COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
INQUIRY PANEL DECISION

INQUIRY: IC1595

DR. STEPHEN JOHN COYLE

On April 25, 2013, a hearing was convened before an Inquiry Panel (the Panel) of the College of Physicians & Surgeons of Manitoba (the College), for the purpose of conducting an Inquiry pursuant to Part X of *The Medical Act*, into charges against Dr. Stephen John Coyle (Dr. Coyle), as set forth in an Amended Notice of Inquiry dated October 30, 2012.

The Amended Notice of Inquiry charged Dr. Coyle with various acts of professional misconduct, and with contravening By-Law No. 1 of the College, and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and with contravening Statements 148 and/or 805 of the College, and with displaying a lack of, or a lack of skill and judgment in the practice of medicine.

Among other things, the Amended Notice of Inquiry alleged that Dr. Coyle:

a) Exploited patients for personal advantage through unethical and inappropriate prescribing practices, including issuing prescriptions for narcotics in the names of various patients when in fact the prescriptions were for his own use;

b) Initiated actions which caused claims to be submitted in the name of a particular patient to that patient's private insurer, which resulted in payments for certain prescriptions in the name of that patient being paid by the patient's private insurer, on the basis that the prescriptions were for the patient's use, when in fact the prescriptions were for the use of Dr. Coyle;

c) Created false and/or misleading medical records thereby breaching Statement 805 of the College and/or the record keeping requirements of By-Law No. 1 of the College and therefore committing acts of professional misconduct;

d) Caused claims to be submitted to Manitoba Health for fictitious visits with respect to three particular patients, thereby committing acts of professional misconduct;

e) Inappropriately prescribed medications for not less than 10 patients, including narcotics and benzodiazepines and/or opioids, thereby committing acts of professional misconduct;

f) Failed to create and maintain adequate clinical records in respect of not less than 10 patients thereby breaching the record keeping requirements of By-Law No. 1 of the College and/or Statement 805 of the College and/or committing acts of professional misconduct;

g) Inappropriately terminated the doctor/patient relationship with two patients without ensuring that another suitable physician had assumed responsibility for their care, or without giving adequate notice that he intended to terminate the relationship thereby breaching Article 10 of the Code of Conduct and/or committing acts of professional misconduct;

h) Violated his ethical obligation to maintain proper boundaries with two patients by giving them money to assist in paying certain of their expenses;

i) During the period between in or about September, 2009 and September, 2010, participated in the creation of misleading medical records by allowing a nurse practitioner who performed office visits and/or house calls to record the visits and/or house calls as if Dr. Coyle had seen the patient and created the records when in fact he

had not, thereby breaching the record keeping requirements of By-Law No. 1 of the College and/or Statement 805 of the College and/or committing acts of professional misconduct;

j) Initiated actions which caused claims to be submitted to Manitoba Health for services as if he had provided the services when in fact the services had been provided by another person who was not a physician, thereby committing acts of professional misconduct;

k) Engaged in the practice of medicine while under the influence of injectable Demerol and/or benzodiazepines while his ability to practice medicine was impaired, thereby committing acts of professional misconduct;

l) Prescribed medications to himself on various occasions between October, 2008 and March, 2010 thereby breaching Article 11 of the Code of Conduct and Statement 148 of the College;

m) Attempted to mislead the College on various occasions between September 16, 2010 and March 3, 2011; and

n) As a result of all of the foregoing, displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

The hearing proceeded before the Panel on April 25, 2013 in the presence of Dr. Coyle and his counsel, and in the presence of counsel for the Investigation Committee of the College.

At the outset of the hearing, Dr. Coyle entered a plea of guilty to all of the charges outlined in paragraphs 1 through 14 of the Amended Notice of Inquiry thereby acknowledging that the facts alleged in the Amended Notice of Inquiry were true and also acknowledging that he:

a) was guilty of professional misconduct;

b) had contravened By-Law No. 1 of the College;

c) had contravened Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College;

d) had contravened Statements 148 and/or 805 of the College;

e) had displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

The Panel reviewed and considered the following documents, which were filed as exhibits in the proceedings, with the consent of Dr. Coyle:

i) the Notice of Inquiry;

ii) the Amended Notice of Inquiry;

iii) a Statement of Agreed Facts which was 35 pages in length;

iv) a Book of Documents consisting of 32 sets of documents, including but not limited to Manitoba Health Billing Summaries relating to certain patients, the electronic medical records (EMR) relating to various patients, portions of the medical charts relating to certain patients, printouts from the Drug Programs Information Network (DPIN) relating to certain patients, and statements from Manitoba Health relating to house call and clinic visit billings for services by a nurse practitioner for a period between February 15 to 28, 2010, and Manitoba Health Psychotherapy Billings for a period between March and September, 2010;

v) a Statement of the Joint Recommendation of the parties as to Penalty; and

vi) various reports from physicians and psychologists who have either treated Dr. Coyle or have been consulted with respect to his

circumstances, all of which were tendered by consent at the Inquiry.

REASONS FOR DECISION

Having considered the above-noted exhibits, and the submissions of counsel for the Investigation Committee of the College and counsel for Dr. Coyle, the Panel is satisfied that all of the charges have been proven. The Panel is also satisfied that the joint recommendation as to disposition is appropriate and ought to be accepted. The Panel's specific reasons for its decision are outlined below.

Background:

1. In 1975, Dr. Stephen John Coyle graduated from Newcastle Upon Tyne University Medical School, England. He completed his medical education and training in the United Kingdom in 1978 and immigrated to Manitoba. He became a member of The College of Physicians & Surgeons of Manitoba in October 1978. He practiced as a family physician in Shoal lake, Manitoba from 1978 to 1981. From 1981 until April 2004, he maintained a family practice at the Charleswood Medical Clinic. From 1981 to 1996, he held a staff position at the Grace Hospital. From July 2004 to February 2008, he was the Chief Medical Officer at the Misericordia Health Centre in Winnipeg, Manitoba, where he continued his family practice. In 2008, from February to July, he worked as a director for research for a private company in British Columbia. From July 2008 until September 2010, he was the Medical Director and maintained a family practice at the Four Rivers Broadway Clinic in Winnipeg, Manitoba.

2. Concerns that Dr. Coyle may have been inappropriately prescribing and abusing narcotics were brought to the attention of the College by colleagues from and the owner of the Four Rivers Broadway Clinic. The

College did not receive any complaints from patients about Dr. Coyle's care.

3. When Dr. Coyle was initially confronted by the College about the concerns relating to suspected abuse of narcotics and benzodiazepines, he denied the allegations. Later, by letter dated October 8, 2010, Dr. Coyle admitted to having abused and diverted narcotics, including injectable Demerol ("Meperidine HCl") and Diazepam.

4. On September 20, 2010, Dr. Coyle signed a voluntary undertaking agreeing not to practice without the express written permission of the Investigation Chair. He sought treatment in relation to his addiction and has been diagnosed as having an opiate dependence (in full remission) and major depressive disorder (symptoms in remission).

5. Dr. Coyle did not practice between September 20, 2010 and March 27, 2012, with the exception of a portion of one day in April 2011 when he made an unsuccessful attempt to resume his practice under strict conditions. At the request of the Investigation Chair of the College, Dr. Coyle signed another undertaking on April 28, 2011 agreeing not to practice without the express written permission of the Investigation Chair. Pursuant to a written undertaking with the College dated March 14, 2012, Dr. Coyle resumed practice on March 27, 2012. He is currently practicing at the Crestview Clinic, Winnipeg under the supervision of an on-site physician supervisor acceptable to the Investigation Committee pursuant to that undertaking. The undertaking includes restrictions and conditions on his practice, including prescribing, and is monitored by the Investigation Chair of the College.

Summary of facts with respect to Admitted Allegations in Notice of Inquiry

Abuse and Diversion of Narcotics and Benzodiazepines

6. Dr. Coyle has stated that:

   a) For a number of years, his treating physicians had prescribed injectable Demerol to him for relief of symptoms related to hemiplegic migraines and Diazepam for relief of restless leg syndrome.

   b) In or about 2008, Dr. Coyle started to experience symptoms of depression, which led to him abusing these medications and becoming addicted to them.

   c) It is difficult for Dr. Coyle to recall exactly when he started to abuse these medications, but it is clear that his use escalated over time and he became increasingly dependent upon them.

   d) His dependency led to him abusing his position as a physician to divert narcotics and benzodiazepines for his own use.

7. There are two categories of patients involved in Dr. Coyle's inappropriate prescribing as it relates to diversion of narcotics and benzodiazepines for his own use:

   a) Patients with whom Dr. Coyle had a close personal relationship to whom Dr. Coyle issued prescriptions without their knowledge and created fictitious records to cover up his own use of the narcotics and benzodiazepines. There were primarily two patients in this category.

b) Patients to whom Dr. Coyle provided care and wrote prescriptions for Demerol without an adequate assessment of the patients' medical condition and/or inadequate medical rationale. In respect to these patients, Dr. Coyle has acknowledged that he prescribed to them partially for the purpose of using a portion of the Demerol prescribed to them for his own use. There were nine patients in this category.

8. Dr. Coyle's activities and misconduct in relation to the patients in the two categories noted above were extensive. His activities commenced in late 2007/early 2008 and escalated over time, and persisted until August/September, 2010. Dr. Coyle's activities involved issuing well over 100 prescriptions of various quantities of narcotics and benzodiazepines with a large proportion of the prescriptions involving Demerol.

9. Dr. Coyle has now admitted that:

a) He was no doubt motivated, at least in part, to use injectable Demerol to treat some or all of these patients so that some Demerol would be left for his own use.

b) He believes that he injected most or all of these patients with some of the Demerol he prescribed and used leftover Demerol in the vials for his own use on occasion, but he cannot recall when and in respect to which prescription.

c) There is no real justification for the use of injectable Demerol for any of these patients. Although he does not specifically recall diverting Demerol prescribed to them for his own use, he has little doubt that he did so. He states there is no excuse for his actions other than his own addiction and depression.

d) He has no recollection of picking up any Demerol prescriptions for these patients but says he may well have done so. He believes

some of these patients took Demerol with them to inject at home but he is not completely certain which ones. For patients injected in the office, Dr. Coyle did keep remnants of some of the vials for his own use, but again cannot be certain for which specific patients. Dr. Coyle believes he provided some patients with training on how to inject themselves at home.

e) Many of his chart entries during the period of his addiction, particularly ones that refer to prescriptions for injectable Demerol, are inadequate.

f) The medical records relating to prescriptions for Demerol to these patients are not only inadequate, but in many instances were most likely for the purpose of covering up Dr. Coyle's own narcotic use rather than creating accurate reflections of encounters with the patients.

g) In respect to each of these patients, he prescribed injectable Demerol without taking an adequate history and/or conducting an adequate physical examination to evaluate the patient's medical condition and the appropriateness of that medication for the patient's condition.

