REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

CORRECTED

At Jubilee Room, Parliament House, Sydney on Friday, 24 February 2017

The Committee met at 11:00 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

The CHAIR: I declare this hearing of the inquiry into off-protocol prescribing of chemotherapy in New South Wales open to the public. Before I commence, I acknowledge the Gadigal clan of the Eora nation who are the traditional custodians of this land. I also pay respect to elders past and present of the Eora nation and extend that respect to other Aboriginal persons present or listening to this broadcast. Today is the fifth hearing to be held as part of this inquiry into off-protocol prescribing of chemotherapy in New South Wales. Today we will hear from the NSW Health Care Complaints Commission, Medical Council of New South Wales and Macquarie University Hospital.

I will now make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the parliamentary website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the *Legislative Council's Guidelines for the Broadcast of Proceedings*, 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. These guidelines are available from the secretariat. I also remind media representatives that they are not authorised to film outside this hearing room without permission. Witnesses coming into or out of this hearing may not be filmed. I also remind members of the media that they must take responsibility for what they publish about the Committee's proceedings.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. I ask witnesses to be careful when using an individual's name during this hearing, and particularly when using a doctor's name. In order to avoid unnecessary harm to people's reputations, please ensure that your comments are relevant to the terms of reference. I also 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 this hearing. I urge witnesses to be careful about comments they may make to the media or to others after they have completed giving their evidence. Such comments would not be protected by parliamentary privilege if another person decided to take action for defamation.

Finally, can I remind members that the content of confidential documents can only be referred to in general terms. Members should also avoid using the names of patients and doctors discussed in proceedings held in camera. I note that one member is not currently in the room; that is the protocol. I now welcome our first witnesses, Ms Dawson and Mr Kofkin. I am sorry that the Committee is running a little behind time, but it was very important that another witness was given some time.

SUSAN ELIZABETH DAWSON, Commissioner, NSW Health Care Complaints Commission, affirmed and examined
TONY ALAN KOFKIN, Director of Investigations, NSW Health Care Complaints Commission, sworn and examined

The CHAIR: Would either of you like to make a brief opening statement?

Ms DAWSON: Thank you. First, I am acutely aware that the issues raised in matters before this Committee have been deeply distressing for the patients and families affected. I wish to acknowledge that distress. I also wish to apologise for any inadvertent additional stress that the Commission's own investigation processes may have caused.

The complaints that have been received by the Commission raise serious matters of significant complexity. Immediately upon receipt of the complaints from St Vincent's Hospital, Macquarie University Hospital and Western NSW Local Health District, the Commission and the Medical Council of New South Wales assessed and consulted on them. In each case they were referred for full investigation, as serious complaints of this nature are. These investigations are of the most complex of their kind. In the case of the complaints of off-protocol dosing, as Committee members will appreciate, there are many layers of complexity. They arise from treatment over more than a decade and they relate to treatment delivered in a range of different service environments—private and public hospitals, and as a visiting medical officer operating in a regional environment. The complaints that we have are from both organisations and individuals and they relate to different clinical conditions, scenarios and patient cohorts.

There are around 150 patients named across these complaints. The issues in the complaints have evolved over time—for instance, the original Western New South Wales complaint related to carboplatin treatments and later expanded to deal with the capecitabine treatments. They give rise to complex questions regarding patient consent practices. They require deep consideration of the clinical governance practices and the scope of work of multidisciplinary teams in the relevant organisations. They raise questions about mandatory reporting policies and practices and, finally, they require sourcing and commissioning a number of subject experts with the necessary expertise and stature to advise the investigation.

The complaints regarding Dr Phadke are of a very different nature and scale, but they are complex in a different way, primarily because they relate to the treatment decisions and clinical consultations of patients with a wide range of presenting illnesses. I can say with confidence that the investigation powers and processes of the commission are second to none. They are peerless in the health regulation field in this country. The investigations undertaken on the complaints before us have applied our wide-reaching coercive and non-coercive powers to address the complexities and questions to which I have just referred. We are able to elaborate on the investigation processes and actions in this hearing, but I must stress that these investigations are still underway. They are well advanced but they are not concluded. I must also stress that the findings of the investigation that is still afoot are not determinant of whether there is disciplinary action to be taken. If there are departures in the standard of care, treatment or conduct of a practitioner that are found in an investigation, the determination of disciplinary action is the statutory purview and responsibility of the independent Director of Proceedings under the Health Care Complaints Act 1993.

