admitted to a psychiatric hospital because he took sleeping tablets and *"went stupid"*. By that time, the respondent had been prescribing sleeping tablets for him since December 1997. Before the consultation on the 11th December, the patient had received 25 temazepam tablets on the 5th, 9th and 10th December. After telling the respondent that he had been admitted to hospital, the doses of temazepam given him increased to the point that in February 1999 he was prescribed 1,000 tablets, in March 775 and in April 1,000 tablets.

79 There is no note that the respondent asked him anything about the admission to hospital.

80 Patient Q also complained of blurred vision which the respondent said he put down to his use of Cogentin (which was not prescribed by the respondent nor is there a note that the respondent asked the patient who had prescribed it). The respondent said that the treatment was to wait for it's effects to wear off. There is no note that he gave this advice to the patient.

81 The respondent said that he was not aware at that time that blurred vision is a noted adverse reaction to temazepam and other benzodiazepine compounds.[60] However, his notes of the 15th December 1998 indicated that he had checked MIMS and recorded *"blurred vision, dilated pupils"* and the respondent made a note that the patient had dilated pupils. Nonetheless, the respondent and his colleagues continued to prescribe temazepam for this patient. On the consultation of the 15th December 1998, he prescribed temazepam for the patient and gave him two extra, post dated prescriptions.

82 On the 22nd December 1998, the respondent recorded that he had been contacted by Patient Q's father who said that his son was injecting Normison, behaving so erratically he had taken out an Apprehended Violence Order against him and said that his son never attended NA. The next note was made by Dr Roberts to whom the patient said that his father was dead and the phone call was made by a flat

mate trying to make trouble for him. The respondent never raised the telephone call with the patient, nor, it seems made any attempt to verify whether it was the patient's father who rang.

83 Patient Q also suffered from Hepatitis C. No liver function test was ever ordered for him.

84 The respondent was asked the following question:

> *"Wasn't there a risk to him irrespective of the hepatitis C that could affect his liver merely by the prescription of benzodiazepine, that is a risk of damage to his liver?*
>
> *"I don't think so.*
>
> *"A risk…that could be aggravated if he's got hepatitis C..*
>
> *"It was certainly not something that concerned ..the patient himself…"*[61]

85 This view that the patient had some informed acquiescence in the respondent's treatment of him was expressed again by the respondent when asked about prescribing temazepam in capsule form. The respondent agreed that he knew a patient could easily extract the drug from a capsule and inject it. He was then asked;

> *You knew that that was extremely dangerous didn't you?*
>
> *I knew it and they knew it.*
>
> *You knew that that could cause serious damage to the veins?*
>
> *I knew it and they knew it"*

86 When asked to explain these answers, the respondent said: *"Well, despite knowing that it was dangerous they insisted on insisting on capsules".*[62] He went on to say that he could only advise people what to do for their health but could not force them.

87 **Patient R** was being prescribed Normison. The respondent said that he prescribed Normison because the patient asked for it.[63]

88 On the 4th September 1998 the notes record the patient asking to be taken off Normison. In response to that request the respondent gave the patient a prescription for Dilantin (in case of fitting) and another prescription for Normison in the same quantity as previously prescribed. No plan for reduction of Normison

was noted, nor any note of or referral to counselling. When asked why he made no efforts to assist the patient in his request, the respondent said that patients came in one day and asked to come off a drug and then the next day say they do not want to come off it yet.[64] Over the next months, the amount of benzodiazepines prescribed for the patient increased.

89 **Patient DD** died on 25th April 1999 while under the care of the respondent. The Coroner's report noted that many packets of prescription medication were found at the scene.

90 She had been a patient of the practice since July 1998 [65]. On 8th September 1998 the respondent recorded *"abusing Pan Forte. Takes 10 at once"*. The preceding notes for this patient show that on each visit she was prescribed 20 Panadeine Forte tablets. On 28th August, she told the respondent that she could see that she was an addict and the respondent wrote *"reducing schedule"* in the notes. He prescribed the same amounts as before – 20 Panadeine Forte and 50 Valium tablets. There is no note of a reduction schedule or any plan to assist her to reduce her intake of drugs. On 18th September the respondent noted the patient was taking up to 30 Panadeine Forte a day. She was prescribed the same amount of Valium and Panadeine Forte as before. On 25th September she told the respondent that she had reduced her intake of Panadeine Forte from 10 to 8 tablets a day. He prescribed the same amount for her as before.

91 The visit immediately after this was on 12th September 1998 with Dr Roberts who prescribed 20 Panadeine Forte tablets. On 2nd October 1998 Dr Roberts prescribed Panadeine Forte and Valium plus gave her two post dated prescriptions for the same amount.

92 On 10th October, the patient saw Dr Roberts and he noted *"feeling more emotional, looking at what is the point of her life etc, that is waking up"*. He prescribed 50 Valium and 20 Panadeine Forte tablets for her. On 17th October the patient saw Dr Roberts who advised her that to take too many tablets would make her more depressed.

93 On 23rd October, the patient told the respondent that she wanted to reduce her intake of Valium to 20 tablets a day. The note then reads *"OK. Takes them all at once"*. The respondent issued her with the usual prescriptions. There is no record of any plan for the reduction of her intake of Valium.

94 The patient attended the practice and received repeat prescriptions every second day for the same amount of drugs. On 11th December, the respondent noted that the patient was *"taking a lot"* . He wrote the same prescription for her on that occasion as he did on the 12th December when she returned.

95 On 18th January the notes record the patient being *"in tears, my life's not worth anything"*. She received a prescription for Serzone tablets, 50 tablets Valium and 20 tablets of Panadeine Forte from a colleague. Her next visit was on the 20th January when the respondent prescribed the same amount of Valium and Panadeine Forte and noted *"depressed"*.

96 On 25th January 1999, the notes show that a psychiatrist from RPA Hospital rang Dr Roberts and told him that she had been admitted to hospital with an overdose. The respondent saw the patient on her next visit to the surgery which was on the 30th January. The note reads *"says keen to live"* and decrease medication slowly. She was advised to attend daily NA and given her usual prescription.

97 On 1st February, she was seen by Dr Roberts who noted that the *"OD was cry for help, not serious suicide attempt. Seriously consider detox",* he gave her the usual prescriptions and a referral to the Langton Clinic. The notes of 3rd and 5th February record the same prescribing that on the 3rd noted *"to cut down pan forte"*. On 8th and 10th February she received the same prescription plus an extra prescription for Panadeine Forte. The prescription was repeated on the 12th,15th, 18th February and another day in February (the date is obscured) when codeine phosphate was substituted for Panadeine Forte. She then received codeine phosphate and Valium on 24th February, 27th February, 1st March. She received the same prescriptions on 3rd March from the respondent, on another date in March, 10th, 11th (plus a repeat of both prescriptions post dated for the 12th March) from the respondent. On 11th March the respondent noted her to be *"a bit vague"*.

She received the same prescription on the 22nd, 26th (when she received a post dated prescription for the 28th March), 29th March (plus a post dated prescription for 30th March) and 30th March (when she also received post dated prescriptions for 1st and 3rd April) from the respondent.

98 On 1st April the respondent noted that she was *"confused"*. On 12th April the respondent saw her and the notes indicate that she had fallen down stairs on 8th April and been admitted to hospital. The notes also show *"Valium (reduced) in hosp"*. On that day she received a prescription for Valium (which asked the chemist to dispense 12 tablets per day). The notes are that she was also receiving 13 tablets each day at the hospital. She was given a prescription for codeine phosphate. The patient received a prescription for Valium to be dispensed 12 per day and codeine phosphate on 16th, 17th 19th, 21st and 24th April.

99 On 28th April the notes record that the police rang and informed the respondent that the patient had been found dead on 25th April.

100 In the month of March 1999 the patient received 220 tablets of Panadeine Forte or codeine phosphate. In the same period she received 550 tablets of Valium. Many of those prescriptions were written by the respondent.

101 The respondent said that when he heard that she had died he did think that his treatment of her may have contributed to her death. His notes of 28th April include: *"Police notified by another resident. I was not keen to sign death certificate for autopsy etc"*. The respondent said that he was not keen to sign the Death Certificate because he did not know the cause of death. He made no inquiries of the police after he was notified of her death. He said that at the time it did occur to him that his prescription of benzodiazepines could have contributed to her death. Her death did nothing to change his prescribing practice. [66]

102 **Patient Z** also died while under the care of the respondent. She was 16 years old.

103 The first entry in the notes was made by the respondent on 4th December 1998. It records that she was using "*heroin - $100 a day, trying to get on Methadone and*

wanted help with detoxification". She was prescribed Valium. The next day she returned, saw a colleague and received another prescription because she said the previous prescription had been stolen. This prescription was given notwithstanding that she is noted as appearing a *"bit dopey"*.

104 On 10th December the patient saw a colleague who noted *"normison 10(25). Won't put her on methadone. Min of 3 x NA if comes here"*.

105 She attended again on 17th December. The notes record she was on 30mg Methadone and she received a prescription for Normison. On 22nd December she was seen by the respondent who noted that her methadone had been increased to 40mg per day. *"2 NA encouraged"*. She received the prescription for Normison.

106 On 23rd December she said that her tablets had been stolen and was given another prescription. On 5th and 6th January, she received prescriptions because she said someone had torn up her prescription. On 7th January she saw another doctor who noted that he challenged her about the claim to have lost the prescription and he prescribed Normison. She received the same prescription on the 9th, 11th, 12th and 14th January.

107 On the 16th January, the patient saw a colleague who noted *"crying a lot..cuts both wrists"*. She was prescribed the Normison and Zoloft. On 18th January she again was prescribed Normison and Zoloft.

108 She received Normison on the 18th, 19th, 20th, 21st, 22nd, 23rd, 25th, 27th, 28th and 30th January. The notes of the 21st January made by another doctor record that she was sometimes injecting the Normison which was being prescribed in capsule form.

109 On 30th January, her boyfriend told the respondent that the patient had been anally raped the night before. She continued to receive regular prescriptions for Normison.

110 On 10th February, she received a prescription for Normison (after the doctor who saw her *"pleaded"* with her not to inject the drug), and again on 11th February.