Inappropriate Prescribing of Narcotics, Benzodiazepines and Opioids

10. Dr. Coyle has admitted to inappropriately prescribing narcotics, benzodiazepines and opioids to not less than nine patients, some, but not all of whom were also patients affected by his misconduct as earlier described in these Reasons.

11. With respect to the several patients with respect to whom Dr. Coyle inappropriately prescribed narcotics, benzodiazepines and opioids, Dr. Coyle has advised that:

a) In some cases, his charting practices were clearly inadequate and any physician who viewed his chart would not be able to follow what was going on with the patient.

b) Dr. Coyle has no excuse for his deficient charting practices. The only explanation he has provided was that he was depressed and becoming increasingly addicted to Demerol and benzodiazepines.

c) In many cases, Dr. Coyle prescribed medications without any medical justification whatsoever, and without making any entry on the patient's chart.

d) Some of the patients involved in this category were abusing street narcotics. Dr. Coyle's method of dealing with these patients, including the dosages he prescribed did not meet appropriate clinical standards, and he failed to follow the recommendations available from a specialist in addictions medicine as to how to manage such patients. As a result, Dr. Coyle switched many of these patients from one medication to another around May/June of 2010, but did not have an adequate plan in place to deal with withdrawal symptoms or ongoing management of those patients' underlying conditions. These events were taking place at the height of Dr. Coyle's addiction in the late spring and summer of 2010.

12. With respect to several of the patients in this category, Dr. Coyle inappropriately terminated the doctor/patient relationship without giving the patients involved any notice of the termination of the relationship, nor making any alternative arrangements for the patients' ongoing care.

Boundary Violation - Gift of Money

13. Dr. Coyle has admitted that he gave at least two patients money to assist them with certain expenses.

Inappropriate Billing to Manitoba Health and Participation in the Creation of Misleading Medical Records

Nurse Practitioner (NP)

14. Dr. Coyle has stated that:

a) In September of 2009, an NP who had been employed at the Four Rivers Broadway Clinic entered into a new working and financial arrangement with Dr. Coyle and the Clinic.

b) The arrangement involved patients being seen by the NP in the Clinic and on a house call basis and those visits being billed by the Clinic to Manitoba Health using Dr. Coyle's billing number.

15. The information contained in the Statement of Agreed Facts with respect to inappropriate billing and the creation of misleading medical records was lengthy and detailed. The Statement of Agreed Facts included a comprehensive description of the clinical practices and procedures and the billing procedures of Dr. Coyle, the NP and the Clinic, and the method of sharing those billings between the Clinic, Dr. Coyle and the NP with respect to both clinic billings and house call billings. It is not necessary to outline or summarize all of the information contained in the Statement of Agreed Facts on this topic. The Panel recognizes that Dr. Coyle may not have been fully knowledgeable about how those types of matters should have been handled, but Dr. Coyle has admitted that:

i) It was never intended that he would be present for the entire or every encounter that the NP had with a patient by use of the video stream technology or otherwise. His involvement was only required when requested by the NP.

ii) Dr. Coyle did not see most of the patients that the NP would see either at the Clinic or during house calls, by video stream technology or otherwise. In respect of approximately 75% of the

house calls, Dr. Coyle was not present with the video link at all during the patient encounter. The NP would only contact Dr. Coyle if he had a question or concern.

iii) In retrospect, Dr. Coyle has recognized that the billing arrangement was inappropriate and that he should have been more diligent and met with Manitoba Health in advance and made sure it was appropriate. Dr. Coyle said that he should have been clear that he was not involved in the visits in any way and that another billing method should have been used.

iv) There may have been times when Dr. Coyle was not present in the Clinic when the NP saw patients and billed the visits in Dr. Coyle's name.

Clinical Assistant - Daughter

16. Dr. Coyle has stated that he hired his daughter as his clinical assistant in the spring of 2010. She took notes while Dr. Coyle spoke to patients and assisted him with doing procedures. He paid her a salary out of his own income. She also did some counselling of Dr. Coyle's patients. When it came to counselling:

a) Dr. Coyle would introduce her to the patients.

b) He did some of the initial counselling and she would take over. Dr. Coyle would return and go over what transpired and then go from there.

c) Dr. Coyle's daughter provided counseling and psychotherapy or cognitive therapy.

d) All of the visits involving counselling by Dr. Coyle's daughter were billed to Manitoba Health as psychotherapy services provided by him.

e) Dr. Coyle has acknowledged that the billings submitted to Manitoba Health for psychotherapy services provided by his daughter were inappropriate.

Practicing while under the Influence of Demerol

17. Dr. Coyle has acknowledged that his use of Demerol was increasing throughout the spring of 2010 and into the summer of that year. He initially injected Demerol at night, or would leave work in the afternoon to inject, so as not to be practicing medicine while under the influence of Demerol. However, at some time in 2010 he reached the point at which he was injecting Demerol while at work and was practicing medicine under the influence of Demerol. Dr. Coyle cannot remember the specific dates when he did so, or the frequency with which he did so.

Prescribing to Self

18. Dr. Coyle has also acknowledged that on not less than 8 occasions between October 21, 2008 and March 31, 2010, he prescribed certain medications to himself. Dr. Coyle has acknowledged that he should not have self-prescribed and that he should take medications only if and when they are prescribed by his treating physicians. He can only explain that his self-prescribing was the result of his depression and addiction to narcotics and benzodiazepines, and the impact these matters had on his judgment.

Misrepresentations to the College

19. After the College became involved in reviewing concerns about Dr. Coyle, he initially denied to the College that he was inappropriately prescribing and abusing narcotics. He has subsequently acknowledged that he made a number of false and misleading statements in his communications with the Registrar, Deputy Registrar, and the Investigation Chair between September 16, 2010 and March 3, 2011.

THE JOINT RECOMMENDATION AS TO DISPOSITION

On the basis of the above-noted summary of the background facts, it is self-evident that Dr. Coyle's misconduct and contraventions of the Code of Conduct of the College and of various Statements of the College are extremely troubling and problematic. It is noteworthy that Dr. Coyle's actions and his misconduct were multi-faceted involving the exploitation of vulnerable people, failing to meet appropriate standards in terms of prescribing medications for certain patients, failing to properly manage the care of certain patients, inadequate and incomplete charting and record keeping practices, the submission of false claims to Manitoba Health, engaging in the practice of medicine while his ability to do so was impaired, boundary violations of various types, displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, and misleading the College on multiple occasions.

Although the Panel recognizes that much of Dr. Coyle's misconduct occurred during a time when he was struggling with the worst effects of his addiction to opiates and from a major depressive disorder, those factors do not alter the fact that Dr. Coyle's actions were reprehensible and entirely unacceptable.

Given the seriousness and unacceptability of Dr. Coyle's conduct, this Panel must decide upon the appropriate disposition pursuant to Section 59.6 of *The Medical Act*. The Panel has been greatly assisted in its task by the Joint Recommendation as to Disposition made by counsel for the Investigation Committee of the College and counsel for Dr. Coyle.

In determining the types of orders to be granted pursuant to Section 59.6 of *The Medical Act*, it is useful to carefully consider the several objectives of such orders. In general terms, those objectives are:

a) The protection of the public in a broad context. Orders under Section 59.6 of *The Medical Act* are not simply intended to protect the particular patients of the physician involved, but are also

intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;

b) The punishment of the physician involved;

c) Specific deterrence, in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

d) General deterrence, in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice;

e) Protection against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;

f) The rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services pursuant to conditions designed to safeguard the interests of the public.

The Joint Recommendation is detailed, and has been thoughtfully conceived. Its essential elements are:

i) A reprimand of Dr. Coyle, pursuant to Section 59.6(1)(a) of *The Medical Act;*

ii) A suspension of Dr. Coyle from the practice of medicine for a period of 18 months, deemed to have been served during the period he was out of practice from September 20, 2010 until March 27, 2012, pursuant to Section 59.6(1)(b) of *The Medical Act*;

iii) Conditions imposed upon Dr. Coyle's entitlement to practice medicine pursuant to subsections 59.6(1)(e) and 59.6(2) of *The Medical Act*, which include:

a) prohibitions against Dr. Coyle ingesting any of the drugs on an extensive list known as Schedule "A" and any acetaminophen with codeine, any benzodiazepines, or any alcohol;

b) prohibitions against prescribing any drug listed in Schedule "A", any acetaminophen with codeine, or any benzodiazepines;

c) compliance with the College's rigorous program of random body fluid monitoring;

d) mandatory attendance each and every week at Physicians-at-Risk group meetings, Alcoholics/Narcotics Anonymous meetings, and any other meetings recommended to Dr. Coyle by his treating physicians;

e) mandatory attendance upon his psychiatrist, his family physician, and his specialist in addiction medicine;

f) compliance with the treatments prescribed by his treating psychiatrist, his family physician, and/or his specialist in addiction medicine for the continuing management and monitoring of his addiction;

g) compliance with any direction from his treating psychiatrist, family physician or specialist in addiction medicine with respect to restricting, suspending or ceasing the practice of medicine for a temporary or an intermittent period subject to a right on the part of Dr. Coyle to object to such direction to

the College, pursuant to a process particularized in the Joint Recommendation;

h) the restriction of Dr. Coyle's practice to clinical practice at the Crestview Clinic in accordance with the practice plan approved by the Investigation Committee from time to time with the additional requirement that Dr. Coyle must not change his practice location without the prior written consent of the Investigation Committee of the College;

i) a prohibition against Dr. Coyle providing care to any patient with a chemical dependence or a substance abuse disorder;

j) a requirement on the part of Dr. Coyle to create a complete and accurate record of each patient encounter in accordance with the requirements of By-Law No. 1 of the College. Without limiting the generality of the foregoing, for each prescription written by Dr. Coyle, he must fully document this patient's history, his examination, any investigation ordered, and his diagnosis and treatment plan;

k) a requirement to practice under the supervision of an onsite physician supervisor acceptable to the Investigation Committee;

l) a stipulation that payment for the services of the practice supervisor shall be Dr. Coyle's responsibility;

m) a restriction preventing Dr. Coyle, without the prior written consent of the Investigation Committee, from engaging in any research, teaching or lecturing, or taking after-hours call services or making house calls, or employing any clinical assistant, nurse practitioners, or other individuals to assist him with the assessment and treatment of his patients;

n) a requirement that Dr. Coyle restrict his volume of services in accordance with a practice plan, which must be approved by the Investigation Committee;

o) the continued monitoring of Dr. Coyle's practice of medicine, including his compliance with all of the conditions listed above;

p) a requirement that Dr. Coyle shall pay any and all costs arising from or incidental to the conditions imposed and the monitoring by the Investigation Committee of Dr. Coyle's practice and his compliance with the conditions imposed on his practice;

iv) A requirement that Dr. Coyle shall pay to the College the costs of the investigation and inquiry in the amount of $40,000.00, payable in full by way of certified cheque or a trust cheque from Dr. Coyle's lawyers;

v) Publication, including Dr. Coyle's name, as determined by the Investigation Committee.

