PROFESSIONAL STANDARDS COMMITTEE INQUIRY

Constituted under Part 8 of the *Health Practitioner Regulation National Law (NSW)*

to hold an Inquiry into a Complaint in relation to:

Dr Peter James Mayne
MED0000943438

Dates of Inquiry:	30, 31 March 2017 and 21 April 2017
Committee members:	Ms Geri Ettinger (Chairperson) Dr Margaret Higgins Dr Alison Kesson Mr Christopher Gardiner
Appearances for Health Care Complaints Commission (HCCC):	Mr Peter Aitken of Counsel, instructed by Mr Feneil Shah, Legal Officer
Appearances for Dr Peter Mayne:	Mr Patrick Rooney, instructed by Mr David Brown. Browns Legal & Consulting
Date of decision:	1 May 2017
Decision:	The Committee made findings of unsatisfactory professional conduct, and, as Dr Mayne is currently unregistered, directed that a reprimand, and certain conditions as detailed below, be imposed, which can only be implemented should he regain AHPRA registration. (section 146B(2) of the *National Law*).
Publication of decision:	The Chair made a non-publication order in regard to the identity of Patient A.
Legislation:	*Health Practitioner Regulation National Law (NSW)* *Health Practitioner Regulation (NSW) Regulation 2010*

REASONS FOR DECISION

SUMMARY

Dr Peter James Mayne, MED0000943438, MPO079890, who is 68 years old, and was, from 9 January 1974 until 30 November 2015, registered as a medical practitioner. We noted that Dr Mayne graduated MBBS from the University of Sydney in 1973, and is a Fellow of the College of Rural and Remote Medicine. He is currently unregistered.

Dr Mayne came before this Professional Standards Committee (Committee) as a result of a Complaint prosecuted by the HCCC. The events which gave rise to the Complaint dated 25 July 2016 by the HCCC that Dr Peter James Mayne was guilty of unsatisfactory professional conduct, concerned his diagnosis and treatment of Patient A, whom he found to have Lyme borreliosis (Lyme disease).

The HCCC also alleged that Dr Mayne's documentation in his medical records constituted breaches of Schedule 2, clauses 2(1) and 2(2) of the *Health Practitioner Regulation (NSW) Regulation 2010* (Regulation).

The HCCC alleged that Dr Mayne is guilty of unsatisfactory professional conduct as defined in section 139B of the *Health Practitioner Regulation National Law (NSW)* (National Law), as his conduct in relation to Patient A demonstrated that the knowledge, skill or judgment possessed, or care exercised, by Dr Mayne in the practice medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Dr Mayne admitted many of the Particulars of Complaint, but did not accept that he was guilty of unsatisfactory professional conduct in relation to either of the two Complaints.

The Committee however, found him guilty of unsatisfactory professional conduct in relation to both Complaints. The Committee directed that a reprimand, and certain conditions as detailed below, be imposed, which, however, can only be implemented should r Mayne regain AHPRA registration (section 146B(2) of the National Law).

RELEVANT LAW

1. In matters such as the one before the Committee, the HCCC bears the onus of establishing that the Practitioner has been guilty of unsatisfactory professional conduct pursuant to section 139B of the National Law which provides relevantly:

   (1) Unsatisfactory professional conduct of a registered health practitioner includes:

   (a) Conduct significantly below reasonable standard
   Conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

   (b) Contraventions of this Law or regulations

A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention….

2. The phrase *significantly below* is not defined in the National Law. However in the Second Reading speech when the National Law's predecessor, the *Medical Practice Act 1992* (which contained a similar definition of unsatisfactory professional conduct), was introduced to Parliament it was stated that:

> *The first main purpose of the bill is to refocus the Health Care Complaints Commission (HCCC) on investigating serious complaints about health service providers. To achieve this, Commissioner Walker recommended that unsatisfactory professional conduct be redefined so that only significant instances involving lack of skill, judgment, or care will result in an investigation or disciplinary action. …. the reference to 'significant' in that context may refer to a single act or omission that demonstrates a practitioner's lack of skill, judgment or care, or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the circumstances of the case.*

3. We note also that as a general principle, the use of the term *significant* may in law be taken to mean not trivial, of importance or substantial, (*Re A Medical Practitioner and the Medical Practice Act 40010/07, 3 September 2007* (unreported)).

4. We have noted above that Dr Mayne is not currently registered, but that pursuant to section 146B(2) of the National Law, the Committee may direct that a reprimand, and certain conditions as detailed below, be imposed, which can only be implemented should be regain AHPRA registration.

STANDARD OF PROOF

5. The onus or burden of proof falls on the HCCC. It is well established, due to the protective nature of the jurisdiction, and the seriousness of the complaints, if established, both for the Practitioner and the public, that the standard of proof is on the balance of probabilities, but to the level of satisfaction described by the High Court in *Briginshaw v Briginshaw (1938) 60 CLR 336.* The Court there stated:

> *Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

6. The standard by which Dr Mayne must be judged is that of a Medical Practitioner (General & Specialist General Practice), who graduated in medicine in 1973, and was practising medicine in NSW from when he was first registered

on 9 January 1974, until 30 November 2015. It is noted that he is also a Fellow of the College of Rural and Remote Medicine.

ISSUES

7. The issues to be determined by this Committee are:

    a. Whether the Committee is comfortably satisfied that any or all of the Particulars of the two Complaints are proven;

    b. If so, whether the Practitioner's conduct overall amounts to unprofessional conduct; and

    c. If such finding is made, the Committee must decide whether orders or directions made pursuant to Part 8 Division 3 Sub-division 3 of the *National Law* are appropriate.

BACKGROUND

8. Dr Mayne has worked in general practice since 1975, and has operated general practice clinics in rural areas since 1978. He told us that his practice at which Patient A was treated, was an accredited practice, with himself and two other doctors, and a number of nurses. He told the Committee that if he is re-registered, he does not intend to further deal with Lyme disease patients, but would like to move to Queensland where his son lives, and work part-time in a skin cancer clinic, for which he has training.

9. The Committee noted that Patient A had been a patient at Dr Mayne's surgery from 2006, but relevantly attended at the surgery on 13 February 2012, when Dr Mayne diagnosed him with migratory arthritis. Patient A was 68 years old, a smoker, and was suffering from chronic obstructive pulmonary disease. He also had documented ischaemic heart disease, hypertension and emphysema.

10. Patient A relocated to another regional centre in Queensland, in early 2013, and accordingly, consulted different doctors there. There he was diagnosed with lung cancer with brain secondaries, and died in mid-2013, aged 69.

11. In her Complaint made to the HCCC, Patient A's wife stated that her husband had ongoing symptoms, including weight loss, approximately a year before his diagnosis of lung cancer. She recalled that Patient A experienced rapid weight loss, swelling in his hands and feet, and bowel problems. Approximately six months before the diagnosis, she also noticed the whites of his eyes started to look an orange/red colour. She stated that Dr Mayne was aware of these symptoms, and treated Patient A for some of them. She stated that: *He did not discuss with me any other possible diagnoses, and continued to attribute these symptoms to Lyme Disease.*

12. Dr Mayne told the Committee that he relinquished his medical registration after suffering two strokes in 2015. He had previously also suffered cardiac problems. He attributed some lack of clarity and memory lapses when giving his oral evidence at the Hearing to the effects of the strokes. The Committee is mindful that Dr Mayne's replies to questions asked of him at the Hearing frequently elicited rambling replies.

13. The Committee heard from a number of experts briefed by both the HCCC and Dr Mayne. We also had their reports, and published literature on Lyme disease before us in the tendered documents. The experts who gave oral evidence included Professor Miles Beaman, Infectious Diseases Physician and Clinical Microbiologist, Dr Jeannie Ellis, a General Practitioner with extensive experience in Primary Health Care and Emergency Medicine, who has worked in several foreign countries, and in remote areas. She was Director of the Emergency Department at Queanbeyan Hospital from 2009 to December 2014. We also heard from Dr Cathy Morris, a general practitioner who is in private practice, and who described herself as specifically incorporating integrative approaches to medicine for over 20 years. Amongst other memberships, Dr Morris relevantly holds membership of the International Lyme & Associated Diseases Society, (ILADS) and has attended Lyme disease conferences in the USA, and ILADS Practitioner training in 2015. We noted that Dr Mayne also holds such membership, and that he disclosed he is medical adviser to Australian Biologics, (a non NATA accredited laboratory), through which his tests of Patient A for Lyme disease were made.

14. It is relevant before concluding the background to the Complaint, to briefly consider the history of Patient A's presentation, and what information Dr Mayne obtained to support actual exposure to tick bites, or any activities Patient A had undertaken on his travels in support of a diagnosis of Lyme disease.

15. We noted that following the first consultation relevant to this Complaint which took place on 13 February 2012, Patient A was referred for screening tests on 17 February 2012, and on 22 February 2012, was referred for CD3-CD57, and an *examination for Lyme disease*.