111 On the 12th February the respondent prescribed Normison for her and on 13th February 1999 when he noted that she appeared to be *"a bit sleepy"*, told him that she was homeless, was prostituting herself and *"feels like killing herself.* He prescribed Normison for her.

112 The patient continued to receive Normison which was later changed to Temaze from the doctors at the practice.

113 On 24th February, a colleague noted that when her boyfriend was shooting her up with Temaze, he hit an artery. The respondent issued the next prescription on 26th February but in tablet form not capsule as before and the notes refer to her arm (presumably where she was injected). He noted that she was still homeless.

114 On 8th March she is noted to be off Methadone and using heroin. She was said to be depressed. The respondent prescribed for her on the 10th March and on 11th 16th 17th March (where there is a notation *"nothing tomorrow"*) and on the 19th March.

115 On the 23rd March, the respondent saw the patient and noted that she was *"falling asleep"* in front of him. He did not prescribe for her on that day.

116 On 30th March the respondent noted that she was using heroin daily. On 31st March the respondent prescribed for her and again on 1st April 1999 when she was given a prescription for Temaze and two post dated prescriptions for 3rd and 5th April, 27th April and 28th April.

117 The respondent prescribed two different benzodiazepines for the patient; Valium and Temaze on 10th, 11th, 16th, 17th and 19th March 1999.

118 There is no note that the respondent ever warned the patient of the risks of long term use of benzodiazepines, conducted any review of her continued use of benzodiazepines or offered her any counselling or referred her to an expert in

drug and alcohol addiction. The respondent said that she was a drug user and there would be no medical indication for her use of benzodiazepines. He agreed that she asked for sedatives and he prescribed what she asked for. [67]

119 The patient died sometime between 11pm on the 7th May and 4 am on the 8th May 1999. The Coroner's report [68]noted;

> *"This 16 year old girl was found dead in a bedroom of a boarding house…. Empty bottles of Methadone, empty containers of Temazepam, Alepam and Diazepam as well as used syringes were seen in a small bin located in the room. The toxicological analysis revealed toxic blood levels of morphine and methadone and therapeutic blood levels of benzodiazepines."*

120 The direct cause of death was recorded as *"the combined effects of opiate, methadone and benzodiazepine toxicity"*.

121 The respondent wrote a report for the Coroner about his treatment of Patient Z which included: *"She asked for various sedatives at the consultations and I usually prescribed Normison"*. This statement falls far short of describing the level of the respondent's prescribing for the patient.

122 The report concludes with the opinion that the patient was a poly drug user and: *"Despite the best efforts of my colleagues and myself she continued in this dangerous lifestyle and eventually died from its effects"*.

123 The report contained no reference to the patient speaking of suicide, of the amounts of benzodiazepines which had been prescribed by the respondent and his colleagues nor the frequency with which they had been prescribed, that in addition to prescribing Normison he also prescribed Valium and that he prescribed two different benzodiazepines on the one day.

124 The respondent agreed that the *"flavour"* of the report was that the patient was a drug addict who was bound to die sooner or later. He said that he suspected that *"something similar would have happened to her" whether she had attended the Redfern practice or not".* [69] The respondent said that he did not know if it had been possible to help her and acknowledged that in fact he did nothing to help her.

125 The *"best efforts"* of the respondent was to prescribe large amounts of drugs to a young girl who had told him that she thought about killing herself. The Tribunal is of the view that this report was worded to absolve the respondent of any contribution to the death of the patient.

126 The respondent's treatment of this patient is particularly reprehensible given her age and obvious vulnerability. For the respondent to have continued to give her large quantities of benzodiazepines at her request without making any attempt to assist her to stop by referring her for expert help and then to gloss over his undoubted contribution to her tragic end is, in the view of the Tribunal not only a complete abandonment of all principles of the proper practice of medicine but shows callous indifference and an absence of humanity.

127 Medical practitioners are required to include particular information in their clinical notes.[70] A practitioner is required to record details that are relevant to diagnosis or treatment, particulars of any clinical opinion, any treatment plan and particulars of any medication prescribed. The notes must include information or advice given to the patient about any proposed medical treatment. The information recorded must be sufficient to allow another medical practitioner to continue management of the patient's case.

128 The respondent conceded that there is nothing in his notes to identify the practitioner who made the particular entry, there is no reference to any treatment plan (although the respondent said that Dr Roberts generally developed the treatment plan which would be recorded by him). He agreed that the strength of the drug prescribed was not noted.[71] He said that he and his colleagues prescribed the same strength of drug most of the time and each would have known what the doctor on the previous consultation would have prescribed. If he tried to prescribe a drug at a lower strength than usually prescribed, the patient would not accept it. [72]

Section 66 Inquiry

129 During the Section 66 Inquiry, the respondent continued to support the treatment theory being implemented at the Redfern practice.[73]

130 He told the Inquiry that the patient profile of the practice had changed because he and his colleagues had adopted a *"humane approach" to the patients and said that "they (the patients) don't need to lie…we listen to them"*. He said that the method adopted by them was the starting point of the healing of the patients. He told the Inquiry that it was a condition of treatment that patients attend NA. [74] He also told the Inquiry that in his view they must be *"doing something right"* because patients were prepared to wait up to three hours for a consultation. He asserted that most of the patients only attended their practice.

131 The respondent said that he had been surprised by the visit from the PSB because he had had contact with representatives from the Doctor Shoppers programme and those with whom he had contact were supportive of him and knew the quantities of drugs being prescribed by him.

132 This evidence is not what the respondent said to the Tribunal. He said that in May 1999 when he heard from Mr Thompson he immediately thought that he was in trouble over the level of his prescribing. The suggestion that the HIC knew and approved of the quantities of drugs he was prescribing is unsupported by any evidence before the Tribunal and not a view expressed by the respondent in his evidence. The Tribunal is satisfied that the respondent was not candid with the Inquiry about this.

Insight

133 The respondent came to this hearing with a different attitude to his conduct at the Redfern practice from that which he had espoused before the Section 66 Inquiry. He frequently said that, in retrospect, he was shocked and appalled at his conduct and agreed that he had displayed reckless indifference to his professional obligations and further that his conduct not only did not minimise harm but was potentially inflicting harm on the patients.

134 The respondent was asked how he came to change his view about his conduct between appearing before the Section 66 Inquiry and coming before the Tribunal. He said that he had, over time, reflected on how other doctors prescribe and he had read on the topic.

135 As to what he had read, he agreed that he had read the information given to him by Mr Thompson in 1993 but little else until he read the material which had been served by the applicant. He read that in anticipation of being cross examined. Before that, he had not done any particular reading.

136 Up until January 1999 the respondent was working at the Redfern practice and also at the Emerton Medical Centre. He left Emerton in January 1999 to work more days at Redfern. There were two other doctors working at Emerton. The respondent described Emerton as being a very different practice to Redfern. There were few drug seeking patients although he said that quite of lot of patients there requested benzodiazepines which he prescribed sometimes but: *"not just on request, not as frequently as they probably might have liked."*[75]

137 The respondent said that he knew at the time that he was working at both practices that they way he was managing drug seeking patients in Redfern *"wasn't like most doctors would recognise as an appropriate practice."*[76] He did not conduct himself at Emerton as he did in Redfern because he knew it was inappropriate.

138 He did not tell the doctors at Redfern at any time that he believed what they were doing was inappropriate or wrong. He said that at Redfern: *"the mindset…allowed me to disregard …any misgivings I may have had"*[77] and that it would seem: *"ok at Redfern because that's how we practise there because we had – well developed that method"*.

139 Given that the respondent knew from the outset that what he was doing at Redfern was inappropriate and would not meet the approval of colleagues, there must have been little need to reflect on how others practised before changing his mind about appropriateness of the treatment offered by him at Redfern.

140 In October 2006 the respondent prepared a statement in response to the Complaint. In it the respondent referred to the way in which he practised at the Redfern practice. He said that he had co-operated with the Doctor Shopper Programme and encouraged patients to nominate one doctor or practice and only get prescriptions from that practice.[78]

141 In the statement the respondent also said that at the time he (and the others) believed that the increase in numbers of patients attending the practice was because: *"we were treating this group of patients as human beings, we were spending time talking to them, listening to their problems and trying to help them"*.[79]

142 Neither claim bears close scrutiny. The Tribunal is satisfied that nothing the respondent did in his treatment of the patients encouraged them to stop using drugs or improve their health. In fact, the HIC information shows that for some patients, while the number of distinct prescribers decreased, in many cases, the daily dose of drugs increased. The Tribunal is of the view that the increase in patient numbers at the Redfern practice was due to the unlimited prescription of benzodiazepines there. Only someone turning a deliberately blind eye could have failed to see it.

143 The respondent said in that statement:[80]

> *"While practicing (sic) at Redfern, particularly during the last two years of my practice there, it was my belief at the time that I was providing a much needed service to the patients of the practice. We worked long hours, spending time with patients individually. We considered that we were helping this group of people who were not listened to or helped elsewhere. I have since resiled from that opinion. I am no longer of that view, as despite the substantial amount of time that I spent counselling patients, I recognize now that I did not pay sufficient regard to current principles of treating this group of patients."*

144 It was suggested to the respondent, that as late as October 2006 he was still trying to defend his practice. He said that his statement might seem a bit naïve.[81] The Tribunal finds that this statement of the respondent is indeed an attempt to defend his conduct and demonstrates that as late as October 2006, the respondent had not fully accepted the harm done by his conduct.

145 Although the respondent said that he realised that he: *"had not paid sufficient attention to current principles*"[82] of treating this type of patient, the Tribunal finds that throughout the period of prescribing the respondent was well aware of the important medical indications for the prescription of benzodiazepines, even if he was not fully aware of the fine detail. [83]

146 When asked whether the application of this theory was making any improvement in the patients he said that while he hoped that *"eventually"* some benefit would accrue, one could not judge improvement in a week or even on a month to month basis.[84] He said that the patients that he and his colleagues considered to be successes were those who were not attending the practice as often as before. He conceded that was *"flimsy"* evidence because the patients could have moved away or were going somewhere else for their drugs.