ANALYSIS

On the basis of the Statement of Agreed Facts, the materials in the Book of Documents, the guilty plea of Dr. Coyle to all of the counts in the Amended Notice of Inquiry, and the submissions of counsel for the Investigation Committee, and counsel for Dr. Coyle, the Panel has determined that Dr. Coyle is guilty of professional misconduct, of contravening By-Law No. 1 of the College and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, of contravening Statements 148 and/or 805 of the College, and of displaying a lack of skill or judgment in the practice of medicine.

Section 59.6(1) of *The Medical Act* outlines the types of orders which an Inquiry Panel may make, once determinations such as those noted above have been made. The Panel may make one or more of various types of orders, including reprimanding the member, suspending the member's license for a period of time that the Panel determines appropriate, suspending the member's license until the member has obtained treatment or counselling and has demonstrated that any disability or addiction has been overcome, imposing conditions on the member's entitlement to practice medicine, and/or cancelling one or both of the member's registration and license.

As stated above, the objectives of orders under Section 59.6 of *The Medical Act* include the protection of the public, the punishment of the physician, specific deterrence, general deterrence, and the rehabilitation of the physician in appropriate cases.

This Inquiry Panel has undertaken a review of the above-noted objectives in the context of the Joint Recommendation as to Penalty to satisfy itself that the objectives of the orders which may be granted pursuant to Section 59.6 of *The Medical Act*, will be fulfilled if the Joint Recommendation is accepted.

The Panel first turned its mind to the protection of the public, not only the protection of the patients of Dr. Coyle, but also the protection of the public in the broader sense of maintaining high standards of competence and professional integrity among physicians.

As a result of a variety of events and developments, this matter did not come before the Inquiry Panel until Dr. Coyle had:

i) withdrawn from practice for the period from September 20, 2010 until March 27, 2012 (with the exception of one day in April, 2011 when Dr. Coyle made an unsuccessful attempt to resume his

practice under strict conditions). On September 20, 2010, Dr. Coyle had signed an undertaking agreeing not to practice without the written permission of the Investigation Chair; and

ii) resumed practice from March 27, 2012 to the present, at the Crestview Clinic under the supervision of an on-site physician supervisor acceptable to the Investigation Committee and with the written permission of the Investigation Chair.

There were several reasons why an Inquiry Panel hearing was not convened until April 25, 2013. Those reasons included the complexity of the investigation into Dr. Coyle's misconduct, the length of the treatment which Dr. Coyle received for his depression and opiate addiction, significant delays encountered in obtaining records from Manitoba Health, and the usual type of challenges encountered in scheduling proceedings involving several lawyers, physicians and busy public representatives.

As a result of those delays, Dr. Coyle has been practicing medicine under significant limits and conditions, and under the supervision of an on-site physician supervisor for over a year. The Inquiry Panel has been advised that Dr. Coyle's resumption of practice since March 27, 2012 has been successful.

That factor, namely the successful resumption of practice pursuant to strict restrictions, and under the supervision of another physician, was of particular interest and significance to the Inquiry Panel when considering whether the public interest will best be served by the Joint Recommendation.

As outlined elsewhere in these Reasons, the restrictions on Dr. Coyle's practice are very significant. Those restrictions and conditions have had and will continue to have a major effect on Dr. Coyle's daily activities as a practicing physician. They are designed to protect the public, both in the sense of assuring that Dr. Coyle's patients will receive an acceptable standard of care and of demonstrating that there are

effective means of maintaining high standards of competence and professional integrity among physicians, even physicians who have encountered serious difficulties in their professional and personal lives.

The fact that Dr. Coyle has successfully resumed the practice of medicine and has practiced pursuant to those very strict conditions for over a year, demonstrates that the conditions are practical and efficacious, and that the public good can be served by allowing a trained and educated physician, like Dr. Coyle, to practice medicine pursuant to a carefully designed set of conditions designed to safeguard the interests of the public.

In terms of the other objectives of orders under Section 59.6 of *The Medical Act*, the Joint Recommendation fulfills the objectives of punishing Dr. Coyle and specifically deterring him from committing similar acts of misconduct in the future. The results of his misconduct, and of these proceedings, will have a significant negative financial impact upon him. He has been forced to forego 18 months of professional income. He has also paid to the College the costs of the investigation and inquiry in the amount of $40,000.00; the College has acknowledged the receipt of those funds.

With respect to Dr. Coyle's actions which caused claims to be submitted to Manitoba Health for fictitious visits involving three patients, Dr. Coyle's counsel has advised the Inquiry Panel that Dr. Coyle has reimbursed Manitoba Health for the amounts involved in relation to those fictitious visits in the amount of $2,393.75. Counsel for Dr. Coyle also advised that Dr. Coyle is in an ongoing dialogue with Manitoba Health with respect to the inappropriate billings to Manitoba Health with respect to the NP and the clinical assistant, and that the amount of those billings is substantial (in excess of $285,000.00). Although it has not yet been determined what portion of that amount will be Dr. Coyle's responsibility to repay, it is likely that he will face a significant financial liability in that regard.

In addition to the adverse financial consequences being sustained by Dr. Coyle, there are other punitive aspects of the Joint Recommendation. The reprimand is an expression by the Inquiry Panel of its disapproval and denunciation of Dr. Coyle's conduct and behaviour. The publication of the factual background and outcome of these proceedings, including Dr. Coyle's name, will be a source of embarrassment and humiliation to him.

The objective of specific deterrence, in the sense of preventing Dr. Coyle from committing similar acts of misconduct in the future, will be achieved by the $40,000.00 cost award, the reprimand and the publication. It will also be achieved by various conditions imposed on his practice, most notably being his participation in the body fluid monitoring program, the restrictions on his ability to prescribe certain medications and the requirement that he be supervised by an onsite physician supervisor.

General deterrence, within the profession, will be achieved by a publication of the background and outcome of these proceedings.

Before addressing the remaining objectives of an order under subsection 59.6(1) of *The Medical Act*, namely protection against the betrayal of the public trust in the medical profession, and the rehabilitation of the physician involved, it is also useful to consider the appropriateness of an alternate order under subsection 59.6(1), which was not part of the Joint Recommendation, namely the cancellation of one or both of Dr. Coyle's registration and license.

The Inquiry Panel did consider the advisability of cancelling Dr. Coyle's registration and/or license and has decided against such cancellation for several reasons, which are:

i) The Investigation Committee has reviewed this matter thoroughly. It is knowledgeable of the factual background, the nature and extent

of Dr. Coyle's misconduct, the treatment of his depression and addiction, and his efforts to rehabilitate himself. The Investigation Committee has not recommended the cancellation of Dr. Coyle's registration and/or license.

ii) The Investigation Committee has spent considerable effort in designing conditions which will protect the interests of Dr. Coyle's patients, and the public interests generally, while allowing Dr. Coyle to make productive use of his education, training and experience.

iii) The Joint Recommendation is reasonable in relation to fulfilling the objectives of orders under subsection 59.6(1) of *The Medical Act*, and is also reasonable when compared to other decisions made by this College, and Colleges in other Canadian jurisdictions. The Inquiry Panel does not think the Joint Recommendation is either unfit, unreasonable, or contrary to the public interest. Therefore, the Inquiry Panel is satisfied that it ought to follow the Joint Recommendation (see *Pankiw v. The Chiropractors' Association* (2009) 336 Sask.R. 43 and *Matheson v. The College of Physicians & Surgeons (Prince Edward Island)* 2010 Carswell PEI 16).

iv) Although the Inquiry Panel is aware that subsection 59.6(1) of *The Medical Act* contemplates the possible cancellation of a member's registration and license, the Panel is also aware that *The Medical Act* contemplates the potential reinstatement of a person whose registration or license has been cancelled, subject to any conditions that the Executive Committee may prescribe (see Section 59.13 of *The Medical Act*). On the basis of the information it has received in these proceedings, including the Joint Recommendation, the Inquiry Panel believes it is well able to decide whether Dr. Coyle should be able to continue to practice medicine, and if so, on what conditions.

v) As noted above, the conditions pursuant to which Dr. Coyle is now practicing were designed and implemented following a period of 18 months during which he was not practicing medicine. Those conditions have now been in place for over a year and have proven themselves to be both workable and protective of the interests of Dr. Coyle's patients.

With respect to objectives relating to maintaining the public's trust in the profession, and the rehabilitation of Dr. Coyle, although the College generally adopts a rehabilitative approach towards many types of contraventions by physicians of applicable standards, the College immediately recognized that as a result of the nature and extent of Dr. Coyle's misconduct, a disciplinary response was required. An investigation was conducted and a Notice of Inquiry was issued. Significant discipline is being imposed upon Dr. Coyle as a result of these proceedings.

In circumstances such as this case, in which a disciplinary approach is required, the College must nonetheless be sensitive to mitigating circumstances. There are mitigating circumstances in this case. Over a period of many years, Dr. Coyle demonstrated that he was a capable and competent physician. His misconduct and contraventions of various By-Laws of the College, the Code of Conduct of the College, and various College Statements were the result, either in whole or in part, of his opiate dependence and major depressive disorder.

He has sought and obtained treatment for those conditions from appropriately qualified professionals and has participated meaningfully and conscientiously in his treatment and in the various programs which have been recommended by his caregivers.

