IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 494

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Maree Arthur

Delivered On:	12 June 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria 3000
Hearing Dates:	14 June 2012
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr J Goetz appeared on behalf of Dr David Phillips
Police Coronial Support Unit	Leading Senior Constable T Cristiano appeared to assist the Coroner.

I, JACQUI HAWKINS, Coroner, having reviewed the investigation into the death of MAREE BERNADETTE ARTHUR

AND the inquest[1] held by Coroner Hendtlass on 14 June 2012 into this death

at the Coroners Court of Victoria, Level 11, 222 Exhibition Street, Melbourne,

find that the identity of the deceased was MAREE BERNADETTE ARTHUR

born on 2 August 1962

and the death occurred on 2 February 2008

at 16 Broadlea Crescent, Viewbank, Victoria

from:

1 (a) PETHIDINE TOXICITY

in the following circumstances:

1. Ms Maree Bernadette Arthur lived with her partner Mr Anthony Kayrooz at 16 Broadlea Crescent in Viewbank. She had three children and according to Mr Kayrooz was talented musically as she played the organ and sang at the local church.

2. Ms Arthur had a number of ongoing health issues which were attributed to a motor vehicle collision and previous stomach stapling surgery.[2] Between 1991 and 2008 she underwent numerous surgical procedures and presented regularly to medical practitioners for pain management.[3]

3. Ms Arthur met Dr David Phillips when she played the organ at his wife's funeral in March 2007. Approximately two months after this Dr Phillips became Ms Arthur's treating general practitioner.

4. Ms Arthur was prescribed, and dispensed, significant amounts of pethidine between October 2007 and February 2008. She was also prescribed and dispensed a considerable volume of other medications for pain management during this period.

5. On 2 February 2008, Mr Kayrooz returned home from work and found Ms Arthur beside the bed on the floor not breathing. Mr Kayrooz could not find a pulse and immediately called for

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1 This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

2 Statement of Mrs Eileen Arthur dated 25 December 2012, p1; Medicare Records 1991-2008.

3 Medicare Records, Pharmaceutical Benefit Scheme records.

an ambulance. The Metropolitan Ambulance Service attended but found that Ms Arthur had been deceased for some time.

6. Victoria Police attended as a result of her death and found a large amount of prescription medication in her bedroom and her car.

JURISDICTION

7. At the time of Ms Arthur's death the Coroners Act 1985 (Vic) applied. From 1 November 2009, the Coroners Act 2008 (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

8. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

9. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

10. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[5]

ASSIGNMENT OF INQUEST FINDINGS

11. Coroner Jane Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

12. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements, exhibits and transcripts of both directions hearings and the Inquest.

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[4] Section 89(4) of the Coroners Act.

[5] Sections 72(1) and (2) of the Coroners Act.

CORONIAL INVESTIGATION AND INQUEST

13. Coroner Jane Hendtlass conducted an investigation and held an inquest into Ms Arthur's death on 14 June 2012.

Submissions

14. At the conclusion of the Inquest, Interested Parties were invited to provide written submissions. Counsel representing Dr Phillips provided written submissions which I have considered for the purpose of this Finding.

Viva Voce evidence at the Inquest

15. Mr Kayrooz and Dr David Phillips[6] were called to give *viva voce* evidence at the Inquest.

Issues investigated

16. Section 67 of the Coroners Act requires me to find:

    a) the identity of the deceased

    b) the cause of death

    c) the circumstances in which the death occurred.

IDENTITY OF THE DECEASED

17. I find the identity of Ms Maree Bernadette Arthur was without dispute and required no additional investigation.[7]

CAUSE OF DEATH

18. Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted a post mortem examination on 7 February 2008. Dr Dodd attributed Ms Arthur's death to 1a) PETHIDINE TOXICITY.[8]

19. Results of the toxicological analysis showed that the level of pethidine in her blood was 8.8 mg/L, which is within the recognised range at which fatal overdoses from pethidine have previously been found.[9]

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[6] A successful application was made pursuant to section 57 of the Coroners Act for Dr Phillips to be granted a certificate pursuant to section 57(1)(b) of the Coroners Act, which enables the witness to give evidence without that evidence being used in any proceeding against him.

