MEDICAL TRIBUNAL OF NEW SOUTH WALES **REVISED**

DEPUTY CHAIRPERSON: JUDGE G. J. GRAHAM
Tribunal Members: Dr. F. H. Burns, OAM
Dr. K. Ilbery
Dr. C. Berglund, Ph.D

THURSDAY 25 NOVEMBER 2004

IN RE DR ECKARD ROEHRICH AND THE MEDICAL PRACTICE ACT

REASONS FOR DETERMINATION AND ORDERS

IMPORTANT NOTE

SUPPRESSION ORDER

PURSUANT TO CLAUSE 6 SCHEDULE 2 OF THE MEDICAL PRACTICE ACT 1991 THE TRIBUNAL HAS ORDERED THAT THERE BE NO PUBLICATION OF THE NAMES OF THE PATIENTS OR OF ANY MATERIAL CAPABLE OF IDENTIFYING THEM.

1. The Tribunal has conducted an inquiry into a complaint of the Commissioner of the Health Care Complaints Commission into the professional conduct of a registered medical practitioner, Dr Eckard Roehrich.

HISTORY OF THE TRIBUNAL PROCEEDINGS

2. Before turning to the detail of that complaint, some brief reference to its history in this Tribunal is relevant. These matters have been the subject of more detailed consideration in various judgments given on earlier occasions since the matter was revived in the middle of 2004. 3. There was an initial hearing of an inquiry into the complaint conducted in the middle of 2002. The evidence was complete and the Tribunal had reserved its decision in that matter. Unfortunately the intervening serious illness of the Deputy Chairperson meant that no decision was delivered on that inquiry. By the middle of this year it became clear that it was unlikely that the Deputy Chairperson would be in a

position to participate any further in this inquiry. His illness continued and ultimately on 4 November 2004 the judge retired from the District Court and by virtue of s 148(7) of the **Medical Practice Act** 1992 ceased to hold office as a Deputy Chairperson. 4. Prior to that retirement, but at a time when it was highly unlikely that the then Deputy Chairperson could continue with the inquiry, the inquiry was revived
and the Tribunal reconstituted by appointment of the present Deputy Chairperson and the three Members now sitting on this inquiry. None of the Tribunal members had previously sat on this inquiry. 5. An issue arose before the dates fixed for the formal hearing of the inquiry as to whether the transcript of the earlier hearing in the Tribunal could be tendered. 6. At that stage it was held that the freshly constituted Tribunal had jurisdiction to entertain the complaint and to hold an inquiry. That decision was essentially made on the basis of what might be termed the principle of necessity. As the Deputy Chairperson held on that issue, the Tribunal had jurisdiction to hear the complaint on the same basis that a differently constituted tribunal came to the same conclusion in similar circumstances in the case of Dr Hamad, Medical Tribunal, 11 October 2004 at para 7. In other words, prior to 4 November this was not a matter governed by the provisions of the **Medical Practice Act** dealing with the effect of a vacancy on the Tribunal, in particular, s 149(2) which terminates an inquiry if the:

"Deputy Chairperson vacates office for any

> reason before the Tribunal has completed an inquiry or appeal or made a determination in respect of an inquiry".

7. However, given the cases dealing with analogous circumstances where a judge presiding at a trial in the ordinary courts is unable to continue, this Tribunal took the view that it would be appropriate to proceed with the further hearing of this complaint on the basis that it was to be a new inquiry. 8. Accordingly, the transcript of the earlier proceedings was not a matter which would necessarily be before the Tribunal conducting that new inquiry. However it was held, and that holding was confirmed on 22 November when the matter was re-agitated, that the transcript of the proceedings in 2002 before the Tribunal on this particular complaint ought to be admitted in the exercise of the powers conferred on a tribunal under Sch 2 particularly cl 1 and 4. 9.It was nonetheless clear (when the matter was first raised by a notice of motion put on by the respondent and reiterated on Monday of this week) that the effect of that decision was not to preclude the tendering of other evidence in the proceedings. There was no agreement that the new Tribunal should act solely on the basis of the earlier transcript, nor did the complainant suggest that the matter would have to be conducted in that fashion. It was clear (and directions were given to this effect) that each of the parties should file and serve such material as those parties sought to rely upon in this hearing. The respondent was also advised that he should indicate those witnesses who gave evidence in the previous Tribunal and

whose presence was required at the fresh hearing for the purpose of cross-examination. He gave such a notice but it appeared that he did not ultimately require those witnesses for cross-examination or at least, if he did, he did not seek to avail himself of that right. 10. In other words, although the transcript of the previous hearing has been admitted, it forms but part of the evidence in this case. It was admitted in the face of a purported attempt by the respondent to withdraw any admissions he made in those earlier proceedings. The Deputy Chairperson understood that he was intending to convey by that stance that he sought to withdraw not only a series of written admissions tendered to the Tribunal, but also to, in effect, withdraw evidence which he himself gave on oath in the earlier inquiry. 11. By the time the Tribunal reconvened for the full hearing of the inquiry into this complaint on 22 November 2004, the situation had changed, at least in form, so that s 149(3) then applied. By that time the former Deputy Chairperson had ceased to hold office by virtue of his retirement from the District Court. The effect was that the earlier inquiry was terminated and, thus, s 149(3) became operative so that:

> "the Tribunal may be reconstituted (in accordance with this Part) for the purposes of conducting a new inquiry ….... in respect of the matter concerned."

By 22 November what was being conducted by this Tribunal was that new inquiry envisaged by s 149(3). 12.That made no material difference to the basis upon which the ruling as to the admission of the transcript had been made

earlier, but the admission of that material was confirmed in the course of dealing with the practitioner's notices of motion on Monday of this week. In approaching the admissions made and the evidence given at that earlier hearing the Tribunal is conscious of the desire of the respondent to resile from that material. The material is but part of the evidence before this Tribunal and is to be viewed in that light, as simply part of the material upon which this Tribunal will act. Thus, where any admission made or evidence given, is in conflict with other matters which may be established by the evidence, then the weight to be attached to the material from the earlier hearing would be diminished or nullified by the Tribunal's assessment of the evidence as a whole.

THE PRACTITIONER'S PARTICIPATION

13. The second matter which should be mentioned in a preliminary way that relates to the participation of the respondent in these proceedings. 14. At the first hearing he was represented by senior counsel and by a solicitor experienced in work of this type. He had the opportunity to seek advice from those lawyers, to be guided by it and to place the conduct of the inquiry in their hands. He has sought to assert that he was coerced into the position which was taken by him, and on his behalf, at that earlier hearing. He made a similar claim in relation to the way in which he was interviewed by inspectors from the Pharmaceutical Services Branch on 10 June 1998. The issue as to how he was treated by his lawyers is not the subject of any detailed evidence, nor, in the circumstances, has the practitioner sought to elaborate on that claim. It is difficult to see how that claim could have much bearing on

sworn evidence which he himself gave in those proceedings. The admissions which he made in a formal way were by no means unqualified; some matters were not admitted and some were admitted but with a qualification or attempt at justification. 15. If there is to be any test applied to his claims as to the reliability of the admissions made and the evidence given by the respondent at the earlier hearing, then it is usefully provided by an assessment of his claims concerning the interview with the Pharmaceutical Services Branch inspectors on 10 June 1998. The complainant's material included a transcript of that interview. It is clear from the evidence that, at the conclusion of the interview, the respondent himself was provided with a tape of that interview. The interview was taped and that tape used as the basis of the transcription. The allegation is that the conduct of the inspectors was such as to coerce the respondent into making admissions. That suggestion has been put in various ways, but in the end it amounts to an assertion that he was treated unfairly and somewhat vigorously by the inspectors. 16. One of those inspectors was called to give evidence yesterday and was asked some questions about that interview. It is clear from his evidence and from the Tribunal's own listening to the tape of that interview, which was tendered as exhibit D in these proceedings, that the method of conduct of the interview was quite different to that which the respondent had suggested. In the first place, it is clear that an appointment had been made to see him. It is clear that, prior to the commencement of the interview, he had been advised (in all probability) of the identity of the patients whose records and treatment were the subject of the Branch's concern and there are references in the interview itself to some of these preliminary discussions.

The method of conduct of the interview, so far as it can be judged from the audiotape, was business-like, fair, designed to elicit facts from the respondent and conducted in a manner designed to reassure him as to the need to answer the questions simply to the best of his ability. 17. At one point he was asked about standard or recommended dosages for various drugs and when he appeared to have some difficulty in being precise, it was made clear to him that it was “not a test”. 18. A reading of the transcript and a consideration of the voices on the tape and a consideration of the material put before the Tribunal on behalf of the respondent leads inevitably to only one conclusion and that is that there was no coercion or unfairness, high-handed behaviour, bullying or any other form of unacceptable conduct by the inspectors in conducting that interview. The Tribunal, of course, would make due allowance for the element of surprise, though it was not complete surprise, given that there was an appointment made and some preliminary discussions, including a caution given, before the interview took place. 20. The Tribunal also takes into account what the inspector said yesterday, that is, that he anticipated that a person who was being interviewed in those circumstances might feel under some pressure. That again is understandable and is a matter to be taken into account in weighing up the answers given by Dr Roehrich. 21. The Tribunal has concluded that the answers given by the respondent in that interview are answers which may be treated as being freely given by him at the time and without any pressure of any inappropriate or unfair kind placed on him by the inspectors or by the circumstances of the interview. 22. In that respect, the respondent’s allegations about the conduct of that interview offer some assistance in determining, on the very limited evidence

available, whether the evidence which he gave to the earlier tribunal hearing and the admissions he made to that hearing should be held to have no weight or any significantly diminished weight by virtue of any allegation of coercion. The Tribunal is satisfied that the admissions made, and the evidence given by the respondent, in 2002 before the Tribunal should be given significant weight, though in the context that that evidence and those admissions are but part of the overall evidence before this Tribunal.