Opinions from qualified professionals have been obtained which state that Dr. Coyle's opiate dependence is in full remission and the symptoms of his major

depressive disorder are also in remission. Those professionals have also opined, and the Investigation Committee has agreed that Dr. Coyle was ready to resume the practice of medicine on March 27, 2012. Since that date, Dr. Coyle has demonstrated that he can do so safely, provided appropriate conditions are in place.

The Inquiry Panel has therefore concluded that a properly informed public will not lose faith in the medical profession's ability to regulate itself if the Joint Recommendation is accepted. Similarly, the Inquiry Panel has concluded that Dr. Coyle is capable of successfully rehabilitating himself and is making sincere and concerted attempts to do so.

The Inquiry Panel recognizes that pursuant to the Joint Recommendation, the Investigation Committee will have full and complete authority to vary the terms and conditions upon which Dr. Coyle shall practice, and that Dr. Coyle shall bear the onus of proving that any variation will be in the public interest. The Inquiry Panel is strongly of the view that any variation whereby Dr. Coyle will be able to prescribe any of the drugs listed in Schedule "A", or any acetaminophen with codeine, or any benzodiazepine, should be preceded by a period of further education in the safe use of opiates and benzodiazepines in practice, according to the most recent Canadian recommendations.

Accordingly, it is the decision of the Inquiry Panel that:

1. Dr. Coyle is hereby reprimanded;

2. Dr. Coyle will be suspended from the practice of medicine for a period of 18 months, deemed to have been served by Dr. Coyle during the time he was out of practice from September 20, 2010 until March 27, 2012;

3. Conditions will be imposed upon Dr. Coyle's entitlement to practice medicine as more particularly set forth in the Resolution and Order of this Panel, issued concurrently herewith and attached hereto;

4. If there is any disagreement between the parties respecting any aspect of The Inquiry Panel Order, the matter may be remitted by either party to a Panel of the Inquiry Committee for further consideration, and the Inquiry Committee expressly reserves jurisdiction for the purpose of resolving any such disagreement;

5. Dr. Coyle must pay to the College costs of the investigation and Inquiry in the amount of $40,000.00 forthwith;

6. There will be a publication, including Dr. Coyle's name, as determined by the Investigation Committee. The College, at its sole discretion, may provide information regarding this disposition to such a person(s) or bodies as it considers appropriate.

IN THE MATTER OF:	"*THE MEDICAL ACT*", R.S.M. 1987, c.M90;
AND IN THE MATTER OF:	Dr. Stephen John Coyle, a member of the College of Physicians & Surgeons of Manitoba

RESOLUTION AND ORDER OF AN INQUIRY PANEL
OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

WHEREAS Dr. Stephen John Coyle (Dr. Coyle), a member of the College of Physicians and Surgeons of Manitoba (the College) was charged with professional misconduct, and with contravening By-Law No. 1 of the College, Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and Statements 148 and/or 805 of the College, and with displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, as more particularly outlined in a Notice of Inquiry dated October 30, 2012;

AND WHEREAS Dr. Coyle was summoned and appeared before an Inquiry Panel (the Panel) of the College with legal counsel on April 25, 2013;

AND WHEREAS an Amended Notice of Inquiry dated October 30, 2012, outlining the charges and particularizing the allegations against Dr. Coyle was filed as an exhibit in the hearing before the Panel;

AND WHEREAS Dr. Coyle entered a plea of guilty to all of the counts relating to all of the charges outlined in the Amended Notice of Inquiry;

AND WHEREAS the Panel reviewed the exhibits filed, including a detailed Statement of Agreed Facts and a comprehensive Book of Documents, heard submissions from counsel for the Investigation Committee of the College and counsel for Dr. Coyle, and from Dr. Coyle himself, and received a Joint Recommendation as to Disposition of the charges and allegations outlined in the Amended Notice of Inquiry;

AND WHEREAS the Panel decided that the Joint Recommendation as to Disposition was appropriate in the circumstances;

NOW THEREFORE BE IT AND IT IS HEREBY RESOLVED AND ORDERED THAT:

I. Pursuant to Section 56(3) of *The Medical Act* R.S.M., the identities of third parties, and particularly the patients of Dr. Coyle, shall be protected in the record of these proceedings by referring to them in a non-identifying manner.

II. Dr. Coyle is guilty of professional misconduct, and of contravening By-Law No. 1 of the College, and Articles 1 and/or 2 and/or 10 and/or 11 and/or 15 of the Code of Conduct of the College, and of Statements 148 and/or 805 of the College, and of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

III. Dr. Coyle is hereby reprimanded by the Panel pursuant to Section 59.6(1)(a) of *The Medical Act*;

IV. Dr. Coyle will be suspended from the practice of medicine for a period of 18 months, deemed to have been served by Dr. Coyle during the time he was out of practice from September 20, 2010 until March 27, 2012 pursuant to Section 59.6(1)(b) of *The Medical Act*;

V. The following conditions are imposed upon Dr. Coyle's entitlement to practice medicine pursuant to Sections 59.6(1)(e) and 59.6(2) of *The Medical Act*:

1. Subject to paragraph 2 herein, Dr. Coyle must not ingest in any manner whatsoever:

   a) any drug that is listed in Schedule "A" hereto,

   b) any acetaminophen with codeine, or

   c) any benzodiazepine or any alcohol.

2. If a physician prescribes to Dr. Coyle for medical reasons any of the drugs listed on Schedule "A" hereto, any acetaminophen with codeine or any benzodiazepine:

   a) Dr. Coyle must ingest the drug only if it is prescribed for medical reasons, and

   b) Dr. Coyle must instruct the prescribing physician to provide to the College and to the Monitoring Physician within 14 days of the date of the prescription, full particulars of the medical indications for the prescription and of the treatment plan.

3. Dr. Coyle must not prescribe:

   a) any drug that is listed in Schedule "A" hereto,

b) any acetaminophen with codeine, or

c) any benzodiazepine.

4. Dr. Coyle must comply with the College's program of random body fluid monitoring ("the Program") which Program includes:

a) Monitoring by a physician(s) to be appointed by the College;

b) Authorization for the monitoring physician(s) and any subsequent monitoring physician(s) to report the results of any analysis to the College;

c) Dr. Coyle must submit to all requests for testing with no more than six hours' notice;

d) All specimens are to be collected at a place or places designated from time to time by the monitoring physician(s);

e) All testing shall follow uniform Department of Transport procedures completed by the designate of the monitoring physician collected under the direct observation of the Monitoring Physician or his/her designate;

f) Testing shall include all drugs listed on Schedule "A" hereto, acetaminophen with codeine, benzodiazepines and alcohol;

g) Dr. Coyle will be required to attend for testing at least 12 times per year;

h) Dr. Coyle must not leave Manitoba for a period in excess of 72 hours without notice to the monitoring physician(s). If requested to do so, Dr. Coyle shall submit to testing prior to and upon return to Manitoba;

i) Dr. Coyle must pay all costs associated with the Program which will include laboratory services and payment to the

monitor physician(s). Dr. Coyle must pay the costs to the College within 30 days of any account rendered to him;

j) In the event of a positive test result or in the event Dr. Coyle refuses to provide a specimen when requested to do so, such conduct shall constitute and be deemed to be a breach of these terms and conditions.

5. Dr. Coyle must attend the following meetings each and every week:

a) Physicians-at-Risk group meetings;

b) Alcoholics / Narcotics Anonymous meetings; and

c) Any other meetings recommended to Dr. Coyle by his treating physicians.

6. Dr. Coyle must continue to attend his psychiatrist, or such other psychiatrist as may be approved in writing by the Investigation Committee, as his treating psychiatrist. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.

7. Dr. Coyle must continue to attend his family physician, or such other physician as may be approved in writing by the Investigation Committee, as his family physician. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.

8. Dr. Coyle must continue to attend his specialist in addiction medicine, or such other specialist in addiction medicine as may be approved in writing by the Investigation Committee, as his specialist in addiction medicine. Attendance must be in accordance with the frequency of attendance fixed by the Investigation Committee from time to time.

9. Dr. Coyle must comply with the treatment prescribed by his treating psychiatrist, his specialist in addiction medicine and/or his family physician for the continuing management and monitoring of his addiction.

10. If Dr. Coyle's treating psychiatrist, specialist in addiction medicine and/or family physician advises him to restrict, suspend or cease the practice of medicine for a temporary or intermittent period, Dr. Coyle must comply with that direction subject to his right to take issue with it as set out in paragraph 11 herein.

11. In the event that Dr. Coyle disagrees with any direction referred to in paragraph 10 herein, he must give written notice of his objection to the College whereupon the College will appoint an independent psychiatrist to whom Dr. Coyle must attend. Any direction given to Dr. Coyle by his family physician, specialist in addiction medicine or treating psychiatrist in accordance with paragraph 10 shall continue unless the independent psychiatrist appointed by the College determines that Dr. Coyle is fit to safely practice medicine without the restriction imposed pursuant to paragraph 10 herein.

12. Dr. Coyle's practice must be restricted to clinical practice at the Crestview Clinic and must be in accordance with the plan approved by the Investigation Committee from time to time.

13. Dr. Coyle must not change his practice location without the prior written consent of the Investigation Committee and he must not practice at any location which has not been approved by the Investigation Committee in writing prior to any practice at the location.

14. Dr. Coyle must not provide care to any patient with chemical dependence or a substance abuse disorder. To comply with restrictions on prescribing certain medication and on caring for

patients with dependency issues, Dr. Coyle will ensure that front staff are advised that no patients should be directed to him if they indicate on presentation that their care would involve one of the restricted prescriptions or care related to the restricted conditions. If Dr. Coyle inadvertently attends upon a patient who is requesting or who might appropriately require a restricted prescription, if no reasonable alternative prescription is available, or if it is revealed in the patient history or otherwise that the patient has or may have one of the restricted conditions, Dr. Coyle will not provide any medical care or advice and will bring the patient to the waiting room so that the patient could be seen by another physician within the Clinic. That patient would thereafter not be scheduled to attend upon Dr. Coyle.

15. Dr. Coyle must create a complete and accurate record of each patient encounter in accordance with the requirements of By-Law No. 1 of the College. Without limiting the generality of the foregoing, for each prescription written by Dr. Coyle, he must fully document the patient's history, his examination, any investigation ordered, his diagnosis and his treatment plan.

