REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

CORRECTED

At Macquarie Room, Parliament House, Sydney on Friday, 31 March 2017

The Committee met at 9:30 am

PRESENT

The Hon. Paul Green (Chair)

Mr Jeremy Buckingham
The Hon. Trevor Khan
The Hon. Natasha Maclaren-Jones
The Hon. Daniel Mookhey
The Hon. Walt Secord
The Hon. Bronnie Taylor (Deputy Chair)

The CHAIR: I note for those in the public gallery that there is an overflow room in the room known as the Jubilee Room, where there will be a video feed of proceedings. Welcome to the sixth hearing of the Select Committee inquiry into off-protocol prescribing of chemotherapy in New South Wales. Before I commence with proceedings I acknowledge the Gadigal people, who are the traditional custodians of this land. I would also like to pay respect to the elders past and present of the Eora nation and extend that respect to other Aboriginals who may be present with us today or who are online listening to this hearing. Today we will hear from oncologist and haematologist Dr Kiran Phadke followed by representatives from the Eastern Sydney Local Health District, who are returning to give evidence.

I turn to procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the parliamentary website. The transcript of today's hearing will be placed on the Committee's website when it becomes available. I note we have a large public—I had better not say we have large people in the gallery; that would not be very good—we have a large number of people in the gallery, and of course we welcome you. However, I ask the audience to respectfully observe today's discussion. Please be aware that today's hearing is not an open forum for comment from the floor. Audience interruptions make it difficult for witnesses to communicate with the Committee. If there are interruptions from the audience, I may stop the hearing and ask for quiet or if people continue to make a noise, I will ask them to leave the room. The Committee may decide to hear confidential evidence in camera—that is, in private. If this occurs I will ask for the public gallery to be cleared and audience members will leave the room for the duration of the in-camera hearing.

In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind members of the media that they are not authorised to film outside of the hearing room without permission. They may not film witnesses coming into and out of the hearing. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. The guidelines for broadcast of the proceedings are available from the secretariat and are also on the table.

There may be some questions a witness could only answer if they had more time or with certain documents at hand. In the circumstances, witnesses are advised that they can take these questions on notice and provide an answer within 21 days. I ask witnesses to be careful when using individual's names during the hearing and I remind participants to respect the privacy of individual patients. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing, and so I urge witnesses to be careful about any comments they make to the media or to others after they complete their evidence as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation.

To aid the audibility of this hearing, I remind both Committee members and witnesses to speak into the microphones. In addition, several seats have been reserved near loudspeakers for persons in the public gallery with a hearing difficulty. In terms of mobile phones, please make sure any mobile phones in this room are turned to silent or turned off. I welcome our first witness, Dr Kiran Phadke, and I note that he has a legal adviser beside him who will not participate in the hearing but will be available for Dr Phadke to consult during giving evidence.

Dr KIRAN PHADKE, Medical Oncologist and Haematologist, affirmed and examined

The CHAIR: Would you like to make an opening statement?

Dr PHADKE: Yes, I would. I am a senior staff specialist at St George and Sutherland Hospital, in Sydney. I am in awe of appearing before seven experienced parliamentarians, being a mere clinician like me. I think that is a challenge, but I will do my best and speak the truth. I can see there is a huge amount of support, which I was not aware of. I knew that I had support in the public, and I am grateful for that. I am a medical oncologist and haematologist. I have been practising in these fields in Australia for over 40 years, and 35 of these years have been at St George and Sutherland Hospital in addition to working some of the time in private practice. I was previously a director of medical oncology at both hospitals until I voluntarily stepped down from this position in 2015. Whilst I am an oncologist and haematologist and have practised broadly across these disciplines, in more recent times and in keeping with current practices of subspecialisation I have predominantly treated patients with colorectal cancer and lymphomas. I do not typically treat head and neck cancers, being the cancers in which concerns have been raised as to flat-dosing prescribing practices. I have never had such a practice, nor has such an accusation been made against me.

I have been instrumental over many years in raising funds at the institutions where I work for a cancer care lodge, which treats rural patients and which has been absolutely beneficial to people coming from the countryside to our institution, and improvements in cancer treatment. These include the setting up of a prostate cancer institute at St George Hospital with what we call a brachytherapy unit where there is a specialised slow way of radiotherapy for prostate cancer, a clinical trials unit, some main improvements with buildings at St George and Sutherland Hospital and setting up of McGrath Foundation breast nurses. I just happened to be the treating physician for many years for Jane McGrath, and it was an interesting relationship I had with this lady.

I have previously declined an invitation to attend the inquiry on the basis the terms of reference did not appear to particularly apply to me and the fact that the local health district's investigation concerning me was ongoing. However, I have now chosen to attend, given the further request of the inquiry for me to do so, the matters which have been discussed at the inquiry by the LHD concerning myself and the submissions made by concerned patients of mine. I apologise for the distress that has been caused to my patients and their families as a result of the LHD's inquiry and the investigation process, and any part I have played in that.

The treatment of my patients in my chosen fields has been my life's work and the welfare of my patients has always been of paramount concern to me. Often there are several treatment options available to patients with different risks, side-effects and success rates. Each of these has always been considered by me, including the treatment regime, which accords with the most recent applicable protocol or guideline when recommending and implementing treatment to my patients.

Guidelines are helpful but not always the be all and end all in all treatment. Clinical judgement is therefore required and consideration of the patient's wishes, mental health, physical health conditions, comorbidities and tolerance to previous treatments is extremely important. It has always been my practice to consider all these factors and discuss the pros and cons of various treatment options with my patients in order to obtain their informed consent to proceed with the particular course of treatment.

I would like to thank my former patients and colleagues for their kind submissions to this inquiry and to those who have supported me through various other avenues during the course of the hospital investigation. This investigation by the LHD has been a very difficult time for me, my family, my patients, whether part of the investigation by the LHD or otherwise, as well as some of my colleagues. The open disclosure process adopted by the LHD and the public announcement made by the former health Minister Jillian Skinner, in my view, and in the case of a number of patients who have contacted me, caused great distress.

It just happened on the day of the announcement that we had for three whole days television cameras and media stationed outside my home, which considerably distressed my wife and daughter. It is certainly something we did not wish for. As you can imagine, it would be very distressing for a patient already under the stress of ill health to receive a phone call out of the blue, in terms of the open disclosure process, to be told that their treatment may be wrong, that the outcome may have been compromised, but yet to be told nothing further could be said at this stage.

The decision to publicly announce the LHD investigation and cause distress to patients who were not involved was also unnecessary and some of them then had to be rung later on when the investigation cleared them of any inappropriate treatment, which I thought was very unfair for the poor patients. However, I accept that patient safety is of paramount concern, and if complaints or concerns are raised they do need to be

investigated. Prior to a full investigation being completed, the Medical Council determined to impose some restrictions on my practice. At this stage I decided not to practice until the LHD's investigation is complete.

As there are issues of patient confidentiality involved, as the chairman has already stated, it would be inappropriate for me to discuss individual cases under review by the LHD. However, in general, I would like to note from the hundreds of patients that I have treated in my lengthy career, the LHD, after a lengthy process that involved around 201 oncology patients and 130 haematology patients, only identified a small number of cases falling outside the guidelines, and only in relation to haematology. These cases were, in my experience, some of the most difficult cases I have had in my career, due to patient-specific issues. I have responded to all these issues that were identified and I am satisfied that I provided appropriate care in each case and no patient was harmed.

It is very important to note that in these cases my treatment of patients often extended over a lengthy period of time and involved extremely ill people whose outlook was not positive. However, in many of these cases the patients were able to achieve a good outcome in terms of quality and length of life. It also is hard when you are actually a reviewer doing these reviews because, unlike me, who is the patient's treating doctor, and the oncology nurses who have direct contact with these people over years, the reviewers have only access to the files, the actual guidelines and the data. So it is actually quite tricky for them, and I accept their sort of situations.

There are a few issues that did concern me about the district. Dr Winston Liauw, the Cancer Services Stream Director, initiates the complaint and sits on open disclosure process of patients, when he is not a haematologist, and participates in the reviews and the report. The chief executive officer, Gerry Marr's wife happens to be the CEO of the Clinical Excellence Commission, which makes policies for the health ministry the district implements. Dr Mackertich, who was the Clinical Director of St George Hospital, coordinated the investigation open disclosure, and I have found out that he has been suspended from his post. No haematologist's name from St George Hospital appears on any of the reports despite most of the complaints being in that specialty and not in oncology and they have clearly picked the cases for review.

Finally in this section, Dr Karnaghan, the District Clinical Services Director, on the first day that she informed me of my suspension, at the outset said that the threshold for looking at complaints was now going to be low due to the issues at St Vincent's Hospital. There was clearly some involvement, I believe, by the Chief Medical Officer and other officials at the central health ministry. It is absolutely difficult for a mere individual like me to combat this kind of machinery. I always had a good working relationship with the oncology nursing staff. One of them, interestingly, gave me this quote: If a tailor uses his basic suit pattern without adjustment for every client, one can only imagine the result; some very ill-fitting, uncomfortable and quite peculiar garments would not doubt ensue. I suggest this analogy applies to chemotherapy protocols. I do not want the standard protocol applied to me without significant changes made to cater for my particular body—a design for me.

Use the guidelines as a base and work out an individual recipe for me as a patient. The most important thing in the discussion for all of us here and in the public as a society is to decide whether we want standardised guideline treatment or individualised tailored therapy using the guidelines to get the best outcome for patients. That, I think, is the debate.

Lastly, we often hear the phrase in the media, "Are you OK?"—it seems to be the buzz word. I do not think anyone in the local health district or the health department has bothered to ask me about my physical and psychological wellbeing over the last 11 months, apart from referring on a couple of occasions to the Employee Assistance Program. So much for compassion and empathy. Thank you, Mr Chair.

The CHAIR: I note that there are three nurses on this panel who appreciate that health care very much is an individual response and we acknowledge that great illustration of the tailor's suit. Dr Phadke, have you ever participated in being a peer assessor for other doctors in other circumstances to measure their performance or their prescriptions?

Dr PHADKE: I have. As you can imagine, being a director of medical oncology for nearly 25 years. I was the person responsible for the performance assessments for most of the clinicians in medical oncology anyway, and for some of the other specialists. The difficulty with performance assessments, to frankly say to all of you, is that every institution has different measures and ways of assessing performance. So it depends what you are looking for and it varies a lot. Sometimes they only assess what amount of work you are doing rather than the actual mechanics of what people are doing in clinical terms, which I think is a sad thing. So it varies a lot, but yes I have been involved for that period of time.

The CHAIR: So it would be a fair comment to say that in that role where you play a mentor or a peer assessor or a director and you are overlooking someone else's patient care, you would find there would be

situations where you would maybe either coach or train or have input and that maybe their selection of treatment could have been different for a better outcome for that patient? Would that be fair?