23. The third matter which should be discussed at this preliminary stage relates to the further conduct of the proceedings. At all material times since the matter was first brought back before the Tribunal for further directions in May or June of 2004, the respondent has been representing himself. 24. There was at one stage a suggestion that a firm of solicitors may have been involved, but it would appear that, in practical terms, the respondent has been self-represented throughout that period. On earlier occasions in this present hearing he had the assistance of a woman, who was identified to the Tribunal and described as being his practice manager, and on Monday he was accompanied by the practice manager and also by a solicitor, Mr Bill Henty, who was permitted to sit at the Bar table with him and was seen to be providing some advice or assistance to the respondent during the hearing of the notices of motion which occupied most of Monday. However, it was clear and the Tribunal accepts that Mr Henty’s role was not that of a solicitor representing the respondent in these proceedings, but more the role of a person assisting and perhaps offering some advice, whether legal or otherwise, to the respondent.

25. Notwithstanding that he has been unrepresented, the respondent took part in this inquiry fairly fully until

the last couple of days. He attended at a number of directions hearings. He argued a notice of motion before the Deputy Chairperson sitting alone and again on Monday argued two notices of motion which included reference to legal principles as well as to the facts of this case. 26. Had the respondent turned his mind more completely to the substance of this inquiry, there is little doubt that he would have been in a position to have advanced his interests and to defend the complaint with some measure of skill. 27. However, once the notices of motion were dismissed he indicated that he did not propose to enter a plea, by which he considered there was “no case to answer”. He did not attend on Tuesday, the day to which the inquiry had been adjourned, and faxed a document to the Court. That fax was the subject of a response both from the Tribunal and from the complainant. Notwithstanding clear notice that the matter was proceeding, whether or not he was present, he did not attend yesterday, but sent a further fax concerning a section 16 notice. In view of the evidence which was presented yesterday on behalf of the Commission, the Tribunal considered that there was no substance in that issue. Dr Roehrich failed to attend, again, today but sent a fax to the complainant with a copy to the Deputy Chairperson again requiring that he be sent what he says was the original document dated 14 August 1998. Again, that issue has been dealt with briefly this afternoon. It is a matter which, in truth, is peripheral to the real issues in this complaint. 28. The Tribunal can do no more than simply note that Dr Roehrich has deliberately chosen not to participate further in this matter. 29. In those circumstances, any explanations which he has previously offered in relation to the matter of this complaint or concerning his medical practice generally are all the more

valuable as material for this Tribunal to take into account. 30. The Tribunal has the opportunity of considering the contents of the interview with the Pharmaceutical Services Board and other responses to the complaint including, of course, the evidence which he gave in 2002. 31. In addition, the respondent complied with a direction to file and serve material upon which he relied and did so in the shape of a substantial volume of documents, forty-two in all, including a lengthy affidavit with some twenty-five annexures. 32. Whilst the Tribunal would have been assisted by the continued participation of the respondent in this inquiry, the material before it is nevertheless sufficient to form a concluded view as to the matter, which the Tribunal has done.

THE COMPLAINT

33. The complaint alleges that the respondent has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of ss 36 and 37 of the Act in that, being a registered medical practitioner, he (1) demonstrated:

> "a lack of adequate knowledge, skill, judgement or care in the practice of medicine"

and/or (2) engaged in:

> "improper and unethical conduct relating to the practice of medicine".

34. Under the heading "Particulars", the complaint recites:

> "At all relevant times the practitioner was practising as a general practitioner at Gorokan, New South Wales".

35. The particulars then go on to make specific allegations concerning two patients described in the complaint as patient A and patient B. Those patients are named in a list of patients annexed to the complaint. In

view of the order which has been made prohibiting disclosure of those names, they will be referred to in this judgment as patient A and patient B. 36. In relation to patient A there are four paragraphs of particulars divided into subparagraphs. 37. The first alleges:

> "1. During the period September 1997 to February 1998 the practitioner prescribed a drug of addiction, namely Codeine Phosphate for Patient A on the dates and in the quantities shown in the schedule annexed hereto and marked A for continuous therapeutic use for a period exceeding two months:
>
> (a) without obtaining an authority in respect of patient A to so prescribe the drug of addiction from the New South Wales Department of Health and/or
>
> (b) contrary to the requirements of s 28 of the **Poisons and Therapeutic Goods Act** 1966 and/or
> (c) when he knew or ought to have known that patient A was an addict."

38. In relation to particular 1, the respondent admitted each of those particulars in the admissions tendered to the previous hearing which are set out in tab 32 in exhibit A here. As will be seen, the evidence in any event discloses that this allegation is established. Schedule A covers over six pages and includes prescriptions for - on a substantial number of occasions between 13 January 1997 and 11 February 1998 for Panadeine Forte, Diazepam, Temazepam, Oxazepam and Codeine Phosphate. 39. Particular 2 is as follows:

> "2. During the period January 1997 to February 1998 the practitioner prescribed for patient A on the dates and in the quantities shown in the schedule annexed hereto and marked with the letter A alone and in combination the drugs Panadeine Forte, Diazepam, Temazepam, Oxazepam and Codeine Phosphate:
>
> (a) without exercising responsible judgement".

Subpara (a) was admitted in the 2002 admissions. Para (b) reads:

> "in quantities in excess of recognised therapeutic standards".

That allegation was also admitted in 2002. Para (c):

> "inappropriately on a long-term basis for the treatment of pain".

That allegation was admitted in 2002 but the admission was qualified on the basis that patient A was treated for his addiction and not for pain. Para 2(d) reads:

> "in a manner likely to induce and/or maintain dependency in the patient ".

That paragraph was admitted but as to maintaining only. Para (e) reads:

> "in circumstances where the practitioner knew or ought to have known patient A was an addict and likely to abuse the prescribed drugs".

That paragraph was the subject of an admission in 2002 but qualified by an assertion that he “was treated for his known addiction”. 40. Para 3 alleges:

> "During the period January 1997 to February 1998 the practitioner in his treatment of patient A:
>
> (a) failed to consider and/or provide more appropriate treatment options".

That paragraph was “not admitted” on the basis that patient A was unwilling to consider detoxification/rehabilitation. Para (b):

> "prescribed the drugs in schedule A on demand".

That paragraph was not admitted with a note that it was “mostly prescribed according to weekly plan in clinical notes”. Para 3(c) alleges:

> "prescribed the drugs when his practice

> partner, Dr Sztulman, was also prescribing similar drugs for the patient as shown in the schedule annexed hereto and marked with the letter C".

That was the subject of an admission without qualification in tab 32. Para (d):

> "failed to reduce either the quantity or the combinations of the drugs".

That was admitted as to “quantity”, but it was asserted that the combination had been reduced. Para 3(e):

> "failed to recognise as a Methadone prescriber that the patient was likely to abuse the prescribed medication".

That allegation was “not admitted” in 2002.

Given the evidence in this inquiry, it is open to conclude that the respondent had some understanding or recognition that patient A was likely to abuse the prescribed medication. However, without doing violence to the terms of that particular, the evidence, on the other hand, discloses that he failed to <u>properly</u> recognise that likelihood or to act upon it in his prescribing methods with this patient. Para (f):

> "failed to refer the patient to a drug and alcohol specialist or detoxification facility".

That paragraph was admitted but with the qualification that the patient “was counselled and refused to attend a drug and alcohol specialist or detoxification facility”. Para (g) was not admitted but is, in any event, not now pressed by the complainant. For the record, it alleged,

> "in December 1997 and January 1998 abruptly ceased all prescriptions for drugs for a period of three weeks without referring the patient to an in-patient detoxification centre".

It is clear from the clinical notes, as the document in

tab 32 asserts, that there was prescription of drugs within that three week period. Thus, that particular is not pressed. 41. Para 4 alleges that the practitioner failed to maintain adequate clinical records for patient A in that he failed to record (a) a proper medical history, (b) a full drug history. That was admitted ultimately in 2002. It was initially not admitted but the written admission signed by the respondent were amended to admit those particulars which, as the evidence disclosed in this hearing, has been fully made out. 42. As to patient B, there are three paragraphs of particulars. 43. The first alleges that:

> "During the period February 1997 to February 1998 the practitioner prescribed for patient B on the dates and in the quantity shown in the schedule annexed hereto and marked with the letter B, alone and in combination the drugs Panadeine Forte, Diazepam, Temazepam, Oxazepam and Codeine Phosphate:
>
> (a) without exercising responsible medical judgement,
>
> (b) in quantities in excess of recognised therapeutic standards."