16. Dr. Coyle must practice under the supervision of an on-site physician supervisor acceptable to the Investigation Committee who must:

    a) On a monthly basis, until otherwise directed by the Investigation Committee, review Dr. Coyle's chart entries from a minimum of 15 charts selected by the Practice Supervisor, without input from Dr. Coyle as to the chart's selected, in addition to any specific charts identified by Dr. Coyle in respect to which he is seeking his Practice Supervisor's advice, guidance or instruction, and discussing with him with the patient care provided, and providing

advice, instructions or guidance as to the proper management of the patients;

b) Document any advice or instructions provided to Dr. Coyle.

17. The requirement for on-site supervision does not prohibit Dr. Coyle from practising if his Practice Supervisor is temporarily unavailable during the day for period of not more than two hours (e.g. for lunch, personal errands, etc.).

18. Payment for the services of the Practice Supervisor shall be Dr. Coyle's responsibility.

19. Dr. Coyle will not, without the prior written consent of the Investigation Committee:

i. engage in any research, teaching or lecturing;

ii. take after hours call services and will not make house calls;

iii. employ any clinical assistants, nurse practitioners or other individuals to assist him with assessment and treatment of his patients.

20. Dr. Coyle will restrict his volume of services in accordance with a practice plan which must be approved by the Investigation Committee.

21. If Dr. Coyle wishes to change practice locations or if Dr. Coyle wishes to change his practice arrangement, he must provide a copy of these terms and conditions to:

a) The Chief Medical Officer of any Regional Health Authority where he applies for privileges;

b) The supervisor or chief executive officer at any facility or business whatsoever where he obtains employment or acts as an independent contractor, and

c) Any physician with whom he proposes to enter a practice arrangement, whether as a partner, associate or otherwise.

22. The Investigation Committee shall continue to monitor Dr. Coyle's practice of medicine, including his compliance with the conditions herein.

23. The Investigation Committee shall have full and complete authority to vary these terms and conditions, provided that the onus is on Dr. Coyle to prove that variance is in the public interest.

24. Dr. Coyle shall pay any and all costs arising from or incidental to the conditions described herein and the monitoring by the Investigation Committee described in paragraph 22.

VI. If there is any disagreement between the parties respecting any aspect of The Inquiry Panel Order, the matter may be remitted by either party to a Panel of the Inquiry Committee for further consideration, and the Inquiry Committee hereby expressly reserves jurisdiction for the purpose of resolving any such disagreement.

VII. Dr. Coyle must pay to the College costs of the Investigation and Inquiry in the amount of $40,000.00, on the basis of an agreement between Dr. Coyle and the College as to the amount of the costs, payable in full by certified cheque or Dr. Coyle's lawyer's firm's trust cheque on or before the date of the Inquiry pursuant to Section 59.7 of *The Medical Act*.

VIII. There will be publication, including Dr. Coyle's name, as determined by the Investigation Committee. The College, at its sole discretion, may

provide information regarding this disposition to such person(s) or bodies as it considers appropriate pursuant to Section 59.9 of *The Medical Act*.

DATED this 6 day of August, 2013.

SCHEDULE "A"

1. Opium Poppy (Papaver somniferum), its preparations, derivatives, alkaloids and salts, including:

    (1) Opium
    (2) Codeine (methylmorphine)
    (3) Morphine (7,8 didehydro-4,5-epoxy-17-methylmorphinan-3,6-diol)
    (4) Thebaine (paramorphine), and the salts, derivatives and salts of derivatives of the substances set out in subitems (1) to (4) including:
    (5) Acetorphine (acetyletorphine)
    (6) Acetyldihydrocodeine (4,5-epoxy-3-methoxy-17–methylmorphinan-6-ol acetate)
    (7) Benzylmorphine (7,8-didehydro,1,5-epoxy-17 –methyl-3-(phenylmethoxy) morhpinan-6-ol)
    (8) Codoxime (dihydrocodeinone O-(carboxymethyl) oxime)
    (9) Desomorphine (dihydrodeoxymorphine)
    (10) Diacetylmorphine (heroin)
    (11) Dihydrocodeine (4,5-epoxy-3-methoxy-17-methylmorphinan-6-ol)
    (12) Dihydromorphine (4,5-epoxy-17, methylmorphinan-3,6-diol)
    (13) Ethylmorphine (7,8 didehydro-4,5-epoxy-3-ethoxy -17-methylmorphinan-6-ol)
    (14) Etorphine (tetrahydro-**7**α -1-hydroxy-1-methylbutyl)-6, 14-endo-ethenooripavine)
    (15) Hydrocodone (dihydrocodeinone)
    (16) Hydromorphinol (dihydro-14-hydroxymorphine)
    (17) Hydromorphone (dihydromorphinone)
    (18) Methyldesorphine (Δ6-deoxy-6-methylmorphine)
    (19) Methyldihydromorphine (dihydro-6-methylmorphine)
    (20) Metopon (dihydromethylmorphinone)
    (21) Morphine-N-oxide (morphine oxide)
    (22) Myrophine (benzylmorphine myristate)
    (23) Nalorphine (N-allylnormorphine)
    (24) Nicocodine (6-nicotinylcodeine)
    (25) Nicomorphine (dinicotinylmorphine)
    (26) Norcodeine (N-desmethylcodeine)
    (27) Normorphine (N-desmethylmorphine)
    (28) Oxycodone (dihydrohydroxycodeinone)
    (29) Oxymorphone (dihydrohydroxymorphinone)
    (30) Pholcodine (3-[2-(4-morpholinyl)ethyl]morphine)
    (31) Thehacon (acetyldihydrocodeinone)

    But not including

    (32) Apomorphine (5,6,6a,7-tetrahydro-6-methyl-4H-dibenzo[de,g]-quinoline-10,11-diol)
    (33) Cyprenorphine (N-(cyclopropylmethyl)-6,7,8,14-tetrahydro-7α–(1-hydroxy-1-methylethyl) -6,14-endo-ethenonororipavine)

(34) Naloxone (4,5α-epoxy-3, 14-dihydroxy-17- 2-propenyl) morphinan-6-one)
(34.1) Naltrexone (17-(cyclopropylmethyl)-4,5α –epoxy-3,14-dihydroxymorhphinan-6-one)
(35) Narcotine (6,7-dimethoxy-3-(5,6,7,8-tetrahydro-4-methoxy-6-methyl- 1,3-dioxolos [4,5-g] isoquinolin-5-yl)-1(3H)-isobenzofuranone)
(36) Papaverine (1-[(3,4-dimethoxyphenyl)methyl] 6, 7-dimethoxyisoquinoline)
(37) Poppy seed

2. Coca (Erythroxylon), its preparations, derivatives, alkaloids and salts, including:

(1) Coca leaves
(2) Cocaine (benzoylmethylecgonine)
(3) Ecgonine (3-hydroxy-2-tropane carboxylic acid)

3. Phenylpiperidines, their intermediates, salts, derivatives and analogues and salts of intermediates, derivatives and analogues, including:

(1) Allylprodine (3-allyl-1-methyl-4-phenyl-4-piperidinol propionate)
(2) Alphameprodine (α-3-ethyl-l-methyl-4-phenyl-4-piperidinol propionate)
(3) Alphaprodine (α-I.3-dimethyl-4-phenyl-4-piperidinol propionate)
(4) Anileridine (ethyl 1-[2-(p-aminophenyl)ethyl]-4-phenylpiperidine-4-carboxylate)
(5) Betameprodine (β-3-ethyl-1-methyl-4-phenyl-4-piperidinol propionate)
(6) Betaprodine (β-1,3-dimethyl-4-phenyl-4-piperidinol propionate)
(7) Benzethidine (ethyl 1-(2-benzyloxyethyl)-4-phenylpiperidine-4-carboxylate)
(8) Diphenoxylate (ethyl 1-(3-cyano-3,3-diphenylpropyl)-4-phenylpiperidine-4-carboxylate)
(9) Difenoxin (1-(3-cyano-3,3-diphenylpropyl)-4-phenylpiperidine-4-carboxylate)
(10) Etoxeridine (ethyl 1-[2-(2-hydroxyethoxy) ethyl]-4-phenylpiperidine-4-carboxylate)
(11) Furethidine (ethyl 1-(2-tetrahydrofurfury loxyethyl)-4-phenylpiperidine-4-carboxylate)
(12) Hydroxypethidine (ethyl 4-(m-hydroxyphenyl)-1-methylpiperidine-4-carboxylate)
(13) Ketobemidone (1-[4 – m-hydroxyphenyl)-1 –methyl-4-piperidyl]- 1 –propanone)
(14) Methylphenylisonipecotonitrile (4-cyano-1-methyl-4-phenylpiperidine)
(15) Morpheridine (ethyl 1-(2-morpholinoethyl – 4 – phenylpiperidine-4-carboxylate)
(16) Norpethidine (ethyl 4-phenylpiperidine-4-carboxylate)
(17) Pethidine (ethyl 1-methyl-4-phenylpiperidine-4-carboxylate)
(18) Phenoperidine (ethyl 1-(3-hydroxy-3-phenylpropyl) -4-phenylpiperidine-4-carboxylate)
(19) Piminodine (ethyl 1-[3-(phenylamino)propyl]- 4-phenylpiperidine-4-carboxylate)
(20) Properidne (isopropyl 1-methyl-4-phenylpiperidine-4-carboxylate)
(21) Trimeperidine (1,2,5-trimethyl-4-phenyl-4-piperidinol propionate)
(22) Pethidine Intermediate C (1-methyl-4-phenylpiperidine-4-carboxylate)

but not including:
(23) Carbamethidine (ethyl 1-(2-carbamylethyl)- 4-phenylpiperidine-4-carboxylate)

(24) Oxpheneridine (ethyl 1-(2-hydroxy-2-phenylethyl) -4-phenylpiperidine-4-carboxylate)

4. Phenazepines, their salts, derivatives and salts of derivatives including:

(1) Proheptazine (hexahydro-1,3-dimethyl-4-phenyl-1H-azepin-4-ol propionate)

but not including:
(2) Ethoheptazine (ethyl hexahydro-1-methyl-4 –phenyl-azepine-4-carboxylate)
(3) Metethoheptazine (ethyl hexahydro-1,3-dimethyl-4 - phenylazepine-4-carboxylate)
(4) Metheptazine (ethyl hexahydro-1,2-dimethyl-4 -phenylazepine-4-carboxylate)