147 The Tribunal is satisfied that at the time that the respondent was implementing Dr Robert's theory at Redfern he did so knowing full well that this practice would not have attracted the approval of other doctors, knowing that there were risks to patients of which he never warned. He knew, for example, that it was dangerous for patients to inject temazepam from capsules, yet he continued to prescribe them. His choice of strength of drug was largely dictated by the patients as was the type of benzodiazepine prescribed to the extent that the respondent said that had he offered a 2mg Valium to a patient, it would not have been acceptable to the patient.[85] He frequently prescribed two different types of benzodiazepine on the same day because the patient asked for them. He prescribed opiates and benzodiazepines at the same time for patients.

148 In his evidence to this Tribunal, the respondent, in effect, used the implementation of the theory to explain his complete abandonment of all principles of the proper practice of medicine.

149 Even before the implementation of Dr Robert's theory of treatment of addiction, his over prescription of benzodiazepines was a matter of concern. After being visited by Mr Thompson in 1993, he was given information about drug seeking patients, how they presented and how to deal with them. He said he read that information. When asked whether he knew in 1999 that what he was doing was wrong said:

> *"…I'd been in the previous years very unsatisfied with the way that we had approached addicts….I knew that I shouldn't prescribe unrestricted amounts but this theory just seemed to solve or address those concerns so that I went along with it…"*[86]

150 He said that the difference between his practice in 1993 and his practice in 1999 was, that in 1999 he was helping his patients.

151 The dissatisfaction that the respondent had felt was perhaps as he expressed it to Mr Thompson in 1993 when he told him that his problem was a mixture of being a *"soft touch"* and being "*conned"* by people who were effective at getting drugs from doctors. The respondent agreed that this represented a *"character flaw"* in him.

152 By embracing the theory the respondent absolved himself from having to refuse patients who wanted drugs.

153 In the evidence, both written and oral, there is no word of apology or sympathy for his patients, even in relation to patients DD and Z. The respondent was asked whether he accepted his treatment may have played a part in their deaths and he said;

> *"I think I have to accept it…..It's no excuse at all but those two people were quite wilful and if we had…..refused to prescribe for them they still would have obtained those things somewhere. We did prescribe for them so we have to or I have to take, admit, say that I played some part in their demise."*

154 Given that he had read the Coroner's report which in the Tribunal's view clearly implicates benzodiazepines in combination with other drugs as the cause of death, it is hard to see why the respondent found it difficult to come to the view that he had played a part in the deaths.

155 The Tribunal finds that the respondent knew while he was conducting his practice at Redfern that what he was doing was anathema to the proper practice of medicine. His reluctant acceptance of any contribution by him to the deaths and the lateness in which the respondent came to abandon the pretence of there being a treatment rationale behind his conduct at Redfern, persuade the Tribunal that he has scant insight into the gravity of his conduct.

Gravity and Duration of Conduct

156 Barely understanding the basis for the treatment and with no training, the respondent embarked on a course of conduct which amounted to using his drug addicted patients as guinea pigs.

157 The respondent knew at all relevant times that his course of prescribing posed significant risks to his patients and was contrary to everything he had learned about the proper practise of medicine. He knew full well the correct approach to prescribing benzodiazepines.

158 It was in the face of this knowledge that for a period of at least two years, the respondent prescribed massive quantities of benzodiazepines for his drug addicted patients and during that time two of his patients, one, a child, died of overdoses from a combination of drugs including benzodiazepines.

Rehabilitation

159 The respondent has not done any particular reading nor attended any course aimed at improving his understanding of drug addicted patients.

160 He conceded that his inability to act on his misgivings about the practises at Redfern reflected a *"character flaw"*, yet he has sought no counselling nor any other assistance in addressing this.

161 Since June 1999 the respondent has continued to practise medicine without the authority to prescribe drugs of addiction. He has not been placed in the position of having to refuse to prescribe for an addict seeking drugs.

162 The respondent said that he has been asked to prescribe drugs since June 1999 and has told the patients that he cannot prescribe them. However he said that if the patient absolutely insisted, he would refer them to another practitioner in the practice. [87]

163 The Tribunal is not satisfied that the respondent has done anything to address the matters which caused him to abandon what he knew to be proper medical practice

and is not confident that he would be able to withstand the importuning of patients seeking drugs.

164 There is support for this finding in the respondent's evidence that he was shocked when visited by Mr Thompson in 1993 over the amounts of benzodiazepines he had been prescribing and he promised that he would not prescribe in that way again yet he was unable to keep that promise. He rationalised breaking that promise by claiming that the counselling of the patients made the difference between his prescribing in 1993 and 1996 and the following years.

165 The respondent presently works at the Majors Bay Medical Centre and at the Chullora Medical Centre.

166 Dr Garg who works with him at Chullora wrote a reference for the respondent. She said that she has found him to be competent and caring and his clinical skills are of a high order. She wrote that she knows that he cannot prescribe *Schedule 8* drugs, however she made no reference to his not being able to prescribe *Schedule 4D* drugs. Dr Garg said that she had not discussed with the respondent why he is subject to restrictions. The respondent said that he had told Dr Garg that he could not prescribe Schedule 4D drugs. Whether he told Dr Garg cannot be determined on the evidence before the Tribunal.

167 Dr Peries with whom the respondent works in Majors Bay also wrote a reference for him[88]. She described him as having maintained high professional standards and as a caring and responsible general practitioner. As to the matters which bring him to the Tribunal she said *"He has displayed genuine remorse and contrition for his behaviour in the past"*. She did not expand on that statement.

168 The Tribunal accepts that since the Section 66 Inquiry, the respondent has been practising without complaint. There is no evidence that he has breached the conditions on his registration. He is well regarded by his professional colleagues.

Discussion

169 This matter concerns *sections 36 and 37 of the Medical Practice Act 1992* (the **Act**).

170 *Section 36* defines *"unsatisfactory professional conduct"* to include;

> *(a) Any conduct that demonstrates that the knowledge, skill, judgement 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;*
>
> *(b) Any contravention by the practitioner (whether by act or omission) of a provision of this Act or the regulations;*
>
> *(c) Any other improper or unethical conduct relating to the practice or purported practice of medicine."*
>
> *S 37 "For the purposes of this Act, professional misconduct of a registered medical practitioner means unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register."*

171 *Section 64* of the *Act* provides for a range of orders which may be made by the Tribunal on making a finding of either unsatisfactory professional conduct or professional misconduct.

172 The Tribunal considers the concession by the respondent that he is guilty of professional misconduct well made.

173 Both a peer reviewer, Dr Chung and Associate Professor James Bell who is the Director of the Langton Centre[89], were extremely critical and disapproving of the respondent's conduct.

174 Dr Chung said[90] that there were occasions *"too numerous to mention"* when the respondent breached the accepted standards of prescribing of drugs including the quantities, the times between prescribing, concurrent prescription of related drugs and drugs with potential for interaction, drugs prescribed not for the approved purpose and post dating prescriptions. Dr Chung set out in his report the *"recognised standard"*[91] for the proper practice in relation to prescribing *Schedule*

4D and *Schedul*e 8 drugs. The respondent contravened each of them and admitted that he had.

175 Dr Chung strongly criticised the other aspects of the respondent's practice as demonstrated in the complaint and its particulars.

176 Professor Bell said of the respondent's conduct:

> *"Dr Goodman….was aware that most of the patients were on methadone. There is occasional evidence in files that some primary health care was delivered but this was the exception. The patients attended to obtain benzodiazepines. Dr Goodman did not present a rationale for prescribing.*
>
> *The fact that patients saw any and all doctors from the practice to gain prescriptions, rather than establishing a therapeutic relationship with one practitioner, is inconsistent with good medical or counselling practice. Lack of a coherent treatment plan, and failure to set limits on patients makes for very poor management of vulnerable patients."*

177 The Tribunal is satisfied that the conduct complained of amounted to an abandonment of all skill, judgment and care expected of a medical practitioner by the respondent. It is misconduct of the gravest kind, exacerbated by the respondent's persistence in the conduct over years until it was stopped by the intervention of the PSB.

178 The conduct of the respondent was abhorrent and would be regarded as such by any member of the profession or the public who was informed of his prescribing practises. He was indifferent to and negligent in his professional duties. The Tribunal regards his conduct as being disgraceful and dishonourable.

179 Given the particulars which are voluminous and barely canvassed in this judgment but all of which are admitted, the Tribunal is satisfied to the requisite standard[92] that the respondent is guilty of professional misconduct.

180 The jurisdiction of the Tribunal is a protective not punitive one [93]. 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 his misconduct and deterring others who might be

tempted to behave in a similar way. The role of the Tribunal is also to ensure that public and professional colleagues can place their confidence in the practitioner:

> *"One element of deterrence is providing an assurance to the public that serious lapses in the conduct of… .practitioners will not be passed over or lightly put aside, but will be appropriately dealt with".*[94]

181 To give effect to the protective jurisdiction of the Tribunal, it may make orders which operate in a number of ways; by preventing the practitioner from practising or by deterring him from repetition of the conduct.[95]

182 When considering what orders to make it is important to have regard to the gravity of the conduct which comprises the professional misconduct. The practice of prescribing benzodiazepines on demand to drug addicted patients flew in the face of everything the respondent had learned as a medical practitioner, was anathema to proper standards of professional medical practice and drew extreme disapproval from a peer and an expert in the field of treating drug addiction. It was conduct that he embraced to rationalise his difficulties in refusing drug seeking patients. In the process, the respondent repeatedly breached the *Poisons and Therapeutic Goods Act and Regulations* and the *Medical Practice Act.*

183 The respondent relied on testimonials from friends and associates who said that he enjoys a good reputation in their circle. George van Mal[96], said that the respondent was greatly embarrassed by the complaint before the Tribunal. Mr van Mal had been told very little about the detail of the complaint but knew that it was concerned with prescribing. The Tribunal has taken these into account.

184 Evidence of good character is relevant to the determination of the issues before the Tribunal. It is only one factor to be considered and in this case is heavily outweighed by the evidence that the respondent was able to conduct himself appropriately while practising at Emerton and not at Redfern and could so readily abandon what he knew to be proper medical practice. It is also to be considered in the light of the evidence given by the respondent before the Tribunal about his own conduct.