16. On 27 February 2012, Dr Mayne recorded in his clinical notes: *Consult re possibility of Lyme disease – history of tick bites – 40yr ago sust – History of EM reaction – no – travel yes, Europe yes – endemic tick area yes - Symptom list generated and scanned.*

17. Dr Mayne also conducted a review of Patient A's cranial nerves on 27 February 2012, and listed a number of investigations which could be ordered. However, relevantly, he recorded *neuroborreliosis* as the *reason for the visit.* For the diagnosis, he recorded: *Lyme disease – Lyme neuroborreliosis.*

18. On 27 February 2012, Dr Mayne also had the Patient consider a self-assessment which appears on pages 147 and 148 of Exhibit H2. Page 147 was headed *Symptoms of complex Lyme disease* The Patient was required to consider an extensive list of symptoms, and mark the ones he considered applied to him.

19. In his oral evidence, Professor Beaman commented on the self-assessment Patient A had completed, including, for example, indicating he had *brain fog* and concerns about his memory. Professor Beaman opined that there are simple tests for those self-assessments, e.g. the mini mental state exam. He also noted the age of the patient, which in 2012, was 68 years, and considered that the symptoms described may have been age related. Further, he noted that Patient A also suffered hypertension, ischaemic heart disease and abdominal aortic aneurysm.

20. Dr Ellis was in full agreement with Dr Beaman as regards the lack of detail and certainty in Dr Mayne's diagnosis of Lyme disease, and the general, and age related factors arising from the self-assessment form. Dr Ellis stated that in addition, the possibility of an occult malignancy in a 68 year old male with COPD who is a smoker should have been considered.

21. Dr Ellis was critical of the records of the consultation on 27 February 2012. She opined that the list of symptoms and signs noted could be attributed to Lyme disease, but could also be attributed to a large number of other clinical conditions that cause generalised migratory arthritis. She noted that Dr Mayne had failed to undertake an examination of the joints involved in the migratory arthritis. She noted that no examination of the musculoskeletal system was conducted, and no x-rays of the joints affected had been requested. This was admitted by Dr Mayne in connection with Particular 1.j. Dr Ellis considered that would have been standard first line investigation by a GP into any patient presenting with migratory arthritis.

22. The Committee noted from the NSW Health Factsheet that: *Lyme disease is most commonly diagnosed by a screening test called ELISA and this is then confirmed using a western blot test. Both of these tests detect antibodies that are produced by the immune system of someone with Lyme disease.* There was no indication Dr Mayne used either of these tests in relation to Patient A.

23. Dr Morris, whilst not critical of Dr Mayne with regard to his examination of Patient A, agreed that CD57 is not a test suitable to diagnose Lyme disease. She told us of her general satisfaction with Dr Mayne's examinations, even though she agreed the documentation was meagre. She was satisfied to infer that he had dealt with many areas of examination without documenting them, or the discussion with the Patient. As will be seen below, the Committee could not be so satisfied.

DISCUSSION OF THE COMPLAINTS

24. The HCCC alleged that Dr Mayne is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law* in that he has engaged in conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience

Particulars of Complaint One

25. The Particulars of Complaint in this matter are very detailed, often overlap, and range from Particular 1.a. – 1.j., where it is alleged Dr Mayne inappropriately diagnosed Patient A with Lyme disease on 27 February 2012.

26. Further, Particular 2.a. – 2.d., where it is alleged that, Dr Mayne inappropriately commenced Patient A on intramuscular penicillin injections from 6 March 2012.

27. Further, Particular 3.a. – 3.l.. it is alleged that Dr Mayne inappropriately managed Patient A between 5 March 2012 and 2 January 2013.

28. In Particular 4 it is alleged that Dr Mayne failed to obtain informed consent before commencing Patient A on *experimental, novel or unproven* antibiotic treatment.

29. Dr Mayne admitted certain of the Particulars of the Complaints which we discuss below, but he did not admit that he was guilty of unsatisfactory professional conduct or that he had breached any Regulation in relation to record keeping.

Particular 1. of Complaint One

30. *The HCCC alleged that on or about 27 February 2012, the practitioner inappropriately diagnosed Patient A with Lyme disease in circumstances where he:*

    a. *did not document or obtain a history from Patient A to support actual exposure to tick bites from a relevant endemic area, overseas or locally;*
    b. *did not document or obtain a history from Patient A concerning the activities he had undertaken on his travels and exposure to tick bites to support a diagnosis of Lyme disease;*
    c. *ought to have been aware that Patient A's report of a tick bite approximately 40 years prior in Australia was unlikely to be the cause of Patient A's migratory arthritis at the time of the consultation or relevant to the diagnosis of Lyme disease;*
    d. *did not observe or obtain a history of positive clinical signs and/or symptoms sufficient to support a diagnosis of Lyme disease;*
    e. *relied on CD3-CD57+ testing which is not a recognised diagnostic test for Lyme disease;*
    f. *did not have available to him positive pathology results, including Borrelia serology, to support a diagnosis of Lyme disease;*
    g. *was aware or ought to have been aware that there was no validated evidence for local transmission of Lyme disease in Australia;*
    h. *did not document, obtain or conduct an adequate examination or history concerning Patient A's generalised migratory arthritis;*
    i. *did not involve an infectious diseases physician to assess the probability of Lyme disease;*
    j. *had not obtained plain imaging of the joints involved in Patient A's complaints to assist in diagnosing Patient A's generalised migratory arthritis.*

31. Dr Mayne disputed Particulars 1.a. and 1.b., and 1.g., and conceded Particulars 1.c., 1.f., 1.i. and 1.j. He partially conceded Particular 1.h.

32. **In relation to Particular 1.a**., we considered the HCCC's allegation that Dr Mayne did not document or obtain a history from Patient A to support actual exposure to tick bites from a relevant endemic area, overseas or locally.

33. In that regard we noted Dr Mayne's evidence that the North Coast of NSW where he practised, and Patient A also lived, was endemic for ticks, and his general, but unspecific recollections of asking Patient A a history regarding his exposure to tick bites. Dr Mayne admitted in relation to this and other Particulars of Complaint that his documentation was meagre, although he appeared to us to be arguing that it was adequate.

34. Professor Beaman was critical of Dr Mayne's history taking in regard to Patient A.

35. Dr Morris appeared to us to be excusing Dr Mayne for his paucity of records by expressing her confidence in his abilities, and her observation of his examination of the cranial nerves which she found satisfactory. She also indicated that she was satisfied he did not document all he asked and observed.

36. Dr Ellis was not satisfied with the record of Dr Mayne's exploration of the possibility of tick bite, and considered his conduct in relation to Particular 1.a. below the standard reasonably expected of a practitioner of equivalent level of training and experience.

37. Dr Ellis considered that a detailed exploration of the Patient's activities in regard to travel and tick bite, and the recording of signs and symptoms was indicated. She opined that any patient presenting to a GP with generalised migratory arthritis should be interviewed, examined and the family situation explored. She felt that in this case there should also have been an occult malignancy considered. Dr Ellis' opinion was that Dr Mayne took a history focusing on risk factors for Lyme disease as a cause for Patient A's migratory arthritis.

38. We were satisfied from the evidence that Dr Mayne did not sufficiently document or obtain a history from Patient A in regard to any exposure to tick bite as alleged by the HCCC in Particular 1.a.

39. **In regard to Particular 1.b.**, where the HCCC alleged that Dr Mayne did not document or obtain a history from Patient A concerning the activities he had undertaken on his travels and exposure to tick bites to support a diagnosis of Lyme disease;

40. The Committee found Particular 1.a., above, proven, and considered Dr Mayne's evidence in regard to the supposed exposure to tick bite in order to support his diagnosis of Lyme disease.

41. Dr Mayne maintained that he took a history from Patient A about tick bite even though he conceded that his documentation may not have fully reflected that.

42. Dr Morris, who like Dr Mayne, accepted that Lyme disease could be contracted in NSW, was satisfied with his examination and diagnosis.

43. Dr Ellis considered that a detailed exploration of the Patient's activities in regard to travel and tick bite, and the recording of signs and symptoms was indicated. She opined that any patient presenting to a GP with generalised migratory arthritis should be interviewed, examined and the family situation explored. She felt that in this case there should also have been an occult malignancy considered. Dr Ellis' opinion was that Dr Mayne took a history focusing on risk factors for Lyme disease as a cause for Patient A's migratory arthritis.

44. Professor Beaman opined that Dr Mayne did not have sufficient clinical or laboratory evidence to diagnose and commence treatment for Lyme disease. Professor Beaman noted that Patient A did not present with erythaema chronical migrans (ECM), acrodermatitis, lymphocytoma, joint swelling, Bell's palsy, radiculoneuropathy, lymphocytic meningitis, encephalitis or heart block. He commented that the Patient did not manifest any diagnostic clinical criteria for Lye disease at the time Dr Maybe made the clinical diagnosis. He opined that: *The history of tick bites in Australia was not germane to this diagnosis and the Patient's origins in the northern hemisphere was too distant to be relevant either.*

45. The Committee preferred the evidence of Dr Ellis and Professor Beaman, commenting on the meagre documentation in regard to Patient A's examination and diagnosis. We accepted from Professor Beaman's evidence that any signs and symptoms which Patient A appeared to have in 2012, did not justify a diagnosis of Lyme disease, particularly given the only history of tick bite was 40 years previously, and in Australia. We found Particular 1.b. proven.

46. **In Particular 1.c**., the HCCC alleged that Dr Mayne ought to have been aware that Patient A's report of a tick bite approximately 40 years prior in Australia was unlikely to be the cause of Patient A's migratory arthritis at the time of the consultation, or relevant to the diagnosis of Lyme disease. Dr Mayne conceded this Particular, and we find accordingly that it was proven.