The Tribunal notes that both of those subparagraphs were admitted in 2002. Subpara (c):

> "inappropriately on a long-term basis for the treatment of pain"

was admitted but with the qualification that patient B “was treated for his addiction not for pain”.

Subpara (d):

> "in a manner likely to induce and/or maintain dependency in the patient ".

That particular was admitted as to the question of maintaining dependency only. Subpara (e) alleges:

> "in circumstances where the practitioner knew or ought to have known patient B was an addict and likely to abuse the prescribed drugs".

That was admitted, but with the qualification that patient B was being treated for addiction and not for pain. 44. Para 2 alleged that,

> "During the period February 1997 to February 1998 the practitioner in his treatment of patient B (a) failed to consider and/or provide more appropriate treatment options, (b) prescribe the drugs in Schedule B on demand, (c) prescribe the drugs when his practice partner, Dr Sztulman, was also prescribing similar drugs for the patient as shown in the schedule annexed hereto and marked with the letter D."

Those three sub-particulars were all admitted in 2002. Subpara (d) alleged:

> "failed to reduce either the quantity or the combinations of the drugs".

That was admitted in 2002 but was qualified in these words:

> "Because I infrequently prescribed for patient B".

Para (e) alleged:

> "failed to recognise as a Methadone prescriber that the patient was likely to abuse the prescribed medication".

Again, that was not admitted but, if the failure to recognise is read as being a failure to recognise in a proper fashion and to act accordingly, (as it should be), then the evidence would establish that that particular has been made out. And, in any event, the respondent knew that that was a likelihood as may be inferred from his answers in relation to both patient B and also in relation to patient A, the evidence which has been given in these

proceedings indicating a general risk of abuse in the ways, for example, described by Dr Sidler in his evidence yesterday. Para (f) alleged that he failed to refer the patient to a drug and alcohol specialist or detoxification facility. That was admitted in 2002. Para (g), again, was not pressed but, for the record, alleged that “in December 1997 abruptly ceased all prescriptions for drugs without referring the patient to an in-patient detoxification centre”. That allegation, in fact, was not admitted with a reference to evidence in the clinical records. In the light of those clinical records, the complainant does not press that allegation.

45. Finally, particular 3 in relation to patient B alleges:

> "The practitioner failed to maintain adequate clinical records for patient B in that he failed to record:
>
> (a) a proper medical history,
>
> (b) a full drug history".

Again, that was a matter which was initially not admitted in 2002 but the written admissions were amended to turn that into a matter which was admitted. In any event, the evidence fully supports that particular in both its aspects

THE COMPLAINANT’S CASE

46. The complainant’s case here is that the matters particularised, subject to those not pressed, have been proved to a level whereby the Tribunal would be comfortably satisfied, on the balance of probabilities, that:

1. each particular has been made out as a matter of fact;

2. in each particular, the conduct so proved amounts to unsatisfactory professional conduct on the part of the practitioner;

3. individually and cumulatively the unsatisfactory professional conduct, when evaluated, amounts to professional misconduct.

47. The complainant submits that the practitioner's professional misconduct warrants the Tribunal reprimanding the practitioner and imposing conditions upon his registration designed to act for the protection of the public, by requiring a measure of training and supervision for this practitioner.

LEGAL PRINCIPLES

48. There is no need to deal in detail with the legal principles governing the conduct of these inquiries. It is sufficient, for example, to refer to those principles as set out in the decision of the Tribunal in relation to Dr Phillip Michael Furey, Medical Tribunal, 23 December 2002, particularly at paras 9 to 26. It is sufficient to note, however, some features of the principles discussed in those passages. Errors of judgement, do not necessarily amount to unsatisfactory professional conduct. The conduct in question must have a connection with the practice of medicine. In order to amount to professional misconduct, conduct must, first, be unsatisfactory professional conduct in breach of s 36 of the Act but, in order to amount to conduct in the more serious category of

professional misconduct, it must be conduct which is sufficient to justify suspension or the removal of the practitioner's name from the register: s.37 of the Act. Thus, the conduct must be sufficient to attract a finding that the practitioner has conducted himself or herself in a manner which attracts the severe or strong disapproval of peers of reputable standing or has been guilty of conduct so obviously wrong that a peer who did not strongly disapprove would not be thinking reasonably. It follows that a practitioner who acts on a respectable, though minority, view as to what is acceptable conduct, especially in the actual practice of medicine, cannot be said to be guilty of professional misconduct. 49. So far as the standard of proof is concerned, it is the civil standard of proof on the balance of probabilities but qualified by the gravity of the question to be determined, particularly the seriousness of the allegations made, the inherent unlikelihood of an occurrence or the gravity of the consequences which may flow from the particular finding. This requires the Tribunal to be comfortably satisfied on the balance of probabilities that the complaint is established and that standard of proof applies to each of the particulars. 50. The task of the Tribunal, having considered whether particulars have been established on that basis, then is to consider the practitioner's conduct, so established, in order to evaluate the totality of that conduct with a view, for example, to determining whether the whole of that conduct amounts to professional misconduct. 51. The Tribunal is

bound, in addition to considering the whole of the practitioner's conduct, to take into account other relevant matters such as prior disciplinary action, character, the need in a local community or within a particular specialty for the skills of a practitioner and a host of other matters, in arriving at the ultimate sanction to be imposed. One relevant consideration in the present case is the lapse of time since the conduct complained of – a period in excess of six years.

THE PRACTITIONER'S BACKGROUND

52. It is appropriate to consider the general background of this respondent. Much of it can be gleaned from various parts of the material placed before the Tribunal on both sides of the record. Most conveniently, as a starting point, is the curriculum vitae which is tab 2 in exhibit 1, the material provided by the respondent for this hearing. 53. He graduated with medical degrees in 1971 from the University of Kiel Medical School in Germany. He obtained his Doctorate of Philosophy at that university in 1975 in experimental physiology. He obtained fellowships in Physician for Surgery and Physician for Trauma Surgery in Germany in 1979 and 1981 respectively. He sat the United States medical entry exam in 1981 and the Canadian Medical Council evaluating examination in the same year. He sat for the Australian Medical Examining Council exam in September 1982.

54. Between 1971 and 1975 he was a part-time research assistant in the Institute of Physiology at the University of Kiel. In 1972 and 1973 he was an intern at two

hospitals in West Germany and in 1974 to 1977 was a resident in the Department of Surgery in a hospital in Hamburg and again between 1977 and 1978 in that hospital. Between 1978 and 1979 he was a registrar in emergency medicine and orthopaedics at another hospital in Germany and in 1979 a registrar in plastic and hand surgery at an emergency hospital in the Hamburg area. In 1979 to 1980 he was a registrar in orthopaedics and trauma surgery at a hospital in Germany. 55. In 1982 he became a surgical registrar at a hospital in Sydney, in 1983 a paediatric resident in the hospital on the Central Coast and in 1983 a registrar in the Department of Surgery and Orthopaedics in that same hospital at Gosford. In 1983 he was a registrar in the Department of Surgery and Orthopaedics at Gosford Hospital and in 1983 or 1984 a registrar in accident and emergency at that hospital. 56. From 1985 to September 2002 he was in general practice at Gorokan, that being the practice in which he was working at the time with the matters in the complaint. He then moved to the Berkeley Vale Health Clinic where he remained in practice until a suspension in September this year. 57. He described the special interests in his practice as including pain management, nutritional medicine, environmental medicine, drug and alcohol management, procedural medicine, integrative medicine. 58. He obtained a Methadone Prescriber’s Accreditation in February 1997. That would appear to have been as a result of a one day course, that course now taking two days. He has been a member of a Central Coast Balint Group since

May 1995 and, for an unspecified time, has been a member of the Australian Integrative Medical Association.

59. Whilst his curriculum vitae does not deal with all of the courses or other professional or educational activities in which he has been involved, some of the other material provided on his behalf tends to fill out some of that history. For example, Dr Tony Gill was the director of Drug and Alcohol Services in the Central Coast Area Health Service between 1993 and 1999. He says, in a reference of 15 May 2002, exhibit 1, tab 21, that the respondent attended drug and alcohol training sessions and was interested in learning more about the management of patients with drug and alcohol problems. He appeared to Dr Gill to be a caring general practitioner. In the balance of that reference he was not entirely complimentary of the respondent. He stated that the respondent:

> "struggled with the conflicted aims of setting limits on patients and being a caring and trusting general practitioner. In my view his management of dependent and demanding patients was not always in accordance with my views on good drug and alcohol clinical practice, however it was founded on a caring approach to his patients. It always appeared to me that his aim was to achieve the best possible outcome for his patient."

