Submission No 48

INQUIRY INTO OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

Name: Mr Dennis King

Date received: 24 October 2016

DWK:CW
03 October 2016

Parliamentary Committee

Dear

RE: Dr Kiran Phadke

I am writing for comment on issues that have arisen concerning Dr Phadke and wish to approach the issues initially from the perspective of a colleague, and then from my perspective as someone long involved in clinical administration, and now Chair of a Local Health District Board.

As background, I have known Dr Phadke since he became a consultant at St George Hospital in 1983, and have worked with him closely in the intervening thirty-three years. In that time I have referred many patients to him, and in fact he has been my preferred referral oncologist for that time, my referrals including close family members and friends.

As well, I have a great deal to do with Dr Phadke in the late 1980s and early 1990s when St George Hospital was attempting to establish cancer services. Prior to that time, our patients needed to go to the central metropolitan hospitals for chemo- and radio-therapy. The difficulty of access meant that many were effectively denied optimal treatment purely because of access issues.

Dr Phadke worked tirelessly for many years to enhance services in Southern Sydney and is owed a great debt of gratitude by the people of that region.

From a clinical standpoint oncologists often appear to fall broadly into two categories. One is those who treat cancer almost in isolation from the host. They will often tend to be protocol-driven with perhaps less awareness and consideration of the many things that are happening to patients once that diagnosis is made. While protocols usually reflect the perceived optimum treatment for a specific set of cancer parameters from information gathered in randomised controlled clinical trials (RCT), they should be but one consideration in the appropriate management of any given patient.

For a start, many trials exclude people with comorbidities in order to maintain the purity of the trial and in order to produce a better chance of obtaining a meaningful result by excluding confounding variables as much as possible. That is an entirely appropriate and well accepted scientific approach to such trials. In the implementation of the results on a broad basis, many other factors become very relevant. Protocols based on RCTs, as best the evidence base, must always underpin rational treatment, but should only be the starting point for discussion of the most appropriate treatment for an individual patient.

There are those oncologists who treat people with cancer with what one might call a holistic approach. That has been defined as engaging the whole person at a number of different levels,

physical, emotional, mental and spiritual. It acknowledges that a human being is multi-dimensional, with conscious and unconscious aspects; rational and irrational aspects.

Once a patient is diagnosed with cancer there are many other factors that come into play, the stress of the diagnosis itself, the impact of the illness on the patients and their carers, the patient's general physical and emotional state, the patient's wishes in terms of their lifestyle, the level of morbidity they are prepared to accept in the hope of a cure or significant prolongation of life, and importantly their basic approach to matters of life and death.

Dr Phadke treats patients as people and communicates well with them, and takes all of these factors into account, hence the amount of support he has from his colleagues and from his patients, and the reason that he is the oncologist that I would have treat me, as I have asked him to treat my close family.

It is extraordinarily regrettable that recent events have sullied the reputation of a fine person and fine physician, who is held in such high regard by his colleagues and his patients.

I note that part of the brief if this inquiry relates to process and the Code of Conduct, which places defined and important obligations upon those dealings with allegations such as were those made against Dr Phadke. Broadly speaking they define a standard of behaviour which respects and protects patients, their relatives and carers, and, importantly in this case, staff. Staff surveys in the recent decade or two in Health in NSW have consistently highlighted the disengagement of staff, in part due to the lack of support they receive in a number of ways.

From my specific experience of the handling of complaints against staff and clinicians, and I suspect from what is termed “natural justice”, the first stages are to establish the facts, where necessary have genuinely independent reviews of the matter, and offer the accused a reasonable opportunity to reply. I believe that none of these were in place in Dr Phadke’s case.

As may would be aware, Dr Phadke has had the humiliation of having the popular press harassing him at home, and of employees of NSW Health making what I suspect may have been ill-judged contact with some of his patients. It is some of the aspects of process which I believe should be explored by your inquiry.

The reason for that is to attempt to reverse what I believe to be the egregious harm done to Dr Phadke, but also so that it may be possible to set in place measures that prevent the same thing happening to other members of staff.

The level of concern I think is apparent from the press release of the Medical Oncology Group of Australia, who legitimately asked if this can happen to Dr Phadke then who among us is immune?

Among the aspects that I believe should be looked at is the conflicts of interest that have been involved in the management of this process from the beginning, and the decision to contact patients directly a mere hour or two after Dr Phadke received the reports of his alleged misconduct, with clearly no opportunity to reply in that timeframe. Although a timeframe I gather of four hours was suggested, that is clearly absurd, particularly bearing in mind that the only reviews were of public hospital documentation, whereas many of these patients are also seen in private rooms and the discussions may take place there.

I understand that as many as 20 patients were contacted to advise them that their treatment was or may have been inappropriate before the processes as outlined above had been completed, in other words on the basis of incomplete information. I also understand that in the majority that was found not to be the case. Once that had been done, “the die had been cast”, and there was then no option but to advise the public at large, lest accusations of a “cover-up” were to be made.

The person who made those approaches, and the attempt to reverse the damage, may have done so of his own accord, but it was such a significant decision that he was presumably acting under instructions, and if you are to correct the system issue in this matter, that aspect must be clarified and addressed.

It may be worth reviewing the feedback from the helpline set up to counsel patients who were being advised that they have suffered adverse consequences by virtue of Dr Phadke's treatment, and the feedback that came into that service, which I believe will clearly support the fact that the people who have been lucky enough to be treated by Dr Phadke over the years clearly have an entirely different view of him as a clinician.

If the specific allegations against Dr Phadke are taken into account, many of them appear to be related to haematology at The Sutherland Hospital. It may be worth bearing in mind that Dr Phadke only starting seeing haematology patients at The Sutherland Hospital when those clinicians at St George Hospital who were specifically appointed to provide that service refused to do so, and Dr Phadke was asked by the staff of The Sutherland Hospital if he would help them out by providing that service, which he did.

Much is made of “open disclosure” but from my practical experience in this from an administrative aspect implicit in the policy is what is said to be a general medical maxim, “first do no harm”. I suspect that the way this has been handled has generated a great deal of unwarranted community anxiety about the quality of cancer services, and reflected poorly on cancer services in NSW, and those who deliver them, despite the clear evidence of the overall high quality of those services by international standards.

It is my understanding that no adverse findings have been made in relation to Dr Phadke’s management of oncology patients for example, yet he is now subject to severe Medical Board restrictions, and I believe that to be an aspect that warrants scrutiny.

In my opinion, the system has inflicted great harm on a fine physician, and human being, and I hope you take this opportunity to address the egregious wrongs visited upon Dr Phadke.

With kind regards

Yours sincerely

Denis W King