[7] Statement of Identification dated 2 February 2008.

[8] Exhibit 8 - Autopsy Report of Dr Malcolm Dodd, Inquest Brief, p26.

[9] Exhibit 9 - Toxicology Report, Inquest Brief, p30.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

20. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

21. For the purpose of this finding I have considered the following issues:

- Medical management of Ms Arthur
- Legal requirements for permits for prescription medications
- Patient honesty in a therapeutic relationship
- Relationship between Dr Phillips and Ms Arthur

Medical management of Ms Arthur

22. Between 1991 and 2008 Ms Arthur underwent numerous surgical procedures and received regular medical attention for pain management. Ms Arthur suffered from numerous health problems that disrupted her quality of life and for which she required ongoing medical treatment. Consequently, the therapeutic needs of Ms Arthur were complex.

23. Dr Phillips became Ms Arthur's general practitioner after meeting her in March 2007. From that point onwards he assumed overall management of her medical issues including diagnosis and treatment of her various symptoms and referral to other medical specialists.

Referrals to other medical specialists

24. Dr Phillips sought the assistance of a number of specialists.

25. Ms Arthur presented to different health care providers with abdominal pain during March and May 2007. This was attributed to kidney stones, a diagnosis which later accounted for her presentation to the Epworth Hospital and subsequent admission to Freemasons Hospital in late May 2007.

26. Around this time Dr Phillips was concerned about the amount of pethidine Ms Arthur seemed to need and enlisted the assistance of Dr Peter Ellims, an oncologist and clinical haematologist with considerable experience in the management of severe pain. Dr Ellims took a history and noted that from as early as 2003 there was a suspicious need for pethidine to relieve Ms Arthur's pain.

27. Dr Ellims investigations revealed no clinical cause for Ms Arthur's pain and he considered that she had developed chronic pain syndrome.[10] Dr Phillips described this syndrome as "a condition where the causes of the pain may have been treated effectively but the pain itself continues".[11]

28. Dr Ellims informed Dr Phillips that he believed the multiple stomach-related operations Ms Arthur had undergone were playing a role in her pain and recommended a Norspan[12] patch to reduce her need for pethidine injections.

29. Some time in late May 2007, Ms Arthur was noted to have developed a complex pattern of pain.[13] Dr Phillips referred her to Dr Tony Kostos, Rheumatologist who recommended a computed tomography (CT) scan to diagnose the source of her abdominal pain however this did not yield any useful information.[14]

30. In October 2007, Dr Phillips referred Ms Arthur to a rheumatologist and pain specialist, Dr Clayton Thomas from the Dorset Rehabilitation Service in Pascoe Vale. Dr Thomas essentially concurred with Dr Phillips' management and had little to offer in the way of any new modalities of treatment.[15]

31. Ms Arthur also saw Dr Barry Rawicki, a neurologist who scheduled a cervical epidural injection for 6 December 2007 because this procedure had previously been successful in controlling her pain.

32. In December 2007 and January 2008, Ms Arthur developed abdominal pain and saw surgeon and gastroenterologist, Mr Ian Michel, who suggested a CT scan. The CT scan showed a lesion in the scar in the midline of her abdomen but could not differentiate whether it was a seroma or a small incisional hernia.[16] Following this, her pain continued as did her need for analgesic relief.

33. The referrals to other specialists during this time demonstrate that Dr Phillips was aware of a need for assistance in treating Ms Arthur. He was committed to investigating the cause of Ms Arthur's pain and seeking appropriate treatment, particularly with respect to her reliance on pethidine for pain management.