Nonetheless Dr Gill confirms his attendance and interest in drug and alcohol training sessions. 60. That continuing interest is attested to by a reference from Dr McKenna, the Clinical and Medical Director of Alcohol and Other Drug Services for Central Coast Area Health Service as at May of 2002. She had been in contact with

the respondent only from a period around the end of 2000, some time after the time period of these complaints. She was able to comment on a number of matters, including what she says was the respondent's "clear statement that in retrospect he saw that his management was far from ideal in relation to these two patients". She certainly did not support the prescription of long-term high dose Benzodiazepines in a primary health care setting, however, she reported that the respondent felt that there are demonstrable harm reductions both for the patient and the community justifying, in-part, his chosen management. She noted that he was working under the principles of the Sole Prescriber's Initiative designed to deliver better care to doctor shopping patients. She certainly supported that approach as the preferred model of care but went on to say:

> "However, as these patients can be demanding and manipulative I would recommend that they are co-managed with the assistance of an alcohol and other drug specialty unit."

The Tribunal observes that it cannot be said that there was any such relevant co-management in the case of the two patients here. She went on to say:

> "I am very surprised that Dr Roehrich's prescribing practices were allowed to continue for so long unchecked. Under the Sole Prescriber Initiative Dr Roehrich incorrectly assumed that if a problem was identified he would have been given feedback much earlier from the Pharmaceutical Services Branch."

With those somewhat critical qualifications, Dr McKenna goes on to say:

> "Since working for Central Coast Health Alcohol and Other Drugs Service Dr Roehrich has to the

> best of my knowledge appropriately accessed consultation and assistance from our service. He also regularly attends alcohol and other drug service educational sessions where he contributes very appropriately."

She was also of the view that, if the Tribunal found that he would benefit from specialist supervision around the management of dependency, then she would be happy to act as his clinical supervisor.

61. So far as his involvement in the Balint Group is concerned, that is dealt with in a detailed reference from Dr Karen Douglas from a medical practice in Terrigal who herself became a Methadone prescriber in 1999. She first met Dr Roehrich at a number of continuing medical education meetings and workshops run by the Central Coast Division of General Practice. This would appear to date from the time which she first met him in 1994. In May 1995 he joined the Balint Group of which she had been a member since 1994. The Group consists of a small group of general practitioners and specialists meeting once a month with a trained experienced counsellor acting as a facilitator. The aim of the Group is to offer a forum for peer support in a non-judgmental and confidential environment. She states that:

> "Since its inception the Group has focused on issues arising from our professional work as medical practitioners and how certain patients, their problems and relationships have impacted on our own personal abilities to practice medicine appropriately."

62. She indicates that the discussions include discussions about persons requesting drugs of dependence and addiction and other matters. She describes the respondent as always a willing and co-operative

participant in the Group and as "a very active listener and contributor". She regards his input as always appearing to be based on:

> "truth, compassion and medical expertise. His comments and approaches to patient care to be evidence-based and peer supported".

63. She indicates the difficulties of treating patients with problems of drug dependence and addiction, like patients A and B, and refers to the limited resources available in general practice and in in-patient detoxification and in relation to drug and alcohol counselling. She notes (as others in this case have noted) that such patients are often deceitful, manipulative, demanding and aggressive. In order to avoid that behaviour, she expresses the view that many colleagues are not interested in becoming involved in their care and that it requires a dedicated and compassionate doctor to take the time to deal with such patients. 64. Again, it is appropriate to record both sides of her view of Dr Roehrich. She certainly believes, as her concluding sentence states, that he has the necessary skills and knowledge to continue to work as a general practitioner in his practice but she states:

> "In conclusion I believe that whilst being the sole prescriber for patient A Dr Roehrich provided care to the best of his ability with the aim of minimising harm to the patient by providing a drug maintenance program. From the reports I have been provided, I feel that Dr Roehrich is now well aware that his prescribing of drugs of dependence and addiction to patient A and patient B were excessive, however necessary to prevent doctor shopping and other harm to the patient. I am sure that should a similar case present in the future Dr Roehrich would seek advice and

> guidance regarding appropriate treatment and management from appropriate resources, clinical evidence and qualified practitioners."

65. There are other references furnished on behalf of the practitioner which need not be dealt with in detail at this stage.

66. The picture then is of a practitioner with relatively extensive general experience in various facets of medical practice. Both before and after these events, he was attending sessions on the treatment of patients with drug and alcohol dependency and is well thought of, in general terms, by his peers in that area of medicine and also in that geographical area. 67. However the qualifications in each of those references clearly indicate some misgivings on their part as to the way in which the respondent handled these two cases in particular. It is significant in the light of those comments, that he subsequently obtained general practice accreditation through the body AGPAL in June 2000. He sat for the primary examination for registrar of nutritional and environmental medicine in the Australasian College of Nutritional and Environmental Medicine in August 2001. In 2001 he also obtained a certificate in applied approaches to Benzodiazepine detoxification through the Central Coast Area Alcohol and Other Drugs Service. He also was involved in specialist training program through the Australian College of Nutritional and Educational Medicine in September 2001 and obtained a certificate from that latter college in 2002 for a specialist training program relating to multiple chemical sensitivity. A certificate from that college was

also obtained as a result of the specialist training program in February 2001 concerning gut health. He has been described as a registrar of that association since August 2001. 68. In other words, since this matter came to light in 1998, he has taken various steps to advance his medical knowledge, including particularly the certificate in relation to Benzodiazepine detoxification. No doubt it was in the light of his experience in relation to this matter and the steps which he took thereafter, that he has been able to impress on those peers his hindsight view of the less than satisfactory nature of his conduct in treating patients A and B. 69. The attitude expressed in those references is, in broad terms, similar to the approach which he took when he appeared in the inquiry in 2002. 70. To bring the matter up-to-date, as is evident from the chronology thus far, he was registered as a medical practitioner in New South Wales on 1 December 1982. The s 192A evidentiary certificate, exhibit B, recites that, on 21 September 2004 the Medical Board conducted an inquiry under s 66 of the Act, following which he was suspended for a period of eight weeks from 25 September, but that suspension was extended for a further period of eight weeks on 19 November in accordance with s 67 of the Act and he remained suspended as at the date of the certificate, which was 19 November 2004. 71. The conditions proposed by the complainant, in the event that the Tribunal concluded that conditions were appropriate, were framed to commence upon his resumption of medical practice and thus framed to take into account the

existence of that present period of suspension.

THE PRACTITIONER'S ATTITUDE TO THE COMPLAINT

72. When initially interviewed by the Pharmaceutical Services Branch officers in June 1998, the respondent made a number of admissions, though not admissions which would amount to admissions to each and every one of the particulars which later emerged as the particulars of complaint. He was partly seeking to justify his treatment of these patients but partly acknowledged areas of deficiency in relation to that treatment. 73. His attitude in the 2002 hearing was largely conciliatory, in the sense that he made a significant number of admissions and, in his evidence before that Tribunal, tended to accept the validity of the complaint, at least in general terms, and specifically in relation to some of the specific allegations. 74. More recently, in these proceedings, the respondent's attitude, as evidenced by the material which he has filed, is to seek rather to justify his conduct than to admit any lapse in his conduct. That attitude has extended to his attempt to withdraw or resile from his earlier admissions. As has been observed, those admissions were, in any event, consistent with the evidence which he gave in the witness box before that Tribunal in 2002. 75. It is not appropriate for the presently constituted Tribunal to consider further apparent conflicts with the Medical Board and other authorities in more recent years. It is sufficient to say, however, that the suspension which he is presently serving is as a result of his failure to

comply with an order from the Board to undergo a practice assessment. That practice assessment, in turn, was sought on the basis of an accumulation of matters, which included the unresolved complaint now before the present Tribunal and some other matters which had not reached the level of a disciplinary matter, together with what is described as a “triggering complaint” which had been received in relation to his conduct. 76. The respondent has vigorously defended himself in relation to those matters but is clearly concerned, as his affidavit in these proceedings makes clear, that he feels that he is somehow destined to spend a considerable time before this Tribunal and other disciplinary bodies as a result of this and the other matters. 77. The Tribunal has had the opportunity of reading the material he provided for this hearing and of observing him as he conducted the interlocutory proceedings in this hearing, including during the submissions which he made on Monday of this week. It is fair to observe that the respondent, on the basis of those observations and of the written material, appears to have become, to some extent, obsessed about these various matters which have brought him into apparent conflict with disciplinary authorities. As a consequence, his attitude seems to have hardened towards the present complaint. 78. Not unnaturally, he was distressed to learn that the inquiry would reconvene into the present complaint when, for some two years, he had heard nothing and presumably hoped that it would all go away. He expressed some distress at the fact that these proceedings have been