Dr PHADKE: That is a fair comment, and I used to do that routinely. But my way of dealing with things was quite different from what has happened to me. I would call them in and discuss the issues with them first, have some counselling and see if we could come to a good agreement so that people would understand what was happening. My situation was that there was no opportunity for me to respond to any of these things and the district chose to raise the levels to what they call SAC 1. All these acronyms are terrible, but I am sure most of you have heard them, sitting on these committees, it is a severity assessment code.

I always thought to myself if you had severity assessment code 1, which is the worst one, and you decided to suspend somebody, you should at least before that have afforded them some opportunity of having some discussion what the reasons were. If, as I heard, there were 35 or so more SAC1 reports in the district that year, I just wondered what happened to the other 34, compared to me. Were they afforded the same treatment or not?

The CHAIR: In terms of the pure assessment, would it be fair to say that, if you were in that situation and you had medical information on a patient's file and the luxury of looking over that file, you could set a judgement on a better line of treatment in hindsight?

Dr PHADKE: Yes, that is correct.

The CHAIR: Would you suggest that the investigation of you was set in that particular scene—that someone has come through, reviewed your files in some cases, and come to a conclusion that, in hindsight, with some of those treatments, that may have been another way to do it with maybe a better outcome?

Dr PHADKE: There may have been but I just wish somebody had told me of that. I think it is fair to actually communicate these issues, like I used to with other people in my performance assessments with other individuals. Some of these patients went back 13 to 14 years. For somebody to trawl through these documents, somebody must have been looking through these files for months and months to get to that conclusion.

The Hon. WALT SECORD: Dr Phadke, thank you for coming. I think it has been 11 months now—is that correct?

Dr PHADKE: That is correct.

The Hon. WALT SECORD: It has been a long process to get you to front the committee. Thank you for finally coming.

Dr PHADKE: Thank you.

The Hon. WALT SECORD: In your opening statement you mentioned that there were restrictions placed on your practice but you are not practising now. What are the restrictions that have been placed on you?

Dr PHADKE: The restrictions that have been placed on me are by the Medical Council of New South Wales and the restrictions for medical oncology applied to basically having supervision from a supervisor to practice in medical oncology. The supervision is every two weeks. I have to present cases to the supervisor of all the patients I have seen, whether they are new or follow-up patients. And basically, at the end of three months, I have to submit a report, through the supervisor to the directors of medical services wherever I work. In haematology, the committee deemed that I should not see new patients and they should only allow me to see follow-up patients, but with the same restrictions.

The Hon. WALT SECORD: Are you, as we speak now, currently seeing your follow-up patients?

Dr PHADKE: No, I am not because at the moment, as you can imagine, with all this stuff going on, I have to spend a lot of time responding to the district with problems and so on. I did not think it was fair to patient care for me to possibly practise good medicine in this setting.

The Hon. WALT SECORD: I have heard in interviews on 2GB that you have made reference that your case—the investigation into you—differs from the investigation into Dr John Grygiel. How does it differ?

Dr PHADKE: Well, I think I have no issues about flat-dosing or under-dosing. And when the media publicity first started, everybody in society assumed that that is what I was doing. It was as if I were some rogue doctor coming out the woodwork, doing terrible things to people. I felt that was not fair. So, in the way that differs, in the sense that each of these cases have a different issue, in terms of what we are doing. That is the main difference really, that I was not doing any flat- or under-dosing for these patients.

The Hon. WALT SECORD: In your opening statement you mentioned that there were 201 patients examined and 130 of those were haematology, and you said that a very small number of those cases resulted in the local health district having concern. What is your response to, I think, 27 of those cases—is that correct?

Dr PHADKE: That is correct.

The Hon. WALT SECORD: Of the 27 cases, the local health district said that more than half involved inappropriate care or care that would cause harm to them. What do you say to that? They said that your treatment was inappropriate or would cause future harm to 14 of the 27 patients—more than half.

Dr PHADKE: Firstly, the cases for oncology were 201 and the total haematology was 130.

The Hon. WALT SECORD: I am interested in the 27 cases.

Dr PHADKE: I understand what you are saying. So out of the 27, they were saying that in half of those cases I caused harm.

The Hon. WALT SECORD: Fourteen.

Dr PHADKE: Fourteen. "Harm", to me, means something different from what the Local Health District is saying and that might sound strange. I will tell you what I perceive as "harm".

The Hon. WALT SECORD: I can tell you what "harm" means to me.

The CHAIR: Order! The witness is about to tell you what "harm" is, for him. Dr Phadke?

Dr PHADKE: I am used to this, that is life. "Harm", to me, means you have delivered some excessive chemotherapy to somebody and you have actually killed them or caused them terrible catastrophe. It was quite different from what the district is pursuing the "harm" issue to be, to be frank with you. There were certain cases-—I actually disputed the number 14, because we had a series of reviewers, as probably some of you know. We had internal reviewers, which I thought was not quite appropriate. Some people had worked with me, which was not fair. And the last external reviewer, professor Joshua, was probably the fairest of them all. I think he did indicate there were some cases where there were issues with the kind of treatment. But he also indicated that I had actually discussed some of these issues with the patients and the fact that I actually tailored the patient's treatment, rather than just simply followed the guidelines, is where the issue lay.

The Hon. WALT SECORD: When you say that you discussed it with those patients, did you document that you had those conversations?

Dr PHADKE: I had orally discussed with most of the patients. In a few of those cases the argument was that the documentation was not absolutely perfect.

The Hon. WALT SECORD: That is right, because you, in some cases, did not complete the documentation.

Dr PHADKE: In a few of the cases, that is correct.

The Hon. WALT SECORD: How many, would you say, of those cases?

Dr PHADKE: I would say probably, at the most, about three or four. And, in some cases, the documentation was there and then the reviewers had to accept that, even though they did not agree with me, that I had actually documented that.

The Hon. WALT SECORD: Of the 14 cases in which we are talking about the issue of harm, your definition of "harm" differs from that of the Local Health District. When you say "harm", you mean "death". So, of the 14 final cases, how many of those, in your words, did you cause harm?

Dr PHADKE: I do not believe I caused anybody any harm, according to what I am saying to you. That is what I am trying to get to you.

The Hon. WALT SECORD: Of those 27 patients, how many of those patients are with us today, are alive today?

The CHAIR: Order! I have already warned the gallery, this is not an open forum; it is an inquiry.

Dr PHADKE: I will try to answer to the best of my ability.

The Hon. WALT SECORD: I am acting in good faith and I am asking serious questions.

The CHAIR: Order! I am not referring to you, the Hon. Walt Secord, I am reminding the public gallery that this is not an open forum and if we are going to give doctor Phadke every opportunity to be heard, this is it.

Dr PHADKE: I am happy to answer. It is difficult in cancer, because people like to believe they have all been cured of the cancer, and I would hope they would be. But on occasions we cannot cure people with cancer and they do die with cancer. I am sorry to say that and I would not wish it on anybody. So I do not believe that I have done anything wrong in this setting. But off the top of my head—for example, one of the patients that they were accusing me of doing some terrible things to, with lymphoma, the patient survived 13 years. The median average survival for those lymphomas is 12 years. How am I supposed to have caused harm? Because people do die during the course of the disease—with or without the treatment.

The Hon. WALT SECORD: So the 14 cases where they say that you provided inappropriate care or caused future harm, you disagree with that figure?

Dr PHADKE: I do. I do, Mr Secord. I do.

The Hon. WALT SECORD: You also mentioned that you decided not to provide new or different treatment because you were concerned that it may cause anxiety to those patients. What does that mean?

Dr PHADKE: Well, I think some patients present with anxiety about—

The Hon. WALT SECORD: Well, you would be pretty anxious, if you had cancer.

Dr PHADKE: I know, that is what I am saying. And some are even more anxious than others, when they have cancer. There are different types of anxiety with cancer patients. Looking after them, over many, many years, you realise, you work with them and you find out how that anxiety manifests itself and you have got to take that into account. The district report says: I do not think anxiety is an issue we can actually address, in terms of controlling the treatment or deciding who gets what treatment. I do not agree with them. If you are a patient you want somebody to have empathy with you and look after your physical as well as psychological issues. Anxiety is an important thing. I honestly say that.

The Hon. WALT SECORD: Dr Phadke, in your opening statement you made reference to the local health district chief executive officer [CEO] Mr Gerry Marr and you made reference to his wife. Why is his relationship with his wife and his activity overseas relevant? I know that you engaged a public relations [PR] company earlier this year to work for you and represent your interests. That PR company has made numerous representations to us on your behalf. What is the relevance of the local health district CEO and his wife to your case?

Dr PHADKE: I think the relevance of the local health district and his wife is that if you get a situation where somebody is a CEO of an organisation making health policies and then you have a district implementing them, the agenda is that you want everybody to toe the line and follow the guidelines. That is all I am saying.

The Hon. WALT SECORD: Do you have any evidence of this?

Dr PHADKE: No, I do not. I am just saying it as a matter of putting it out there, that is all.

The Hon. WALT SECORD: You are just putting it out there?

Dr PHADKE: You and I both know that I could not possibly have evidence of this kind. You know that.

The Hon. WALT SECORD: We have representations from people representing you presenting it to media organisations and to me saying that there should be an investigation into him and his wife. What do you say to that? Do you deny that?

Dr PHADKE: No, I do not deny that at all. You and I both know that he has been in Scotland before and he has had issues there with the health district in many of those health areas. That is all that was about.

The Hon. TREVOR KHAN: Point of order: We have terms of reference and we have serious matters to investigate.

The CHAIR: I am glad you took a point of order because this is erring outside the terms of reference.

The Hon. WALT SECORD: I will cede my time.

The Hon. DANIEL MOOKHEY: I will concentrate on the 27 cases. The language you used was "clinical judgement" that led to a departure from the guidelines as they would otherwise apply. You characterised that as "customised care" or "tailored care". Does that apply to these 27 cases?

Dr PHADKE: I do it in all of my cases.

The Hon. DANIEL MOOKHEY: Indeed. But in these 27 cases is it correct or incorrect that they involved a departure from the guidelines?

Dr PHADKE: They involved a departure from the guidelines only in the sense that I tailored the treatments to suit the individual patients, yes.

The Hon. DANIEL MOOKHEY: In respect to the departure from the guidelines, how did you explain that to the patients?

Dr PHADKE: I tell patients the different options of treatment and say, "The guidelines say that I should do treatment A". I say, "There is another option". And I invite them to respond and say what they actually want.

The Hon. DANIEL MOOKHEY: Do you explain to them the different risk levels that are attached to the decisions that you recommend?

Dr PHADKE: Yes, I do. You have to otherwise you would not get a proper answer or proper outcome from that sort of discussion.

The Hon. DANIEL MOOKHEY: In so far as you obtain patient consent for a treatment course, how do you document patient consent?

Dr PHADKE: Nowadays—unlike when I first started there was no formal patient consent, as some of you will know—

The Hon. DANIEL MOOKHEY: When you say "nowadays", given we are talking about a period of time that spanned—how long?

Dr PHADKE: I would say from memory, I cannot give you an exact figure. Formal consent, we have a signed consent for chemotherapy and radiation therapy that only came into being three or four years ago.

The Hon. DANIEL MOOKHEY: In those three or four years how do you now document consent?