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10 Statement of Dr David Phillips, p3, Transcript of evidence, p34, Inquest brief, p73.

11 Transcript of evidence, p52

12 Also known as Buprenorphine transdermal patches is an opioid analgesic used for chronic pain.

13 Exhibit 3 - Letter and statement of Dr Phillips, p2

14 Appendix 8 - Letter from Dr Peter Ellims to Dr Phillips, dated 17 May 2007, Inquest brief, p119.

15 Exhibit 3 - Letter and statement of Dr Phillips, p5

16 Exhibit 3 - Letter and statement of Dr Phillips, p6

Prescription of analgesic medications

34. It is evident that Ms Arthur's analgesic medication increased in both strength and volume between 2007 and her death in February 2008. The Pharmaceutical Benefit Scheme (PBS) records indicate that pethidine was prescribed and dispensed in large quantities over a number of months in combination with oxycodone.[17]

35. The first time Dr Phillips administered pethidine to Ms Arthur was at her home on 8 March 2007. He left additional ampoules of pethidine behind on the strength of Ms Arthur's account that her mother was a trained nurse who could administer them if necessary.[18] However Ms Arthur's mother, Mrs Eileen Arthur, stated that she was not a trained nurse and raised concerns that Dr Phillips had not confirmed this with her.[19]

36. Of some concern is that during Ms Arthur's admission to the Epworth Hospital in May 2007 Dr Phillips prescribed pethidine to her.[20] At the same time Ms Arthur used a prescription she received from Dr Kirti Gunawardana in November of the previous year to obtain 120 tablets of codeine phosphate with paracetamol from Chandler Pharmacy.

37. In mid-June 2007 Ms Arthur saw Dr Phillips at his clinic for tenderness in the trapezius muscles on the right side and her left loin, which was treated with a pethidine injection.[21] A home visit by Dr Phillips followed four days later on 16 June 2007. Two days after that, Ms Arthur was prescribed a further five ampoules of pethidine by Dr Phillips and obtained a further 10 ampoules from another pharmacy from a prescription by Dr Gunawardana.[22]

38. In October 2007, Dr Phillips attended Ms Arthur's residence and treated her for pain in her right neck and occiput with a pethidine injection.

39. A letter to Dr Phillips from Dr Thomas in late October 2007 provided no indication that he was aware of the volume of Dr Phillips' prescriptions, which that month amounted to 70 ampoules of pethidine, 50 diazepam and 60 oxycodone.

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17 Oxycodone is an opioid analgesic prescribed for moderate to severe chronic pain when other forms of treatment have not been effective.

18 Transcript of evidence, p22.

19 Statement of Mrs Eileen Arthur dated 25 December 2012, p2.

20 Prescription records for Dr Phillips.

21 Exhibit 3 - Letter and statement of Dr Phillips, pp 3-4.

22 Appendix 9 - Rowville Pharmacy records.

40. On 23 November 2007 Dr Barry Rawicki wrote to Dr Phillips and suggested there was potential for Ms Arthur's pain management to become problematic. He noted that he booked her in for a cervical epidural[23] to assist with her pain.

41. While both Dr Rawicki and Dr Phillips indicated that they anticipated Ms Arthur would receive a cervical epidural shortly after this consultation, however this never occurred. Instead, Ms Arthur underwent a gastric bypass procedure on 3 December 2007 and received post-operative care at the Epworth Hospital until 12 December 2007.