47. **As to Particular 1.d.;** The HCCC alleged that Dr Mayne did not observe or obtain a history of positive clinical signs and/or symptoms sufficient to support a diagnosis of Lyme disease.

48. Professor Beaman opined from his consideration of Patient A's records, that Dr Mayne's examination of Patient A had been inadequate, and that he did not have sufficient clinical or laboratory evidence to diagnose and commence treatment for Lyme disease. He commented that Dr Mayne had not included any objective measurements in his records, so that no evaluation as to how the patient was progressing or improving could be made. He opined that the symptoms ticked on the self-assessment document were not specific to Lyme disease, and could have referred to a number of illnesses. He cited the Patient's complaint about *pins and needles,* stating that there could have been tests for those, and that Dr Mayne did not include any measurement, so that it was not clear whether that symptom was persistent or progressive. He also mentioned *brain fog* of which Patient A complained, stating that Dr Mayne could easily have explored that symptom which was perhaps even age related.

49. Professor Beaman also commented that the tests undertaken of the various facial nerves were not relevant, in that specific tests for specific nerves were available, e.g. the eighth nerve. He opined that Dr Mayne did not positively diagnose Lyme disease in this patient. He further opined that there was no such

thing as *Lyme-like illness*. He was also emphatic in his view that the organism was not to be found in Australia. He emphasised that there were other infectious diseases in Australia, and that often no cause could be found for auto-immune disorders.

50. Dr Morris' evidence was that she had observed Dr Mayne conduct examinations of the cranial nerves in his surgery, and understood how he did it. She endorsed his examination. The Committee decided that the statement made by Dr Morris regarding Dr Mayne's examination techniques was not relevant to the considerations and decisions it had to make.

51. Professor Beaman also commented on the ILADS Guidelines which he considered to be discredited, and which Dr Mayne professed to follow. Professor Beaman commented however, from the documentation, and Dr Mayne's records that he had, in any case, not adhered to those Guidelines in treating Patient A. Dr Ellis opined that the ILADS Guidelines were based on advocacy for Lyme disease.

52. We are mindful of Dr Mayne's evidence that many doctors, including he, himself, are members of ILADS. Dr Morris disclosed in her report that she too is a member, and that she had met Dr Mayne at various conferences in relation to Lyme disease issues both in Australia and overseas.

53. Dr Morris commented unfavourably on Dr Ellis' reliance on the IDSA Guidelines, saying that in the USA, they had been removed from the website of the National Guidelines Clearinghouse, and that the ILADS Guidelines had replaced them.

54. Dr Morris opined that one could not conclude from a lack of documentation that Dr Mayne did not conduct an appropriate examination. She indicated that the clinical notes of 27 February 2012 documented the Patient's travel history and tick exposure. She opined that the records did not indicate that Dr Mayne attributed Patient A's migratory arthritis to the tick bite 40 years previously. She noted however that in Patient A's location on the Mid North Coast of NSW, ticks were endemic.

55. As to diagnosis; Professor Beaman opined in his report: The Australian Department of Health and Royal College of Pathologists of Australasia have similar diagnostic criteria which are based on protocols from Lyme disease endemic countries. He specified that they required typical clinical signs which he enumerated, emphasising that those must occur in a patient exposed in a recognised endemic region who has positive two-tiered serology testing (i.e. screening EIA followed by confirmatory Western Blot) performed in a NATA-accredited pathology laboratory using TGA-licensed tests. He added that there was also a strong body of opinion that cases of neurological Lyme disease should also have lumbar puncture for cerebrospinal fluid analysis.

56. Professor Beaman opined that the tests upon which Dr Mayne relied were carried out by Ms Jenny Bourke who is not a pathologist, and works in Australian Biologics, a non-NATA accredited laboratory, using non-TGA licensed tests. He opined that her data is not accepted by the expert medical community or Medicare. The Committee noted from a Factsheet of NSW Health confirmed the above opinion, and that Dr Ellis agreed. Dr Morris on the other hand, noted that that whereas Lyme testing itself is controversial in Australia, *Ms Bourke's*

laboratory is highly regarded and credentialed overseas. We noted from Dr Mayne's disclosure that he is a medical advisor to Australian Biologics.

57. Dr Ellis opined that Dr Mayne's conduct in relation to the diagnosis of Lyme disease fell below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

58. The HCCC submitted that Dr Mayne's attitude to diagnosis in this Patient, and non-consideration of diagnoses other than Lyme disease, indicated a lack of insight

59. The Committee did not accept the explanation Dr Morris proferred on behalf of Dr Mayne regarding the lack of documentation about Patient A's signs and symptoms. We rejected the proposition that we could infer Dr Mayne had nevertheless conducted an appropriate examination. The Committee was satisfied on the expert evidence of Professor Beaman and Dr Ellis, noted above, that Particular 1.d. was proven.

60. **As to Particulars 1.e. and 1.f.;** the HCCC alleged that Dr Mayne relied on CD3-CD57+testing which is not a recognised diagnostic test for Lyme disease.

61. The HCCC alleged in Particular 1.f. that Dr Mayne did not have available to him positive pathology results, including Borrelia serology, to support a diagnosis of Lyme disease. Dr Mayne conceded Particular 1.f. and we find that Particular proven.

62. Professor Beaman opined that there was no role for CD57 testing in the diagnosis of Lyme disease, as it is neither sensitive nor specific for Lyme disease. Referring to the records in Exhibit H2, he opined that Patient A did not have any laboratory tests that were diagnostic of Lyme disease. Specifically, he opined, he did not have two-tiered serological testing by an accredited laboratory, cerebrospinal fluid analysis or culture or molecular testing of any tissues.

63. Dr Ellis agreed with regard to CD57, stating that it is not useful in diagnosing Lyme disease, and referring to the opinion of the Royal Australian College of Pathologists.

64. Dr Morris noted that Dr Mayne suggested tests to the Patient to be carried out in the USA, which the Patient declined to undertake due to the cost involved. Professor Beaman told us that he was satisfied that any testing for Lyme disease could be carried out in Australia.

65. Dr Morris agreed, noting that the test is a non-specific serological marker of Lyme disease, and that she would no longer use it. She indicated that low numbers of CD57 lymphocyte subset had been used as a marker of chronic Lyme disease, but agreed it was not a diagnostic test for Lyme disease.

66. We noted that Dr Mayne admitted Particular 1.f., in that he did not have available to him positive pathology results, including Borrelia serology, to support a diagnosis of Lyme disease.

67. The Committee was satisfied that Particulars 1.e. and 1.f. were proven.

68. **We were mindful of Particular 1.g.,** which was that Dr Mayne was aware, or ought to have been aware that there was no validated evidence for local transmission of Lyme disease in Australia.

69. Dr Mayne disputed Particular 1.g. He is otherwise convinced, and has written about Lyme disease. We had two lengthy studies written up by him in the documents before us.

70. We were also mindful of Professor Beaman's opinion in his report to this Committee, that: *The cause of Lyme Disease in Australia is overseas travel to endemic regions, (the Americas, Europe, Asia and Northern Africa), associated with sustaining a bite from a local Lyme Disease-transmitting arthropod vector (predominantly lxodes ticks such as I.scapularis, I. pacificus, I.ricinus, and I. persulcatus) which is infected with one of the subtypes of Borrelia burgdorferi sensu stricto (principally B.burgdorferi sensu lato, B. afzelli, B, garini). There is no validated evidence for local transmission of Lyme Disease in Australia.*

71. Dr Ellis drew the Committee's attention to advice by the Clinical Advisory Committee on Lyme disease in Australia which indicated that whilst there is still no routine finding of Boerrlia spp in Australian ticks, the possibility of a bacterium causing a Lyme disease like syndrome requires further research.

72. Dr Morris told the Committee that there is a growing body of scientific documentation of Borrellia in Australian patients, noting that it was *not accepted in some quarters.* She indicated that there has been confirmation of endemic Lyme disease in Australia by detecting and characterising Borrelia genotypes of the Bbss group from biopsies of EM in patients who had had a recent tick bite in Australia. Dr Morris relied upon Dr Mayne's studies and reports of Lyme disease patients.

73. We noted that Dr Mayne admitted Particular 1.c., which was that he ought to have been aware that Patient A's report of a tick bite approximately 40 years prior, in Australia, was unlikely to be the cause of his migratory arthritis at the time of the consultation, or relevant to the diagnosis of Lyme disease.

74. However, the Committee was not satisfied from Dr Mayne's evidence and his records that he obtained a history from Patient A to support actual exposure to tick bites from a relevant endemic area, overseas or locally, neither that he documented that (Particular 1.a.).

75. Neither was the Committee satisfied from Dr Mayne's evidence that he documented or obtained a history from Patient A concerning the activities he had undertaken on his travels and exposure to tick bites to support a diagnosis of Lyme disease, (Particular 1.b.).

76. We preferred the evidence of Professor Beaman with regard to the unlikely incidence of Lyme disease in Australia, and found him and his research more authoritative than Dr Mayne's opinion. We noted that Dr Mayne when questioned, agreed that the criteria for Lyme disease to be classed as endemic on the North Coast of Australia were not fully met. We found Particulars 1.a. and 1.b, & 1,g proven.