Dr PHADKE: We have to get a written consent and the patient has to sign off on it and I have to sign off that I have explained what the treatment program is and the side-effects.

The CHAIR: You have patients at their most vulnerable, they are highly anxious, they have just got really terrible news in a lot of cases and their world has been blown apart. How do you believe they have the capacity to absorb exactly the treatment you are trying to discuss with them?

Dr PHADKE: It is a difficult process, as you well know. Sometimes they are so tense when you first deliver the news that you have to have a second interview before they actually sign the consent. It is not often and it is a tricky procedure, absolutely. I have no doubt about that. The fact that you have given written consent—you still have to go through the process of explaining all this to them. It is not easy.

The Hon. TREVOR KHAN: Getting a signed consent is different to the patient understanding the treatment?

Dr PHADKE: That to some extent is right.

The CHAIR: That is my point.

The Hon. DANIEL MOOKHEY: The contribution of the Hon. Trevor Khan clarifies that.

The Hon. TREVOR KHAN: I always try to be constructive.

The Hon. DANIEL MOOKHEY: And you always are, and modest. Dr Phadke, there is a difference between written consent and informed consent. Do you appreciate there is a difference between that?

Dr PHADKE: There always will be. How do you marry those together? It is not easy.

The Hon. DANIEL MOOKHEY: I am asking you how you marry them together.

Dr PHADKE: I have to make a judgement—I have informed the patient—as to whether they understood that before they signed the bit of paper. If I feel they have not then we have another, second interview to try and go through it again.

The Hon. DANIEL MOOKHEY: Did you have to undertake any second interviews in respect of any of these 27 cases?

Dr PHADKE: Some of the 27 cases, in fact a large majority of them, were well before the period of signed consent, written consent.

The Hon. DANIEL MOOKHEY: In examining the documentary records it is your evidence that it is not possible to see any written consent because that was not the standard operating procedure at the time?

Dr PHADKE: Not at that time. If I can take the analogy back to the eviQ guidelines, which are the ones we use from NSW Cancer Institute, they did not come into being until 2009. I was treating some of these patients from 2000, or the year before that even. Robin Ward set them up. She is a professor now in Queensland but she used to work for me as a registrar and I know her quite well. They were meant to be guidelines but they did not come into being until 2009.

The Hon. DANIEL MOOKHEY: Insofar as you agree there was a departure from guideline-instructed practice in respect of these patients, which you say was a result of you tailoring the care to the patient's needs, who did you tell inside the hospital that there was such a departure? Who would you ordinarily have to tell?

Dr PHADKE: Ordinarily I do not know if you have to tell anybody. You have to make sure you have written consent and explained all these things to them. I am not sure if there is any particular policy to tell anybody in the hospital, to be frank with you.

The Hon. DANIEL MOOKHEY: Was that because of your seniority in the hospital or is that because there is no standard operating procedure?

Dr PHADKE: That is nothing to do with seniority, I have to tell you. It is the standard operating procedure. I am not aware of any seniority issues.

The CHAIR: Dr Phadke, if you were moving outside the eviQ guidelines that were considered to be reasonable treatment to what is considered unreasonable, what sort of actions would you take in terms of accountability and transparency of your treatment?

The Hon. DANIEL MOOKHEY: Perhaps another way of characterising the departure, as opposed to "unreasonable", would be a "significant departure".

The Hon. BRONNIE TAYLOR: Off-protocol.

The Hon. TREVOR KHAN: That has no meaning either. Can I ask if the transcript of the evidence on the very first day is in evidence or is it still in camera?

The CHAIR: It is public.

The Hon. TREVOR KHAN: I am wondering if all the members of the Committee have read that.

The CHAIR: I am trying to get evidence from Dr Phadke on what he would do if he was using the eviQ system and the guidelines that gave the boundaries on treatment. In your professional view, Dr Phadke, knowing that a patient may be advantaged by going outside these guidelines, what would be the process you would take?

Dr PHADKE: The main thing is that you have to discuss this with the patient.

The CHAIR: None of your colleagues? No accountability.

Dr PHADKE: Sometimes you do discuss it with your colleagues.

The CHAIR: The pharmacist?

Dr PHADKE: Sometimes you discuss it with the nursing staff, the pharmacist, other haematology or oncology colleagues, you would.

The Hon. DANIEL MOOKHEY: Did you do that with respect to any of the 27?

Dr PHADKE: Yes, some of them.

The Hon. DANIEL MOOKHEY: Who did you discuss it with?

Dr PHADKE: Normally they get discussed with my other haematology and oncology colleagues, but not always. Sometimes they do.

The Hon. DANIEL MOOKHEY: Forgive me for wanting to drill down to specifics, but when you say "normally", with respect to these 27, how many of these were discussed with your haematology colleagues?

Dr PHADKE: I cannot be honest with you and quote off the top of my head the number.

The Hon. DANIEL MOOKHEY: Was that documented?

Dr PHADKE: No, not specifically.

The Hon. DANIEL MOOKHEY: You said that you discussed it. How did you discuss it? Was there a meeting, was it over coffee, or was it in the hallway? How was it discussed?

Dr PHADKE: It can be discussed at any time. Sometimes it is informal discussions in the clinic, sometimes it is over coffee, other times it is formally documented and occasionally you have to take the cases into what they now call—again these are things that have been sent up recently—the multidisciplinary clinics.

The Hon. DANIEL MOOKHEY: I understand that it is hard to recall earlier events and that it is hard to nail down specifics. If you need to take this question on notice you are welcome to do so. Are you able to provide the Committee with any further details in respect of those 27 specifics as opposed to general mechanisms that you would discuss?

Dr PHADKE: I would have to take that on notice.

The Hon. BRONNIE TAYLOR: Earlier you referred to consent and I appreciate what you said. During the course of the inquiry the Committee received evidence to the effect that consenting to chemotherapy is not a standardised thing. Looking at treatment in the future, when you are discussing a diagnosis with a patient, often after that point in time—the Committee has documented evidence as you would know—people do not really hear anything. When you are explaining chemotherapy to patients it is difficult to talk about consent. Could signed consent at different stages in the process be documented? Would that be beneficial to patients in that they would understand their care and be more likely to give consent?

Dr PHADKE: I think you are right. I mean in future this may happen to be the case because the first interview is often fraught with drama and stress from the patient's point of view. The only problem from a practical point of view, as you know, is that when you are running these clinics it becomes a difficult thing because of time constraints. If you have second and third interviews for every patient it is a good idea, but how do you practically implement that into the treatment clinic program?

The Hon. BRONNIE TAYLOR: I understand what you are saying and I appreciate that. My point is that after the initial consultations when that is discussed perhaps we need second and third interviews. When that patient presents for treatment on the first day are they able to have that discussion as well? You talked about the eviQ guidelines coming into effect in 2009—a matter about which the Hon. Daniel Mookhey asked questions. When you go through the eviQ guidelines now and you alter from the standard protocol that is presented it will flag that guideline. If that happens in the future—and I am sure it would happen often as you said it is catered towards individual needs—we have addressed that issue as well.

Dr PHADKE: Yes, I think you are right. The other problem is that the eviQ guidelines, as you know, change all the time so there are so many permutations of the guidelines. They remove the old guidelines and put new ones in as evidence changes. It makes it very difficult for all of us to implement all these things. You have to accept that in future maybe there will be a need for a subsequent consultation before you get a signed consent. Another practical issue is that a lot of the patients, when they have treatment, are keen to start the therapy straight away, so therein lies the problem. You have this terrible situation and you are trying to explain all these things to them and you then say, "I want you to have another interview", and they say, "I want to start treatment tomorrow." How do you fit that all in? I do not know.

The CHAIR: If the flag came up to indicate that it was off protocol would it be fair to say that it should be signed off by a second person as well?

Dr PHADKE: If that is what people and society have to judge in future. I am not in a position to make that judgement.

The Hon. BRONNIE TAYLOR: As you would know, it takes a team to treat these patients. So we go back to a multidisciplinary team situation when they present at the clinic. We need the different disciplines to ensure that it is informed consent.

Dr PHADKE: Yes, I agree. I think that may be the way of the future, for sure. I agree with you.

The Hon. DANIEL MOOKHEY: Specifically relating to the 14 patients for which the Local Health District says your treatment caused harm or future risk of harm, which you dispute, over what period were you treating those 14 patients?

Dr PHADKE: It would vary from three years to something like 14 or 15 years over their illness.

The Hon. DANIEL MOOKHEY: Insofar as those 14 patients were embarking upon a course of personalised treatment that you designed, in your view did the treatment work successfully for all 14?

Dr PHADKE: I said to you I think it did and the patients were quite happy and comfortable with the treatment programs that I had given them.

The Hon. DANIEL MOOKHEY: In the course of the three-year period that you were treating each patient did anything occur that caused you to reconsider your design or whether the treatment was working? What steps did you have in place to evaluate its success?

Dr PHADKE: That is the sad part of it. As I said right at the beginning, none of these patients complained. The complaints were not patient directed; they eventually came from the administration.

The Hon. DANIEL MOOKHEY: I understand that the patients themselves did not complain. As a medical practitioner did any event occur, be it how the body was responding or not responding to the treatment, that caused you to consider that perhaps your treatment course was not working as intended and, therefore, there should be a return to the protocol?

Dr PHADKE: If that happens in my practice I actually look at changing the treatment. That is what normally happens.

The Hon. DANIEL MOOKHEY: I am asking you whether it happened in respect to those 14 patients?

Dr PHADKE: No, I do not believe it did. That is what I am saying to you.

Mr JEREMY BUCKINGHAM: Would you take the Committee through the process—how you notified when there was a complaint, the internal review, the review of that internal review and the external review? Would you take the Committee through that process?

Dr PHADKE: In detail?

Mr JEREMY BUCKINGHAM: Yes. Specifically, you said a few things that peaked my interest. You said that the internal review was conducted by someone who had worked with you, which you said was not fair. I am interested in hearing about that internal review. Why was that not fair and would you describe the process?

Dr PHADKE: First, I will give you a brief idea, as that is what you want. I was on leave and I came back in May 2016. I can tell you the exact date; on 16 May 2016. I was summoned to the board room of St George Hospital by the clinical services director for cancer and the clinical director of the district. Having been a director of a department for 25 years you are not that stupid. You think, "Why am I going to a boardroom with two people with nobody else there?" I asked them what the meeting was about and for an agenda. It was not given to me and that got me really worried because I thought, "What is actually going on here?" I had no inkling at all, I have to be honest with you, that there was an issue with any of the treatments or the things I had done. I have been there for years and years and that was the first I found out.

I got into the boardroom there and Dr Karnaghan who I mentioned basically said exactly what I have said to you in that little submission earlier on and told me that I was going to be suspended from clinical duties from both the hospitals and that they had convened for the last two or three weeks a hearing of the district committee that looks at it with the director of governance and the patient services manager, and the services manager for cancer and deemed that I had fallen into the SAC 1 category. I said to them, "Isn't it fair that you give me an opportunity to state my point of view?" They said, "No. We have determined that that is the case and if you do not accept these findings we will convene a meeting of the credentialing committee of the medical appointments advisory committee and suspend you anyway." That was exactly what they said to me.