5. Amidones, their intermediates, salts, derivatives and salts of intermediates and derivatives including:

(1) Dimethylaminodiphenylbutanonitrile (4-cyano-2-dimethylamino-4,4-diphenylbutane)
(2) Dipipanone (4,4-diphenyl-6-piperidino-3 –heptanone)
(3) Isomethadone (6-dimethylamino-5-methyl-4,4 –diphenyl-3-hexanone)
(4) Methadone (6-dimethylamino-4,4-diphenyl-3 –heptanone)
(5) Normethadone (6-dimethylamino-4,4-diphenyl-3 –hexanone)
(6) Norpipanone (4,4-diphenyl-6-piperidino-3-hexanone)
(7) Phenadoxone (6-morpholino-4,4-diphenyl-3-heptanone)

6. Methadols, their salts, derivatives and salts of derivatives including:

(1) Acetylmethadol (6-dimethylamino-4,4-diphenyl-3 –heptanol acetate)
(2) Alphacetylmethadol (α-6-dimethylamino-4,4 –diphenyl-3-heptanol acetate)
(3) Alphamethadol (α-6-dimethylamino-4,4-diphenyl-3-heptanol)
(4) Betacetylmethadol (β-6-dimethylamino-4,4-diphenyl-3-heptanol acetate)
(5) Betamethadol (β-6-dimethylamino-4,4-diphenyl -3-heptanol)
(6) Dimepheptanol (6-dimethylamino-4,4-diphenyl -3-heptanol)
(7) Noracymethadol (α-6-methylamino-4,4 –diphenyl-3-heptanol acetate)

7. Phenalkoxams, their salts, derivatives and salts of derivatives including:

(1) Dimenoxadol (dimethylaminoethyl 1-ethoxy-1,1 -diphenylacetate)
(2) Dioxaphetyl butyrate (ethyl 2,2-diphenyl-4 –morpholinobutyrate)
(3) Dextropropoxyphene ([S-(R*,S*)]-α-[2-(dimethylamino)-1-methylethyl]-α-phenylbenzeneethanol, propanoate ester)

8. Thiambutenes, their salts, derivatives and salts of derivatives including:

(1) Diethylthiambutene (N,N-diethyl-1-methyl-3,3 –di-2-thienylallylamine)
(2) Dimethylthiambutene (N,N,1-trimethyl-3,3 –di-2-thienylallylamine)

(3) Ethylmethylthiambutene (N-ethyl-N,1-dimethyl-3,3 –di-2-thienylallylamine)

9. Moramides, their intermediates, salts, derivatives and salts of intermediates and derivatives including:

(1) Dextromoramide (d-1-(3-methyl-4-morpholino-2,2-diphenylbutyryl)pyrrolidine)
(2) Diphenylmorpholinoisovaleric acid (2-methyl-3 –morpholino-1,1-diphenylpropionic acid)
(3) Levomoramide (*l*-1-(3-methyl-4-morpholino-2,2 –diphenylbutyryl)pyrrol idine)
(4) Racemoramide (d,1-1-(3-methyl-4-morpholino-2,2 –diphenylbutyryl)pyrrolidine)

10. Morphinans, their salts, derivatives and salts of derivatives including:

(1) Buprenorphine (17-(cyclopropylmethyl)-α-(1, 1-dimethylethyl)-4,5-epoxy-18,19-dihydro-3-hydroxy-6-methoxy-α-methyl-6, 14-ethenomorphinan-7-methanol)
(2) Drotebanol (6β, 14-dihydroxy-3,4-dimethoxy – 17-methylmorphinan)
(3) Levomethorphan (1-3-methoxy-17-methylmorphinan)
(4) Levorphanol (1-3-hydroxy-17-methylmorphinan)
(5) Levophenacylmorphan (1-3-hydroxy-17-phenacylmorphinan)
(6) Norlevorphanol (1-3-hydroxymorphinan)
(7) Phenomorphan (3-hydroxy- 17-(2-phenylethyl) morphinan)
(8) Racemethorphan (d,1-3-methoxy-17-methylmorphinan)
(9) Racemorphan (d,1-3-hydroxy-N-methylmorphinan)

but not including
(10) Dextromethorphan (d-1,2,3,9,10, 10a-hexahydro-6-methoxy-11-methyl-4H-10,4a-iminoethano-phenanthren)
(11) Dextrorphan (d-1,2,3,9,10, 10a-hexahydro-11-methyl-4H-10,4a-iminoethanophenanthren-6-ol)
(12) Lavallorphan (1-11-allyl-1,2,3,9,10, 10a-hexahydro-4H-10,4a-iminoethanophenanthren-6-ol)
(13) Levargorphan (1-11-propargyl- 1,2,3,9,10, 10a-hexahydro-4H-10,4a-iminoethanophenanthren-6-ol)
(14) Butorphanol (17-(cyclobutylmethyl)morphinan -3,14-diol)
(15) Nalbuphine (17-(cyclobutylmethyl) - 4,5α-epoxymorphinan-3,6α,14-triol)

11. Benzazocines, their salts, derivatives and salts of derivatives including:

(1) Phenazocine (1,2,3,4,5,6-hexahydro-6,11-dimethyl-3-phenethyl-2,6-methano-3-benzazocin-8-ol)
(2) Metazocine (1,2,3,4,5,6-hexahydro-3,6, 11-trimethyl-2,6-methano-3-benzazocin-8-ol)
(3) Pentazocine (1,2,3,4,5,6-hexahydro-6, 1-dimethyl-3-(3-methyl-2-butenyl)-2,6-methano-3-benzazocin -8-ol)

but not including

(4) Cyclazocine (1,2,3,4,5,6-hexahydro-6, 11-dimethyl-3-cyclopropylmethyl)-2,6-methano-3-benzazocin-8-ol)

12. Ampromides, their salts, derivatives and salts of derivatives including:

    (1) Diampromide (N-[2-(methylphenethylamino) propyl] propionanilide)
    (2) Phenampromide (N-(1-methyl-2-piperidino) ethyl) propionanilide)
    (3) Propiram (N-(1-methyl-2-piperidinoethyl)-N-2-pyridylpropionamide)

13. Benzimidazoles, their salts, derivatives and salts of derivatives including:

    (1) Clonitazene (2-(p-chlorobenzyl)-1-diethylaminoethyl-5-nitrobenzimidazole)
    (2) Etonitazene (2-(p-ethoxybenzyl)-1-diethylaminoethyl-5- nitrobenzimidazole)
    (3) # Bezitramide (1-(3-cyano-3,3-diphenylpropyl)-4-(2-oxo-3-propionyl-1-benzimidazolinyl)-piperidine)

14. Phencyclidine (1-(1-phenylcyclohexyl)piperidine), its sales, derivatives and analogues and salts of derivatives and analogues

15. Piritramide (1-(3-cyano-3,3-diphenylpropyl)-4-(1-piperidino)piperidine-4-carboxylic acid amide), its salts, derivatives and salts of derivatives

16. Fentanyls, their salts, derivatives and analogues and salts of derivatives and analogues, including:

    (1) Acetyl-α-methylfentanyl (N-[1-(α-methylphenethyl)-4-piperidyl] acetanilide)
    (2) Alfentanil (N-[1-[2-(4-ethyl-4,5-dihydro -5-oxo- 1H-tetrazol-l-yl)ethyl]-4-(methoxymethyl) -4-piperidyl]propionanilide)
    (3) Carfentanil (methyl 4-[(1-oxopropyl)phenylarnino]-1-(2-phenethyl)-4-piperidinecarboxylate)
    (4) p-Fluorofentanyl (4'fluoro-N-(1-phenethyl-4 –piperidyl) propionanilide)
    (5) Fentanyl (N-(1-phenethyl-4–piperidyl) propionanilide)
    (6) β-Hydroxyfentanyl (N-[1-β-hydroxyphenethyl -4-piperidyl] propionanilide)
    (7) β-Hydroxy-3-methylfentanyl (N-[1-(β –hydroxyphenethyl-3-methyl-4- piperidyl] propionanilide)
    (8) α-Methylfentanyl (N-[1-(a-methylphenethyl)-4-piperidyl] propionanilide)
    (9) α–Methylthiofentanyl (N-[1-[1-methyl-2-(2-thienyl) ethyl] 4 piperidyl] propionanilide)
    (10) 3-Methylfentanyl (N-(3-methyl-1-phenethyl -4-piperidyl) propionanilide)
    (11) 3-Methylthiofentanyl (N-[3-methyl-1-[2-(2-thienyl)ethyl]-4-piperidyl] propionanilide)
    (12) Sufentanil (N-[4-methoxymethyl)-1-[2-(2-thienyl)ethyl]-4-piperidyl] propionanilide)
    (13) Thiofentanyl (N-[1-[2-(2-thienyl)ethyl]-4 -piperidyl] propionanilide)

17. Tilidine (ethyl-2-(dimethylamino)-1-phenyl-3-cyclohexene-1-carboxylate), its salts, derivatives and salts of dirivatives.

18. Cannabis, its preparations, derivatives and similar synthetic preparations, including:

    (1) Canabis resin
    (2) Cannabis (marihuana)
    (3) Cannabidiol (2-[3-methyl-6-(1-methyl-ethenyl – 2-cyclohexen- 1 -yl]-5-pentyl-1,3 – benzenediol)
    (4) Cannabinol (3-n-amyl-6,6,9-trimethyl-6-dibenzo-pyran-1-ol)
    (5) Nabilone ((±)-(trans-3-(1,1-dimethylheptyl – 6,6a,7,8,10,10a-hexahydro-1-hydroxy-6,6-dimethyl-9H-dibenzo[b,d]pyran-9-one)
    (6) Pyrahexyl (3-n-hexyl-6,6,9-trimethyl-7,8,9,10-tetrahydro-6-dibenzopyran-1-ol)
    (7) Tetrahydrocannabinol (tetrahydro-6,6,9-trimethyl-3-pentyl-6H-dibenzo[b,d]pyran-1-ol)

    but not including
    (8) Non-viable Cannabis seed
    (9) Mature cannabis stalks that do not include leaves, flowers, seeds or branches; and fiber derived from such stalks.