185 Time has passed since the respondent behaved in the way complained of. The lapse of time can be relevant to the orders made by a Tribunal. For example time which has passed may persuade a Tribunal that the respondent has become a *"changed person"* since the conduct complained of. However as Walsh JA said in *Ex Part Tziniolis: Re Medical Practitioners Act* (1966) 67 SR (NSW) 448 at 461;

> *"Reformations of character and of behaviour can doubtless occur but their occurrence is not the usual but the exceptional thing. One cannot assume that a change has occurred merely because some years have gone by and it is not proved that anything of a discreditable kind has occurred. If a man has exhibited serious deficiencies in his standards of conduct and his attitudes it must require clear proof to show that some years later he has established himself as a different man."*

186 Lapse of time then may be relevant in determining whether the respondent has undergone a reformation of character or in whether the conduct complained of was an isolated or passing departure from proper professional standards. [97]

187 The passage of time and the evidence of the respondent do not persuade the Tribunal that the respondent has reformed his character over the passing years or that his conduct was an isolated or passing departure from proper standards.

188 The Tribunal is satisfied that the only order which could give effect to it's protective functions and to assure the public and the medical profession that this conduct is not taken lightly, is to order that the respondent's name be removed from the register of medical practitioners.

189 The Tribunal will order that he not apply to be registered for a period of three years from the date of the orders.

Orders:

1. On the respondents undertaking that he will cease the practice of medicine at 8.00pm this day, the respondent's name be removed from the Register of Medical Practitioners on 3rd May 2007.

2. The respondent be not permitted to apply to be re-registered for a period of three years from today.

3. The respondent pay the costs of the complainant

[1] Annexure A to the Reasons for Determination
[2] As defined in Section 4(1) of the *Poisons and Therapeutic Goods Act 1966*
[3] Statement Respondent 16th October 2006– Exhibit 1 tab 1,
[4] transcript page 28 line 13 ff
[5] transcript page 31
[6] transcript page 59 line 28
[7] All patients referred to in the proceedings were referred to by letter. A schedule of the names of patients is annexed to the Complaint in the records of the Tribunal
[8] Report of Ken Thompson 20th May 1999, Exhibit A tab 9
[9] *Section 66 Medical Practice Act*
[10] "*Recognising and Handling Addicts. Notes for Medical Practitioners*" Exhibit A tab 4
[11] Exhibit H
[12] transcript page 25
[13] On one occasion the respondent referred a patient to Dr Alex Wodak, a recognised expert in the field of Drug and Alcohol addiction, not for advice, but because he sought authority to prescribe a *Schedule 8* drug for a patient and it was a condition of the granting of authority that the patient be referred to Dr Wodak.
[14] transcript page 93 line 12
[15] transcript page 93
[16] transcript page 79 line 25
[17] transcript page 110 line 5
[18] transcript page 16 line 15
[19] Patient N; transcript pages 108 ff
[20] transcript page 110
[21] Report of *Section 66 Inquiry*, Exhibit A tab 10 page 5
[22] transcript page 133 line 7
[23] transcript page 133 line 22
[24] transcript page 122
[25] transcript page 86 line 40
[26] transcript page 86-87
[27] transcript page 87 line 10-22
[28] transcript page 88
[29] transcript pages 147-148
[30] transcript page 56
[31] transcript page 55 line 33
[32] transcript page 92 line 3
[33] transcript page 113 line 15
[34] transcript page 120
[35] transcript page 138 line 10 and Exhibit B tab Z
[36] transcript page 113 line 50
[37] transcript page 89
[38] transcript page 116
[39] transcript pages 85-86
[40] transcript page 98 line 10ff
[41] transcript page 100 line 25
[42] transcript page 101
[43] transcript page 102 line 56
[44] transcript page 103 line 3
[45] transcript page 103 line 15
[46] transcript page 106 line 19
[47] transcript page 143 line 57
[48] transcript page 29 line 35 ff
[49] transcript page 29 line 41
[50] transcript page 108
[51] Exhibit A, tab 33, Expert in Drug and Alcohol addiction
[52] transcript page 103 line 25

[53] transcript page 163
[54] transcript page 113 line 34
[55] transcript page 116 line 13
[56] transcript page 118
[57] transcript page 119
[58] transcript page 122 line 55
[59] Exhibit B, tab P, entry 15 September 1998
[60] transcript page 128
[61] transcript page 128 line 25
[62] transcript page 87 line 10ff
[63] transcript page 131 line 1
[64] transcript page 132 line 25
[65] Exhibit B, tab DD
[66] transcript page 135
[67] transcript page 141 line 35
[68] Exhibit A tab 22
[69] transcript page 140 line 25
[70] *Medical Practice Regulation 1998 – Schedule 2*
[71] transcript page 157 ff
[72] transcript page 158 line 48
[73] Exhibit A tab 10
[74] Exhibit A tab 10, Report of *Section 66 Inquiry*
[75] transcript page 40 line 27
[76] transcript page 40 line 38
[77] transcript page 40 line 42
[78] Statement 16th October 2006, Exhibit 1 tab 1 - paragraph 9
[79] Statement Respondent, - paragraph 9
[80] Statement Respondent - paragraph 13
[81] transcript page 54 line 57
[82] Statement Respondent - paragraph 13
[83] transcript page 159 line 10
[84] transcript page 93
[85] Evidence of respondent, transcript page 158
[86] transcript page 28 line 2
[87] transcript page 34
[88] Exhibit 2
[89] A specialist facility for the treatment of addictive disorders
[90] Exhibit A tab 30 page 5 and following
[91] Exhibit A tab 30 page 11
[92] *Briginshaw v Briginshaw* (1938) 60 CLR 336. The Tribunal must be comfortably satisfied on the balance of probabilities but that having regard to the serious nature of the charge and the consequences that follow, the satisfaction cannot be produced by "*inexact proofs, indefinite testimony or indirect references*"
[93] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 637D and F
[94] *Law Society of NSW v Foreman* (1994) 34 NSWLR 408 at 441B, 471B. Also *Craig v Medical Board of South Australia* [2001] SASC 169 at [45]-[47]
[95] *NSW Bar Association v Meakes* [2006] NSWCA 340 at [114] per Basten JA
[96] Exhibit 1, tab 8
[97] *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 637

ANNEXURE A

AMENDED COMPLAINT

MEDICAL PRACTICE ACT 1992

The Chairperson
Medical Tribunal
86 – 90 Goulburn Street
SYDNEY NSW 2000

The **Health Care Complaints Commission** of Level 13, 323 Castlereagh Street, Sydney, New South Wales, having consulted with the New South Wales Medical Board pursuant to Section 51 of the *Medical Practice Act 1992* ("the Act")

HEREBY COMPLAINS that **Dr Steven Goodman, Medical Practitioner** of 11 McCulloch Street, Five Dock, New South Wales ("the Practitioner"), being a medical practitioner registered under the Act:-

COMPLAINT

Has been guilty of unsatisfactory professional conduct within the meaning of section 36 of the Act and/or professional misconduct within the meaning of section 37 of the Act, in that the Practitioner has:

(i) demonstrated that the knowledge, skill or judgment possessed, and/or the 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) contravened the *Medical Practice Regulation 1998*; and/or

(iii) engaged in improper or unethical conduct relating to the practice of medicine.

PARTICULARS OF COMPLAINT

Patient A

1. During the period 19 April 1997 to 13 May 1999 the Practitioner prescribed ***restricted substances*** and ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient A in the quantities and on the occasions shown in **Schedule A**:

   (a) when the Practitioner knew or ought to have known that Patient A was dependent or was likely to become dependent on the restricted substances and/or drugs of addiction prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient A was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient A; and/or

(c) when the Practitioner knew or ought to have known that Patient A was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances and/or drugs of addiction was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

2. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient A's medical notes with respect to medical treatment or services provided to Patient A on 23 January 1999.

3. During the period 16 October 1998 to 13 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient A's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient A; and/or

(c) record a plan of treatment for Patient A; and/or

(d) full particulars of the medication prescribed to Patient A; and/or

(e) record information or advice given to Patient A in relation to medical treatment proposed by the Practitioner in relation to Patient A; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient A; and/or

(g) record sufficient and appropriate detail as to Patient A's case so as to allow another registered medical practitioner to continue the management of Patient A; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient A's medical notes.

4. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient A during the period 19 April 1997 to 13 May 1999 (as shown in **Schedule A**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

5. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient A as shown in **Schedule A1**.

6. During the period 19 April 1997 to 13 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient A (as shown in **Schedule A**) and failing to record the particulars of:

   (a) the name, strength and quantity of the substance prescribed; and/or

   (b) the maximum number of times the substance may be supplied on the prescription; and/or

   (c) the directions for use, as shown on the prescription.

7. The Practitioner contravened clause 81 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing a prescription for Codeine Phosphate, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966)* to Patient A on 10 March 1999 (as shown in **Schedule A**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what is appropriate in the circumstances.

8. The Practitioner contravened clause 84(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing Codeine Phosphate, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient A (as shown in **Schedule A**) on 10 March 1999 and failing to record the particulars of:

   (a) the name, strength and quantity of the drug prescribed; and/or

   (b) the maximum number of times the drug may be supplied on the prescription; and/or

   (c) the directions for use as shown on the prescription.

9. The Practitioner contravened section 28(b) of the *Poisons and Therapeutic Goods Act 1966* by prescribing Codeine Phosphate, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient A on 10 March 1999 otherwise than in accordance with an authority given to the Practitioner, when the Practitioner knew or ought to have known that Patient

A was at that time an ***addict*** (as defined by section 27 of the *Poisons and Therapeutic Goods Act 1966*).