77. **As to Particulars 1.j. and 1.h.;** We noted that Patient A presented with migratory arthritis on 13 February 2012. In regard to Particular 1.j., Dr Mayne

conceded that he had not obtained plain imaging of the joints involved in Patient A's complaints to assist in diagnosing Patient A's generalised migratory arthritis.

78. As to Particular 1.h; the HCCC alleged that Dr Mayne did not document, obtain or conduct an adequate examination or history concerning Patient A's generalised migratory arthritis. Dr Mayne conceded that his documentation of the examination of Patient A's generalised migratory arthritis may have been inadequate, but he insisted that he had conducted an adequate examination and obtained a history concerning Patient A's generalised migratory arthritis.

79. Although Dr Mayne admitted that his records were not complete, he insisted that it was in part because he did not document everything for which he examined his patients. This was further exacerbated, he explained, in that his spreadsheets on which he had documented various findings in relation to Patient A, had been *lost* or deleted from his computer when he closed his practice in 2015.

80. We considered the whole of the evidence with regard to Patient A's presentation and Dr Mayne's examinations. We are mindful of the doubts expressed with regard to the possibility of Lyme disease occurring in Australia by expert opinion such as Professor Beaman and Dr Ellis. Dr Ellis pointed out that a musculo-skeletal examination should have been carried out, and that there was no indication of that.

81. We noted the rather pre-emptive diagnosis of Lyme disease which Dr Mayne made, and were accordingly not convinced that Dr Mayne had fully explored Patient A's generalised migratory arthritis with which he presented in February 2012.

82. We deal further with Dr Mayne's paucity of records in our consideration of Complaint Two, but note here Dr Morris' opinion that she accepted Dr Mayne's examination of Patient A was satisfactory, and that a lack of documentation about a particular point did not mean that he had not considered it, or examined the Patient appropriately. Given the requirements in Schedule 2 of the Regulation, and the evidence before us, we cannot accept that opinion.

83. **Re Particular 1.i**.; In Particular 1.i., the HCCC alleged that Dr Mayne did not involve an infectious disease physician to assess the probability of Lyme disease. Dr Mayne conceded the Particular, although he appeared to not accept that the referral was relevant, or that it would have been of assistance to him or the Patient.

84. Dr Ellis considered such referral would have been appropriate, whereas Dr Morris suggested a neurologist would have been more appropriate. She added that there were additional difficulties in treating Patient A because of his age and co-morbidities. Dr Morris stated that Patient A's migratory polyarthritis may have been a feature of early stage Lyme disease, and that Dr Mayne, an experienced Lyme-literate doctor may not have deemed it necessary to involve an infectious disease specialist in diagnosing Lyme initially. Dr Morris said that she would not be critical of his approach.

85. Dr Mayne told us that he had referred the Patient to Dr B Houghton, a specialist physician on 20 June 2012, for his respiratory problems. However, correspondence between the HCCC and Dr Houghton elicited a reply that the

doctor had made searches and found no evidence Patient A had ever consulted him.

86. Dr Mayne also told us that he had referred Patient A to Dr M Kinchington, a geriatrician. We noted that the referral was dated 22 January 2013, well after the diagnosis of, and treatment for Lyme disease. The appointment made for 7 May 2013 was cancelled as the practice was informed Patient A was relocating to Queensland.

87. Dr Mayne's counsel submitted that Dr Mayne was a more experienced practitioner than Dr Ellis in regard to Lyme disease, and submitted that his evidence regarding the need for referral to an infectious disease physician should be preferred. Notwithstanding the difficulties experienced in regional areas, in obtaining specialist appointments, we are satisfied from the evidence of Professor Beaman and Dr Ellis that Patient A should have been referred to an infectious disease specialist.

88. Dr Mayne's denial, even to date, of the desirability of referral of Patient A to an infectious diseases specialist indicates a lack of insight to the Committee, and is of concern. The Committee finds Particular 1.i. proven.

The Committee's findings in regard to Particular 1. of Complaint One

89. The Committee has found all the Particulars of Particular 1. of Complaint One proven, as noted above.

90. We were mindful that Dr Ellis, who is a General Practitioner, and accordingly a peer, and was the only one of the expert witnesses to so comment, told us that in relation to Particular 1.of Complaint One, her opinion was that Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience, but that his conduct did not invite her strong criticism.

91. Mr Rooney of counsel who represented Dr Mayne, sought to infer from Dr Ellis' evidence that she was not critical of Dr Mayne's in his diagnosis of Patient A. We rejected that submission. The Committee was satisfied that Dr Ellis was of the opinion expressed in the paragraph above, which was that in relation to Particular 1. of Complaint One, Dr Mayne's conduct in regard to diagnosis of Patient A in February 2012 fell significantly below the standard expected of a practitioner of equivalent training and experience.

Particular 2. of Complaint One

92. *The HCCC alleged that the practitioner inappropriately commenced Patient A on intramuscular penicillin injections on 5 March 2012 in circumstances where:*

    a. *he did not seek the advice of an infectious diseases physician before commencing the intramuscular penicillin injections;*
    b. *the injections were not medically indicated as Patient A did not have a verifiable diagnosis of Lyme disease;*
    c. *the use of intramuscular penicillin injections were not appropriate for proven non-neurological Lyme disease or neurological infections;*

d. *the practitioner failed to first trial oral Doxycycline for 10-14 days followed by a review.*

93. **As to Particular 2.a**., the HCCC alleged that Dr Mayne did not seek the advice of an infectious diseases physician before commencing Patient A's intramuscular penicillin injections.

94. Dr Mayne admitted that he did not seek the advice of an infectious diseases physician before commencing Patient A on intramuscular penicillin injections prescribed on 5 March 2012, (and commenced on 6 March 2012).

95. He told us that he referred Patient A to Dr B Houghton, a respiratory physician, and to Dr Kinchington, a geriatrician. We noted that Patient A did not attend at either. We noted further that the referrals were not in connection with Particular 2.a., which dealt with whether Dr Mayne had sought the advice of an infectious diseases physician before commencing Patient A on intramuscular penicillin injections from 5 March 2012. On his admission, he had not sought such advice.

96. In the paragraphs above we noted the fact that even at the hearing Dr Mayne expressed a view that he did not think it was necessary or desirable to consult an infectious diseases specialist in connection with the diagnosis and/or treatment of Patient A. We found that that amounted to a lack of insight. We do not resile from that position.

97. Dr Mayne did not agree that he had commenced intramuscular penicillin injections inappropriately.

98. In that connection, Dr Ellis opined that if she thought a patient had CNS manifestations, and neuroborrelliosis, she would not manage the patient without seeking the advice of a specialist. She stated that she would then follow the advice of that doctor, and standardised Australian guidelines which specify intravenous antibiotics for a CNS infection.

99. It was Professor Beaman's view that a General Practitioner would be able to diagnose Lyme disease if the right checks were made, but that specialist advice would be required to manage the patient.

100. When asked whether Dr Mayne should have referred Patient A to an infectious diseases specialist, Dr Morris agreed with the proposition, if there was a suspicion of neuroborreliosis, she said. She opined however, that Dr Mayne did not, at the time, suspect neuroborreliosis. Further on in her evidence, Dr Morris opined that if at all, depending on results of testing, referral to a neurologist would have been more appropriate. She also expressed the view that an experienced Lyme-literate practitioner such as Dr Mayne had the expertise to diagnose and treat a patient such as Patient A.

101. The Committee was satisfied on the evidence, including the opinion of Dr Kesson, who was a Member of the Committee, and is an infectious diseases specialist, that referral of Patient A to an infectious diseases specialist would have been the appropriate action for Dr Mayne to take before treating the Patient. We are satisfied that Particular 2.a. is proven in that Dr Mayne did not seek the advice of an infectious diseases physician before commencing Patient A on intramuscular penicillin on 6 March 2012.

102. **As to Particular 2.b**; the HCCC alleged that the injections were not medically indicated as Patient A did not have a verifiable diagnosis of Lyme disease.

103. We are mindful of the evidence of Professor Beaman, already noted above, who opined in his report to the Committee that: *The cause of Lyme Disease in Australia is overseas travel to endemic regions, (the Americas, Europe, Asia and Northern Africa), associated with sustaining a bite from a local Lyme Disease-transmitting arthropod vector,* and that *there is no validated evidence for local transmission of Lyme Disease in Australia.*

104. We also noted Dr Ellis' reference to the Clinical Advisory Committee on Lyme Disease in Australia, which indicated that whilst there is still no routine finding of Boerrlia spp in Australian ticks, the possibility of a bacterium causing a Lyme disease like syndrome requires further research.

105. We are also mindful that Dr Morris told the Committee that there is a growing body of scientific documentation of Borrellia in Australian patients, although she indicated that it was *not accepted in some quarters.*

106. We noted that Patient A, aged 68, with co-morbid conditions such as hypertension, ischaemic heart disease**,** and abdominal aortic aneurysm, attended at Dr Mayne's surgery in February 2012, with migratory arthritis. Following brief questioning about tick bite, recorded as reported by the Patient to have occurred in Australia some 40 years previously, on 27 February 2012, (the fourth consultation), Dr Mayne had ordered certain tests, but had also diagnosed Lyme disease. He had also recorded Lyme neuroborelliosis as the reason for the consultation.