In terms of the reviews, which is what you are asking, what happens normally with these reviews is that you would like to get some external reviewer who has not had any contact with you or has not worked in the same institution to ideally hopefully exercise some fairness. That is all I am saying. Normally what happens in most of these reviews—some of you know better than me—is that they usually pick somebody from interstate that you have had no contact with or nothing to do with in terms of not having any conflict of interest. The first thing I found out was the first reviewer was a man called Professor Hertzberg who used to work for me as my registrar interestingly. He did one review and then sadly found out that he had treated at least one of the other patients and clearly then decided that he could not continue the review process. They then appointed another reviewer internally, Dr Brighton from Prince of Wales, who used to work with me at St George Hospital. Since Mr Secord asked me do I have any proof—no, I do not, but he had not had good relationships with me because of previous interactions with the hospital where he was at, and he left to go to another institution. So I had some

concerns about him being there on the review process. Then, of course, after all that was complete, the chief executive officer [CEO] decided that he was going to have another external review—

Mr JEREMY BUCKINGHAM: After that one, you were basically given a clean bill of health. Despite your concerns, they said there was no—

Dr PHADKE: No, the internal reviewers—

Mr JEREMY BUCKINGHAM: The internal reviewers said there was no problem?

Dr PHADKE: No, they did not. They said that they found issues with some of the haematology cases. Sorry, I will be blunt and fair with you since everybody is asking me those questions. That is when I thought this is not exactly the way this process should be run. The external reviewer, the first reviewer, Dr Benson, I had also worked with at one of the Sydney hospitals—interestingly, around here—years ago at Macquarie Street. Again, the same thing I said to you before Mr Secord asked me: You cannot prove these things and I have no reason to believe anything that was unfair, but I just felt that they should pick somebody that I had no association with, and that was eventually done with Professor Joshua at Prince Alfred Hospital. His review generally took into account patient issues a lot more than just looking at the straight guidelines. He is an experienced reviewer who basically said in his final review that I had a very large practice and it was unfair to take a small snapshot of my practice with these patients and that we should judge my whole practice. Over the 35 years I would have treated thousands of patients let alone this review.

Mr JEREMY BUCKINGHAM: Are you suggesting that that snapshot was cherrypicked?

Dr PHADKE: I do not know if it was cherrypicked. I have to be frank with you and honest. I do not know, but it is a small snapshot.

The CHAIR: On the back of that question, do you think in any shape or form that the accusations against you are vexatious?

Dr PHADKE: I will tell you, it is not just being vexatious. This is my personal feelings, since you have called me up here. I think the problem started because the haematology department at St George Hospital, like all teaching hospitals, there is always some politics involved in all of these things. This is the problem. We have a satellite—a small unit at Sutherland Hospital and the haematologist from St George Hospital did not want to treat patients there, although there was a unit there. I ended up, because I was there for many years, treating patients because at nights and weekends they would not like to come to Sutherland Hospital and look after the patients. I expressed some concern over many years about this process, that they should either centralise all the treatments or basically have a proper service there. I suspect that that got some of them annoyed with me. I have to be absolutely honest with you. Probably, in retrospect, I am a person who speaks my mind, so that maybe gets me into trouble sometimes.

At some stage we, as a group, started a private practice at Miranda as well as running Sutherland Hospital. Some of the patients preferred to go there. We never persuaded people to go there. I was not the only one working there, let me tell you that; there were five or six oncologists and haematologists there. Some of the patients preferred to have their treatment at other institutions, particularly with specialised care. I always took the patient's view that what they wanted was more important, so I said, "If you want to go to Lifehouse"—which was the major centre a lot of them chose to go to at Prince Alfred Hospital—"you are entitled to go there because that is your choice as a patient." So that explains it to you. I think that was behind some of these issues that created a lot of angst, if you like to put it. I have no way of saying anything else apart from my frank opinion.

Mr JEREMY BUCKINGHAM: Is it a possibility that that culture and the people involved in that used the opportunity of the St Vincent's scandal emerging to throw you under the bus, in effect?

Dr PHADKE: I personally believe so, Mr Buckingham, yes. It was the timing; it was perfect. It was right for doing that to me. I cannot say anything else otherwise.

Mr JEREMY BUCKINGHAM: You can; you have parliamentary privilege.

Dr PHADKE: I do believe so. I do.

Mr JEREMY BUCKINGHAM: If you are going to say it—

The Hon. TREVOR KHAN: We all exercise parliamentary privilege carefully, do we not, Mr Buckingham?

Mr JEREMY BUCKINGHAM: With care, of course, but you have the opportunity to exercise it. How would you characterise your relationship with Mr Gerry Marr prior to that? Were those issues about the

different options that people were taking in respect of their care at a heightened level? Was there conflict between you?

Dr PHADKE: No. I have met Mr Marr on probably only two occasions. It is interesting.

The Hon. WALT SECORD: Dr Phadke, you have been very critical of former Health Minister Jillian Skinner. Can you elaborate on that?

Dr PHADKE: I am only critical in the sense, Mr Secord, that in order to save herself from the problems that were enveloping her, as you know, the baby scandals, the gas scandals and so on, sadly for me, it was an opportunity for her to deflect the attention from those scandals. I feel that she threw me under the bus, if you like to put it. It is my personal view. I am not saying that in any derogatory way, but that is life. It did me a lot of personal harm, personally. These sorts of matters are not usually raised in the public arena. I felt that I was being targeted as some rogue doctor from an overseas country, as you know, in the first media reports. I was born in Uganda and I came here as a refugee. I have never used the race or refugee card ever in my life to benefit myself.

The CHAIR: Dr Phadke, to make it clear, you are virtually saying that if someone of your stature with your experience put the same scrutiny on their treatment of their patients, you would probably find an amount of patients that could have different treatment from that peer assessment?

Dr PHADKE: I would say to you that it is absolutely true, Mr Green. I am not saying 100 per cent, but there is certainly a very high possibility that that is what happened. We do not all get put under the same scrutiny that I have been.

The Hon. TREVOR KHAN: Have you had the opportunity of reading the transcripts of the previous evidence given before the inquiry?

Dr PHADKE: Some of it, Mr Khan, not all.

The Hon. TREVOR KHAN: Did you read Dr Bell's evidence from the first day, which was given on 31 October 2016?

Dr PHADKE: I have read some of Dr David Bell's evidence, yes.

The Hon. TREVOR KHAN: Dr Bell is a doctor from the Northern Cancer Institute at St Leonards. Is that right?

Dr PHADKE: That is correct.

The Hon. TREVOR KHAN: I am particularly interested because questions have been raised about his evidence about off-protocol dosing. In his evidence on page 9, he says:

> If you are utilising eviQ, which we do—with electronic medical prescribing now, the protocol is loaded, bang, into the patient file—you have to go down and look at the data that has led to the decision to put that into eviQ and read the primary documents to see whether your patient will fit and match. Quite often in these trials they are looking for, if you like, very clean patients to prove a point about the efficacy. These patients tend to be younger, on average. They rarely have any significant comorbidities. They tend to have fairly limited metastatic disease, so their prognosis, even without treatment, is likely to be longer than perhaps the average patient we see. They are important studies to do because they do prove efficacy, but the toxicity may be very different because of the type of patient selected from, if you like, the real-world patient.

His evidence generally was that about 35 per cent of patients, or thereabouts, fit within what could be described as the eviQ guideline. That is: young male, no comorbidities that have been in the studies. If we have a protocol or a guideline that only fits 35 per cent of the patients, how useful is the guideline?

Dr PHADKE: I think you have brought up an interesting point. I agree with you. As you get more and more experience as a clinician like me treating patients, you realise that for the majority of the people it is not easy to go according to the guidelines, because they have lots of issues. A lot of the cancer patients are not young, as you know. As you get older, you get more incidence of cancer, so they are not fitting into those guidelines. The actual percentage of patients—the departure from guidelines gets even worse when you have metastatic disease when the patients are not fit and are elderly, and those on clinical trials, because you have very rigid guidelines trying to fit people into clinical trials. I would agree with Dr Bell.

The Hon. TREVOR KHAN: I go to the issue of patient consent forms. As members would know, due to unrelated matters I had to sign consent forms in November last year. I can tell you I think I would have signed anything on the way into the hospital and I did.

The Hon. NATASHA MACLAREN-JONES: He is not a lawyer.

The Hon. TREVOR KHAN: I have to say consent forms are very useful for lawyers. People keep talking about signing consent forms; what they actually do is limit the liability of the hospital.

Dr PHADKE: Yes.

The Hon. TREVOR KHAN: For so many patients, even if told there will be issues about toxicity of the treatment they are going to receive, there is not an understanding by the patient at the time, or if there is they ignore the potential side effects of the treatment. I wonder whether you have a concept as to when the patient actually decides partway through their course of treatment that this is, quite frankly, killing them or leaving them so debilitated, how you document that change in mood or change in inclination by the patient to proceed with the course of chemotherapy.

Dr PHADKE: It is very difficult. We can try and talk to the patients, and sometimes patients do not want to offend their family or their doctor. I have to make a judgement at some stage. My view is that if you are giving chemotherapy, in particular, or even radiation to patients and they are suffering some terrible toxicity, you have to alter the treatment and change it. This is the problem. At times, if you stick rigidly to those guidelines, you are going to cause those patients harm.

The Hon. TREVOR KHAN: Clearly, if the guidelines are based upon a 35-year-old white Anglo-Saxon male with low comorbidities, et cetera, you are going to change the outcome. That seems to be clear from not only your evidence but Dr Bell's evidence. How do you properly document the fact that the patient may be taking control of their own life. You are saying, "Take X," and they are saying, "No, I really do not want to do this"? How do you document or deal with that circumstance?

Dr PHADKE: In a busy clinical practice it is not impossible but difficult. You have to then try to work out what you are going to put in the notes and files. You are running a clinic with 20 or 30 patients, which is the case of some oncology setups now, and it is not an easy thing to do. But you try your best at least to communicate with them orally and change the treatment. In metastatic disease, particularly in oncology, there are quite a lot of cases where we end up changing the treatment during the course of the illness. Sometimes patients change their point of view. They may elect to have some sort of treatment, and down the track two years later they say, "I wish I hadn't had this sort of treatment; I want you to look at some different options for me".

The Hon. TREVOR KHAN: That is, it is only after having been through the course of treatment that they are actually capable of giving their informed consent.

Dr PHADKE: Absolutely, because they have experienced what you have delivered to them.

The Hon. TREVOR KHAN: You are going through the mill. Clearly, one of the issues that has arisen is the documentation that supports the treatment that you say you appropriately gave the patient—I am not making judgement either way. How would you change your practice going into the future to give yourself some degree of protection from the criticism that you face to this point?

Dr PHADKE: The only thing you could do and I could have done is to make sure I document every damn, bloody thing that I do with the patients. That is what will happen in the long run. That will mean that you are going to have a situation where the practical reality of running clinics is going to become a problem, because it takes a lot of time to do all that.