Patient B

10. During the period 24 November 1998 to 29 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient B in the quantities and on the occasions shown in **Schedule B**:

   (a) when the Practitioner knew or ought to have known that Patient B was dependent or was likely to become dependent on the restricted substances prescribed; and/or

   (b) when the Practitioner knew or ought to have known that Patient B was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient B; and/or

   (c) when the Practitioner knew or ought to have known that Patient B was a participant in a methadone program; and/or

   (d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

11. During the period 24 November 1998 to 29 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

   (a) record information relevant to Patient B's diagnosis and/or medical treatment; and/or

   (b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient B; and/or

   (c) record a plan of treatment for Patient B; and/or

   (d) full particulars of the medication prescribed to Patient B; and/or

   (e) record information or advice given to Patient B in relation to medical treatment proposed by the Practitioner in relation to Patient B; and/or

   (f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient B; and/or

   (g) record sufficient and appropriate detail as to Patient B's case so as to allow another registered medical practitioner to continue the management of Patient B; and/or

   (h) clearly identify the Practitioner as being the person who made entries in Patient B's medical notes.

12. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient B during the period 24 November 1998 to 29 April 1999 (as shown in **Schedule B**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

13. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient B as shown in **Schedule B1**.

14. During the period 24 November 1998 to 29 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient B (as shown in **Schedule B**) and failing to record the particulars of:

    (a) the name, strength and quantity of the substance prescribed; and/or

    (b) the maximum number of times the substance may be supplied on the prescription; and/or

    (c) the directions for use, as shown on the prescription.

Patient C

15. During the period 25 July 1997 to 21 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient C in the quantities and on the occasions shown in **Schedule C**:

    (a) when the Practitioner knew or ought to have known that Patient C was dependent or was likely to become dependent on the restricted substances prescribed; and/or

    (b) when the Practitioner knew or ought to have known that Patient C was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient C; and/or

    (c) when the Practitioner knew or ought to have known that Patient C was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

16. During the period 20 October 1998 to 21 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient C's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient C; and/or

(c) record a plan of treatment for Patient C; and/or

(d) full particulars of the medication prescribed to Patient C; and/or

(e) record information or advice given to Patient C in relation to medical treatment proposed by the Practitioner in relation to Patient C; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient C; and/or

(g) record sufficient and appropriate detail as to Patient C's case so as to allow another registered medical practitioner to continue the management of Patient C; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient C's medical notes.

17. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient C during the period 25 July 1997 to 21 April 1999 (as shown in **Schedule C**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

18. During the period 25 July 1997 to 21 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient C (as shown in **Schedule C**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient D

19. During the period 21 August 1998 to 11 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient D in the quantities and on the occasions shown in **Schedule D**:

    (a) when the Practitioner knew or ought to have known that Patient D was dependent or was likely to become dependent on the restricted substances prescribed; and/or

    (b) when the Practitioner knew or ought to have known that Patient D was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient D; and/or

    (c) when the Practitioner knew or ought to have known that Patient D was a participant in a methadone program; and/or

    (d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

20. During the period 15 September 1998 to 11 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

    (a) record information relevant to Patient D's diagnosis and/or medical treatment; and/or

    (b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient D; and/or

    (c) record a plan of treatment for Patient D; and/or

    (d) full particulars of the medication prescribed to Patient D; and/or

    (e) record information or advice given to Patient D in relation to medical treatment proposed by the Practitioner in relation to Patient D; and/or

    (f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient D; and/or

    (g) record sufficient and appropriate detail as to Patient D's case so as to allow another registered medical practitioner to continue the management of Patient D; and/or

    (h) clearly identify the Practitioner as being the person who made entries in Patient D's medical notes.

    (i)

21. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient D during the period 21 August 1998 to 11 May 1999 (as shown in **Schedule D**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

22. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient D as shown in **Schedule D1**.

23. During the period 21 August 1998 to 11 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient D (as shown in **Schedule D**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient E

24. During the period 18 August 1998 to 8 May 1999 the Practitioner prescribed ***restricted substances*** and ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E in the quantities and on the occasions shown in **Schedule E**:

(a) when the Practitioner knew or ought to have known that Patient E was dependent or was likely to become dependent on the restricted substances and/or drugs of addiction prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient E was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances and/or similar drugs of addiction to Patient E; and/or

(c) when the Practitioner knew or ought to have known that Patient E was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances and/or drugs of addiction was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

25. During the period 1 September 1998 to 8 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient E's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient E; and/or

(c) record a plan of treatment for Patient E; and/or

(d) full particulars of the medication prescribed to Patient E; and/or

(e) record information or advice given to Patient E in relation to medical treatment proposed by the Practitioner in relation to Patient E; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient E; and/or

(g) record sufficient and appropriate detail as to Patient E's case so as to allow another registered medical practitioner to continue the management of Patient E; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient E's medical notes.

26. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E during the period 18 August 1998 to 8 May 1999 (as shown in **Schedule E**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

27. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient E as shown in **Schedule E1**.

28. During the period 18 August 1998 to 8 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E (as shown in **Schedule E**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

29. The Practitioner contravened clause 81 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966)* to Patient E during the period 19 August 1998 to 8 May 1999 (as shown in **Schedule E**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what is appropriate in the circumstances.

30. The Practitioner contravened clause 82(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient E as shown in **Schedule E2**.

31. During the period 19 August 1998 to 8 May 1999 the Practitioner contravened clause 84(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E (as shown in **Schedule E**) and failing to record the particulars of:

(a) the name, strength and quantity of the drug prescribed; and/or

(b) the maximum number of times the drug may be supplied on the prescription; and/or

(c) the directions for use as shown on the prescription.

32. The Practitioner contravened section 28(a) of the *Poisons and Therapeutic Goods Act 1966* by prescribing otherwise than in accordance with an authority given to the Practitioner, Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E during the period 19 August 1998 to 19 February 1999 (as shown in **Schedule E**) resulting in the ***drug of addiction*** being prescribed for continuous therapeutic use by Patient E for a period exceeding 2 months.

33. The Practitioner contravened section 28(a) of the *Poisons and Therapeutic Goods Act 1966* by prescribing otherwise than in accordance with an authority given to the Practitioner, MS Contin, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E during the period 26 February 1999 to 8 May 1999 (as shown in **Schedule E**) resulting in

the ***drug of addiction*** being prescribed for continuous therapeutic use by Patient E for a period exceeding 2 months.

34. The Practitioner contravened section 28(b) of the *Poisons and Therapeutic Goods Act 1966* by prescribing Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E during the period 19 August 1998 to 19 February 1999 (as shown in **Schedule E**) otherwise than in accordance with an authority given to the Practitioner, when the Practitioner knew or ought to have known that Patient E was during that period of time an ***addict*** (as defined by section 27 of the *Poisons and Therapeutic Goods Act 1966*).

35. The Practitioner contravened section 28(b) of the *Poisons and Therapeutic Goods Act 1966* by prescribing MS Contin, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient E during the period 26 February 1999 to 8 May 1999 (as shown in **Schedule E**) otherwise than in accordance with an authority given to the Practitioner, when the Practitioner knew or ought to have known that Patient E was during that period of time an ***addict*** (as defined by section 27 of the *Poisons and Therapeutic Goods Act 1966*).

Patient F

36. During the period 24 January 1997 to 13 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient F in the quantities and on the occasions shown in **Schedule F**:

(a) when the Practitioner knew or ought to have known that Patient F was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have that known Patient F was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient F; and/or

(c) when the Practitioner knew or ought to have known that Patient F was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

37. During the period 30 September 1998 to 13 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient F's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient F; and/or

(c) record a plan of treatment for Patient F; and/or

(d) full particulars of the medication prescribed to Patient F; and/or

(e) record information or advice given to Patient F in relation to medical treatment proposed by the Practitioner in relation to Patient F; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient F; and/or

(g) record sufficient and appropriate detail as to Patient F's case so as to allow another registered medical practitioner to continue the management of Patient F; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient F's medical notes.

38. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient F during the period 24 January 1997 to 13 May 1999 (as shown in **Schedule F**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

39. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient F as shown in **Schedule F1**.

40. During the period 24 January 1997 to 13 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient F (as shown in **Schedule F**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient G

41. During the period 24 November 1998 to 18 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient G in the quantities and on the occasions shown in **Schedule G**:

    (a) when the Practitioner knew or ought to have known that Patient G was dependent or was likely to become dependent on the restricted substances prescribed; and/or

    (b) when the Practitioner knew or ought to have known that Patient G was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient G; and/or

    (c) when the Practitioner knew or ought to have known that Patient G was a participant in a methadone program; and/or

    (d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

42. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient G's medical notes with respect to medical treatment or services provided to Patient G on 24 March 1999.

43. During the period 24 November 1998 to 18 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

    (a) record information relevant to Patient G's diagnosis and/or medical treatment; and/or

    (b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient G; and/or

    (c) record a plan of treatment for Patient G; and/or

    (d) full particulars of the medication prescribed to Patient G; and/or

    (e) record information or advice given to Patient G in relation to medical treatment proposed by the Practitioner in relation to Patient G; and/or

    (f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient G; and/or

    (g) record sufficient and appropriate detail as to Patient G's case so as to allow another registered medical practitioner to continue the management of Patient G; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient G's medical notes.

44. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient G during the period 24 November 1998 to 18 April 1999 (as shown in **Schedule G**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

45. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient G as shown in **Schedule G1**.

46. During the period 24 November 1998 to 18 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient G (as shown in **Schedule G**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient H

47. During the period 17 April 1998 to 13 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient H in the quantities and on the occasions shown in **Schedule H**:

(a) when the Practitioner knew or ought to have known that Patient H was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient H was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient H; and/or

(c) when the Practitioner knew or ought to have known that Patient H was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

48. During the period 22 September 1998 to 13 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient H's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient H; and/or

(c) record a plan of treatment for Patient H; and/or

(d) full particulars of the medication prescribed to Patient H; and/or

(e) record information or advice given to Patient H in relation to medical treatment proposed by the Practitioner in relation to Patient H; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient H; and/or

(g) record sufficient and appropriate detail as to Patient H's case so as to allow another registered medical practitioner to continue the management of Patient H; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient H's medical notes.

49. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient H during the period 17 April 1998 to 13 May 1999 (as shown in **Schedule H**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

50. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient H as shown in **Schedule H1**.

51. During the period 17 April 1998 to 13 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and*

Therapeutic Goods Act 1966) to Patient H (as shown in **Schedule H**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient I

52. During the period 23 January 1999 to 12 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient I in the quantities and on the occasions shown in **Schedule I**:

(a) when the Practitioner knew or ought to have known that Patient I was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient I was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient I; and/or

(c) when the Practitioner knew or ought to have known that Patient I was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

53. During the period 23 January 1999 to 12 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient I's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient I; and/or

(c) record a plan of treatment for Patient I; and/or

(d) full particulars of the medication prescribed to Patient I; and/or

(e) record information or advice given to Patient I in relation to medical treatment proposed by the Practitioner in relation to Patient I; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient I; and/or

(g) record sufficient and appropriate detail as to Patient I's case so as to allow another registered medical practitioner to continue the management of Patient I; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient I's medical notes.

54. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient I during the period 23 January 1999 to 12 May 1999 (as shown in **Schedule I**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

55. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient I as shown in **Schedule I1**.

56. During the period 23 January 1999 to 12 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient I (as shown in **Schedule I**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient J

57. During the period 20 November 1998 to 13 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient J in the quantities and on the occasions shown in **Schedule J**:

(a) when the Practitioner knew or ought to have known that Patient J was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient J was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient J; and/or

(c) when the Practitioner knew or ought to have known that Patient J was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

58. During the period 20 November 1998 to 13 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient J's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient J; and/or

(c) record a plan of treatment for Patient J; and/or

(d) full particulars of the medication prescribed to Patient J; and/or

(e) record information or advice given to Patient J in relation to medical treatment proposed by the Practitioner in relation to Patient J; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient J; and/or

(g) record sufficient and appropriate detail as to Patient J's case so as to allow another registered medical practitioner to continue the management of Patient J; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient J's medical notes.

59. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient J during the period 20 November 1998 to 13 May 1999 (as shown in **Schedule J**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

60. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient J as shown in **Schedule J1.**

61. During the period 20 November 1998 to 13 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient J (as shown in **Schedule J**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient K

62. During the period 27 June 1997 to 11 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient K in the quantities and on the occasions shown in **Schedule K**:

(a) when the Practitioner knew or ought to have known that Patient K was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient K was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient K; and/or

(c) when the Practitioner knew or ought to have known that Patient K was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

63. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient K's medical notes with respect to medical treatment or services provided to Patient K on 26 February 1999.

64. During the period 1 September 1998 to 11 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient K's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient K; and/or

(c) record a plan of treatment for Patient K; and/or

(d) full particulars of the medication prescribed to Patient K; and/or

(e) record information or advice given to Patient K in relation to medical treatment proposed by the Practitioner in relation to Patient K; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient K; and/or

(g) record sufficient and appropriate detail as to Patient K's case so as to allow another registered medical practitioner to continue the management of Patient K; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient K's medical notes.

65. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient K during the period 27 June 1997 to 11 May 1999 (as shown in **Schedule K**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

66. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient K as shown in **Schedule K1**.

67. During the period 27 June 1997 to 11 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient K (as shown in **Schedule K**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

68. The Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient K in circumstances where Patient K was not present at the medical consultation and was not

medically examined or assessed immediately prior to the prescription being issued on the following occasions:

(a) 25 July 1997; and/or

(b) 6 March 1998; and/or

(c) 1 May 1998.

Patient L

69. During the period 4 August 1998 to 13 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient L in the quantities and on the occasions shown in **Schedule L**:

(a) when the Practitioner knew or ought to have known that Patient L was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient L was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient L; and/or

(c) when the Practitioner knew or ought to have known that Patient L was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

70. During the period 4 September 1998 to 13 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient L's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient L; and/or

(c) record a plan of treatment for Patient L; and/or

(d) full particulars of the medication prescribed to Patient L; and/or

(e) record information or advice given to Patient L in relation to medical treatment proposed by the Practitioner in relation to Patient L; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient L; and/or

(g) record sufficient and appropriate detail as to Patient L's case so as to allow another registered medical practitioner to continue the management of Patient L; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient L's medical notes.

71. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient L during the period 4 August 1998 to 13 May 1999 (as shown in **Schedule L**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

72. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient L as shown in **Schedule L1**.

73. During the period 4 August 1998 to 13 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient L (as shown in **Schedule L**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient M

74. During the period 20 October 1998 to 23 March 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient M in the quantities and on the occasions shown in **Schedule M**:

(a) when the Practitioner knew or ought to have known that Patient M was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient M was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient M; and/or

(c) when the Practitioner knew or ought to have known that Patient M was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

75. During the period 20 October 1998 to 23 March 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient M's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient M; and/or

(c) record a plan of treatment for Patient M; and/or

(d) full particulars of the medication prescribed to Patient M; and/or

(e) record information or advice given to Patient M in relation to medical treatment proposed by the Practitioner in relation to Patient M; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient M; and/or

(g) record sufficient and appropriate detail as to Patient M's case so as to allow another registered medical practitioner to continue the management of Patient M; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient M's medical notes.

76. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient M during the period 20 October 1998 to 23 March 1999 (as shown in **Schedule M**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

77. During the period 20 October 1998 to 23 March 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient M (as shown in **Schedule M**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient N

78. During the period 11 July 1997 to 14 May 1999 the Practitioner prescribed ***restricted substances*** and ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N in the quantities and on the occasions shown in **Schedule N**:

(a) when the Practitioner knew or ought to have known that Patient N was dependent or was likely to become dependent on the restricted substances and/or drugs of addiction prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient N was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances and/or similar drugs of addiction to Patient N; and/or

(c) participant in a methadone program; when the Practitioner knew or ought to have known that Patient N was a and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances and/or drugs of addiction was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

79. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient N's medical notes with respect to medical treatment or services provided to Patient N on the following occasions:

(a) 23 January 1999; and/or

(b) 24 January 1999.

80. During the period 3 September 1998 to 14 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient N's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient N; and/or

(c) record a plan of treatment for Patient N; and/or

(d) full particulars of the medication prescribed to Patient N; and/or

(e) record information or advice given to Patient N in relation to medical treatment proposed by the Practitioner in relation to Patient N; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient N; and/or

(g) record sufficient and appropriate detail as to Patient N's case so as to allow another registered medical practitioner to continue the management of Patient N; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient N's medical notes.

81. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N during the period 11 July 1997 to 14 May 1999 (as shown in **Schedule N**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

82. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient N as shown in **Schedule N1**.

83. During the period 11 July 1997 to 14 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N (as shown in **Schedule N**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

84. The Practitioner contravened clause 81 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966)* to Patient N during the period 23 January 1999 to 30 April 1999 (as shown in **Schedule N**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what is appropriate in the circumstances.

85. The Practitioner contravened clause 82(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient N as shown in **Schedule N2**.

86. During the period 23 January 1999 to 30 April 1999 the Practitioner contravened clause 84(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N (as shown in **Schedule N**) and failing to record the particulars of:

(a) the name, strength and quantity of the drug prescribed; and/or

(b) the maximum number of times the drug may be supplied on the prescription; and/or

(c) the directions for use as shown on the prescription.

87. The Practitioner contravened section 28(a) of the *Poisons and Therapeutic Goods Act 1966* by prescribing otherwise than in accordance with an authority given to the Practitioner, Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N during the period 23 January 1999 to 30 April 1999 (as shown in **Schedule N**) resulting in the ***drug of addiction*** being prescribed for continuous therapeutic use by Patient N for a period exceeding 2 months.

88. The Practitioner contravened section 28(b) of the *Poisons and Therapeutic Goods Act 1966* by prescribing Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N during the period 23 January 1999 to 30 April 1999 (as shown in **Schedule N**) otherwise than in accordance with an authority given to the Practitioner, when the Practitioner knew or ought to have known that Patient N was during that period of time an ***addict*** (as defined by section 27 of the *Poisons and Therapeutic Goods Act 1966*).

89. On 2 February 1999 the Practitioner prescribed Murelax, being a ***restricted substance*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient N in circumstances where Patient N was not present at the medical consultation and was not medically examined or assessed immediately prior to the prescriptions being issued.

90. On 2 February 1999 the Practitioner prescribed Proladone Suppositories, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic*

Goods Act 1966) to Patient N in circumstances where Patient N was not present at the medical consultation and was not medically examined or assessed immediately prior to the prescription being issued.

Patient O

91. During the period 19 December 1997 to 4 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient O in the quantities and on the occasions shown in **Schedule O**:

(a) when the Practitioner knew or ought to have known that Patient O was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have that known Patient O was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient O; and/or

(c) when the Practitioner knew or ought to have known that Patient O was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

92. During the period 11 September 1998 to 4 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient O's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient O; and/or

(c) record a plan of treatment for Patient O; and/or

(d) full particulars of the medication prescribed to Patient O; and/or

(e) record information or advice given to Patient O in relation to medical treatment proposed by the Practitioner in relation to Patient O; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient O; and/or

(g) record sufficient and appropriate detail as to Patient O's case so as to allow another registered medical practitioner to continue the management of Patient O; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient O's medical notes.

93. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient O during the period 19 December 1997 to 4 May 1999 (as shown in **Schedule O**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

94. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient O as shown in **Schedule O1**.

95. During the period 19 December 1997 to 4 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient O (as shown in **Schedule O**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient P

96. During the period 13 June 1997 to 12 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient P in the quantities and on the occasions shown in **Schedule P**:

(a) when the Practitioner knew or ought to have known that Patient P was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient P was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient P; and/or

(c) when the Practitioner knew or ought to have known that Patient P was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

97. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient P's medical notes with respect to medical treatment or services provided to Patient P on 15 December 1998.