19. Amphetamines, their salts, derivatives, isomers and analogues and salts of derivatives, isomers and analogues including:

    (1) Amphetamine (α-methylbenzeneethanamine)
    (2) Methamphetamine (N,α-dimethylbenzeneethanamine)
    (3) N-ethylamphetamine (N-ethyl-α–methylbenzeneethanamine)
    (4) 4-methyl-2,5-dimethoxyamphetamine (STP) (2,5-dimethoxy-4,α–dimethylbenzeneethanamine)
    (5) 3,4-methylenedioxyamphetamine (MDA) (α–methyl-1,3-benzodioxole-5-ethanamine)
    (6) 2,5-dimethoxyamphetamine (2,5-dimethoxy-α–methylbenzeneethanamine)
    (7) 4-methoxyamphetamine (4-methoxy-α–methylbenzeneethanamine)
    (8) 2,4,5-trimethoxyamphetamine (2,4,5-trimethoxy -α–methylbenzeneethanamine)
    (9) N-methyl-3,4-methylenedioxyamphetamine (N,α–dimethyl-1 ,3-benzodioxole-5-ethanamine)
    (10) 4-ethoxy-2,5-dimethoxyamphetamine (4-ethoxy-2,5-dimethoxy-α–methylbenzeneethanamine)
    (11) 5-methoxy-3,4-methylenedioxyamphetamine (7-methoxy-α–methyl-1,3-benzodioxole-5-ethanamine)
    (12) N,N-dimethyl-3,4-methylenedioxyamphetamine (N,N,α–trimethyl-1,3-benzodioxole-5-ethanamine)
    (13) N-ethyl-3,4-methylenedioxyamphetamine (N-ethyl-α–methyl-1,3-benzodioxole-5-ethanamine)
    (14) 4-ethyl-2,5-dimethoxyamphetamine (DOET) (4ethyl-2,5-dimethoxy-α–methylbenzeneethanamine)

(15) 4-bromo-2,5-dimethoxyamphetamine (4-bromo-2,5 dimethoxy-α–methylbenzeneethanamine)
(16) 4-chloro-2,5-dimethoxyamphetamine (4-chloro-2,5-dimethoxy-α –methylbenzeneethanamine)
(17) 4-ethoxyamphetamine (4-ethoxy- α–methylbenzeneethanamine)
(18) Benzphetamine (N-benzyl-N, α–dimethylbenzeneethanamine)
(19) N-Propyl-3,4-methylenedioxyamphetamine (α–methyl-N-propyl-1 ,3-benzodioxole-5-ethanamine)
(20) N-(2-Hydroxyethyl)-α–methylbenzeneethanamine

20. Methylphenidate (α–phenyl-2-piperidineacetic acid methyl ester) and any salt thereof

21. Methaqualone (2-methyl-3-(2-methylphenyl)-4(3H)-quinazolinone) and any salt thereof

22. Mecloqualone (2-methyl-3-(2-chlorophenyl) 4(3H)-quinazolinone) and any salt thereof

23. Lysergic acid diethylamide (LSD) (N,N-diethyllysergamide) and any salt thereof

24. N,N-Diethyltryptamine (DET) (3-[(2-diethylamino) ethyl]indole) and any salt thereof

25. N,N-Dimethyltryptamine (DMT) (3-[(2-dimethylamino)ethyl]indole) and any salt thereof

26. N-Methyl-3-piperidyl benzilate (LBJ) (3-[(hydroxydiphenylacetyl)oxy]-1-methylpiperidine) and any salt thereof

27. Harmaline (4,9-dihydro-7-methoxy-1-methyl -3H-pyrido(3,4-b)indole) and any salt thereof

28. Harmalol (4,9-dihydro-1-methyl-3H-pyrido (3,4-b)indol-7-ol) and any salt thereof

29. Psilocin (3-[2-dimethylamino)ethyl]-4-hydroxyindole) and any salt thereof

30. Psilocybin (3-[2-(dimethylamino)ethyl]-4-phosphoryloxyindole) and any salt thereof

31. N-(1-phenylcyclohexyl)ethylamine (PCE) and any salt thereof

32. 1-[1-(2-Thienyl) cyclohexyl]piperidine (TCP) and any salt thereof

33. 1-Phenyl-N-propylcyclohexanamine and any salt thereof

34. 1-(1-Phenylcyclohexyl)pyrrolidine and any salt thereof

35. Mescaline (3,4,5-trimethoxybenzeneethanamine) and any salt thereof, but not peyote (lophophora)

36. 4-Methylaminorex (4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine) and any salt thereof

37. Cathinone ((-)-α –aminopropiophenone) and any salt thereof

38. Fenetylline (d,1-3,7-dihydro-1,3-dimethyl-7-(2[(1-methyl-2-phenethyl)amino]ethyl)-1 H-purine-2, 6-dione) and any salt thereof

39. 2-Methylamino-1-phenyl-1-propanone and any salt thereof

40. 1-[1-(Phenylmethyl)cyclohexyl]piperidine and any salt thereof

41. 1-[1-(4-Methylphenyl)cyclohexyl]piperidine and any salt thereof

42. 4-bromo-2,5-dimethoxybenzeneethanamine and any salt, isomer or salt of the isomer thereof

43. Barbihurates, their salts and derivatives including:

    (1) Allobarbital (5,5-diallylbarbituric acid)
    (2) Alphenal (S-allyl-S-phenylbarbituric acid)
    (3) Amobarbital (5-ethyl-5-(3-methylbutyl)barbituric acid)
    (4) Aprobarbital (5allyl-5-isopropylbarbituric acid)
    (5) Barbital (5,5-diethylbarbituric acid)
    (6) Barbituric Acid (2,4,6(1H,3H,5H) – pyrimidinetrione)
    (7) Butabarbital (5-sec-butyl-5-ethylbarbituric acid)
    (8) Butalbital (5-allyl-5-isobutylbarbituric acid)
    (9) Butallylonal (5-(2-bromoallyl)-5-secbutylbarbituric acid)
    (10) Butethal (5-butyl-5-ethylbarbituric acid)
    (11) Cyclobarbital (5-(1 -cyclohexen-1-yl)-5-ethylbarbituric acid)
    (12) Cyclopal (5-allyl-5-(2-cyclopenten-1-yl)barbituric acid)
    (13) Heptabarbital (5-(1 cyclohepten-1-yl)-5 -ethylbarbituric acid)
    (14) Hexethal (5-ethyl-5-hexylbarbituric acid)
    (15) Hexobarbital (5-(1-cyclohexen-1-yl)-1,5-dimethylbarbituric acid)
    (16) Mephobarbital (5-ethyl-1-methyl-5-phenylbarbituric acid)
    (17) Methabarbital (5,5-diethyl-1-methylbarbituric acid)
    (18) Methylphenobarbital (5-ethyl-1-methyl-5 -phenylbarbituric acid)
    (19) Propallylonal (5-(2-bromoallyl)-5-isopropylbarbituric acid)
    (20) Pentobarbital (5-ethyl-5-(1-methylbutyl)barbituric acid)
    (21) Phenobarbital (5-ethyl-5-phenylbarbituric acid)
    (22) Probarbital (5-ethyl-5-isopropylbarbitureic acid)
    (23) Phenylmethylbarbituric Acid (5-methyl-5-phenylbarbituric acid)
    (24) Secobarbital (5-allyl-5-(1-methylbutyl)barbituric acid)
    (25) Sigmodal (5-(2-bromoallyl)-5-(1-methylbutyl) barbituric acid)
    (26) Talbutal (5-allyl-5-sec-butylbarbituric acid)
    (27) Vinbarbital (5-ethyl-5-(1-methyl-1-butenyl) barbituric acid)
    (28) Vinylbital (5-(1-methylbutyl)-5-vinylbarbituric acid)

44. Thiobarbiturates, their salts and derivatives including:

    (1) Thialbarbital (5-allyl-5-(2-cyclohexen-1-yl) -2-thiobarbituric acid)
    (2) Thiamylal (5-allyl-5-(1-methylbutyl)-2-thiobarbituric acid)
    (3) Thiobarbituric Acid (2-thiobarbituric acid)
    (4) Thiopental (5-ethyl-5-(1-methylbutyl)-2-thiobarbituric acid)

45. Chlorphentermine (1-(p-chlorophenyl)-2-methyl-2-aminopropaine) and any salt thereof

46. Diethylpropion (2-(diethylamino)propiophenone) and any salt thereof

47. Phendimetrazine (d-3,4-dimethyl-2-phenylmorpholine) and any salt thereof

48. Phenmetrazine (3-methyl-2-phenylmorpholine) and any salt thereof

49. Pipradol (α,α-diphenyl-2-piperidinemethanol) and any salt thereof

50. Phentermine (α,α-dimethylbenzeneethanamine) and any salt thereof

51. Butorphanol (1-N-cyclobutylmethyl-3,14-dihydroxymorphinan) and any salt thereof

52. Nalbuphine (N-cyclobutylmethyl-4,5-epoxy-morphinan-3,6,14-triol) and any salt thereof

53. Glutethimide (2-ethyl-2-phenylglutarimide)

54. Clotiazapam (5-(o-chlorophenyl)-7-ethyl-1,3-dihydro-1-methyl-2H-thieno[2,3-e]-1,4-diazepin-2-one) and any salt thereof

55. Ethchlorvynol (ethyl-2-chlorovinyl ethynyl carbinol)

56. Ethinamate (1-ethynylcyclohexanol carbamate)

57. Mazindol (5-(p-chlorophenyl)-2,5-dihydro-3H-imidazo[2, 1-a]isoindol-5-ol)

58. Meprobamate (2-methyl-2-propyl-1,3-propanediol dicarbamate)

59. Methyprylon (3,3-diethyl-5-methyl-2,4-piperidinedione)

60. Benzodiazepines, their salts and derivatives, including:

    (1) Alprazolam (8-chloro-1-methyl-6-phenyl-4H-s-triazolo[4,3-a][1,4] benzodiazepine)
    (2) Bromazepam (7-bromo-1,3-dihydro-5-(2 -pyridyl)-2H-1,4-benzodiazepin-2-one)
    (3) Camazepam (7-chloro-1,3-dihydro-3-(N,N-dimethylcarbamoyl)-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one)