The CHAIR: And the doctor to patient ratio is already overloaded, so that does not help.

Dr PHADKE: It is, and it is not going to be practically easy to do. But I accept what you are saying.

The Hon. TREVOR KHAN: I realise that there have been issues with multidisciplinary teams and the availability of multidisciplinary teams. Do the multidisciplinary teams provide the medical professional with a degree of assistance and, dare I say, protection as well if you have patients with serious comorbidities and the like?

Dr PHADKE: They may provide exactly some protection; it is like what you said with the actual signing of the consent. But the problem with multidisciplinary teams is that the actual multidisciplinary teams vary from institution to institution, so I have found in the past you can go to one place and find you get answer A and then you take the problem to another multidisciplinary team and you get answer B. I do not know how you deal with that.

The Hon. TREVOR KHAN: That is not a problem with the design of the multidisciplinary team; it is the fact that you have different professionals who have different opinions.

Dr PHADKE: That is right and that is always going to exist.

The Hon. NATASHA MACLAREN-JONES: Following on from comments and questions in relation to documentation, during the inquiry we have found cases where patients' files have not been available so proper investigations could not occur. In your case in relation to the inquiry that has occurred, have there been any instances where patients' files were not complete or unavailable?

Dr PHADKE: Yes, the problem with patient files is that a lot of patients nowadays are treated in a number of institutions, so although we supply copies of letters and documentation to the other site, sometimes it is a practical issue where people want to be seen earlier and if there is no space in a certain clinic, they go to another clinic which the same clinician works at. That is when the problems start, because sometimes the documentation is not easily available.

In terms of things not being available, the other problem I have found as time went on was at the Medical Council hearing, interestingly. Some of the restrictions placed on me, as I explained to Mr Secord, are quite severe. I looked at it and I said to the people at the council, "You are basing this inquiry and my licensing restrictions on six reports, and out of those you only have four of them. Where are the other two?" They said, "The district has told us they have been inadvertently held up." I thought, maybe I am an idiot, but how come the two favourable reports were inadvertently held up while the other four unfavourable ones have been forwarded to the Medical Council? You can see that that put me in a very bad light. I am just explaining to you about what you asked me concerning documentation. These issues are there to stay. When I am under the microscope, I am the only clinician experiencing this. I am sure it happens at a lot of institutions; it is not just me.

The Hon. NATASHA MACLAREN-JONES: Moving forward, how could this be addressed?

Dr PHADKE: You could address it in one or two ways: First, if a patient is treated at facility X then they have to stay there. Then you would not have these problems of the records not being transferred. That would mean if you start in the public sector, you stay in the public sector; if you start at clinic X, you stay at clinic X and you do not move. That is one way of addressing it.

The Hon. TREVOR KHAN: It is a bit unfair on the patient.

Dr PHADKE: Yes, that is what I am saying; it is unfair on the patient. The only other way is to make sure that you have some system where the records are religiously transferred from one place to another every time the patient moves.

The Hon. NATASHA MACLAREN-JONES: Which would increase the risk of more errors.

Dr PHADKE: Yes, it would.

Mr JEREMY BUCKINGHAM: Is there a protocol for how these investigations are conducted? When the Medical Council is looking at the inquiry, that inquiry is not done in an ad hoc way using various methodologies. Is the methodology of that inquiry set out beforehand? In your case, were you aware beforehand of how the internal and then external reviews were going to happen?

Dr PHADKE: I cannot answer such a detailed question because I really do not know the answer, in truth, to your question; that is the key. But there is a process whereby the actual sections of the Medical Council legislation are set. If the powers that be deem that you have done some harm to patients then of course you get put in under a different section of the Act. I think the other problem was that my hearing before the Medical Council was advanced because of the comments of the then health Minister. It is hard for me to indicate whether there was a correlation between that and the bringing forward of the Medical Council hearing before all the reports had gone in.

Mr JEREMY BUCKINGHAM: That is a really interesting point. You think that because of the health Minister's comments that Medical Council inquiry was expedited.

The Hon. TREVOR KHAN: That is not what he said.

Mr JEREMY BUCKINGHAM: I am asking whether that is what he said. I notice that the Hon. Trevor Khan pipes up when we start talking about the ministry.

The CHAIR: Order!

Mr JEREMY BUCKINGHAM: Earlier you said that you felt like you were going up against this machine, when referring to the Chief Medical Officer. Can you expand on that and whether or not you feel that that was influential in the council's inquiry, doing what they did when they did it and how they did it?

Dr PHADKE: I think in relation to the council hearing the answer is no. All I can give you is my view of things, that is all. If I were a young naive clinician starting out, I would not have a bloody clue what these

people were up to, but when you get experience then you realise that you cannot set this machinery going unless there is involvement at every level of the health ministry as well as the district. For me, as an individual, to combat this kind of machinery—that is what I am saying—whatever the outcome is, it is not an easy process. You are an individual one-man band trying to battle all these entities who have got unlimited resources. I am not saying one way or the other—that is life, and I have to accept that, but, to be frank with you, I just felt, just from my point of view, that is what was happening.

The CHAIR: I have one major question that I would like your comment on about the multidisciplinary team. I find it hard to believe that all the specialists with a holistic approach would not have an understanding of the baseline observations that a patient would be on over the patient's care, right down to at least knowing the medication or the treatment they are on for chemo or something like that. But it seems that there is a distance and that that is not so. Would it be helpful if we tried to put in a process of MDTs, and one of the discussions that needs to take place is the current therapies the patient is on and all specialists are to be aware of that?

Dr PHADKE: I agree with you. I think it needs to be expanded. You need to have some more broader representation, not just the clinicians, because they are not often close to the patients, let me tell you, and I am one. I can tell you who is close to the patient: their family, their relatives, some of the nursing staff who work for them, because you are sitting on a drip there every day when somebody who looks after you as a nurse is spending hours with you while I am spending less time with you.

The CHAIR: How would you take advice from, say, a specialist cancer care nurse, CNC or whatever the position is? How do you take their call if they say, "Dr Phadke, we do not feel, with our experience, that we are actually heading down the right track"? How do you handle something like that?

Dr PHADKE: I always took that call, and that is what upset me with this incident when I was told that some specialist nurse had actually decided that I was not doing the right thing, because I have always taken the view that specialist nursing staff who work for us or work with us have a big role to play, and I have always listened to their views—always have.

The CHAIR: Very wise doctors do listen to nurses' views. I am certainly very aware and some of my colleagues are very aware that the oncology and palliative care treatments over the last 20 or 30 years have developed exponentially but systems obviously have not caught up with them. That is always going to make it hard, given the individual holistic approach that needs to happen, for every person to be catered for individually with all their conditions and humanities. We realise that we are in a situation where we are trying to play catch-up with some of these systems, but we appreciate deeply that, given your great history in medical oncology and haematology, you have been able to put forward your side of the story, which is very important to the inquiry in framing its terms of reference and recommendations to the Government. We applaud you for coming today and giving evidence.

I am going to do something slightly different. We normally give you 21 days to return answers to questions on notice, but I believe we will need to make it 14 days on this occasion to fit in with the time frame we are working on. You took only one question on notice. Given your evidence, we may put further questions to you. The committee secretariat will be glad to help you out with that if there are any issues there. That concludes this morning's session. Thank you very much for presenting this morning. It has been very helpful.

Dr PHADKE: Thank you, Mr Chairman. I am going to be having a week off, probably next week—just one week. I need some time out after 12 months of this horrendous experience. That is all I would like to say, but I will try and make sure we do that.

(The witness withdrew)

(Short adjournment)

GERRY MARR, Chief Executive, South Eastern Sydney Local Health District, on former affirmation

JAMES MACKIE, Medical Executive Director, South Eastern Sydney Local Health District, before the Committee via teleconference, on former affirmation

JO KARNAGHAN, District Director, Medical Services, South Eastern Sydney Local Health District, on former affirmation

MARGARET SAVAGE, Director, Professional Practice Unit, South Eastern Sydney Local Health District, on former oath

The CHAIR: Would you like to make an opening statement?

Mr MARR: Thank you for the opportunity to make an opening statement. The investigation into the practice of Dr Kiran Phadke is drawing to a close and I would like to acknowledge the expert external reviewers who gave their time willingly to complete the investigation and it is the expert reviewers who I am able to rely on in any findings that I make. The findings, as they relate to individual patients, have been fed back to patients and their families via a formal open disclosure process, in line with New South Wales policy. This process has identified a number of discrepancies in Dr Phadke's submissions that have currently been worked through. The District has complied with relevant ministry policy and privacy obligations at all times.

I acknowledge that there have been delays in bringing this process to a conclusion and I apologise to the patients and families affected and waiting for the process to be finalised. The matter coming into the public domain in the manner that it has done has contributed to the delays. The Local Health District has entered 22 media statements in response to inquiries and we have aimed to balance the accuracy of reports with our obligations to protect the privacy of patients and to ensure that Dr Phadke is treated fairly.

I would like to respond to the inaccuracies and misinformation included in the paid advertisement published by the *St George and Sutherland Shire Leader* newspaper on Wednesday because I believe they are relevant to our discussions this morning. The advertisement stated that there was an anonymous allegation about a haematology patient. This is incorrect. Nursing staff directly concerned with patient welfare raised concerns. These concerns were assessed and are substantiated by an internal review. As part of the internal review, additional areas of concern were identified, and subsequently an external review under the relevant Ministry of Health policy was commenced. It is not correct that on 23 June 2016 a review found that there was no under-dosing and no patient had suffered harm. Underdosing was not a major focus of the district's inquiry. The report found that there were serious departures with Dr Phadke's clinical practice, from diagnosis, staging, providing advice to his patients, his treatment choices, documentation and engagement with his peers.

The advertisement incorrectly states that all treatment regimes that Dr Phadke had commenced in those patients should be continued without change. This is not the view of the investigators in all circumstances. A number of patients' treatments were changed immediately following consultation with other treating clinicians. Adverse comments were made about Dr Phadke's oncology practice, although there was no issue of harm. The district has not made unscrupulous accusations against Dr Phadke, as stated in the advertisement and it is a matter of public record that we did not name Dr Phadke. The district is responding directly to the concerns raised by the patient referred to in the advertisement. In addition, senior officers of the local health district have met with and provided detailed feedback and explanations to the family.

Procedural fairness has been afforded to Dr Phadke during the investigation. He has been invited to respond to all external reviews before they were finalised and his feedback was then taken into account by the external experts in finalising their reports. Dr Phadke was provided a copy of the findings of the investigations and all expert reports, which included important feedback from patients and families concerning their experience of the care provided. Dr Phadke was invited to make any submission that he would have taken into account in relation to the final report, having already been given the opportunity to comment on each of the external reviews previously. Dr Phadke's comments will be taken into account in respect of the findings of the investigator's report and will be carefully considered with additional expert advice.