42. While Ms Arthur was in hospital, nursing staff recorded finding approximately 12 Endone[24] tablets on her bedside table, which Ms Arthur stated "was her husband's meds – he forgot them and would be coming in to collect the tabs".[25]

43. Dr Phillips gave evidence during the inquest that he rang Ms Arthur on 7 December 2007 to see how she was after her treatment with Dr Rawicki, and Dr Phillips found Ms Arthur distraught because the injection was put off for a few weeks. Dr Phillips stated that due to this delay in treatment he "maintained her on Pethidine 100mg 6-hourly and Endone 6-hourly."[26]

44. Epworth Hospital nursing staff noted that on 10 December 2007 Ms Arthur requested a pethidine injection, which was administered by a nurse.[27] On 11 December 2007 Ms Arthur's in-patient records note that nursing staff spoke to her about other pain relief, as did her surgeon, Mr Michel. Further she said that she would wean herself off pethidine and understood that she would be discharged without it.[28]

45. However, on discharge from the Epworth Hospital Ms Arthur was prescribed 15 ampoules of pethidine and 20 oxycodone tablets by Dr Phillips[29] both of which were dispensed by Epworth Hospital's Slade Pharmacy. The pharmacy also dispensed a further 20 Codeine Phosphate prescribed by Dr Gunawardana.[30]

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23 Letter from Dr Barry Rawicki to Dr Bryan Smith dated 23 November 2007.

24 Endone is a brand name for the active ingredient Oxycodone, a Schedule 8 poison under the DPCS Act

25 Epworth Hospital Records, staff entry 6 December 2007 at 22:30.

26 Transcript of evidence, p38.

27 Epworth Hospital Records, staff entry 10 December 2007 at 24:00.

28 Epworth Hospital Records, staff entry 11 December 2007.

29 Pharmaceutical Benefit Scheme (PBS) Records; Dr Phillips' records of prescriptions to Ms Arthur.

30 Appendix 5 - Slade Pharmacy Records for Ms Arthur, Inquest brief, p106-107.

46. Other prescriptions subsequently prescribed to Ms Arthur by Dr Phillips in December 2007 amounted to a further 50 ampoules of pethidine and 40 tablets of oxycodone.[31] These prescriptions were also dispensed by Slade Pharmacy.[32]

47. Following a post-operative consultation with Mr Michel on 4 January 2008, Ms Arthur complained of continuing lower abdominal pain[33] and received a CT scan. Results of the scan found no evidence of renal calculi but noted that in the soft tissues of the right pelvis, "there is a small amount of subcutaneous air. This is most likely the result of a recent injection".[34] This corresponds to Slade Pharmacy records that show 10 ampoules of pethidine were dispensed to Ms Arthur on 1 January 2008, with a further 20 dispensed on 6 January 2008. On each of these dates the pharmacy also dispensed 20 tablets of oxycodone from a prescription issued by Dr Phillips.

48. Dr Phillips prescribed a further 20 pethidine ampoules on 14 January 2008[35] which he attributed to Ms Arthur's distress that her uncle had died the previous Friday and that she needed authority for pethidine.[36] Although Mr Kayrooz who was living with Ms Arthur at the time said this was untrue, I note that distress is not a clinical reason for prescribing this level of pethidine. Slade Pharmacy dispensed the ampoules and a further 20 on 18 January 2008 from a prescription dated the same day by Dr Phillips. On each of these days Slade Pharmacy also dispensed 20 tablets of oxycodone to Ms Arthur.

49. Despite the fact that Dr Phillips was concerned about the frequency and amount of pethidine Ms Arthur appeared to require,[37] he did not consider that she was addicted because he believed her major problem was pain. His evidence is that he felt like he was obligated to see her through this problem.[38]

50. It appears that over the time Dr Phillips was her treating general practitioner Ms Arthur became more tolerant of the pethidine and was dependent on analgesic medication.

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31 Appendix 7 - Inquest brief, p106.