107. We have found above in relation to Particular 1.a.,that Dr Mayne did not document or obtain a history from Patient A to support actual exposure to tick bites from a relevant endemic area, overseas or locally.

108. We are also satisfied to the requisite standard, and have found in relation to Particular 1.b., that Dr Mayne did not document or obtain a history from Patient A concerning the activities he had undertaken on his travels and exposure to tick bites to support a diagnosis of Lyme disease.

109. We were similarly satisfied to the requisite standard, and have found in relation to Particular 1.c., that Dr Mayne ought to have been aware that Patient A's report of a tick bite approximately 40 years prior in Australia was unlikely to be the cause of his migratory arthritis at the time of the consultation, or relevant to the diagnosis of Lyme disease.

110. We were similarly satisfied to the requisite standard, and have found in relation to Particular 1.d., above, that Dr Mayne did not observe or obtain a history of positive clinical signs and/or symptoms sufficient to support a diagnosis of Lyme disease.

111. Relevantly we were also satisfied that the HCCC had proven its allegations in relation to Particulars 1.e. and 1.f. and 1.g.

112. We also noted the evidence of Professor Beaman and Dr Ellis in regard to diagnosis of Lyme disease. We were not satisfied that Dr Mayne had indeed

correctly diagnosed Lyme disease in Patient A on 27 February 2012, as recorded in his clinical notes.

113. We were mindful of Professor Beaman's statement that Dr Mayne did not have sufficient clinical or laboratory evidence to diagnose and commence treatment for Lyme disease. In support of his statement, Professor Beaman specifically mentioned that Patient A did not present with erythaema chronicum migrans (ECM), acrodermatitis, lymphocytoma, joint swelling, Bell's palsy, radiculoneuropathy, lymphocytic meningitis, encephalitis or heart block. He noted that Dr Mayne's clinical notes recorded floaters, blurred vision, imbalance, mild rombergism and dysphagia on 22 February 2012. He considered that these were all non-specific symptoms, and that there were no specific clinical signs diagnostic of cranial nerve lesions.

114. Professor Beaman concluded that the Patient did not manifest any diagnostic clinical criteria for Lyme disease at the time Dr Mayne made his clinical diagnosis. Professor Beaman added that Patient A did not have any laboratory tests that were diagnostic of Lyme disease. He did not have two tiered serological testing by an accredited laboratory, cerebrospinal fluid analysis or culture, or molecular testing of any tissues. Professor Beaman added that CD57 is not a diagnostic test for Lyme disease. Dr Ellis agreed with the above. Dr Morris agreed that CD57 is not a diagnostic test for Lyme disease, stating that she would no longer use it.

115. We are satisfied that Patient A did not, on commencement of the intramuscular penicillin injections prescribed on 5 March 2012, and commenced on 6 March 2012 (Exhibit R2. p40), have a verifiable diagnosis of Lyme disease.

116. The Committee was satisfied that Particular 2.b. was proven, and that the injections to which Patient A was subject were not medically indicated because he did not have a verifiable diagnosis of Lyme disease when they were prescribed.

117. **Particulars 2.c and 2.d.;** In these Particulars, the HCCC alleged that the use of intramuscular injections of penicillin was not appropriate for proven non-neurological Lyme disease, or neurological infections. Further that Dr Mayne failed to first trial Doxycycline for 10 – 14 days followed by a review.

118. On 5 March 2012, Dr Mayne noted the Spect brain scan which he had ordered on 27 February 2012, was normal. He ordered weekly intramuscular injections of penicillin (bicillin injections 1.8 gm), for neurological Lyme disease, which he indicated in his statement, would, according to the ILADS/Burrascano Guidelines, continue for between six months and two years.

119. We noted that Patient A was given 30 bicillin injections from 6 March 2012 until they were ceased on 2 October 2012.

120. Dr Mayne stated that Patient A was being treated for neurological Lyme disease, and submitted that the intramuscular penicillin was the appropriate treatment.

121. Dr Mayne also stated that he would use doxycycline and flagyl once he was convinced that Patient A was obtaining clear clinical benefit from the bicillin injections. Dr Mayne also stated that Doxycycline is appropriate for acute tick bite, which was not the case of Patient A.

122. According to Professor Beaman, and Dr Ellis, if Dr Mayne was convinced that Patient A was suffering Lyme disease, he should have trialled him on oral Doxycycline for 10-14 days followed by a review. Professor Beaman told us that there was a high cure rate using Doxycycline for Lyme disease.

123. We noted that both Drs Mayne and Morris who claimed to be following the ILADS Guidelines, indicated that those Guidelines did not recommend Doxycycline be given in Lyme disease. Dr Morris was satisfied that the penicillin prescribed for Patient A was the correct treatment.

124. We were satisfied from the evidence that when Dr Mayne prescribed intramuscular penicillin on 5 March 2012 for Patient A, the Patient did not have a verifiable diagnosis of Lyme disease. (Particulars 1.d. and 1.f.) We were satisfied that intramuscular penicillin was therefore not the correct medication to prescribe without further consultations, referral to an infectious diseases specialist, and tests.

125. We noted Professor Beaman's comments that Dr Mayne had at first indicated he prescribed the intramuscular Penicillin for Lyme disease, but that in a second clinical note, stated that it was for cellulitis the Patient was suffering (first for the right arm (11 April 2012), then the left arm, (30 May 2012). Professor Beaman opined that the treatment was not appropriate for the cellulitis.

126. Professor Beaman also opined that intramuscular Penicillin injections are an outmoded treatment for proven non-neurological Lyme disease. He gave alternatives which are not relevant to the Complaints, and which we do not pursue here. He commented adversely on the length of time the Penicillin was administered, and stated that: *This was a completely experimental regimen.*

127. Dr Ellis opined that the intramuscular weekly Penicillin treatment regime Dr Mayne prescribed is not recommended as a treatment even in areas where Lyme disease is a recognised clinical disease, e.g. the USA and Europe. In her opinion it was *highly unorthodox,* and she suggested that a trial of oral Doxycycline for a month with review if symptoms persisted.

128. We were satisfied from the evidence regarding Patient A that he did not have verifiable Lyme disease at the time he was prescribed intra-muscular penicillin. We prefer the evidence of Professor Beaman and Dr Ellis which was that the treatment Dr Mayne prescribed for Patient A was accordingly not appropriate.

129. We noted that Dr Morris in her statement, advised that in light of the normal Spect CT she would have questioned the diagnosis of neuroborreliosis, adding that intra-muscular Penicillin would have been the correct treatment had the diagnosis been confirmed. Dr Morris opined that she could not condone continuing the treatment without a review at 4 - 6 weeks when there was no clinical improvement.

130. Dr Morris also stated that the differential diagnosis of migratory arthritis is broad, and includes clinical diagnosis of Lyme disease. Dr Morris was critical of Dr Mayne in the early stages of diagnosis, and considered that his clinical judgment at that initial stage of diagnosis fell below an acceptable standard of care.

131. We are also satisfied from the evidence of Professor Beaman that Dr Mayne should have trialled oral Doxycyline for 10 – 14 days followed by a review if he suspected Lyme disease.

132. We have noted that Professor Beaman summarised Dr Mayne's and Dr Morris' views regarding suitable medication for Patient A, and emphasised that notwithstanding their alleged adherence to the ILADS Guidelines,(with which Professor Beaman does not agree), these were not being followed.

133. Dr Ellis' view of Dr Mayne's conduct in relation to the prescription of intramuscular penicillin for approximately 30 treatments, was that it was conduct significantly below the standard reasonably expected of a practitioner of equivalent level of training and experience. She indicated that conduct invited her strong criticism.

134. The Committee was satisfied from the evidence that Dr Mayne inappropriately treated Patient A with intramuscular Penicillin for non-proven Lyme disease, and that he did not trial Doxycycline for a 10 – 14 day period followed by a review. We find both Particulars 2.c. and 2.d. are proven.

The Committee's findings in regard to Particular 2 of Complaint One

135. As noted above in the discussion of the Particulars, we found all the sub-particulars of Particular 2. of Complaint One, proven.

136. Dr Ellis, told us that in relation to Particular 2. of Complaint One, her opinion was that Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience, and invited her strong criticism.

Particular 3. of Complaint One

137. *The HCCC alleged that after 5 March 2012, the practitioner treated Patient A for Lyme disease with intramuscular penicillin injections as set out in Annexure A, and oral Trimethoprim 300mg 1 tablet daily from 30 October 2012 until 2 January 2013. The HCCC alleged that the practitioner inappropriately managed Patient A between 5 March 2012 and 2 January 2013, in that he:*

    a. *failed follow up his request on 27 February 2012 for Borrelia PCR testing;*
    b. *failed to arrange repeat serology markers for his diagnosis of Lyme disease;*
    c. *failed to re-assess Patient A's intramuscular penicillin treatment regime for his diagnosis of Lyme disease after at least one month and instead continued the treatment regime for about 30 weeks and increased the dosage for the last 6 weeks of the treatment;*

d. *failed to re-evaluate his diagnosis of Lyme disease after at least two months;*
e. *failed to refer Patient A for a second opinion to an infectious diseases specialist and a rheumatologist after at least two months;*
f. *failed to reconsider causes other than Lyme disease for Patient A's general migratory arthritis;*
g. *failed to document or conduct an examination of Patient A's hips before or after bilateral hip x-rays dated 28 September 2012 demonstrated osteoarthritis;*
h. *…*
i. *failed to arrange imaging of other joints involved where Patient A was reporting pain, including imaging of Patient A's shoulders on 14 September 2012;*
j. *used Trimethoprim monotherapy, which is not an appropriate drug therapy for Lyme disease and was not indicated after Patient A's trial of penicillin;*
k. *….*
l. *consider and investigate the possibility of an occult malignancy in Patient A, a 68 year old male with chronic obstructive pulmonary disease who continued to smoke.*

138. **Particular 3**. consists of a number of sub-particulars, some of which Dr Mayne conceded. It is not in dispute, and Dr Mayne agrees that he treated Patient A with intra-muscular Penicillin from 6 March 2012, as stated in the Complaint. He also prescribed oral Trimethoprim 300 mg 1 tablet daily from 30 October to 2 January 2013.