On Tuesday 26 March I met with Dr Phadke and his representatives, at his request, to hear further submissions and to discuss options around bringing this matter to a conclusion. At this stage, I have not reached a final decision. The final decision will be made within the next few weeks. I will be making the decision in consultation with two independent people—an experienced medical administrator and a senior lawyer. The district has followed due process in line with the conduct of the inquiry and we will continue to support this inquiry in any way that we can. Thank you.

The CHAIR: Are there any further opening statements?

Mr MARR: No.

The CHAIR: There being no further opening statements, can I ask, in line with the questioning that I had for Dr Phadke: Mr Marr, would you think in the investigation it would be reasonable to expect that a peer assessment could come up with a different view of treatment in hindsight, knowing the patients' outcomes?

Mr MARR: I do not think so, from the findings I have been given by the external experts. Dr Phadke's submissions have, on a number of occasions, made that point. But I don't think this is just a question of clinical judgment. As I said in my opening statement, there were issues where the experts said this was simply the wrong treatment for a patient and that is not about the difference in clinical judgment or a clinical assessment of the patient; this was wrong treatment, wrong staging et cetera. So I think there is a distinct difference.

The CHAIR: Would you be of the view, if you had three experts in a room, that they could all have a different answer on that particular situation, given their great experience?

Mr MARR: I think that is always possible in medicine, I acknowledge that. But actually, in the index case, the experts had never spoken to one another and there had certainly been no collusion.

The Hon. TREVOR KHAN: Just before this proceeds, Chair, I am not being critical of Mr Marr but I am a little concerned that we end up discussing the matters surrounding Dr Phadke and the thought processes that go on, for fear that that may in some way jeopardise the outcome of what the local health district is doing.

The CHAIR: I understand but can I just make it very clear: My comment is a fairly general one. My point is, I have worked under medical officers and I have seen that many of them would have a different approach. If they had the same patient, they could have different approaches. That is all I am trying to get on the record. Clearly, if you had three experts in a room, all of them could take a different tack, based on their experience and their understanding of other treatments to which they might have access. That is what I am trying to put on the record.

The Hon. WALT SECORD: Mr Marr, there has been media coverage of this. Do you stand by the report where it said that six patients were harmed as a result of inappropriate care and that eight may be at risk of future harm as a result of inappropriate care by Dr Phadke?

Mr MARR: I will confirm with my colleagues that that was a direct quote from the report at that particular time.

The Hon. WALT SECORD: It was in the *St George & Sutherland Shire Leader*.

Mr MARR: Yes.

The CHAIR: That is a public document.

Mr MARR: Yes.

The CHAIR: You can answer that.

Mr MARR: Yes.

The Hon. WALT SECORD: To assist you, it was an interview on 1 February with Mr Murray Trembath.

Mr MARR: I stand by that position, yes.

The Hon. WALT SECORD: You mentioned in your introductory statement a final decision in relation to Dr Phadke. What is the matter before you involving a final decision involving Dr Phadke?

Mr MARR: The decision I have to take is the future employment status of Dr Phadke based on the completion of the investigation. I then have to make a finding and then determine the impact that finding has on his future employment.

The Hon. WALT SECORD: Do you feel he has been given due process?

Mr MARR: One of the reasons for the length of the inquiry is that we have been thorough in giving Dr Phadke all of the time we can. These are complex cases. You do not send out the case notes in an envelope; they are often in a box because of the complexity and length of care. I genuinely believe that we have given Dr Phadke provision to make his submission and then to share that with the experts and respond and give Dr Phadke further opportunity, including the meeting I had with him this week.

The CHAIR: Mr Marr, could you step us through where we are in the time line and when the outcome will be delivered?

Mr MARR: We met with Dr Phadke and his representatives on Tuesday and we agreed that we would give him the opportunity for one more submission based on the statement he made at the meeting. He wished to put forward some proposals about how we might bring this matter to a conclusion. Because of the length of time this has gone on I have pencilled in the date of 13 April as the meeting where I will discuss with the two people I have mentioned to assist me to make a finding.

The Hon. WALT SECORD: I have one last question. In evidence earlier today, I put to him there were a number of allegations about conflict involving you and your wife and he conceded that he had no evidence of that. Do you have a comment?

Mr MARR: It is irrelevant. There have been a number of allegations or suggestions about things. I will be honest with you: In some cases I have been involved in I often find that the line of attack is to discredit the process and then discredit the decision-maker. I find that relevant to this case. I am not going to respond to those things other than to say one thing: I know reference was made to my home country. When I retired from the health service the Queen awarded me an Order of the British Empire. I do not think her advisors would have given advice that put the Queen in any difficulty. I was awarded the OBE and my citation included my commitment to patient safety.

The Hon. WALT SECORD: Point taken.

Mr JEREMY BUCKINGHAM: In its various iterations in terms of the health district, Dr Phadke had worked there for decades. Are you aware of any other investigations or concerns about his practice that are similar, or complaints made against him in that time that are relevant?

Mr MARR: No.

Mr JEREMY BUCKINGHAM: In 35 years of practice, he had effectively a clean bill of health—is that right?

Mr MARR: There were never any allegations or complaints made against him.

Mr JEREMY BUCKINGHAM: Were there any interpersonal issues between the complainant and Dr Phadke that you were aware of prior to the complaint being made that initiated the original inquiry?

Mr MARR: The answer to that is no. Just to expand on it: There can be occasions where someone makes a malicious complaint. The reason we took that original complaint into external review by his peers was to satisfy myself that there was justification for an investigation. Sometimes that can happen. We referred it to his peers and his peers said, yes, there are concerns on the treatment and the complaint that has been raised and it was on that basis that I took forward the investigation. I would never take forward an investigation on the basis of a single complaint without validating the veracity of it.

Mr JEREMY BUCKINGHAM: Was that based on the internal review?

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: Dr Phadke maintains that there were not significant issues raised in that internal investigation.

Mr MARR: I would have to say to you that the evidence is otherwise.

The Hon. DANIEL MOOKHEY: Did you have the opportunity to hear or see Dr Phadke's evidence this morning?

Mr MARR: I saw some of it, yes.

The Hon. DANIEL MOOKHEY: Did you hear the line of questioning to do with the circumstantial factors that prevailed in the LHD? He characterised it as some of the internal politics occurring inside the district.

Mr MARR: Yes, I heard him make reference to that. I am not aware of that in any particular way. It has never been drawn to my attention.

The Hon. DANIEL MOOKHEY: To be specific, Dr Phadke made reference to an internal dispute about the calibre and quality of the services provided at Sutherland and whether it ought to be decentralised or centralised. Is that a fair characterisation?

Mr MARR: I would not say that it was interpersonal. Often you have to give consideration to how you design and deliver services in a safe manner and the debate is whether we can sustain haematology and

oncology on both sites. There was, and continues to be, a conversation about what is the right configuration of services. I do not think it was based on personalities or disputes.

The Hon. DANIEL MOOKHEY: To the extent that conversation is happening, has it reached a level of heat, anger or dismay internally that would cause people to have ill will towards each other?

Mr MARR: Not that I am aware of.

The Hon. DANIEL MOOKHEY: There is a theory that perhaps Dr Phadke was targeted by people who have an interest in that dispute and they utilised this procedure as a manner in which to pursue their campaign. Is that something the LHD has inquired into?

Dr KARNAGHAN: Dr Phadke has made a number of assertions in his submissions regarding interpersonal issues with various people and made reference to what could perhaps best be described as professional jealousies. He has not provided any evidence of any of that. We are certainly unaware of any evidence of that. During the discussions that have been occurring in relation to the configuration of services in haematology and oncology across the two sites that matter has not been raised at all.

It is a discussion about how we can best deliver clinical safety and an appropriate clinical care and whether that should occur across both sites or whether there should be some services provided at Sutherland and the more acute end services provided at St George. I am not sure exactly what Dr Phadke is alluding to. I gather in one part of his evidence this morning he made reference to professional jealousies around private practice and referring patients to other facilities. I am not sure why he would think that would have any bearing on anything.

The Hon. DANIEL MOOKHEY: Is it your view that such considerations are irrelevant to the investigation so far as the investigation relates to medical practice?

Dr KARNAGHAN: Absolutely.

The Hon. DANIEL MOOKHEY: Is it your view that appropriate avenues have been provided to Dr Phadke for him to bring evidence of these concerns?

Dr KARNAGHAN: Dr Phadke has been provided with multiple opportunities to respond to concerns that have been raised and criticisms that have been made regarding his practice.

The Hon. DANIEL MOOKHEY: To the extent to which there is a view that Dr Phadke is a victim of a vexatious campaign, do you share that view?

Dr KARNAGHAN: Absolutely not. The matters that we have identified through the investigation do not bear that out.

Mr MARR: Can I just add to that? I am the decision-maker. I would never allow personality clashes to interfere with a decision about the safety and the care of patients. It is irrelevant, absolutely irrelevant. I will base my findings on the evidence of expert people, taking into account Dr Phadke's submissions and response, and come to a conclusion. If there has been ill feeling in the department I am not aware of it will bear no consideration whatsoever on the decision I take in this matter.

The Hon. DANIEL MOOKHEY: To be fair to Dr Phadke, his view was that in the absence of such a complaint he never would have been subjected to the investigation to which he has since been subjected. Therefore, to the extent to which that is correct or not, that is a relevant consideration as to whether an investigation should proceed.

Mr MARR: I would offer you another perspective. I think you could take an opposite view that it was with a great deal of courage that nurses raised these matters and they satisfied their professional body by raising concerns about patient safety.

The Hon. BRONNIE TAYLOR: Dr Karnaghan you said that Dr Phadke was invited to respond. Was that in person or only in writing?

Dr KARNAGHAN: Ms Savage might like to comment on that.

Ms SAVAGE: I certainly had conversations with his legal representatives reaching out to say if there were opportunities Dr Phadke wanted to speak to us either informally or formally. That was on offer throughout.

The Hon. BRONNIE TAYLOR: Did you offer to sit down with him and discuss these matters in a formalised setting, or was it done only by written correspondence?

Ms SAVAGE: It was done informally through his legal representative and otherwise formally in written responses and, more recently, formally in a written and a verbal response.

The Hon. BRONNIE TAYLOR: I return to the issue of clinics. You have an oncology clinic at St George Hospital and an oncology clinic at Sutherland. How many oncologists work out of St George as opposed to Sutherland.

Dr KARNAGHAN: They are all cross appointed so all of them have the right to work across—

The Hon. BRONNIE TAYLOR: But how many practice?

Dr KARNAGHAN: I would have to take that exact question on notice.

The Hon. BRONNIE TAYLOR: Is it fair to say that the majority of your medical oncologists practice out of St George as opposed to Sutherland?

Dr KARNAGHAN: It is probably a fair question but I would like to take it on notice to provide you with an accurate response.

[*Interruption from the gallery*]

The CHAIR: Order! This is not an open forum. I do not mind people in the gallery having a view but they are here only to hear the evidence and they can have conversations outside later.

The Hon. BRONNIE TAYLOR: Is the Sutherland Oncology Clinic considered to be a satellite of the St George Clinic, or is it a clinic in its own right?