pending, in one way or another, since the Pharmaceutical Services Branch visit in 1998. Clearly the long duration of these proceedings, regrettably prolonged by the circumstances which gave rise to the constitution of a fresh Tribunal for this hearing, are no doubt matters which would have been significantly distressing for him. The accumulation of the other difficulties which he was experiencing with the Medical Board and the revival of the present proceedings does appear to have caused him to harden his position and attitude towards the present complaint. He clearly regrets the admissions which he made to the Pharmaceutical Services Branch and regrets the admissions which he made (and the evidence which he gave) in 2002. In some respects the respondent’s present approach to this complaint seems to be dictated by the existence of a number of matters in which he is in conflict with the authorities. 79. It is, in those circumstances, appropriate to place significantly more weight on the material as it stood in 2002 in assessing the respondent’s real attitude to these matters. 80. As was submitted on behalf of the complainant in closing submissions, the account of events given in the affidavit in exhibit 1 is, in some significant respects, inconsistent with what he told the inspectors in 1998 and what he told the Tribunal in 2002. Because of his failure to further participate in the hearing there has been no opportunity to test the respondent on his account given in that affidavit. It is an account which, in a number of respects, is inconsistent with what he told the

inspectors, inconsistent in a number of respects with the way he has presented himself to some of his peers and, more importantly, inconsistent with the admissions he made, on the advice of his lawyers, in 2002 which, in turn, were broadly consistent with the evidence which he gave in that hearing. Indeed, the evidence which he gave in that hearing is itself significantly inconsistent with the approach which he now adopts. 81. In those circumstances, when it comes to assessing the respondent's knowledge, belief, understanding or insight in relation to the allegations, the position which he advanced on those earlier occasions is to be preferred over that which he has sought to advance in the present proceedings. Where there is any material difference the Tribunal has concluded that it would accept the earlier versions in preference to that which he sought to put before this Tribunal. 82. Although the Tribunal has not had the opportunity of testing this hypothesis with the respondent by its own questions addressed to him, it is by no means mere conjecture to conclude, as the Tribunal does, that his present attitude is, in large measure, influenced by the accumulation of more recent problems which he anticipates may affect his standing and registration and which he asserts are making it difficult for him to continue his practice of medicine. Those considerations provide the likely cause for the highly defensive stance which the respondent has taken in these proceedings. It is at odds with his earlier stance and appears to be somewhat at odds with the way in which he has discussed

these issues with his colleagues on the Central Coast.

THE EVIDENCE

83. Turning to whether the particulars have been established to the requisite degree of satisfaction, that is, whether the Tribunal is comfortably satisfied that the complainant has established those particulars, it is sufficient for the Tribunal to indicate fairly briefly the grounds upon which it reaches its conclusions as to those matters.

PATIENT A

84. It is convenient to deal in the first place with patient A. So far as patient A is concerned, particulars 1(a), (b) and (c) were, as already noted, admitted by the respondent in 2002. Apart from other evidence before the Tribunal, the answers given at pp 3 to 5 in the transcript of the interview of 10 June 1998, exhibit A, tab 4, would sufficiently themselves establish those propositions. So far as para 2 is concerned, again, paras (a) and (b) were admitted in 2002 but, in relation to paras (a), (b) and (c), the answers given to the inspectors at exhibit A, tab 4, pp 9, 11 and 12 themselves provide significant support for the validity and reliability of those admissions.

85. In addition, the evidence given by Dr Seidler, particularly in this Tribunal yesterday, at p 60 of the transcript is quite damning of the conduct of the respondent in relation to both patients A and B. For example, the Tribunal accepts the opinion of Dr Seidler that, in relation to patient A, he was prescribed on demand with all sorts of excuses about lost scripts, he

did not consider that there was any plan in relation to his treatment and that no real discretion was exercised in relation to both of these patients. 86. His overall opinion as to the treatment that the respondent gave to patient A and patient B was expressed in these terms:

> "A. I believe that the treatment provided to these patients was in fact harmful and dangerous and extremely hazardous considering the nature of these patients, considering their chaotic lifestyle, their mental health issues and the fact that they were being prescribed on demand without control.

87. In relation to patient A, there was a reference in the clinical notes to suicide attempts. Dr Seidler regarded that as being:

> "an extraordinary flag. To prescribe in the fashion that this patient was provided in the knowledge that the patient had suicidal attempts in the past is to fly in the face of good medicine. One of the things that most GPs know is first do no harm. It's a Latin edict that pervades medicine, 'primum non nocere'. I think that in this case this doctor did definite harm to these patients."

88. In relation to Dr Seidler's evidence generally, and in response to some critical comments made by the respondent in his material as to the experience of Dr Seidler, at p 61, he set out his extensive experience in relation to dependent patients who engaged in doctor shopping. He has written a book, published this year for New South Wales Health, on how to manage drug-seeking patients. He started writing articles on doctor shoppers in 1996 or 1997. He sees them on a daily basis in his practice. The evidence which, of course, was not challenged in the absence of the respondent, clearly establishes the standing of Dr Seidler to express views,

even of the somewhat trenchant kind which were quoted from the passages on pp 60 and 61.

89. So far as para 2(d) is concerned, again, at p 7 of the 10 June 1998 interview transcript there is, sufficient by way of admission from the respondent to establish that particular. But it is, in any event supported by other material before the Tribunal.

Patient A was, of course, clearly known to be drug-dependent by the respondent and his admission as to maintaining dependency in that particular is simply a recognition of the fact that he knew, from the outset, that he was dealing with a person who was drug-dependent and the evidence clearly establishes, to the comfortable satisfaction of the Tribunal, that he was prescribing in a manner likely, at least, to maintain dependency in the patient even if it had already been induced otherwise.

90. So far as particular 2(e) is concerned, again, the comments of the respondent at p 9 of the transcript of his interview in June 1998, together with the comments of Dr Seidler on p.p. 62-63 of yesterday’s transcript clearly establish, along with the other evidence before the Tribunal, the assertion made in that particular.

91. Turning to para 3 of the particulars, again, what was said by Dr Seidler clearly establishes the truth of that assertion. The reference to detoxification in relation to patient A only occurred in a letter dated 15 June 1998, which was outside the period covered by this complaint, and indeed a few days after the visit by the Pharmaceutical Services Branch inspectors. Again, the

answers given at p 12 of the transcript, tab 4 are themselves sufficient, in conjunction with that other evidence, to support the existence of the proof of para 3(a).

92. Three(b), the allegation of prescription of the drugs in Schedule A on demand, was not admitted in 2002, but a reading of the transcript indicates that Dr Seidler is correct in categorising the respondent's conduct as amounting to prescription on demand.

93. At p 160 in folder 3, that being the transcript of 22 May 2002, he was being asked some questions about supplying on demand to patient B and at line 42, after some intervention by the Deputy Chairperson as to what was understood by 'on demand', counsel for the complainant asked:

> "Q. Is your understanding of the term 'on demand' where a patient attends a doctor's surgery, asks for particular drugs nominated and they are prescribed by the doctor in response?
> A. That would be on demand."

The Deputy Chairperson then asked,

> "Q. Can I just add to that, without any further intervention by the doctor to determine whether there was some medical justification for such a prescription?
> A. Yes.
>
> Q. You agree with that?
> A. Yes."

At the top of p 161 the questioning went on:

> "Q. Is that how you have regarded supplying on demand when it has been asked of you by questions Mr Saidi has asked up until now?
> A. Yes."

94. Prior to that exchange there had been some other

questions about supplying on demand. For example, at p 80 on 22 May, he agreed that prescribing to a patient on demand can never be justified and was asked at line 11:

> "Q. And by prescribing on demand, if you understand what I mean, it is prescribing to a patient medication or drugs as requested and on occasions nominated by the patient ?
> A. That is correct.
>
> Q. And that is your understanding of the term 'prescribing on demand'?
> A. That is, that's correct.
>
> Q. And would you agree with the proposition that prescribing drugs, particularly Benzodiazepines or narcotic substances to a patient for a non-therapeutic purpose can never be justified?
> A. That is correct.
>
> Q. And would you agree with the proposition that a doctor who has a patient who presents requesting Benzodiazepines should be assessed very critically by the doctor before any prescription takes place?
> A. That's correct.
>
> Q. And would you agree with the proposition that if it appears that a patient may be taking heroin or some such similar elicit drug substances, a doctor, before prescribing any Benzodiazepines, should undertake further investigation and inquiry before he puts those drugs into that patient 's hands?
> A. Yes."

95. In relation to patient A specifically, he was asked in cross-examination questions at pp 150 to 151 on 22 May 2002. The exchange, which continues onto p 153, clearly leads to the conclusion that the respondent was simply prescribing on demand to patient A.

96. Similarly, in relation to patient B, at p 163, particularly lines 14 to 21,there is essentially a concession of prescription on demand, though he sought to resile from that concession in the following question.

> “Q. Is the simple answer to my question, ‘yes, I did prescribe on demand to him on those occasions’?
> A. No, I did not".

The context of that cross-examination, however, can again only lead to one conclusion, and that is that in respect of patient B also he was effectively simply prescribing on demand as that concept was clarified with him, particularly at p 160 and thereabouts.

97. Dr Seidler clearly spelled out the dangers of such a practice in the evidence which he gave in the Tribunal in 2002 at p 56 on 21 May. He was being cross-examined as to his considerable doubt about the likely outcomes being favourable for patient A in any setting and his answer was recorded in these terms:

> "Many of these patients overdose and die prior to receiving appropriate treatment but the prescribing on demand merely facilitates their potential to overdose and die."