139. Whilst conceding Particulars, 3.b., 3.e. 3.g. and 3.i., Dr Mayne did not concede that he inappropriately managed Patient A between 5 March 2012, and 2 January 2013.

140. **As to Particular 3.a.;** we are satisfied from the evidence that Dr Mayne failed to follow up his request on 27 February 2012 for Borrelia PCR testing as alleged by the HCCC. His evidence was that Patient A was unable to meet the expense and hence refused to undergo the testing. We noted from the evidence of Professor Beaman that appropriate tests can be provided free of charge to the patient in Australia. There is not evidence these tests were offered to Patient A. The Particular is proven.

141. **As to Particular 3.b**.; Dr Mayne conceded that he failed to arrange repeat serology markers for his diagnosis of Lyme disease as alleged by the HCCC. The Particular is proven.

142. **As to Particulars 3.c and 3.d.;** In those Particulars the HCCC alleged that Dr Mayne's follow-up, re-assessment, and dosage of the treatment of Patient A

with intra-muscular penicillin, was inappropriate. Dr Mayne told us that his reviews of Patient A's treatment were recorded in the now missing spreadsheet. He said that he re-assessed Patient A after a month of intramuscular penicillin treatment, and that further reviews were conducted. He stated that he noted improvements until August 2012, when no further improvement was noted. Accordingly, he increased the frequency of the injections for the final four weeks, before ceasing them on 2 October 2012.

143. The HCCC alleged that the twice weekly injections took place for the last six weeks of treatment. The schedule of injection dates provided (see Appendix to these Reasons for Decision), does not assist with a decision whether the twice weekly injections took place for the last four or last six weeks of treatment.

144. As we have found in the paragraphs above, that intramuscular Penicillin was contraindicated for this Patient due to the inadequate examination, testing and diagnosis, the issue of whether the increase in frequency of injections was for the last four or last six weeks to 2 October 2012, is not highly relevant.

145. However the Committee was not satisfied with Dr Mayne's explanation that he had recorded reviews undertaken of the Patient in his spreadsheet. Dr Mayne had no personal recollection of the dates of review, and the spreadsheets having been allegedly *lost,* were not available to the Committee.

146. We noted from the statement of the Patient's wife, that Dr Mayne spoke to him when he attended at the surgery for his Penicillin injections. We were however not satisfied that this could count as a *review* as contemplated in the HCCC's Particulars 3.c. or 3.d. We did not see any record of such review, and cannot accept it occurred, particularly as the Penicillin injections continued for approximately 30 weeks. Further, there is no evidence to convince us that the diagnosis of Lyme disease was re-evaluated after at least two months, or at all.

147. Dr Ellis opined that following a presumptive diagnosis of Lyme disease Dr Mayne commenced treatment with his regime of intramuscular Penicillin. She commented that this treatment regime is not recommended as a treatment even in areas where Lyme disease is a recognised clinical disease e.g. the USA and Europe. She stated: *It is highly unorthodox and a trial of oral Doxycycline could have been given for one month with review if symptoms persisted. A maximum, of two months oral antibiotics treatment would not be inappropriate if there was substantial evidence of clinical and investigative results to support a diagnosis of Lyme disease.* She stated that this inappropriate use of antibiotics has significant ramifications for the wider community specifically with respect to the development of resistant bacteria. In that regard Dr Ellis considered Dr Mayne's conduct fell significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

148. Dr Morris agreed that a review after one month of Penicillin injections would have been prudent. She also opined that continuing treatment for approximately 30 weeks in the absence of clinical improvement was not good practice. She also considered that re-evaluation of the clinical diagnosis is prudent.

149. The Committee was satisfied to the requisite standard from the evidence stated above, that Particulars 3.c. and 3.d. are proven.

150. **As to Particular 3.e.** Dr Mayne admitted that he failed to refer Patient A for a second opinion to an infectious diseases specialist and a rheumatologist after at least two months as alleged by the HCCC. He continues to maintain that such referral was not necessary.

151. Dr Mayne told us that he referred Patient A to a respiratory specialist, and a geriatrician. We have already noted above in relation to Particular 1.i., that whilst referrals were written, Patient A did not attend at either. We were satisfied that there appeared to be no follow-up with regard to those specialists. The evidence indicates that no second opinion was discussed with the Patient, or sought from an infectious diseases specialist. Notwithstanding Dr Morris' view that referral to a rheumatologist was preferable, the evidence of Professor Beaman and Dr Ellis satisfies the Committee that referral of Patient A to an infectious diseases specialist was strongly indicated in the circumstances.

152. We find Particular 3.e. proven.

153. **As to Particular 3.f.,** Dr Mayne did not accept the allegation of the HCCC that he had failed to reconsider causes other than Lyme disease for Patient A's migratory arthritis.

154. In his written statement, he stated: *I made a diagnosis of Lyme-Neuroborelliosis. I did consider other differential diagnoses including: Borreliosis, Bartonellosis, Amyloid or Sarcoid, Guillain Barre Syndrome, and Neurological autoimmune disease.*

155. However, the Committee noted that there was no record in the clinical notes of such considerations having been made. The existing clinical notes record that on 13 February 2017, Dr Mayne diagnosed generalised migratory arthritis, which Dr Mayne did not follow up, and that by the time of the Patient's fourth consultation on 27 February 2012, Dr Mayne had recorded Patient A as attending for Lyme disease. Notwithstanding the clear result in the Spect CT, Dr Mayne had decided by 27 February 2012 that Patient A was suffering Lyme disease.

156. The Committee could not be satisfied on the evidence, written and oral, that Dr Mayne had considered causes other than Lyme disease. Accordingly Particular 3.f. is proven.

157. **As to Particular 3.g.,** Dr Mayne conceded that he failed to document or conduct an examination of Patient A's hips before or after bi-lateral hip x-rays dated 28 September 2012 demonstrated osteoarthritis as alleged by the HCCC. We so find. Particular 3.g. is proven.

158. **As to Particular 3.i**., Dr Mayne conceded that he failed to arrange imaging of other joints involved where Patient A was reporting pain, including imaging of Patient A's shoulders on 14 September 2012, as alleged by the HCCC. We so find. Particular 3.i. is proven.

159. **As to Particular 3.j.,** The HCCC alleged that Dr Mayne used Trimethoprim monotherapy, which is not an appropriate drug therapy for Lyme disease, and was not indicated after Patient A's trial of Penicillin.

160. In his statement, Dr Mayne stated that he used Trimethoprim because he suspected Bartonella. He conceded he had not documented his thoughts about this alternate diagnosis, and the Committee did not accept his evidence in that regard.

161. Professor Beaman noted that Trimethoprim is not the drug of choice for Bartonellosis, and noted that cases of failure with this antibiotic had been described in the medical literature. He also noted that he had not seen any evidence Dr Mayne had tested the Patient for Bartonella, sarcoidosis or Amyloid

162. Dr Ellis commented on the treatment Patient A had received which was some 30 weeks of intramuscular Penicillin and some weeks of IMI Ceftriaxone, and stated that she saw very little value in adding oral Trimethoprim unless Patient A had another reason for it such as E.coli urinary tract infection.

163. Dr Morris stated that she presumed the Trimethoprim was prescribed in case Patient A's symptoms were due to Bartonella. She added that another opinion should have been sought rather than another course of antibiotics.

164. We noted the opinions of the doctors who gave evidence before us regarding the Trimethoprim, and were satisfied it was not indicated after Patient A's intramuscular Penicillin. Particular 3.j. is proven.

165. **As to Particular 3.l.** The HCCC alleged that Dr Mayne failed to consider and investigate the possibility of an occult malignancy in Patient A. Dr Mayne denied that Particular, stating that he ordered a CT Spect scan of the brain, and blood tests. He also stated that although it was not for the specific purpose of investigating lung cancer, he referred the Patient to a respiratory physician for review of his advanced COPD. As already stated above, that referral was dated 19 June 2012, and not followed up. Dr Houghton did not see Patient A.

166. Dr Ellis agreed that Dr Mayne had failed to consider and investigate the possibility of an occult malignancy in Patient A.

167. Dr Ellis stated that overall, with regard to Particular 3. of Complaint One, Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience, and invited her strong criticism.

168. We noted that all the doctors who gave evidence made mention of Patient A's age and co-morbidities, and considered that Dr Mayne should have sought a second opinion with regard to his diagnosis and management of Patient A.