32 Appendix 5 - Slade Pharmacy Records for Ms Arthur, Balance of the brief, p106-107.

33 Letter from Dr Ian Michell to Dr Bryan Smith dated 4 January 2008, Medical Records.

34 MIA Record dated 10 January 2008.

35 Dr Phillips' medical records.

36 Exhibit 3 - Letter and statement of Dr Phillips.

37 Exhibit 3 - Letter and statement of Dr Phillips, p2

38 Transcript of evidence, p70

Legal requirements for permits for prescription medications

51. At the time of Ms Arthur's death, legislation and an associated permit system regulated the prescription of Schedule 8 poisons.[39] Pethidine and oxycodone are both Schedule 8 poisons. The permit system was established to coordinate treatment and minimise the risk of concurrent treatment of a patient with the same or similar drugs by different practitioners. The stated policy intentions of the permit system for Schedule 8 poisons are to maximise patient safety, to minimise the risk of patients developing or maintaining dependence, and to avoid diversion of licit drugs for illicit purposes.[40]

52. At the time of Ms Arthur's death it was a requirement of the *Drugs, Poisons and Controlled Substances Act* 1981 (Vic) (DPCS Act) that a medical practitioner obtain a permit to administer, prescribe or supply a schedule 8 prescription medication to a patient in some circumstances.

53. Specifically, the DPCS Act imposes a requirement on medical practitioners to apply for a Schedule 8 permit from the Secretary of the Victorian Department of Human Services if:
    - the practitioner has reason to believe that the patient is a drug-dependent person;[41] or
    - if the practitioner considers it necessary to 'administer, supply of prescribe a schedule 8 poison for a continuous period greater than 8 weeks'.[42]

Permit for Pethidine

54. A *Permit to Administer, Prescribe or Supply a Schedule 8 Poison* was issued by the Victorian Department of Human Services (DHS) to Dr David Phillips on 21 January 2008, almost eight months after he had commenced prescribing it to her.[43]

55. The permit was for the period 21 January 2008 to 18 February 2008 inclusive and provided for a maximum daily dose of 400mg of pethidine.[44] It also provided the following condition:

    > It is recommended that the patient be seen by Prof Barry Rawicki for a course of cervical epidural injections before any further pethidine injections permit application be considered.[45]

56. The issuing of this permit coincided with Dr Phillips' prescription of 25 ampoules of pethidine to Ms Arthur[46] and dispensing of 20 ampoules by Slade Pharmacy.[47]

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39 *Drugs, Poisons and Controlled Substances Act 1981* (Vic)
40 Department of Health (2014) *Policy for issuing Schedule 8 Permits.*
41 Sections 34(1) and 34(2) of the DPCS Act
42 Section 34(2) of the DPCS Act
43 Section 34A of the DPCS Act
44 Appendix 7 - Brief of evidence, p114.
45 Permit to Administer, Prescribe or Supply a Schedule 8 Poison dated 21 January 2008
46 Dr Phillips' medical records.

57. On 24 January 2008, a further 30 ampoules of pethidine and 20 tablets of oxocodone were prescribed and dispensed by Dr Phillips and Slade Pharmacy, respectively. A further 30 were obtained in the same manner by Ms Arthur on 29 January 2008. Dr Phillips gave evidence that the pethidine prescribed on 29 January 2008 was issued as a consequence of a claim by Ms Arthur that Mr Kayrooz had "thrown out some of her ampoules".[48]

58. On 1 February 2008 Ms Arthur attended an appointment with Dr Phillips. He testified that he provided Ms Arthur with another prescription on the basis that Mr Kayrooz had again thrown out her pethidine and Endone.[49] Excuses like these are often a strong indicator of drug seeking behaviour and of someone who is dependent on prescription medications. Despite this, Dr Phillips prescribed a further 30 ampoules of pethidine and 20 tablets of Oxycodone which was dispensed on the same day by Slade Pharmacy.[50]

Permit for Oxycodone

59. Oxycodone is noted for its propensity to produce physical and psychological dependence and tolerance and the related potential for abuse. Indicated precautions for its use include the need to reduce dosage during concomitant administration of other narcotic analgesics.[51]

60. Like pethidine, oxycodone was (and still is) classified as a Schedule 8 drug and regulated by the DPCS Act and a permit is required for a prescription for a period exceeding 8 weeks.[52]

61. Although Ms Arthur was prescribed oxycodone regularly between October 2007 and her death on 2 February 2008, no application for a Schedule 8 permit was made to DHS by Dr Phillips. He provided no compelling explanation at inquest or elsewhere in the evidence for not doing this.