98. During the period 15 September 1998 to 12 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient P's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient P; and/or

(c) record a plan of treatment for Patient P; and/or

(d) full particulars of the medication prescribed to Patient P; and/or

(e) record information or advice given to Patient P in relation to medical treatment proposed by the Practitioner in relation to Patient P; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient P; and/or

(g) record sufficient and appropriate detail as to Patient P's case so as to allow another registered medical practitioner to continue the management of Patient P; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient P's medical notes.

99. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient P during the period 13 June 1997 to 12 May 1999 (as shown in **Schedule P**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

100. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the

Poisons and Therapeutic Goods Act 1966) issued to Patient P as shown in **Schedule P1**.

101. During the period 13 June 1997 to 12 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient P (as shown in **Schedule P**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient Q

102. During the period 4 August 1998 to 27 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Q in the quantities and on the occasions shown in **Schedule Q**:

(a) when the Practitioner knew or ought to have known that Patient Q was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient Q was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient Q; and/or

(c) when the Practitioner knew or ought to have known that Patient Q a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

103. During the period 15 September 1998 to 27 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient Q's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient Q; and/or

(c) record a plan of treatment for Patient Q; and/or

(d) full particulars of the medication prescribed to Patient Q; and/or

(e) record information or advice given to Patient Q in relation to medical treatment proposed by the Practitioner in relation to Patient Q; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient Q; and/or

(g) record sufficient and appropriate detail as to Patient Q's case so as to allow another registered medical practitioner to continue the management of Patient Q; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient Q's medical notes.

104. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Q during the period 4 August 1998 to 27 April 1999 (as shown in **Schedule Q**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

105. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient Q as shown in **Schedule Q1**.

106. During the period 4 August 1998 to 27 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Q (as shown in **Schedule Q**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient R

107. During the period 15 May 1998 to 28 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient R in the quantities and on the occasions shown in **Schedule R**:

(a) when the Practitioner knew or ought to have known that Patient R was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient R was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient R; and/or

(c) when the Practitioner knew or ought to have known that Patient R was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

108. During the period 4 September 1998 to 28 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient R's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient R; and/or

(c) record a plan of treatment for Patient R; and/or

(d) full particulars of the medication prescribed to Patient R; and/or

(e) record information or advice given to Patient R in relation to medical treatment proposed by the Practitioner in relation to Patient R; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient R; and/or

(g) record sufficient and appropriate detail as to Patient R's case so as to allow another registered medical practitioner to continue the management of Patient R; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient R's medical notes.

109. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient R during the period 15 May 1998 to 28 April 1999 (as shown in **Schedule R**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

110. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient R as shown in **Schedule R1**.

111. During the period 15 May 1998 to 28 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient R (as shown in **Schedule R**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient S

112. During the period 29 April 1997 to 12 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient S in the quantities and on the occasions shown in **Schedule S**:

(a) when the Practitioner knew or ought to have known that Patient S was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient S was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient S; and/or

(c) when the Practitioner knew or ought to have known that Patient S was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

113. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient S's medical notes with respect to medical treatment or services provided to Patient S on 4 September 1998.

114. During the period 4 September 1998 to 12 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient S's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient S; and/or

(c) record a plan of treatment for Patient S; and/or

(d) full particulars of the medication prescribed to Patient S; and/or

(e) record information or advice given to Patient S in relation to medical treatment proposed by the Practitioner in relation to Patient S; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient S; and/or

(g) record sufficient and appropriate detail as to Patient S's case so as to allow another registered medical practitioner to continue the management of Patient S; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient S's medical notes.

115. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient S during the period 29 April 1997 to 12 May 1999 (as shown in **Schedule S**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

116. During the period 29 April 1997 to 12 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient S (as shown in **Schedule S**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

117. The Practitioner contravened clause 57 of the *Poisons and Therapeutic Goods Regulation 1994* by supplying ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient S during the period 18 September 1998 to 20 November 1998 (as shown in **Schedule S**) in quantities

and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

118. During the period 18 September 1998 to 20 November 1998 the Practitioner contravened clause 59 of the *Poisons and Therapeutic Goods Regulation 1994* by supplying ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient S in quantities exceeding that required for 3 days treatment (as shown in **Schedule S**) and failing to adequately record the particulars of the name, strength and quantity of the substance supplied.

Patient T

119. During the period 24 November 1998 to 27 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient T in the quantities and on the occasions shown in **Schedule T**:

(a) when the Practitioner knew or ought to have known that Patient T was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient T was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient T; and/or

(c) when the Practitioner knew or ought to have known that Patient T was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

120. During the period 24 November 1998 to 27 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient T's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient T; and/or

(c) record a plan of treatment for Patient T; and/or

(d) full particulars of the medication prescribed to Patient T; and/or

(e) record information or advice given to Patient T in relation to medical treatment proposed by the Practitioner in relation to Patient T; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient T; and/or

(g) record sufficient and appropriate detail as to Patient T's case so as to allow another registered medical practitioner to continue the management of Patient T; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient T's medical notes.

121. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient T during the period 24 November 1998 to 27 April 1999 (as shown in **Schedule T**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

122. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient T as shown in **Schedule T1**.

123. During the period 24 November 1998 to 27 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient T (as shown in **Schedule T**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient U

124. During the period 17 January 1997 to 12 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient U in the quantities and on the occasions shown in **Schedule U**:

(a) when the Practitioner knew or ought to have known that Patient U was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient U was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient U; and/or

(c) when the Practitioner knew or ought to have known that Patient U was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

125. During the period 18 September 1998 to 12 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient U's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient U; and/or

(c) record a plan of treatment for Patient U; and/or

(d) full particulars of the medication prescribed to Patient U; and/or

(e) record information or advice given to Patient U in relation to medical treatment proposed by the Practitioner in relation to Patient U; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient U; and/or

(g) record sufficient and appropriate detail as to Patient U's case so as to allow another registered medical practitioner to continue the management of Patient U; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient U's medical notes

126. The Practitioner contravened clause 36 of the Poisons and Therapeutic Goods *Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient U during the period 17 January 1997 to 12 May 1999 (as shown in **Schedule U**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

127. During the period 17 January 1997 to 12 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by

prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient U (as shown in **Schedule U**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient V

128. During the period 23 September 1997 to 5 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient V in the quantities and on the occasions shown in **Schedule V**:

(a) when the Practitioner knew or ought to have known that Patient V was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient V was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient V; and/or

(c) when the Practitioner knew or ought to have known that Patient V was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

129. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient V's medical notes with respect to medical treatment or services provided to Patient V on 17 February 1999.

130. During the period 15 September 1998 to 5 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient V's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient V; and/or

(c) record a plan of treatment for Patient V; and/or

(d) full particulars of the medication prescribed to Patient V; and/or

(e) record information or advice given to Patient V in relation to medical treatment proposed by the Practitioner in relation to Patient V; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient V; and/or

(g) record sufficient and appropriate detail as to Patient V's case so as to allow another registered medical practitioner to continue the management of Patient V; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient V's medical notes.

131. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient V during the period 23 September 1997 to 5 May 1999 (as shown in **Schedule V**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

132. During the period 23 September 1997 to 5 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient V (as shown in **Schedule V**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient W

133. During the period 20 January 1999 to 12 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient W in the quantities and on the occasions shown in **Schedule W**:

(a) when the Practitioner knew or ought to have known that Patient W was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient W was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient W; and/or

(c) when the Practitioner knew or ought to have known that Patient W was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

134. During the period 20 January 1999 to 12 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient W's diagnosis and/or medical treatment; and/or

(b)

(c) record particulars of any clinical opinion reached by the Practitioner in relation to Patient W; and/or

(d)

(e) record a plan of treatment for Patient W; and/or

(f) full particulars of the medication prescribed to Patient W; and/or

(g) record information or advice given to Patient W in relation to medical treatment proposed by the Practitioner in relation to Patient W; and/or

(h) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient W; and/or

(i) record sufficient and appropriate detail as to Patient W's case so as to allow another registered medical practitioner to continue the management of Patient W; and/or

(j) clearly identify the Practitioner as being the person who made entries in Patient W's medical notes.

135. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient W during the period 20 January 1999 to 12 May 1999 (as shown in **Schedule W**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

136. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the

Poisons and Therapeutic Goods Act 1966) issued to Patient W as shown in **Schedule W1**.

137. During the period 20 January 1999 to 12 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient W (as shown in **Schedule W**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient X

138. During the period 22 September 1998 to 7 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient X in the quantities and on the occasions shown in **Schedule X**:

(a) when the Practitioner knew or ought to have known that Patient X was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient X was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient X; and/or

(c) when the Practitioner knew or ought to have known that Patient X was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

139. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient X's medical notes with respect to medical treatment or services provided to Patient X on 2 December 1998.

140. During the period 22 September 1998 to 7 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient X's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient X; and/or

(c) record a plan of treatment for Patient X; and/or

(d) full particulars of the medication prescribed to Patient X; and/or

(e) record information or advice given to Patient X in relation to medical treatment proposed by the Practitioner in relation to Patient X; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient X; and/or

(g) record sufficient and appropriate detail as to Patient X's case so as to allow another registered medical practitioner to continue the management of Patient X; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient X's medical notes.

141. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient X during the period 22 September 1998 to 7 May 1999 (as shown in **Schedule X**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

142. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient X as shown in **Schedule X1**.

143. During the period 22 September 1998 to 7 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient X (as shown in **Schedule X**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient Y

144. During the period 23 December 1997 to 27 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Y in the quantities and on the occasions shown in **Schedule Y**:

(a) when the Practitioner knew or ought to have known that Patient Y was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient Y was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient Y; and/or

(c) when the Practitioner knew or ought to have known that Patient Y was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

145. During the period 3 September 1998 to 27 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient Y's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient Y; and/or

(c) record a plan of treatment for Patient Y; and/or

(d) full particulars of the medication prescribed to Patient Y; and/or

(e) record information or advice given to Patient Y in relation to medical treatment proposed by the Practitioner in relation to Patient Y; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient Y; and/or

(g) record sufficient and appropriate detail as to Patient Y's case so as to allow another registered medical practitioner to continue the management of Patient Y; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient Y's medical notes.

146. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Y during the period 23 December 1997 to 27 April 1999 (as shown in **Schedule Y**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

147. During the period 23 December 1997 to 27 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Y (as shown in **Schedule Y**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

148. The Practitioner contravened clause 57 of the *Poisons and Therapeutic Goods Regulation 1994* by supplying ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Y during the period 3 September 1998 to 11 December 1998 (as shown in **Schedule Y**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

149. During the period 16 October 1998 to 11 December 1998 the Practitioner contravened clause 59 of the *Poisons and Therapeutic Goods Regulation 1994* by supplying ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Y in quantities exceeding that required for 3 days' treatment (as shown in **Schedule Y**) and failing to adequately record the particulars of the name, strength and quantity of the substance supplied.

Patient Z

150. During the period 4 December 1998 to 28 April 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Z in the quantities and on the occasions shown in **Schedule Z**:

(a) when the Practitioner knew or ought to have known that Patient Z was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient Z was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient Z; and/or

(c) when the Practitioner knew or ought to have known that Patient Z was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

151. During the period 4 December 1998 to 28 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient Z's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient Z; and/or

(c) record a plan of treatment for Patient Z; and/or

(d) full particulars of the medication prescribed to Patient Z; and/or

(e) record information or advice given to Patient Z in relation to medical treatment proposed by the Practitioner in relation to Patient Z; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient Z; and/or

(g) record sufficient and appropriate detail as to Patient Z's case so as to allow another registered medical practitioner to continue the management of Patient Z; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient Z's medical notes.

152. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Z during the period 4 December 1998 to 28 April 1999 (as shown in **Schedule Z**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

153. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient Z as shown in **Schedule Z1**.

154. During the period 4 December 1998 to 28 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient Z (as shown in **Schedule Z**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient AA

155. During the period 23 October 1998 to 7 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient AA in the quantities and on the occasions shown in **Schedule AA**:

(a) when the Practitioner knew or ought to have known that Patient AA was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient AA was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient AA; and/or

(c) when the Practitioner knew or ought to have known that Patient AA was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

156. During the period 23 October 1998 to 7 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient AA’s diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient AA; and/or

(c) record a plan of treatment for Patient AA; and/or

(d) full particulars of the medication prescribed to Patient AA; and/or

(e) record information or advice given to Patient AA in relation to medical treatment proposed by the Practitioner in relation to Patient AA; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient AA; and/or

(g) record sufficient and appropriate detail as to Patient AA's case so as to allow another registered medical practitioner to continue the management of Patient AA; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient AA's medical notes.

(i)

157. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient AA during the period 23 October 1998 to 7 May 1999 (as shown in **Schedule AA**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

158. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient AA as shown in **Schedule AA1**.

159. During the period 23 October 1998 to 7 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient AA (as shown in **Schedule AA**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient BB

160. During the period 23 December 1997 to 5 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient BB in the quantities and on the occasions shown in **Schedule BB**:

(a) when the Practitioner knew or ought to have known that Patient BB was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient BB was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient BB; and/or

(c) when the Practitioner knew or ought to have known that Patient BB was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

161. During the period 11 September 1998 to 5 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient BB's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient BB; and/or

(c) record a plan of treatment for Patient BB; and/or

(d) full particulars of the medication prescribed to Patient BB; and/or

(e) record information or advice given to Patient BB in relation to medical treatment proposed by the Practitioner in relation to Patient BB; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient BB; and/or

(g) record sufficient and appropriate detail as to Patient BB's case so as to allow another registered medical practitioner to continue the management of Patient BB; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient BB's medical notes.

162. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient BB

during the period 23 December 1997 to 5 May 1999 (as shown in **Schedule BB**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

163. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient BB as shown in **Schedule BB1**.

164. During the period 23 December 1997 to 5 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient BB (as shown in **Schedule BB**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

Patient CC

165. During the period 23 December 1997 to 14 May 1999 the Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient CC in the quantities and on the occasions shown in **Schedule CC**:

(a) when the Practitioner knew or ought to have known that Patient CC was dependent or was likely to become dependent on the restricted substances prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient CC was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances to Patient CC; and/or

(c) when the Practitioner knew or ought to have known that Patient CC was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

166. The Practitioner contravened clauses 13(1) and 14(1) of the *Medical Practice Regulation 1998* by failing to make contemporaneous entries in Patient CC's medical notes with respect to medical treatment or services provided to Patient CC on the following occasions:

(a) 27 November 1998; and/or

(b) 18 December 1998; and/or

(c) 20 December 1998; and/or

(d) 20 January 1999; and/or

(e) 27 January 1999.

167. During the period 3 September 1998 to 14 May 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient CC's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient CC; and/or

(c) record a plan of treatment for Patient CC; and/or

(d) full particulars of the medication prescribed to Patient CC; and/or

(e) record information or advice given to Patient CC in relation to medical treatment proposed by the Practitioner in relation to Patient CC; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient CC; and/or

(g) record sufficient and appropriate detail as to Patient CC's case so as to allow another registered medical practitioner to continue the management of Patient CC; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient CC's medical notes.

168. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient CC during the period 23 December 1997 to 14 May 1999 (as shown in **Schedule CC**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

169. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient CC as shown in **Schedule CC1**.

170. During the period 23 December 1997 to 14 May 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient CC (as shown in **Schedule CC**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

171. The Practitioner prescribed ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient CC in circumstances where Patient CC was not present at the medical consultation and was not medically examined or assessed immediately prior to the prescription being issued on the following occasions:

(a) 4 May 1999; and/or

(b) 11 May 1999.

Patient DD

172. During the period 21 August 1998 to 21 April 1999 the Practitioner prescribed ***restricted substances*** and ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD in the quantities and on the occasions shown in **Schedule DD**:

(a) when the Practitioner knew or ought to have known that Patient DD was dependent or was likely to become dependent on the restricted substances and/or drugs of addiction prescribed; and/or

(b) when the Practitioner knew or ought to have known that Patient DD was under the care of other medical practitioners who were also concurrently prescribing similar restricted substances and/or similar drugs of addiction to Patient DD; and/or

(c) when the Practitioner knew or ought to have known that Patient DD was a participant in a methadone program; and/or

(d) without exercising adequate medical judgment as to whether the prescribing of the restricted substances and/or drugs of addiction was appropriate in the circumstances and/or in accordance with recognised therapeutic standards.

173. During the period 18 September 1998 to 21 April 1999 the Practitioner contravened clause 13(1) of, and clauses 1(2)(a) to (d), 1(3), 1(4)(c), 2(1), 2(2) and 3(2) of Schedule 2 to, the *Medical Practice Regulation 1998* by failing to:

(a) record information relevant to Patient DD's diagnosis and/or medical treatment; and/or

(b) record particulars of any clinical opinion reached by the Practitioner in relation to Patient DD; and/or

(c) record a plan of treatment for Patient DD; and/or

(d) full particulars of the medication prescribed to Patient DD; and/or

(e) record information or advice given to Patient DD in relation to medical treatment proposed by the Practitioner in relation to Patient DD; and/or

(f) record the name of the person, being the Practitioner, who treated and prescribed medication to Patient DD; and/or

(g) record sufficient and appropriate detail as to Patient DD's case so as to allow another registered medical practitioner to continue the management of Patient DD; and/or

(h) clearly identify the Practitioner as being the person who made entries in Patient DD's medical notes.

174. The Practitioner contravened clause 36 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD during the period 21 August 1998 to 21 April 1999 (as shown in **Schedule DD**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what was appropriate in the circumstances.

175. The Practitioner contravened clause 37(1)(a) of the *Poisons and Therapeutic Goods Regulation 1994* by recording a date, other than the date of issue, on prescriptions for ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) issued to Patient DD as shown in **Schedule DD1**.

176. During the period 21 August 1998 to 21 April 1999 the Practitioner contravened clause 40(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***restricted substances*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD (as shown in **Schedule DD**) and failing to record the particulars of:

(a) the name, strength and quantity of the substance prescribed; and/or

(b) the maximum number of times the substance may be supplied on the prescription; and/or

(c) the directions for use, as shown on the prescription.

177. The Practitioner contravened clause 81 of the *Poisons and Therapeutic Goods Regulation 1994* by issuing prescriptions for ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966)* to Patient DD during the period 3 March 1999 to 21 April 1999 (as shown in **Schedule DD**) in quantities and/or for purposes not in accordance with recognised therapeutic standards of what is appropriate in the circumstances.

178. During the period 3 March 1999 to 21 April 1999 the Practitioner contravened clause 84(1) of the *Poisons and Therapeutic Goods Regulation 1994* by prescribing ***drugs of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD (as shown in **Schedule DD**) and failing to record the particulars of:

(a) the name, strength and quantity of the drug prescribed; and/or

(b) the maximum number of times the drug may be supplied on the prescription; and/or

(c) the directions for use as shown on the prescription.

179. The Practitioner contravened section 28(a) of the *Poisons and Therapeutic Goods Act 1966* by prescribing otherwise than in accordance with an authority given to the Practitioner, Codeine Phosphate, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD during the period 3 March 1999 to 21 April 1999 (as shown in **Schedule DD**) resulting in the ***drug of addiction*** being prescribed for continuous therapeutic use by Patient DD for a period exceeding 2 months.

180. The Practitioner contravened section 28(b) of the *Poisons and Therapeutic Goods Act 1966* by prescribing Codeine Phosphate, being a ***drug of addiction*** (as defined by section 4(1) of the *Poisons and Therapeutic Goods Act 1966*) to Patient DD during the period 3 March 1999 to 21 April 1999 (as shown in **Schedule DD**) otherwise than in accordance with an authority given to the Practitioner, when the Practitioner knew or ought to have known that Patient DD was during that period of time an ***addict*** (as defined by section 27 of the *Poisons and Therapeutic Goods Act 1966*).

Dated this 31st day of January 2007