98. On the evidence given before this Tribunal orally, Dr Seidler also made it clear that, in his view, the uncontrolled provision of such medications makes the likelihood of overdose and/or death by misadventure extraordinarily high. He also pointed out the risk of overdose by the patient or diversion of the drugs to others.

99. Indeed in relation to patient A, he was asked yesterday (at p 57) as to his opinion of the regime of the dosage maintenance regime that the respondent was attempting to introduce. His answer was:

> "I thought it was ill-conceived and carried out very poorly".

He considered it ill-conceived because it appeared that the respondent was prescribing on demand for patient A; the patient was haphazard and chaotic, would lose prescriptions and sustain injuries. He said:

> "The prescription of the drugs in the combination that was prescribed was not in the patient ’s best interest nor fulfilled any of the criteria involved in withdrawing a patient from Benzodiazepine dependence."

100. He went on to set out what those criteria for withdrawing a person from that dependency are and later dealt with the lack of complete utility of some English articles which the respondent sought rely upon in exhibit 1. They were, in his view, useful in general terms but failed to provide any working guide to the actual practice of detoxification.

101. So far as patient A was concerned, Dr Sidler’s view was that he was amongst the highest end of users of Benzodiazepines and opiate containing drugs, including Codeine Phosphate and Panadeine Forte. He did not consider, with regard to the records that he had seen, that that patient was amenable to out-patient detoxification at any level, particularly on the combination (of drugs) that was being prescribed.

102. Ideally the appropriate procedure, in his view, would have been in-patient detoxification. In his belief there were a number of centres available on the Central Coast and in Newcastle, at Gosford Hospital and Wyong Hospital. He acknowledged that it might not have been easy to get the patient into those facilities, but that, at least, the patient should have been put on a waiting list. There is

no evidence, as he noted, that that had ever happened Iin the relevant period).

103. Whilst some of the material in the respondent's documents, emanating from practitioners in the Central Coast area, suggest that there may have been some difficulty in obtaining admission to such facilities, Dr Seidler's view was that, at least, the respondent should have attempted to arrange that for patient A.

104. Turning to para 3(c), that was a paragraph admitted in the earlier hearing. The information in tab 3 clearly indicates that the factual basis for that allegation is made out and, indeed, was admitted by the respondent in 2002. In addition, the respondent and Dr Sztulman, who were both involved in the same practice, were using a common set of clinical notes. When the respondent had the clinical notes produced in typewritten form during the course of the progress of the complaint, he was not only able to interpolate editorial comments or explanations for various entries, but also identify them as to whose particular notes they were. In the main, the two practitioners writing the prescriptions shown on those clinical notes were one or other of this practitioner or Dr Sztulman.

105. In general terms, patient A was the respondent's patient while patient B was Dr Sztulman's patient but each of them also, from time to time, treated the other practitioner's patient. That arrangement is reflected also in the evidence which was placed before the Medical Tribunal considering a complaint against Dr Sztulman,

which was in very similar terms to the present complaint. Thus, by virtue of the common medical records, the respondent was clearly and actually seized of knowledge as to what was being prescribed for patient A by Dr Sztulman.

106. Para 3(d) was admitted in 2002, but, again, is essentially a matter confirmed by the admission made at tab 4 at p 25 in the June 1998 interview.

107. As to para (e), the failure to recognise the likelihood of abuse of the prescribed medication, that was not admitted, but again the answers given at p 8 on tab 4, together with Dr Seidler's view as to the risk of abuse, either by overdose or diversion, was one which a Methadone prescriber ought to have recognised. The inference, indeed, is that the respondent himself did recognise it. The real gist of that allegation is that he failed to properly recognise it in a way which meant that he was prepared to act upon that recognition.

108. In the end the conclusion that must be reached is that the respondent simply ignored what must have been apparent to him as risks of abuse in either of those ways. He had available to him knowledge and information which must have suggested, at least, the risk of overdose from prescriptions which had been filled which he had written.

109. So far as para (f) is concerned, again, that seems to be a matter which is partially admitted but is supported, in any event, by what appears on p 12 of the transcript of the interview with the inspectors in tab 4. In the circumstances expressed by Dr Seidler, even if the respondent had counselled the patient to attend drug and

alcohol specialists or a detoxification facility, it is clear from the very strong opinion expressed by Dr Seidler that the response of the patient provided no excuse for a failure to seek such a reference. The alternative was, as the respondent did, to continue with what was a dangerous course, in the view of Dr Seidler, of continuing to provide what was, in effect, prescription on demand. Thus, para (f) is made out.

110. Para (g) is withdrawn and need not be the subject of any further reference.

111. So far as para 4 is concerned, the inadequacy of the records was identified, for example, in the report of the inspector of 1 July 1998, tab 3 in exhibit A at p 24. Mr Szwarcberg stated that the respondent's "patient notes appear to be inadequate". The name of the drugs prescribed was all that was recorded most of the time, although, on the odd occasion, the strength and/or quantity was shown, but never the dose or directions. He also supplied post-dated prescriptions which he notated in the patient notes as a date indented to the right of where the date was normally written. There did not appear to be any notations made of patients' past medical history, physical examination, diagnostic process nor management protocols.

112. During the course of the interview he was made aware of the legal requirements at cll 40 and 84 of the **Poisons and Therapeutic Goods Regulation** 2002 which pertain to records of the prescribing of prescribed restricted substances and drugs of addiction.

113. The Tribunal's own examination of the handwritten medical records for patient A and, indeed, for patient B is consistent with the view expressed by the inspector in July 1998.

114. Dr Seidler was also critical of the standard of record keeping in his evidence on 21 May 2002. He was critical, at p 40, of the apparent failure to examine the patient , for example, where there was an allegation of the use of illicit drugs recently by the patient. At p 41 he said:

> "The clinical notes do not reflect a clear drug history nor a clear examination of the patient at any stage and I would find it difficult to imagine in the absence of that information that this procedure took place on a regular basis."

115. Given the significance of the course of treatment upon which he had embarked with patient A (and, indeed, to the extent that he was involved with patient B, the same would be said), the failure to keep adequate records in the terms specified in the particular is a matter of some considerable significance. It is patent from those records that they were inadequately kept in the respects identified in para 4.

116. The Tribunal is comfortably satisfied that the complainant has made out particulars 1, 2, 3 and 4 in relation to patient A in all respects save for particular 3(g) which was, of course, withdrawn.

PATIENT B

117. So far as patient B is concerned, the evidence again discloses, in relation to Particular 1 that Paras (a) and

(b) were admitted in the 2002 inquiry. Para (b) is the subject of admissions at p 12 of the transcript.

118. Dr Seidler’s view at pp 58 and 66 of the transcript of evidence yesterday is relevant, particularly to the situation of patient B, given his history of schizophrenia. Patient A had a history of suicide attempts, but the view of Dr Seidler is that the mental state of patient B ought to have been regarded as of more significance, given the history of schizophrenia, when he did not appear to have been prescribed any anti-psychotic medication by the practitioners here and there was no evidence of any liaison with any mental health team by this respondent in relation to patient B.

119. In those circumstances, the prescriptions which are set out in annexure B to the complaint can only be held to have been provided without exercising responsible medical judgement, in quantities in excess of recognised therapeutic standards and inappropriately on a long-term basis for the treatment of pain or even, as the respondent says, for the treatment of addiction.

120. As to para (d), that form of treatment, as tab 3 establishes, is likely either to induce or, in the case of a dependent patient , to maintain that dependency. Again, in relation to this para and paras (c) (e), both doctors had access to the same clinical notes when treating patient B.

121. So far as para (e) is concerned, at least on the basis of his knowledge of treatment of patient A, the respondent ought to have become aware of the likelihood of

abuse of the prescribed drugs by patient B, but the records in relation to patient B themselves ought to have raised that awareness with the respondent, though he admitted, as was clearly the case, that he knew that he was an addict. In those circumstances he must have known that that patient was likely to abuse the prescribed drugs.

122. So far as para 2 is concerned, the evidence of Dr Seidler referred to earlier is itself damning evidence on that point. The respondent himself admitted that particular as he did particulars (a) and (b).

123. In the earlier hearing he was asked some questions pertaining to that allegation at pp 159 and 163. By the time he saw B on 17 February he agreed that, by looking at the clinical notes, he would have been aware that he was a doctor shopper and agreed that he would have been on guard about prescribing to him, given that he was a doctor shopper and that it would have been wrong to prescribe on demand to him. He agreed that on 17 February 1997 he had prescribed on demand. Although he gave some explanation that it was only the fifth visit he had had in five years, he confirmed at p 160 that he had prescribed on demand. When asked to explain why he said:

> "I can only assume by the lack of any further entry that he played it as before about his back ache and possibly about his dependency".

He then confirmed that he understood by ‘on demand’ to include the additional factor that it was done without any further intervention by the doctor to determine whether there was some medical justification for such a

prescription.