169. The Committee was satisfied that Particular 3.l. was proven.

The Committee's findings in regard to Particular 3. of Complaint One

170. The Committee found all the sub-particulars in Particular 3. of Complaint One proven.

171. We noted that Dr Ellis opined that overall, in relation to Particular 3. of Complaint One, her opinion was that Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience, and invited her strong criticism.

Particular 4. of Complaint One

172. *The HCCC alleged that the practitioner failed to obtain informed consent from Patient A, before commencing Patient A on experimental, novel or unproven antibiotic treatment with:*

    a. *intramuscular penicillin injections for a duration of 30 weeks from 5 March 2012;*
    b. *combination intramuscular penicillin injections and Ceftriaxone between May and August 2012;*
    c. *Trimethoprim from 30 October 2012.*

173. In his written statement, Dr Mayne referred to Particular 4.,stating that the HCCC based its view about *informed consent* on what it considered was *experimental, novel or unproven* treatment prescribed for Patient A. Dr Mayne denied the allegation, stating that by administering the treatment, he followed the ILADS and Burrascano Guidelines.

174. In his oral evidence, Dr Mayne emphasised that the LA Bicillin he prescribed for Patient A was not experimental, but stated that he told the Patient what the treatment would be. We were mindful of Professor Beaman's evidence which was that the LA Bicillin does not cross the blood brain barrier, and that it was therefore not effective in treating neuroborelliosis, Dr Mayne expressed the view that if LA Bicillin was used with a statin (which Patient A was already taking), it would be effective. He admitted when questioned that it was a novel treatment. He agreed he had not documented those conversations, and also told us that as the Patient was already taking statins, the interaction of those drugs did not require further discussion with the Patient. He demonstrated even at the time of the Hearing, a lack of insight into the importance of explaining a novel treatment to a patient, and obtaining informed consent for it.

175. As at other times, Dr Mayne's evidence was opportunistic and inconsistent. At paragraph 47 of his Statement, he indicated that four weeks after ceasing bicillin, (30 October 2012), Patient A demonstrated no change in neurological status.

176. Also in his Statement, Dr Mayne wrote that Bartonella infection was suspected, and Triprim was started.

177. However in his oral evidence, Dr Mayne stated that he had not considered Bartonella, and that at the time, he did not know that in the case of Bartonella, that condition should be treated first. His decision to consider Bartonella, nor his explanation to the Patient, (if any), was documented.

178. The Committee did not accept Dr Mayne's reasoning or recollections in this regard. We are also mindful that neither ILADS nor Burrascano are mainstream. They were described by Professor Beaman as fringe.

179. Professor Beaman opined that: *The treatment in this case was not concordant neither with the generally accepted expert guidelines …. nor the*

recommendations of ILADS. It was therefore experimental and the Declaration of Helsinki would mandate that signed informed consent be obtained prior to commencement.

180. Dr Ellis indicated that as to informed consent, verbal consent would suffice. She emphasised however, that there was no evidence to suggest that Dr Mayne explained to Patient A that his treatment regime was not at all typical of general practice in Australia, nor was there any suggestion on the patient file that Dr Mayne explained to the Patient that Lyme disease in Australia is a controversial diagnosis.

181. Dr Ellis emphasised that it appeared the Patient was not given the option to seek a second opinion, or an expert opinion from a rheumatologist or infectious diseases specialist. We found from the evidence of Dr Mayne that he did not consult a rheumatologist or infectious diseases specialist in relation to Patient A, and that he believed he did not need to do so. We are accordingly satisfied that Dr Mayne did not discuss obtaining a second opinion with Patient A.

182. Dr Morris stated that the antibiotic treatment prescribed for Patient A was not experimental. She noted however, that as Lyme disease is not an accepted diagnosis in Australia, Patient A's consent should have been sought for the treatment.

183. The Committee considered that Patient A's consent to an unusual treatment such as he received, should have been sought. We were mindful that in answers to questioning, Dr Mayne admitted he did not advise or explain to the Patient, that the treatment were not following Australian guidelines and that they were novel. He also accepted that he did not offer or discuss alternative approaches. We were satisfied that Particular 4. of Complaint One was proven.

The Committee's findings in regard to Particular 4 of Complaint One

184. The Committee found that all the sub-particulars of Particular 4. of Complaint One were proven.

<u>The Committee's conclusions regarding Complaint One</u>

185. Professor Beaman was critical of Dr Mayne's diagnosis of Patient A's illness. He found the examination of the Patient inadequate, and the tests (non-specific). He opined that the medical records showed no coherent treatment plan, and that the management plan was inadequate and chaotic.

186. Dr Ellis stated that overall, with regard to all the Particulars of Complaint One, with the exception of Particular 4. of Complaint One, (informed consent), Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience. All but one invited her strong criticism.

187. Dr Morris gave evidence about all the Particulars of Complaint, and provided comment in her written report. She and Dr Mayne both maintain that tick bite on the North Coast of NSW has caused Lyme disease in Australia. Both Drs Mayne and Morris are members of ILADS, and subscribe to those non mainstream guidelines.

188. The Committee made findings in relation to all the Particulars of Complaint One, as noted above. We found them all proven. We were satisfied on the basis of the evidence, and our findings in relation to diagnosis, treatment, review, documentation and follow-up, that, in relation to Complaint One, Dr Mayne Is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law.* We were satisfied that he engaged in conduct that demonstrated the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

COMPLAINT TWO

Particulars of Complaint Two

189. The HCCC alleged that Dr Mayne is guilty of unsatisfactory professional conduct under section 139B(1)(b) of the *National Law* in that he has contravened (whether by act or omission) Part 4 clause 7 and Schedule 2 of the *Health Practitioner Regulation (New South Wales) Regulation 2010* (*the Regulation*).

1. *The HCCC alleged that on 25 September 2012**,** when Patient A presented with right hip pain, the practitioner failed to document a detailed history or examination. The practitioner acted contrary to Schedule 2, clauses 2(1), and 2(2) of the Regulation.*
2. *On 25 February 2013**,** when Patient A presented with constipation, the practitioner failed to document a detailed history or examination. The practitioner acted contrary to Schedule 2, clauses 2(1), and 2(2) of the Regulation.*
3. *The detail in practitioner's record of Patient A's history, signs and symptoms, and risk factors for Lyme disease from 27 February 2012 to 2 January 2013 was inadequate. The practitioner acted contrary to Schedule 2, clauses 2(1) and 2(2) of the Regulation.*
4. *The practitioner failed to document any clear plan of management with respect to his antibiotic therapy for Patient A from 27 February 2012 to 2 January 2013. The practitioner acted contrary to Schedule 2, 2(1) and 2(2) of the Regulation.*
5. *The practitioner failed to document any or any adequate review of Patient A's antibiotic therapy after February 2012. The practitioner acted contrary to Schedule 2, clauses 2(1) and 2(2) of the Regulation.*

190. Dr Mayne conceded that, he failed to document various events and observations about Patient A in his clinical notes and/or other records as alleged by the HCCC, in relation to all the five Particulars of Complaint Two. He argued however, that he carried out reviews of the Patient's medication, and discussed various matters with him, which however, he neglected to document.

191. Dr Mayne also sought to explain at the hearing that his spreadsheet which would indicate the reviews he undertook of Patient A and his treatment, had somehow been deleted from his computer, and was no longer available. In substitution he provided a de-identified copy of a spreadsheet relating to another patient. The Committee did not find that of assistance, and was not satisfied with the excuses Dr Mayne provided.

192. Dr Mayne did not accept that he had acted contrary to Schedule 2, clauses 2(1) and 2(2) of the Regulation in connection with each of the Particulars of Complaint Two, neither that he was guilty of unsatisfactory professional conduct.

193. Schedule 2, clauses 2(1) and 2(2) of the Regulation are reproduced below:

2 General requirements as to content

(1) In general, the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned.

(2) A record must include sufficient information concerning the patient's case to allow another medical practitioner to continue management of the patient's case.

(3) ….

194. Professor Beaman stated that agreed stated with the Complaints of the HCCC in relation to Complaint Two.

195. Dr Morris' view was that a lack of documentation did not necessarily indicate Dr Mayne had not examined or reviewed the Patient, and submitted the Committee should consider that as an alternative.

196. Dr Ellis stated that overall, with regard to Complaint Two, Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience, and invited her strong criticism.

197. The Committee has already found in relation to Complaint One, that Dr Mayne failed to adequately detail in his record, Patient A's history, signs and symptoms, and risk factors for Lyme disease from 27 February 2012 to 2 January 2013. We were also satisfied from the expert evidence before us,that Dr Mayne failed to document any clear plan of management with respect to his antibiotic therapy for Patient A from 27 February 2012 to 2 January 2013.

198. We were satisfied on the basis of the evidence, and our findings in relation to diagnosis, treatment, review, documentation and follow-up, that, in relation to Complaint Two, Dr Mayne Is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law.* We were satisfied that he engaged in conduct that demonstrated the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

<u>The Committee's findings in relation to Complaint Two</u>

199. The Committee was satisfied on the basis of Dr Mayne's concessions regarding the extent of his documentation of events and medication relating to Patient A, and the expert evidence of Professor Beaman and Dr Ellis which it preferred over that of Dr Morris in this regard, that Particulars 1. – 5. of Complaint Two were proven in regard to the factual situation therein described.