(4) Chlordiazepoxide (7-chloro-2 -(methylamino)-5-phenyl-3H-1,4-benzodiazepine-4-oxide)
(5) Clobazam (7-chloro-1-methyl-5-phenyl-1H-1,5-benzodiazepine-2,4(3H,5H - dione)
(6) Clonazepam (5-(o-chlorophenyl)-1,3-dihydro-7 –nitro-2H-1,4-benzodiazepin-2-one)
(7) Clorazepate (7-chloro-2,2-dihydro-2,3-dihydroxy-5-phenyl-1H- 1,4-benzodiazepine-3-carboxylic acid)
(8) Cloxazolam (10-chloro-11b-(o-chlorophenyl)-2,3,7,11b-tetrahydrooxazolo[3,2-d] [1,4]benzodiazepin 6-(5H) - one)
(9) Delorazepam (7-chloro-5-(o-chlorophenyl)-1,3 –dihydro-2H-1,4-benzodiazepin-2-one)
(10) Diazepam (7-chloro-1,3-dihydro-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one)
(11) Estazolam (8-chloro-6-phenyl-4H-s-triazolo [4,3-a][1,4]benzodiazepine)
(12) Ethyl Loflazepate (ethyl 7-chloro-5-(o-fluorophenyl)2,3-dihydro-2-oxo-1H-1,4-benzodiazepine-3-carboxylate)
(13) Fludiazepam (7-chloro-5-(o-fluorophenyl)-1,3-dihydro-1-methyl-2H-1,4-benzodiazepin-2-one)
(14) Flunitrazepam (5-(o-fluorophenyl)-1,3-dihydro-1-methyl-7-nitro-2H-1,4-benzodiazepin-2-one)
(15) Flurazepam (7-chloro-1-[2-(diethylamino)ethyl]-5-(o-fluorophenyl)-1,3-dihydro-2H-1,4-benzodiazepin-2-one)
(16) Halazepam (7-chloro-1,3-dihydro-5-phenyl-1 –(2,2,2-trifluoroethyl)-2H-1,4-benzodiazepin-2-one)
(17) Haloxazolam (10-bromo-11b-(o-fluorophenyl)-2,3,7,11b-tetrahydrooxazolo[3,2-d] [1,4]benzodiazepin-6(5H)-one)
(18) Ketazolam (11-chloro-8,12b-dihydro-2,8-dimethyl-12b-phenyl-4H-[1-3]-oxazino-[3,2-d] [1,4]benzodiazepine-4,7(6H)-dione)
(19) Loprazolam (6-(o-chlorophenyl)-2,4-dihydro-2-[(4-methyl-1-piperazinyl)methylene] -8-nitro-1H-imidazo[1,2-a][1,4]benzodiazepin-1-one)
(20) Lorazepam (7-chloro-5-(o-chlorophenyl)-1,3-dihydro-3-hydroxy-2H-1,4-benzodiazepin -2-one)
(21) Lormetazepam (7-chloro-5-(o-chlorophenyl)-1,3-dihydro-3-hydroxy-1-methyl-2H- 1,4-benzodiazepin-2-one)
(22) Medazepam (7-chloro-2,3-dihydro-1-methyl-5-phenyl-1H-1,4-benzodiazepine)
(23) Nimetazepam (1,3-dihydro-1-methyl-7-nitro-5-phenyl-2H-1,4-benzodiazopin-2-one)
(24) Nitrazepam (1,3-dihydro-7-nitro-5-phenyl-2H-1,4-benzodiazepin-2-one)
(25) Nordazepam (7-chloro-1,3-dihydro-5-phenyl-2H-1,4-benzodiazepin-2-one)
(26) Oxazepam (7-chloro-1,3-dihydro-3-hydroxy-5-phenyl-2H-1,4-bennzodiazepin-2-one)
(27) Oxazolam (10-chloro-2,3,7,11b-tetrahydro-2-methyl-11b-phenyloxazolo[3,2-d][1,4]benzodiazepine-6(5H)-one)
(28) Pinazepam (7-chloro-1,3-dihydro-5-phenyl-1-(2-propynyl)-2H-1, 4-benzodiazepin-2-one)

(29) Prazepam (7-chloro-1-(cyclopropylmethyl)-1,3-dihydro-5-phenyl-2H-1,4-benzodiazepin-2-one)
(30) Temazepam (7-chloro-1,3-dihydro-3-hydroxy-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one)
(31) Tetrazepam (7-chloro-5-(cyclohexen-1-yl)-1,3-dihydro-1-methyl-2H-1,4-benzodiazepin-2-one)
(32) Triazolam (8-chloro-6-(o-chlorophenyl)-1-methyl-4H-s-triazolo[4,3-a][1,4]benzodiazepine)

61. Catha edulis Forsk., its preparations, derivatives, alkaloids and salts, including:

(1) Cathine (d-threo-2-amino- 1 – hydroxyl- 1 –phenylpropane)

62. Fencamfamin (d,1-N-ethyl-3-phenylbicyclo[2,3,1]heptan-2-amine) and any salt thereof

63. Fenproporex (d,1-3-[(x-methylphenethyl)amino] propionitrile) and any salt thereof

64. Mefenorex (d,1-N-(3-chloropropyl)-x-methylbenzeneethanamine) and any salt thereof

65. Anabolic steroids and their derivatives including:

(1) Androisoxazole (17β-hydroxy-17α-methylandrostano [3,2-c] isoxzole)
(2) Androstanolone (17β-hydroxy-5α-androstan-3-one)
(3) Androstenediol (androst-5-ene-3β, 17β-diol)
(4) Bolandiol (estr-4-ene-3β, 17β-diol)
(5) Bolasterone (17β–hydroxy-7α,17-dimethylandrost-4-en-3-one)
(6) Bolazine (17β-hydroxy-2α-methyl-5α -androstan-3-one azine)
(7) Boldenone (17β-hydroxyandrosta-1,4-dien-3-one)
(8) Bolenol (19-nor-17α-pregn-5-en-17-ol)
(9) Calusterone (17β–hydroxy-7β,17-dimethylandrost-4 -en-3-one)
(10) Clostebol (4 - chloro-17β-hydroxyandrost-4-en-3 -one)
(11) Drostanolone (17β–hydroxy-2α-methyl-5α-androstan-3-one)
(12) Enestebol (4,17β–dihydroxy-17-methylandrosta-1,4 -dien-3-one)
(13) Epitiostanol (2α, 3α-epithio-5α-androstan-17β–ol)
(14) Ethylestrenol (19-nor-17α-pregn-4-en-17-ol)
(15) 4-Hydroxy-19-nor testosterone
(16) Fluoxymesterone (9-fluoro-11β,17β–dihydroxy- 17-methylandrost-4-en-3-one)
(17) Formabolone (11α,17β–bihydroxy-17-methyl-3 –oxoandrosta-1,4 di-en-2-carboxaldehyde)
(18) Furazabol (17-methyl-5α-androstano[2,3-c] furazan-17β–ol)
(19) Mebolazine (17β–hydroxy-2α,17-dimethyl-5α-androstan-3-one-azine)
(20) Mesabolone (17β–[(1 -methoxycyclobexyl)oxy]-5α-androst-1-en-3-one)
(21) Mesterolone (17β–hydroxy-1α-methyl-5α-androstan-3-one)
(22) Metandienone (17β-hydroxy- 17-methylandrosta- 1,4 –dien-3-one)
(23) Metenolone (17β–hydroxy-1-methyl-5α-androst- 1 –en-3-one)
(24) Methandriol (17α–methylandrost-5-ene-3β, 17β–diol)

(25) Methyltestosterone (17β-hydroxy- 17-methylandrost-4-en-3-one)
(26) Metribolone (17β–hydroxy- 17-methylestra-4,9,11-trien-3-one)
(27) Mibolerone (17β–hydroxyl-7α,17-dimethylestr-4-en-3-one)
(28) Nandrolone (17β–hydroxyestr-4-en-3one)
(29) Norboletone (13-ethyl-17β-hydroxy-18, 19-dinorpregn-4-en-3-one)
(30) Norclostebol (4-chloro-17β-hydroxyestr -4-en-3-one)
(31) Norethandrolone (17α-ethyl-17β–hydroxyestr -4-en-3-one)
(32) Oxabolone (4,17β–dihydroxyestr-4-en-3-one)
(33) Oxandrolone (17β–hydroxy-17-methyl-2-oxa-5α-androstan-3-one)
(34) Oxymesterone (4,17β–dihydroxy- 17-methylandrost-4-en-3-one)
(35) Oxymetholone (17β–hydroxy-2-(hydroxymethylene) -17–methyl-5α-androstan-3-one)
(36) Prasterone (3β–hydroxyandrost-5-en-17-one)
(37) Quinbolone (17β–(1-cyclopenten-1-yloxy)androsta- 1,4-dien-3-one)
(38) Stanozolol (17β–hydroxy-17-methyl-5α-androstano [3,2-c]pyrazole)
(39) Stenbolone (17β–hydroxy-2-methyl-5 α-androst- 1 –en-3-one)
(40) Testosterone (17β–hydroxyandrost-4-en-3-one)
(41) Tibolone ((7α,17α)-17-hydroxy-7-methyl- 19-norpregn -5(10) –en-20-yn-3-one)
(42) Tiomesterone (1α,7α-bis(acetylthio)-17β –hydroxy-17-methylandrost-4-en-3-one)
(43) Trenbolone (17β–hydroxyestra-4,9,11-trien-3-one)

66. Zeranol (3,4,5,6,7,8,9,10,11,12-decahydro-7, 14,16-trihydroxy-3-methyl- 1H-2-benzoxacyclotetradecin-1-one)

67. Phenylpropanolamine (2-amino- 1 –phenyl- 1 –propanol) and any salt thereof

68. Propylhexedrine (1-cyclohexyl-2-methylaminopropane) and any salt thereof

69. Pyrovalerone (1-(1-pyrrolidinyl)butyl p-tolyl ketone and any salt thereof

70. Benzyl methyl ketone (P2P) (1-phenyl-2-propanone)

71. Ephedrine (1-erythro-2-(methylamino)- 1 –phenylpropan- 1 –ol)

72. Ergometrine (9,10-didehydro-N-(2-hydroxy-1 –methylethyl)-6-methylergoline-8-carboxamide)

73. Ergotamine (12’-hydroxy-2’-methyl-5’-(phenylmethyl) ergotaman-3’,6’,18 trione)

74. Lysergic acid (9,10-didehydro-6-methylergoline-8 –carboxylic acid)

75. Pseudoephedrine (d-threo-2-(methylamino)- 1 –phenylpropan-1-ol)

Substance
76. Cannabis resin
77. Cannabis (marijuana)

78. Cannabis resin
79. Cannabis (marihuana)