Dr KARNAGHAN: I am not quite surely exactly what you mean when you say it is a satellite clinic.

The Hon. BRONNIE TAYLOR: I am starting to pick up that there may have been conversations around the long-term sustainability of the clinic at Sutherland. I am happy to be corrected. I am picking up on some issues. You had an oncologist who was practising a lot out of Sutherland. I was wondering whether that was getting geared towards St George.

Dr KARNAGHAN: I must admit I am a bit unclear as to the line of questioning.

The Hon. BRONNIE TAYLOR: I am sorry, Dr Karnaghan; I will try to be a little clearer.

The Hon. TREVOR KHAN: Was there a view that Sutherland was, in a sense, developing as a practice for oncology which was against the objectives of the local health district of concentrating it at St George?

Dr KARNAGHAN: I think the answer to that has to be no. There was no definitive view of the district that all the services should be consolidated at St George Hospital.

The CHAIR: You referred earlier to a community advertisement, part of which states, "the community is waiting." Are you familiar with that document?

Mr MARR: Yes.

The CHAIR: It also states, "Given that no adverse findings were identified in the review of Dr Phadke's oncology practice why has the area management persisted with the termination of Dr Phadke?"

Mr MARR: We have not continued with the termination of Dr Phadke. No decision has been made on his employment. In respect of oncology it is proper to say that the findings from the reviews were that there appeared to be no harm associated with patients in oncology. The harm that we have talked about is exclusively in haematology. However, at the present time the credentialing committee of the district did suspend Dr Phadke's credentialing for oncology as well as haematology. It would be for the committee to reinstate those oncology privileges. As Dr Phadke said this morning, he is also under significant supervision from the medical board. Those issues will have to be addressed because one of the representations that Dr Phadke has made is that he should be able to re-enter oncology practice. That issue will be taken into consideration but it is not straightforward because of the credentialing issues and because of the supervision order from the medical board.

The CHAIR: That is from the medical council?

Mr MARR: Yes.

The CHAIR: The Committee received evidence from it about the pathway and why it does those things. The advertisement also states, "It has been more than nine months and the community wants to know how this could happen. Why did Area Health have a former Minister for Health make unscrupulous accusations against Dr Phadke and place some of Dr Phadke's patients with psychological damage?"

Mr MARR: On 27 July 2016 I provided written advice to the Ministry to go to the Minister to say that I thought it was inadvisable to name Dr Phadke in public because it may compromise our ability to sustain

natural justice and confidentiality in the ongoing inquiry. The Minister then announced Dr Phadke's name on 2 August. I do have to say that my advice was in the narrow definition of the inquiry. The Minister must have other considerations that I have no privilege to and she took that decision based on a whole number of factors. I am absolutely sure of that.

The Hon. WALT SECORD: So your advice was not to name Dr Phadke?

Mr MARR: Yes.

The Hon. DANIEL MOOKHEY: And that was written advice?

Mr MARR: Yes.

The CHAIR: Will you table that document for the Committee?

Mr MARR: Yes.

The CHAIR: The article continues, "Why did the Area Health contact one of Dr Phadke's patients in August 2016 stating she had been wrongly treated by Dr Phadke and they would get back to her within three weeks. Six months later she had not heard from Area Health and proclaimed that the only reason she is alive today is because of the treatment of Dr Phadke." Are you familiar with that particular episode?

Mr MARR: I am familiar with that particular individual. Maybe Ms Savage could respond to the question.

Ms SAVAGE: The family concerned attending a meeting with the director of clinical services and the director of clinical governance at Sutherland Hospital who met with them for, I think, about two hours to go through their concerns in some detail. They have provided us a copy of the complaint that they submitted. That complaint was lost—we do not know how. We heard about it for the first time in the parliamentary inquiry. We asked them for a copy. They provided us a copy and we responded to them directly.

The Hon. TREVOR KHAN: That does not quite answer the question. Essentially, the allegation is that a patient was contacted, told that the patient had received inappropriate treatment by Dr Phadke, and that somebody would get back to them within three weeks.

Mr MARR: That is correct.

The Hon. TREVOR KHAN: Putting aside whether a complaint has been lost, when were they contacted? If it was not three weeks later, why not?

Ms SAVAGE: I cannot answer for why they were told three weeks. It was never going to take three weeks to get this finished. That was a problem from the outset. The family were contacted by Justine Harris and Kim in November—

[*Interruption from the gallery*]

The CHAIR: Order! As much as I would love that evidence, I cannot take it. I do not want to encourage verbalisation from the public gallery.

The Hon. TREVOR KHAN: Let me invite you to check the date.

Ms SAVAGE: I will.

The Hon. TREVOR KHAN: And give an explanation as to why it essentially took so long. I suppose one of the things that comes out of our inquiry is the question about whether the LHD or St Vincent's have handled the disclosure to patients—this is not sought to be critical of you—of concerns appropriately, including ongoing communication with those patients after they had become aware of the potentiality that their treatment had been less than adequate. The invitation is essentially to explain how you did it and why, and if there are any inadequacies in the way you proceeded in this matter.

The Hon. DANIEL MOOKHEY: On that theme, is there a policy that determines a contact?

Mr MARR: Yes, there is a NSW Health open disclosure policy, which is a policy that we follow.

The Hon. DANIEL MOOKHEY: Does the open disclosure policy that you follow require or provide any guidance as to how interactions between the LHD and affected patients should take place?

Mr MARR: I will refer to Margaret.

Ms SAVAGE: Very broadly.

The Hon. DANIEL MOOKHEY: Does it include specifics on how patients are to be communicated with and according to what time frame?

Ms SAVAGE: Again, very broadly.

The Hon. DANIEL MOOKHEY: Is it fair that you have to apply a great degree of discretion?

Ms SAVAGE: And judgement.

The Hon. DANIEL MOOKHEY: Who does that in the LHD?

Ms SAVAGE: In this case it was the director of clinical services for St George-Sutherland Hospital with assistance from the director of clinical governance.

The Hon. DANIEL MOOKHEY: And they answer to whom?

Ms SAVAGE: They answer to the general managers [GMs] at the two hospitals, and the director of clinical governance answers to the director of innovations.

The Hon. TREVOR KHAN: There is potentially a problem, is there not? You cannot come down with a schedule that says, "I will get back to a patient in three weeks", because each patient is going to be different?

Ms SAVAGE: That is right.

Dr KARNAGHAN: That is right.

The Hon. TREVOR KHAN: For instance, some patients will be in remission or in fact cured, so they will be dealing with a set of issues such as "Is this going to come back?" and there will be other patients who are ongoing patients who are receiving treatment. So who makes the clinical judgement or who sets up a strategy for communication with the individual patient?

Dr KARNAGHAN: To start with, it is difficult to communicate with patients when you have very little to tell them. When you are relying on external expert reviewers to provide you with an assessment, you are really reliant upon their timing, and for us to assess what they have given us, give Dr Phadke an opportunity to respond to their assessment. So when we go to the patient, we go to the patient or their families with the best information that we can give them. In some cases—and it depends very much on the matter—that can be done very, very quickly, sometimes within a space of days, but in those cases that have been very complex—

The Hon. TREVOR KHAN: I am not doubting that.

Dr KARNAGHAN: —when we have been reliant on external experts and when we have then had to give the clinician the opportunity to respond, sometimes there has been—

The Hon. TREVOR KHAN: That is the problem, is it not? You have got two competing interests. You have the natural justice issues that relate to Dr Phadke in this case, or Dr Grygiel, and then you have the patient concern issues. Those interests do not necessarily intersect. In fact, they may directly conflict.

Dr KARNAGHAN: There is certainly a tension at times between—

The Hon. TREVOR KHAN: It is more than that, is it not?

The CHAIR: It is still unacceptable if no-one got back to them for six months. That is unacceptable, especially given the fact that you are investigating the very same allegations against the doctor.

Dr KARNAGHAN: If the conclusion has been—

The CHAIR: Order! Let us get the evidence.

Dr KARNAGHAN: We would agree with you, Chairman.

The Hon. TREVOR KHAN: How would you do it differently next time?

Ms SAVAGE: Can I add to that that we were given one day to contact all of those patients.

The CHAIR: That is not the issue. The issue is the follow-up call. Six months is unacceptable because of the psychological trauma that many of those patients would have been put under immediately.

The Hon. NATASHA MACLAREN-JONES: Could you not have sent a letter?

The CHAIR: You are meant to be at the top of the tree, not the bottom. You are meant to deliver care to those patients in the absence of the person you are investigating.

Mr JEREMY BUCKINGHAM: When was the complaint against Dr Phadke first made?

Dr KARNAGHAN: On 28 April.

Mr JEREMY BUCKINGHAM: It was made on 28 April and he was informed on 16 May?

Dr KARNAGHAN: Yes, that is correct.

Mr JEREMY BUCKINGHAM: When was the Ministry first informed of those matters, either through the chief medical officer or directly?

Mr MARR: I do not have that particular document in front of me. Can I take it on notice?

Ms SAVAGE: It was 9 May.

Mr JEREMY BUCKINGHAM: On 9 May the Ministry was told. How was the Ministry told? Was it by a letter, phone call? Was it through the chief medical officer?

Mr MARR: The standard procedure is to do an in-brief up to the Ministry almost always in writing, and there would have been a written brief gone up to the Ministry. That is the standard procedure. That does not mean that you would not then have subsequent phone calls with the chief medical officer, or whatever. That would be normal in the course of events, but the Ministry rely on the written brief.

Mr JEREMY BUCKINGHAM: Was the written brief informing the Ministry in the context of the matters that had emerged at St Vincent's, or was it done completely independently? Is there any reference to the St Vincent's matters?

Mr MARR: As I said, I do not have the document in front of me, but I am happy to take that on notice.

Mr JEREMY BUCKINGHAM: Can you supply the Committee with that document?

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: The Ministry was aware of those issues and it was notified on 9 May about the issue of potentially off-protocol or outside guidelines prescribing by the doctor?

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: Why did you write to the Minister on 27 July and recommend that the Minister not use Dr Phadke's name publicly?

Mr MARR: For the reasons I have described, because I thought in the context of the inquiry there would not be—it would potentially compromise the inquiry by Dr Phadke being named.

The Hon. TREVOR KHAN: Then you were going to contact all of the patients and tell them Dr Phadke may have given them inappropriate treatment, is that not right?

Mr MARR: There is a balance of judgement here, because when we—

The Hon. TREVOR KHAN: I am not doubting that you went through a balance of judgement, but it is right, is it not, you are saying to the Minister, "Do not tell anyone about Dr Phadke", and then you are going to the patients and saying, "Dr Phadke may have given you bad treatment." This was going to blow up in the papers in five minutes, was it not?

Mr MARR: If you recall yourself, one of the criticisms of St Vincent's was that the patients were not informed and found out about it through the paper.

The Hon. TREVOR KHAN: I am not being critical of the patients being told, but it was going to go public.

Mr MARR: Given the timing, our judgement was that we should get in touch with those patients who were potentially affected.

Mr JEREMY BUCKINGHAM: When did you do that? What date did you start contacting patients?