124. As to para 2(c), again, that was admitted and, for the same reasons as apply to patient A, he must have known what was being prescribed by Dr Sztulman, that is, the various drugs shown in Schedule D to the complaint.

125. So far as para (d) is concerned, that matter is apparent from the material which is in tab 3 in exhibit A. The excuse which was offered as part of the admission in 2002 was that it was because he was only infrequently prescribing patient B. As to that justification, he was, of course, prescribing in tandem with the other practitioner in the practice and they were sharing clinical notes when they each wrote prescriptions for this particular patient.

126. So far as para (e) is concerned, again, that was not admitted, but the evidence clearly establishes that he ought to have recognised that patient B was also likely to abuse the prescribed medication and probably recognised that possibility or probability but failed to fully recognise it and to take it into account appropriately in determining what to prescribe and in what quantities.

127. However, the general concessions made by the respondent in the questions at around those pages are relevant also to his state of knowledge as to what he could do and what problems there might be in relation to patient B. For example, he knew that both patient A and patient B lived in the same household and he understood that patient B was a heroin user, but understood him to be not a regular heroin user or, at best, an infrequent

heroin user. In any event, for reasons similar to those given in respect of patient A, the particular in para 2(f) is also made out.

128. Para 2(g) was withdrawn.

129. So far as the medical records are concerned, they are the subject of para 3 and, for the same reasons as the records in relation to patient A are concerned, have attracted a comfortable satisfaction on the part of the Tribunal that the complainant has made out the allegations in para 3.

130. In other words, with the exception of para 2(g), the Tribunal is comfortably satisfied that paras 1, 2 and 3 relating to patient B have been established.

EVALUATION OF THE PRACTITIONER'S CONDUCT

131. The next question is the evaluation of that conduct as to whether it constitutes unsatisfactory professional conduct and/or professional misconduct. That process of evaluation is, to some extent, expedited by two principal considerations.

132. Firstly, the reports of Dr Seidler, the oral evidence which he gave in the 2002 hearing and the further evidence which he gave in the present inquiry. It is clear that his opinion, which the Tribunal accepts, is to the effect that the conduct alleged against the practitioner in each case amounts to conduct which is more than merely unsatisfactory professional conduct, but rises to the level where it would attract serious or severe criticism on the part of his professional peers. Dr Seidler had essentially expressed that view, but if there remained any

doubt as to whether that was his view, it was dispelled by the evidence which he gave yesterday in which he, quite forcefully, made it clear that his view of the conduct of this practitioner was that it was far below the appropriate standard.

133. In particular, the Tribunal notes (and accepts) his views, which have already been quoted, as to his treatment both of patients A and B and his view, when asked whether the Tribunal should understand his view to be that the respondent had bitten off more than he could chew in trying to deal with these patients so that he was, in effect, out of his depth in trying to deal with their problems, his response:

> "And did not put his hand up to indicate that he was out of his depth but continued on for a number of years treating these patients in a completely unscientific and unvalidated way."

134. He expressed the view later on p 63 that he considered that it was a “miracle” that these two patients were still alive, though he was not entirely sure whether that was actually the case. So far as his claim to be an experienced drug and alcohol general practitioner was concerned, he expressed the view:

> "I think he is ill-formed, inexperienced and extremely naïve".

135. The second basis upon which the evaluation of the conduct of the respondent here may be more readily concluded rests on the decision of a differently constituted Tribunal in relation to Dr Sztulman.

136. He came before the Tribunal on 11 December 2002. The complaint was in broadly similar terms to the complaint

made against this practitioner. The conduct of the treatment of these two patients was shared, with patient A predominantly being the patient of this respondent and patient B being predominantly the patient of Dr Sztulman; but each of them shared in that treatment.

137. In that case the facts were largely admitted. Significiantly, Dr Sztulman had, in 1995, been counselled in relation to his prescribing of drugs, particularly to two addicts. He effectively admitted prescribing drugs on demand to patients A and B when he was also interviewed formally on 10 June 1998.

138. The Tribunal held that the prescription of such a large number of drugs carried a safety risk for those patients who may be ill or poorly managed and noted that the difficulties were compounded because the two patients were, in fact, brothers and were co-operating to assist each other, for example, one brother allegedly stealing the medication of the other. Both were on the Methadone program and the Tribunal then concluded, that the prescribing compromised their management. There was also a finding that both patients could be described as ‘doctor shoppers’. As to the sharing of treatment of the two patients, the Tribunal then concluded, as this Tribunal does, that there was nevertheless a continuity in the management of the care of the patients by the present respondent.

139. Likewise in that case, the peer review evidence was given by Dr Seidler, though he was not apparently called to give oral evidence in relation to Dr Sztulman’s case.

He expressed broadly similar views about Dr Sztulman's conduct.

140. The Tribunal considered that Dr Sztulman was certainly not professionally equipped to deal with the very difficult cases of patient A and patient B.

141. In his case also there was no doubt that, from the very outset, the prescribing for both patients was excessive and, as the Tribunal noted, the peer reviewer correctly asserted that that prescribing would attract strong disapproval from the profession. However, as with the present respondent, the motivation seems to have been similar. The Tribunal noted:

> "Hence at the outset there appears to be a genuine concern to do the right thing"

however it became apparent that Dr Sztulman's clinical judgement became clouded as both the number of visits to the doctor and the medication prescribed remained excessive.

142. In addition, his medical records were well below the standards expected from a competent general practitioner, "thereby providing little support for his poorly articulated defence of his treatment".

143. In all likelihood (the Tribunal found) the doctor was unable to deal with the clinical situation of recommending detoxification to a severely addicted, devious, drug-seeking patient. He dealt with this by taking the line of least resistance, by simply accepting that the problem existed and allowed it to continue without ever raising the possibility of doing something about it. "He

became a maintenance prescriber akin to the Methadone program and happy to provide a form of damage control". In his clouded thinking, he failed to address the potential issues of:

1. overdosage leading to death or disability of his patients;

2. on-selling of pharmaceutical drugs to other people leading to similar problems in other members of the community.

144. The Tribunal noted that there was no evidence presented to suggest shortcomings in his clinical performance other than for the two patients described. The Tribunal concluded that that suggested a limited, but ongoing, significant deficit in Dr Sztulman's knowledge and clinical performance and a persisting naïveté in his perception of and response to his problems. That lack of insight into those problems and lack of response was a matter of concern to the Tribunal. In the Tribunal's opinion, that vulnerability to inappropriate professional conduct continued, so that he required supervision and those performance issues were regarded as an appropriate subject for the conditions which were attached to his registration.

145. In assessing the level of the practitioner's misconduct, and after noting the terms of ss 36 and 37 of the Act, the Tribunal there was comfortably satisfied that the complaints were made out and considered that the practitioner's conduct involved a significant departure from the proper standards, noting the great importance of

the proper handling of the prescription of drugs by medical practitioners.

146. In the Tribunal's opinion the breaches by Dr Sztulman were serious and repeated. There were two patients involved in his misconduct and the authorities had, over a period of time, provided guidance and direction generally to medical practitioners in the management of drug-addicted patients. In the Tribunal's view, the conduct of Dr Sztulman was sufficiently serious to justify his suspension from practising medicine or the removal of his name from the register. (The reference to guidance and direction to medical practitioners is to be understood as a reference to the availability of brochures, articles and other documents and other sources of assistance available to general medical practitioners. Some of that material is contained in the complainant's folder, exhibit A).

147. Whilst it is the case that Dr Sztulman had been the subject of some specific advice or warning as to his prescribing conduct in relation to two other patients a couple of years earlier whereas the present practitioner had not been the subject of such a warning, the level of his conduct, as evaluated in the opinion of Dr Seidler and in the view of this Tribunal is itself sufficient to justify a finding, which the Tribunal is comfortably satisfied should be made, that the respondent's conduct amounted to unsatisfactory professional conduct and, for the same reasons expressed in relation to Dr Sztulman, that conduct rises to the very severe level of criticism

involved in a finding of professional misconduct. The misconduct was conduct which would justify a suspension or the removal of the respondent's name from the register.

148. However, as the Tribunal noted in the case of Dr Sztulman, the Tribunal must be guided by the primary consideration that its responsibility is the protection of the public. The Tribunal is required to uphold the standards of the medical profession and its orders should deter like-minded people from engaging in inappropriate conduct. The orders are not imposed as a punishment.

149. In the present case, in determining whether something less than the severe form of orders of suspension or deregistration is appropriate, the Tribunal is mindful of a number of considerations.

150. Firstly, the conduct of the respondent was motivated by an attempt, misguided and wrongheaded though it may have been, to assist his patients.

151. Secondly, his misconduct was apparently confined to the two patients A and B. This distinguishes his situation from cases commonly encountered where there is a wholesale pattern of such over-prescribing or inappropriate prescribing to a whole range of dependent patients. The difficulties which the respondent here had in appropriately treating them were difficulties which were confined to the treatment of these two patients. On the other hand, the fact that he behaved in the fashion in which he did in relation to these two patients and also the totally inadequate system of record keeping that he maintained in respect of those patients is troubling and

indicative of the need for some form of order which would monitor his conduct as a practitioner.