Patient honesty in a therapeutic relationship

62. To facilitate a good therapeutic relationship medical practitioners rely on the honesty and trust of their patient. Dr Phillips gave evidence that he believed Ms Arthur to be "an honest and truthful person"[53] and that she provided him with an honest account of her condition. Further,

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47 Appendix 5 - Slade Pharmacy Records for Ms Arthur, Inquest brief, p106-10.
48 Exhibit 3 - Letter and statement of Dr Phillips
49 Exhibit 3 – Letter and statement of Dr Phillips.
50 Appendix 5 - Slade Pharmacy Records for Ms Arthur Arthur, Inquest Brief, p106-10.
51 MIMS Online (2010) *MIMS full prescribing information: Endone.*
52 Ss 34B, 34C and 35A DPCS Act
53 Transcript of evidence, p74

he noted that "she was convincing in her description of her symptoms"[54] and that "it just didn't cross [his] mind that she was lying to [him] and yet in retrospect it should have".[55]

63. He testified that his belief in her reliability of her medication needs derived at least in part from her role as the church organist. He stated "I made the dreadful mistake of assuming that [...] she was the organist there [and] she must be just below the parish priest in standing..."[56]

64. At inquest he acknowledged that he was wrong about that belief. Dr Phillips stated that in retrospect he felt as if he had been "manipulated by a very smart woman, determined to get what she wanted'[57] and he failed to recognise this. He added that he thought he should have treated her with a lot more scepticism earlier in the piece.[58]

65. The evidence does indicate Ms Arthur was either selective or dishonest in the information she divulged to Dr Phillips. For example she told Dr Phillips that:
   - her mother was a nurse and therefore could assist with the pethidine injections;
   - Mr Kayrooz had thrown out her medications on two occasions;
   - she had attended appointments with Dr Rawicki but had not;
   - her uncle had died in January 2008 which had caused her distress but this was untrue.

66. Dr Phillips conceded at inquest that

> with subsequent information and the benefit of hindsight I fear that my trust in Ms Arthur's truthfulness was quite unjustified. Not only did she give me information about her medical condition which, on retrospect, could be now considered as suspect but, on occasion, she made statements to me which have proved to be untrue.[59]

Relationship between Dr Phillips and Ms Arthur

67. Both Mr Kayrooz and Mrs Arthur communicated their concern that the relationship between Ms Arthur and Dr Phillips may have exceeded the boundaries of an acceptable doctor-patient relationship.[60]

68. The evidence before me established that Dr Phillips developed a friendship with Ms Arthur after the death of his wife. Dr Phillips stated they had coffee together several times and on one occasion shared a meal together.[61] He commented that when Ms Arthur sought medical treatment from him he did not believe their friendship impacted on his ability to treat her.[62]

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54 Transcript of evidence, p75
55 Transcript of evidence, p75
56 Transcript of evidence, p73-4.
57 Transcript of evidence, p86
58 Transcript of evidence, p86
59 Exhibit 3 – Letter and statement of Dr Phillips, p8
60 Exhibit 1, Statement of Mr Anthony Kayrooz, p2; Statement of Mrs Eileen Arthur, p2.
61 Exhibit 3 – Letter and statement of Dr Phillips, p7
62 Exhibit 3 – Letter and statement of Dr Phillips, p7

69. Over time, there were many consultations, home visits and mobile phone calls between Ms Arthur by Dr Phillips as her general practitioner.[63] Dr Phillips attributed his home visits to being an old-fashioned country doctor.[64]

70. Dr Phillips was adamant that the relationship was one of friendship. He commented "We were friends. We both had an interest in music and it was just a friendship relationship, nothing more than that".[65] Further, he explicitly denied that there was an intimate or sexual relationship.[66] However, he did note that he should have recognised the signs earlier that the boundaries of the doctor/patient relationship had become blurred and should have acted to remedy this. Having reviewed all of the evidence available to me I am not satisfied to the requisite degree that the relationship extended beyond a friendship.