200. The Committee had however, to also consider whether Dr Mayne acted contrary to Schedule 2, clauses 2(1) and 2(2) of the Regulation. We were satisfied that Dr Mayne's level of record keeping was contrary to the stipulations of Schedule 2, clauses 2(1) and 2(2) of the Regulation in that the level of detail contained in a record must be appropriate to the patient's case, and to the medical practice concerned. On the basis of Dr Mayne' admissions, and the written evidence in his clinical notes, as well as the expert evidence, we concluded that Dr Mayne had acted contrary to the requirement of Schedule 2, clauses 2(1) and 2(2). We noted in addition, that Dr Mayne's records about Patient A's diagnosis, management and other plans were not adequately recorded, and that another medical practitioner who took over to continue management of the patient's case would not be able to do so properly.

201. We were satisfied that the Complaint was proven. We are also satisfied in relation to Complaint Two, that Dr Mayne's conduct fell significantly below the standard expected of a practitioner of equivalent training and experience.

202. We were satisfied on the basis of the evidence, and our findings in relation to diagnosis, treatment, review, documentation and follow-up, that, in relation to Complaint Two, Dr Mayne is guilty of unsatisfactory professional conduct under section 139B(1)(a) of the *National Law.* We were satisfied that he engaged in conduct that demonstrated the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

DOCUMENTS

203. The Committee had before it two folders of documents lodged by the HCCC and one folder of documents lodged by Dr Mayne which it took into evidence.

DETERMINATION AND ORDERS

204. The Committee, having heard the evidence and submissions, and taking into account the legislation, and Dr Mayne's admissions, was satisfied that all the Particulars of the both of the HCCC's Complaints have been proven.

205. The Committee is satisfied the HCCC has established in relation to both Complaints, that Dr Mayne is guilty of unsatisfactory professional conduct under section 139B of the National Law in that he has engaged in conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

206. The Committee takes into account the fact it is well established that the jurisdiction exercised by the Professional Standards Committee is protective, not punitive. Disciplinary proceedings against members of a profession are intended to maintain proper ethical and professional standards, primarily for the protection of the public but also for the protection of the profession. (*Health Care Complaints Commission v Litchfield (1997) 41 NSWLR 630*)

207. The reach of the concept of protection of the public was set out by the NSW Court of Appeal in *HCCC v Do [2014] NSWCA 307*, where the Court made clear that a broad understanding of protection was appropriate.

208. We are also mindful that whilst the primary role of the Inquiry is protective, it also has a role in maintaining public confidence in the profession, and maintaining the reputation of the profession. Orders of the Committee may operate to have a general deterrent effect for other members of the profession. (*Prakash v Health Care Complaints Commission* ([*2006] NSWCA 153*)

209. As noted above, the Committee found Dr Mayne guilty of unsatisfactory professional conduct in relation to both Complaints. The Committee heard submissions from the parties regarding protective orders, and has directed that a Reprimand, and the Conditions as detailed below, be imposed. We made those Conditions taking into account that Dr Mayne has not been in practice since 2015, and that his medical practice, rather than encompassing all manner of general practice, was concentrated on Lyme disease. We noted also that as Dr Mayne is currently not registered, the Reprimand and Conditions can only be implemented should Dr Mayne regain AHPRA registration (section 146B(2) of the National Law).

CONDITIONS
Pursuant to section 146B(2) of the *National Law*

Reprimand

1. To practise only in an accredited group general practice where there are at least two registered medical practitioners (excluding the subject practitioner), where the patients and patient records are shared between the medical practitioner and where there is always one other registered medical practitioner on site.

2. Not to advise (other than to refer a patient to another practitioner), diagnose or treat patients who the practitioner believes to have or may have Lyme disease or similar tick-borne diseases.

3. To practise under Category C Supervision in accordance with the Medical Council of NSW's Compliance Policy – Supervision (as varied from time to time and as subsequently determined by the appropriate review body). The supervisor must practise at an accredited practice.

    a) to authorise the Medical Council of NSW to provide the approved supervisor with:
        i. a copy of the report of the proceedings that imposed this condition; and
        ii. a copy of the conditions on the practitioner's registration.

    b) At each monthly supervision meeting the practitioner is to review and discuss his practice with his approved supervisor with a particular focus on:
        i. at the first meeting he and the supervisor are to develop a written learning plan, identifying any gaps in medical knowledge and ways to address these deficiencies. Progress against this plan is to be regularly

reviewed at the supervision meetings and reported in the supervision report.

ii. the practitioner's plan and approach for new patients, in particular those who have not been referred to the practitioner by their general practitioner.

iii. Case reviews, medical record reviews, workload, pathology result reviews, clinical outcomes, patient follow up, overall patient care and appropriate prescribing practices;

iv. the practitioner's compliance with the condition 2;

v. the practitioner's referrals to, and communication with patients' specialists and their regular general practitioners.

vi. The supervisor forwards to the Council, initially on a quarterly basis, a Supervision Report in a format prescribed or approved by the Council. The first supervision report is to include a copy of the learning plan referred to in Condition 3)b)(i).

vii. To be supervised for a minimum period of twelve months and as subsequently determined by the Council.

4. To submit to an audit of his medical practice, by a random selection of his medical records by a person or persons nominated by the Medical Council of NSW and:

   a) The audit is to be held within 6 months from his return to practise and subsequently as required by the Council;
   b) The auditor is to assess his compliance with good medical record keeping standards, legislative requirements and compliance with the conditions, particularly Condition 2.
   c) To authorise the auditor(s) to provide the Council with a report on their findings and;
   d) To meet all costs associated with the audit and any subsequent reports.

5. To complete within 6 months of returning to the Register the Issues in general practice prescribing course organised by Monash University.

   a) Within one month of returning to the Register he must provide evidence to the Medical Council of NSW of his enrolment in the abovementioned course.
   b) Within one month of completing the abovementioned course, he is to provide documentary evidence to the Council that he has satisfactorily completed the course.
   c) To bear responsibility for any costs incurred in meeting this condition.

   In the event that the Issues in general practice prescribing course is unavailable, he must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 2 months from the date of returning to the Register.

6. To complete within 6 months of returning to the Register a course on good record keeping organised by his medical indemnity insurer.

a) Within one month of returning to the Register he must provide evidence to the Medical Council of NSW of his enrolment in the abovementioned course.
b) Within one month of completing the abovementioned course, he is to provide documentary evidence to the Council that he has satisfactorily completed the course.
c) To bear responsibility for any costs incurred in meeting this condition.

In the event that a course on good record keeping organised by his medical indemnity insurer is unavailable, he must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 2 months from the date of returning to the Register.

7. To complete within 12 months of returning to the Register The John Murtagh Update Course organised by Monash University.

a) Within two months of returning to the Register he must provide evidence to the Medical Council of NSW of his enrolment in the abovementioned course.
b) Within one month of completing the abovementioned course, he is to provide documentary evidence to the Council that he has satisfactorily completed the course.
c) To bear responsibility for any costs incurred in meeting this condition.

In the event that a course on The John Murtagh Update Course is unavailable, he must propose to the Council for approval a similar course to be undertaken in accordance with the requirements of this condition no later than 2 months from the date of returning to the Register.

APPEAL AND REVIEW RIGHTS

210. Dr Mayne has the right to appeal this decision to the NSW Civil and Administrative Tribunal.

211. An appeal must be lodged with the Tribunal within 28 days of the date of these written reasons.

212. Dr Mayne also has the right to seek a review by the Medical Council of NSW of the Committee's Order to impose Conditions. The Medical Council is the appropriate review body for the purposes of Part 8, Division 8 of the Health Practitioner Regulation National Law (NSW).

213. Sections 125 to 127 of the National Law are to apply whilst the practitioner's principal place of practice is anywhere in Australia other than in New South Wales, so that a review of these conditions can be conducted by the Medical Board of Australia.

214. As already stated above, the Committee directed that a Reprimand, and certain Conditions as detailed above, be imposed, which can only be implemented

should Dr Mayne regain AHPRA registration (section 146B(2) of the *National Law*).

DISTRIBUTION OF THE REASONS FOR DECISION

215. The non-publication order over the name and any other identifying factors of Patient A made by the Chairperson is continued indefinitely.

216. A copy of the Reasons for Decision which may be published in full, will be provided to Dr Mayne, the Health Care Complaints Commission, Mr David Brown of Browns Legal and Consulting, the National Board and the Complainant.

Geri Ettinger
Chairperson

1 May 2017
(Date)

Annexure A

	Date of Intramuscular penicillin injection (Bicillin LA 900mg x 2) received by Patient A
1	13 March 2012
2	20 March 2012
3	27 March 2012
4	3 April 2012
5	10 April 2012
6	17 April 2012
7	24 April 2012
8	1 May 2012
9	8 May 2012
10	15 May 2012
11	22 May 2012
12	29 May 2012
13	5 June 2012
14	19 June 2012
15	26 June 2012
16	3 July 2012
17	10 July 2012
18	17 July 2012
19	24 July 2012
20	7 August 2012
21	14 August 2012
22	21 August 2012
23	28 August 2012
24	31 August 2012
25	4 September 2012
26	11 September 2012
27	18 September 2012
28	21 September 2012
29	25 September 2012