152. There are further considerations which tend to point towards a less serious form of principal order.

153. As the evidence described earlier establishes, he did continue to attend sessions in relation to drug and alcohol with the Area Health Service, he has maintained an association with the peer group described by Dr Douglas and he has expressed, both to her and to other practitioners, his view as to the inappropriateness of his conduct in relation to patients A and B.

154. Certainly in the evidence he gave in the Tribunal in 2002, coupled with the formal admissions he made there, he demonstrated, with some measure of resistance, an attitude of understanding of what he had done and an insight into the inappropriateness of that behaviour.

155. Furthermore, he is an experienced practitioner, in general terms, and one who is regarded as a valuable asset by his peers in his local area.

156. Whilst his conduct in relation to these two patients has attracted a serious finding, that is, one of professional misconduct, even Dr Seidler’s criticism of him was ultimately confined, particularly, to his involvement in drug and alcohol treatment. He was asked whether he was likely or unlikely to pose a risk to the public in his treatment of drug-addicted patients in the future. His view (expressed at p 65) was that, once a doctor has transgressed to the extent that the respondent has with these two patients, in the light of their

histories, he considered that the thermostat, as it were, was out of order. He did not know that it could ever be rectified. He would also think that, for the future safety of the population of the Central Coast, Dr Roehrich should not engage in the treatment of drug or alcohol problems. He went on to say:

> "and there are some people who are constitutionally or intellectually unable to set limits and that is a big issue for general practitioners and I note from his notes that he would write 'no more scripts' in bold capital letters and underline them and then two consultations later he would begin prescribing again. So despite his best intentions, both intellectually and probably scientifically he was manipulated by these patients and some people are just not designed to work with this clientele and should not do it."

157. Another member of the Tribunal asked whether there was any formation open to him in terms of education, re-education, supervision etcetera to make him fit, in some way, to manage alcohol-related illness in his general practice.

Dr Seidler thought it was possible, but in view of the latest affidavit, thought that he may have already decided not to practice in that area of medicine. But, he went on to add:

> "I would be concerned as limit setting is something that is hard to teach middle-aged doctors in my experience and once you have difficulties setting limits you tend to have it all the time and I would be loath to recommend that he would be a suitable GP to get involved in this sort of treatment without lots of supervision over a long period of time."

158. He was then asked by the Tribunal Member what assistance could be offered to him, given that, as a general practitioner, he would find it hard to avoid at

least alcohol-related illness in his practice and some drug-related illness. In answer to that question Dr Seidler indicated that there are a number of general practitioners confronted with such dependence problems who do not treat those patients but refer them on. He considered that Dr Roehrich should be encouraged to refer patients in that category to the Gosford Hospital, to a doctor who was formerly the director of Alcohol and Drug Services for the Central Coast Area Health Service and to other specialists at a nearby centre and not involve himself in the treatment of such patients because they would increasingly be problematic for him.

159. Dr Seidler considered that, as time went on and as the respondent aged, he would become less able to resist their manipulative behaviour.

160. It is, thus, clear from the evidence that, whilst the respondent is well motivated in relation to his practice of medicine and his services would appear to be valuable in the geographical area in which he practices, his capacity to engage in the treatment of alcohol/drug-dependent patients has been thrown under a very dark cloud by his conduct on this occasion.

161. Even though the conduct was related only to two patients and ceased about six years ago or more, and even though he has taken further steps to improve his knowledge and skill in that particular area of medicine, the Tribunal could not be confident, in the public interest, that it would be appropriate for him to engage in treatment in the alcohol and drug area.

162. His record keeping itself is a troublesome concern as to his practice of medicine generally. Observations which have been made about the importance of record keeping with drug-dependent patients apply though perhaps not with the same precise force, to the general need for practitioners to keep proper records of their treatment, examination and prescribing.

163. The Tribunal, in dealing with Dr Sztulman, considered that the appropriate course was to reprimand him and to make his registration subject to a number of conditions. The Tribunal is comfortably satisfied that similar orders are both necessary and appropriate in the case of the present practitioner.

CONDITIONS

164. The conditions imposed on Dr Sztulman's registration are essentially proposed as being appropriate conditions for this practitioner also.

165. They include (1) attendance at a course of pain management, (2) attendance at a Pharmaceutical Services Branch course to ensure that he has a proper knowledge of prescribing practices and requirements, particularly relating to Schedule 4 and Schedule 8 drugs, (3) a condition that he attend what the evidence discloses is an external studies course of five weeks on Issues in General Practice Prescribing conducted by the Department of General Practice at Monash University in Victoria and (4) that he attend meetings with a supervisor approved by the Medical Board, with meetings on a monthly basis, including case reviews and discussion of no less than ten records of

patients seen in the preceding months; the supervisor to complete a record of the matters discussed and to report to the Board on a three-monthly basis and to provide those meeting records and for the respondent to provide the supervisor with a copy of the conditions and authorise the supervisor to inform the Board of a failure to attend for meetings or of any termination of meetings.

166. As well as those training and supervisory conditions, the complainant seeks a condition that the respondent not prescribe or administer Sch 4D and 8 drugs and that the conditions are to operate for two years of medical practice, or for such other period as the Medical Board may determine.

167. The Tribunal is satisfied that the circumstances of this complaint and the present circumstances of the respondent are such that such a restriction on his prescription and administration of those drugs is wholly warranted in the public interest. The courses and the supervision are also justified by the circumstances of the proven misconduct in this case. The conditions essentially mirror those applied to Dr Sztulman and are applicable in the case of this respondent for very similar reasons.

168. One variation is that condition 6 in the proposed conditions specifies that they are to operate for two years of medical practice or for such other period as the Medical Board may determine. The reference to “two years of medical practice” is incorporated to take account of the present suspension of the respondent’s registration

arising out of the s 66 inquiry. The intent of the conditions, thus, is that they will commence to operate once any such suspension is lifted and will operate for two years thereafter.

169. In those circumstances, whilst the Tribunal is satisfied that the six conditions ought to be imposed, it proposes to do so with one amendment and that is that the conditions are to operate for two years of medical practice or for such shorter period as the Medical Board may determine. It is not appropriate, nor conducive to the purpose for which conditions may be ordered, to make the period open-ended as it would be, should the Tribunal impose conditions in the terms originally suggested. “Two years of medical practice or for such shorter period of medical practice at the discretion of the Board” would be appropriate in this instance.

COSTS

170. So far as the question of costs is concerned, the complainant has submitted that the respondent should be required to pay the costs of the second set of proceedings, to put it broadly.

171. It has been held that costs follow the event in proceedings under the Act. The complainant has been wholly successful on the new hearing and, indeed, has succeeded on each of the notices of motion brought by the respondent. In those circumstances the appropriate course would be to accede to the submission that the respondent should pay the costs which will be spelt out as being the costs of the Commission (including the costs of the

practitioner's notices of motion) from and including 1 May 2004.

172. So far as the earlier hearing is concerned, the complainant has submitted that it would not seek the costs of that hearing, given the circumstances of the inability of the Tribunal to bring in a determination in that inquiry. The appropriate order is simply to make no order as to the costs of the proceedings prior to 1 May. In terms of the general outcome the complainant has been successful. It was no fault of either party that the original inquiry had to be terminated. In those circumstances, an order that there be no order as to the costs of the proceedings before 1 May this year would seem to appropriately recognise those circumstances. No submissions have been made or on behalf of the respondent, nor any position as to costs signalled in any material which he has filed.

ORDERS

173. The Tribunal unanimously makes the following orders:

1. Dr Eckard Roehrich is reprimanded;
2. The practitioner's registration is to be subject to the conditions numbered 1 to 6 annexed hereto and marked A;
3. the practitioner is to pay the costs of the Health Care Complaints Commission (including the costs of the practitioner's notices of motion) from and including 1 May 2004 but the Tribunal makes no order as to the costs of the proceedings prior to that date.

NOTICE OF THESE REASONS AND ORDERS

174. The Tribunal hands down those orders. The reasons given today have been tape recorded by the Reporting Services Branch and in due course, once they have been typed up, revised and signed they will become available to the parties. In the circumstances the Tribunal took the view that it was better to avoid any further delay in its determination by reserving judgment. That means that the reasons can be given today and have been able to be heard by the party represented. The orders are available in written form and may be transmitted by the Board to the respondent in due course. The down side of that procedure is that the written judgment of the Tribunal will not be available for some time, depending on when it becomes available in draft form and when it can be put into its final form. Dr Roehrich will thus not be able to find out in detail why it is that the orders have been made, but that is essentially because he has declined to attend the Tribunal for the hearing. He was aware that the matter was listed for four days this week and the Tribunal, both in his presence and in correspondence with him thereafter, made it clear that the matter was proceeding. He was also anxious for the matter to be finalised in any event and thus it was considered to be in his interests as well in the public interest for our decision to be announced orally today with the orders being pronounced and handed down this afternoon.

DATED **25 November 2004**

Judge G J Graham
Deputy Chairperson
On behalf of the Tribunal

Seal of the Medical Tribunal