71. There is no doubt that Dr Phillips' intentions were to assist his friend with her medical conditions, particularly her difficulty with pain management. Nevertheless, the evidence gives the distinct impression that Dr Phillips' friendship with Ms Arthur impacted his ability to treat her objectively and in turn may have compromised his professional integrity. For example, Dr Phillips provided evidence that he occasionally purchased pethidine for Ms Arthur.[67]

72. In addition, stories of lost or stolen medications are well established indicators of prescription medication dependence. Despite this, it is evident that Dr Phillips suspended his clinical judgment and ignored these potential warning signs and continued to prescribe pethidine to her.

73. I acknowledge that the circumstances of Ms Arthur's chronic pain presented a challenge to Dr Phillips which he to some degree recognised. However, patients, even those who have a personal friendship with their doctor, have an absolute right to expect that fiduciary obligations will be met. As such, there is a legitimate expectation that a doctor will not allow a friendship to cloud his or her clinical judgment. Where there is the potential for this to be compromised, the doctor, who is in a position of power in the relationship and who has professional obligations, should identify this potential and take pro-active steps to prevent any therapeutic detriment by referring their client to another medical practitioner.

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63 Exhibit 7 - Inquest Brief, p136.
64 Transcript of evidence, p73.
65 Transcript of evidence, p91
66 Transcript of evidence, p92
67 Transcript of evidence, p78.

FINDINGS

74. On the basis of all the evidence available to me and on the balance of probabilities, I make the following findings.

75. I accept the medical cause of death provided by Dr Malcolm Dodd and find that Ms Maree Bernadette Arthur died on 2 February 2008 from:

    1(a) PETHIDINE TOXICITY

76. I acknowledge that Ms Arthur presented many difficulties to Dr Phillips. I find that not only did Ms Arthur have complex medical issues including a recent diagnosis of chronic pain syndrome, she was dependent on the analgesic medication that was originally designed to treat her symptoms of pain.

77. I find that although Dr Phillips was well intentioned in his medical care and management of Ms Arthur, his friendship with her clouded his clinical judgment, particularly in the nature and frequency of prescriptions for addictive medications for her chronic pain.

78. I find it problematic that Dr Phillips frequently prescribed large amounts of pethidine to Ms Arthur for many months without a permit and whilst she was also being treated by other medical practitioners in hospital.

79. I find that Dr Phillips also frequently prescribed oxycodone concurrently with the pethidine which is not advisable and that he did not obtain a permit for the oxycodone.

80. I acknowledge that Dr Phillips was committed to investigating the cause of Ms Arthur's pain and made referrals and sought assistance from other pain specialists, which was appropriate. Dr Phillips appears to have been naïve in not suspecting that Ms Arthur had an addiction to pethidine and other analgesic medications. Although Dr Phillips believed that as a church organist Ms Arthur had standing in the community and therefore placed significant trust in her word, it would have been beneficial for him to have applied a greater level of objectivity.

81. Ms Arthur's death highlights the potential problems with medical practitioners prescribing addictive medications such as pethidine and oxycodone concurrently and for an extended period of time without a permit and supports the rationale for the permit system for prescription medication.

82. Finally, I acknowledge the grief that Ms Arthur's family and friends have experienced as a result of losing their loved one.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that finding be published on the internet.

I direct that a copy of this finding be provided to the following:

- Ms Anthony Kayrooz
- Mrs Eileen Arthur
- Dr David Phillips

Signature:

CORONER JACQUI HAWKINS
Date: 12 June 2014