Ms SAVAGE: On 1 August.

Mr JEREMY BUCKINGHAM: It was only when the Minister had made a public statement about Dr Phadke—

Ms SAVAGE: It was the day before.

Dr KARNAGHAN: It was prior.

Mr JEREMY BUCKINGHAM: By how many hours?

Ms SAVAGE: Day before.

Dr KARNAGHAN: The day before.

Mr JEREMY BUCKINGHAM: So 24 hours before. Were you aware that the Minister was going to name Dr Phadke at that press conference?

Mr MARR: Yes, I was advised because I was invited to the press conference, and I attended the press conference.

Mr JEREMY BUCKINGHAM: You were advised he would be named. Is that why you decided to start contacting patients?

Mr MARR: Yes, because we did not want them to find out through the newspaper.

The Hon. DANIEL MOOKHEY: Who advised you and invited you to the press conference?

Mr MARR: The press conference was attended by a number of officials including me. I was there because presumably if any questions arose specifically about the St George—

The Hon. DANIEL MOOKHEY: Yes, but who advised you the press conference was happening?

The CHAIR: The question was fairly clear: Who advised you to be there?

Mr MARR: The Ministry, yes.

The CHAIR: Who in the Ministry? The secretary?

Mr MARR: Yes, it would be through the secretary's office.

Mr JEREMY BUCKINGHAM: Did they give you written correspondence saying Dr Phadke would be named?

Mr MARR: No.

Mr JEREMY BUCKINGHAM: That was just a phone call?

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: Who from?

Mr MARR: I cannot recall just immediately. It would be one of the senior people in the ministry.

The CHAIR: Could you take that on notice?

Mr MARR: Yes, sure.

The CHAIR: One possible interpretation of the event was that in the context of the scandal at St Vincent's Hospital the Minister for Health overreacted to the allegations that surfaced soon after with Dr Phadke. Now that your LHD has had to follow through on that overreaction, what is your response to that suggestion?

Mr MARR: I cannot comment on whether the Minister overreacted.

The CHAIR: You are an expert; do you think it was an overreaction, given what she had to deal with?

Mr MARR: No.

The Hon. WALT SECORD: How many patients did you try to contact or contact? Were there 27?

Ms SAVAGE: No, 20.

The Hon. WALT SECORD: Did you contact all of them?

Ms SAVAGE: I do not have that information with me.

The Hon. WALT SECORD: You must know whether you contacted all 20 patients.

Ms SAVAGE: Contact was attempted at least with all 20, yes. There might have been some messages left, which was a bit unfortunate.

The Hon. WALT SECORD: Are you not sure whether you contacted all 20?

Ms SAVAGE: On that day.

The Hon. WALT SECORD: Have all patients involved with Dr Phadke been contacted?

Ms SAVAGE: Yes.

The Hon. WALT SECORD: As of when?

Ms SAVAGE: As of 1 or 2 August. Shortly thereafter there were a number of the patients who called in to a hotline.

The Hon. WALT SECORD: How many patients in total?

Ms SAVAGE: There were 27.

The Hon. TREVOR KHAN: I think some of this was subject to questioning last time.

The CHAIR: I think it is in light of new evidence.

The Hon. BRONNIE TAYLOR: At the last hearing you mentioned that you were doing a review into your clinical governance arrangements after this. What have you learned from that?

Mr MARR: The formal report on the review of clinical governance is in draft form. I should have it within a matter of weeks. It is being commented on by the people involved and the people affected by it. But I do not need a report to learn lessons. We learn lessons very, very quickly. The whole issue of this incident has been taken to the district clinical council and the relevant hospital clinical councils.

The CHAIR: Can you forward that to the Committee when you get it?

Mr MARR: Yes. Each of the councils have shown a commitment to particularly work on the reliability of the multidisciplinary team [MDT] process.

The Hon. WALT SECORD: When will Dr Phadke ultimately know his fate?

Mr MARR: The day I want to make the decision on the findings is 13 April, so very shortly thereafter.

Mr JEREMY BUCKINGHAM: Would you table for the benefit of the Committee all the correspondence between the LHD and the ministry regarding this matter between 9 May and 2 August?

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: Was the ministry involved in any way in the investigations once you had told them there had been a complaint? The two things were happening in parallel, so was the ministry involved in any way in how those investigations were conducted and making recommendations, say, about the time frame? Did the ministry seek to have these investigations expedited et cetera?

Mr MARR: No, the responsibility for the investigation is exclusively the responsibility of the LHD within the four policies that are set down by the ministry. The ministry's role was only to satisfy itself that we were doing the investigation within the policies as set out by the ministry. The ministry would not be involved in any way actually on the investigation.

The Hon. NATASHA MACLAREN-JONES: You mentioned that you had heard this morning's evidence of Dr Phadke. He said that the decision made by the Medical Council to restrict his practice to having supervision was made without all documentation being provided to the council. He said two documents were not provided. Could you elaborate on why those documents were not provided in time?

Ms SAVAGE: I am not sure which two documents were not provided to the Medical Council.

The Hon. DANIEL MOOKHEY: He had a view that they were reports favourable to his practice.

Mr JEREMY BUCKINGHAM: Two of the four patient cases were not before that body to consider.

Mr MARR: There would be no reason to submit where there are no adverse findings. It is not a case of saying he did well in these two cases, but these four cases give us a concern. The HCCC would only communicate in areas of interest because there was a question of poor care or adverse events. We would not send the HCCC favourable reports; that is not our role. That would have no influence on the decision the HCCC took about Dr Phadke's supervision. I think what Dr Phadke said is quite irrelevant.

The Hon. DANIEL MOOKHEY: In fact it could cause prejudice if the HCCC were to find on matters to do more with character than facts, in your view?

Mr MARR: No, I think they were dealing entirely with the facts that were submitted.

The Hon. NATASHA MACLAREN-JONES: If they are not provided with all the documents, how can the Medical Council make a clear recommendation?

Mr MARR: No, they had the complete documentation on the four reports that raised concerns about Dr Phadke's practice.

Mr JEREMY BUCKINGHAM: Were there not six reports that raised concerns?

Mr MARR: For accuracy, I will ask—

The CHAIR: The public document talks about six.

Mr JEREMY BUCKINGHAM: There were six cases that were the subject of a complaint. They were significant; it was not just a random sample and only the bad ones were provided. They said there had been complaints about six cases, and two of those had been investigated and found to be unsubstantiated. That is the case.

Mr MARR: Yes.

Mr JEREMY BUCKINGHAM: Is it not material that the complainant had got it wrong, in effect, in two cases?

Mr MARR: I take a different view. The requirement that we operated under was to send those cases where there was concern about the practice of Dr Phadke.

Mr JEREMY BUCKINGHAM: No, was it not about to assess the complaints?

Mr JEREMY BUCKINGHAM: Let the witness finish answering the question.

Mr JEREMY BUCKINGHAM: No, he is reiterating previous evidence. Is it not the case that they were to investigate in toto the complaints and two of the complaints were found to be favourable to Dr Phadke?

Mr MARR: When you look at the totality of the complaints, you must remember there were 130 cases in oncology et cetera. We were dealing only with those cases we had reviewed at that point in time.

Mr JEREMY BUCKINGHAM: That was the review but not the complaints.

The Hon. NATASHA MACLAREN-JONES: I return to my question. I am interested in the six matters that the council was looking at that made the determination on Dr Phadke's ability to practice. He stated that the council only had documentation provided in relation to four cases. Are you saying you chose not to provide additional documentation of those other two patients because they were favourable?

Mr MARR: I will confirm that in writing, but—

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take it on notice. There are two parts to the question: Please provide what you chose to provide and what you were asked to provide.

Mr MARR: We will take that on notice, but for the record I am saying it would not be a normal practice to notify favourable outcomes. That is not the role of HCCC.

The CHAIR: We understand. We went through some of the critical pathways of complaints, and some in the public gallery probably do not understand those processes. You made contact with 20 people, Ms Savage, at some stage, from leaving a voice message to eventually, one would think, catching up in real time with them.

Ms SAVAGE: Or a letter if we were unable to.

The CHAIR: How many of those end up waiting six months for further follow-up?

Ms SAVAGE: I was not involved so I am going to have get Kim Brookes and Justine Harris to answer those.

The CHAIR: Can you take it on notice, in light of the previous question and you saying that someone was contacted and said, "We'll get back to you in three weeks" and it took six months? I want to know how many of those 20 people were in that same situation. The second question I want to ask before we conclude: Mr Marr, in answer to a question from the deputy chair, you talked about the outcomes of the multidisciplinary team. Can you give a quick summation of where that is going?

Mr MARR : We are working with the clinical councils. They have taken responsibility to ensure that there is a much more reliable process. In fact, straight after this hearing I am going to meet with the clinical council and that is one of the issues I will be raising with them. But I note Dr Phadke's evidence. When I met

with him he conceded that he did not follow MDT process. In my meeting with him on Tuesday he acknowledged that his documentation fell short of the standards that would be expected and that he did not involve himself in the MDT process. The normal standard for documentation—Dr Phadke quoted 11 patients, I think, where anxiety was a factor.

The Hon. TREVOR KHAN: I am just a little bit concerned. This seems to be going beyond the question.

The Hon. WALT SECORD: But it is interesting and we are listening to it.

The Hon. TREVOR KHAN: I understand that, but we potentially are opening up another area of inquiry.

The CHAIR: That is right, we are. I am not asking Dr Phadke, I am asking more about the outcomes of the earlier question that the deputy chair asked. In light of the commission of a review of the clinical governance arrangements, that is the spirit of the question, not in terms of Dr Phadke. Dr Phadke made it very clear in his evidence that if he wrote down every single thing he would have no time for many patients. Anyone who works in nursing would understand that is exactly how it works—you would spend all your time documenting rather than seeing patients.

Dr KARNAGHAN: I would make the point though that I think there are certain things that it would be prudent to document.

The CHAIR: Correct, and hopefully you are going to come up with that within clinical governance. I note that we have still got Dr James Mackie on the phone. Is there anything that you want to add before we close this session?

Dr MACKIE: I would just like to say that I think it is really important to understand the difference between making a judgement about a treatment that is not correct and modifying treatment based on clinical circumstances. I think the first case to highlight this is the index case who, despite the assertions that anxiety and other factors are taken into consideration, when they see another doctor the treatment is changed immediately to a different course of action. I just think that is an important thing to understand: the difference between modifying treatment for the circumstances, which is appropriate, to being on the wrong treatment path.

The CHAIR: Thank you, Dr Mackie. That concludes our session this morning. I thank all the witnesses for coming. We have agreed on a motion to reduce the number of days for replies to questions on notice to 14 days. If that is changed the committee will notify you, but you have 14 days to reply to the questions taken on notice and to supply the paperwork that we asked you for. The secretariat will be here to help with that if there are any issues. Thank you very much for presenting. Once again, we appreciate the evidence you have given; it will be very helpful for the outcomes of the inquiry not only to do with processes of treatment but also to save lives in the future.

(The witnesses withdrew)

(The Committee adjourned at 11:54)