I mention these matters because the Commission very much wishes to cooperate with and support the Committee in this inquiry to the fullest extent possible, noting that there may be some constraints in the information that can be provided. We will need to be particularly cautious not to taint the investigation process or to pre-empt its findings, and we must not get ahead of the due processes that are set down in the legislation. It is also essential that nothing is said that could undermine any future decisions that may need to be made by the independent Director of Proceedings. The Commission is very happy to support the inquiry in any way it can, being mindful therefore that the responses that we give must not inadvertently compromise the investigation findings or any legal determinations, should they arise from the investigation. I appreciate the understanding of the Committee in that regard.

The CHAIR: We appreciate you appearing this morning as a witness, and we appreciate the sensitivities of the matter. We also appreciate that we may have to tiptoe through this a bit, given your pre-emptive statement. Can you give the Committee an update of where things are up to?

Ms DAWSON: I am able to tell you what our investigation actions have been so far; I will need to pull up in terms of determinations and findings. I referred earlier to the wide-ranging coercive and non-coercive powers that we have. We have applied the full suite of those powers in undertaking our investigation. We have written to all patients and all their next of kin to advise them of the investigation and their option to lodge a separate complaint if they choose to do so. We have used our coercive notice powers to secure all patient

records and responses from the doctor on all relevant patients. This means we have records for 82 patients who were the subject of the St Vincent's complaint, 12 patients treated with carboplatin in Bathurst-Orange, 23 patients treated with capecitabine in Bathurst-Orange, 21 patients treated at Macquarie University Hospital and a further nine patients who are the subject of individual complaints. We have responses from Dr Grygiel in relation to all except the 23 capecitabine patients—and, in relation to those, responses are expected in coming weeks.

We have plainly reviewed all investigation reports and information provided by the hospital. That includes internal and external review reports. That includes records of relevant clinical and management meetings. That includes a progress report on the implementation of the section 122 report recommendations. It delves down into review of the training and policy materials relating to incident management and open disclosure. I will not go on, but you can imagine that there is a rich reservoir of material that we are examining. We have issued notices to the relevant health organisations to produce the relevant documents. I will not chronicle what those are—but I can if you wish—and you can assume that it is an extensive list. We have obviously reviewed the section 122 inquiry report and all of the records of interviews undertaken by that inquiry, the purpose of that being to determine what further statements the Commission may need to seek in its investigation.

We used our coercive powers to seek information from individuals who chose not to be interviewed in the section 122 inquiry, and we have received submissions from those folk. We have interviewed current and ex-senior personnel from St Vincent's, the purpose of that being to clarify or confirm issues and actions, and this process is still underway.

The Hon. DANIEL MOOKHEY: Without coercive powers?

Ms DAWSON: Yes. We have sought advice from the Ministry for Health on the actions taken following the section 122 inquiry, and that relates to issues including the status of any actions on any recommendations for which New South Wales has implementation responsibility and the extent to which they are collaborating with the Cancer Institute in relation to actions it is undertaking. It includes seeking from it further information on the status of the statewide random sample of cancer patients. It includes questions as to whether there are any policy considerations afoot in relation to the regulatory framework for private health facilities, and it includes also a request as to whether there are any other system-wide actions that the Ministry may be considering flowing from the section 122 recommendations.

We have also sought further detailed information from St Vincent's Hospital on the implementation of the section 122 inquiry recommendations and also its own governance review. Finally, we have commenced commissioning opinions from eminent independent experts on the standard of treatment provided to different cohorts of patients and in relation to the conduct of the practitioners.

The Hon. WALT SECORD: In your opening statement, Ms Dawson, you made reference to Dr Phadke and said there were different complaints involving different illnesses. On the Dr Phadke matter, there have been media reports and comments to talkback radio that there was concern that the original section 122 inquiry called by former Minister Skinner lumped him into different cases in which she had mixed up complaints that were unrelated to chemotherapy. Can you clarify that for us?

Ms DAWSON: The complaints that we have relating to Dr Phadke cover a range of different patients that he was treating in his capacity as a haematologist and, given that he is also an oncologist, a complaint relating to that.

From our perspective, there is no confusion. We have those original complaints and we also have recently received from the local health district a further report based on their look back of other patients. So we are quite confident that we are clear about the scope of the investigation relating to Dr Phadke.

The Hon. WALT SECORD: What were you referring to when you said "different illnesses"?

Ms DAWSON: I can offer you more information on that. In relation to Dr Phadke, I was referring to the fact that there were a number of different cancers involved in his treatment; there were the haematological malignancies, and they related to diseases such as Hodgkin's lymphoma, non-Hodgkin's lymphoma and the like, and then there was the oncology patient relating to a testicular cancer. So there were just different kinds of clinical presentations that we were dealing with and, therefore, different kinds of treatments relating to each of those.

The Hon. WALT SECORD: Taking you back, you made reference to policy considerations for private facilities. Was the Department of Health or were you able to determine the number of patients? Because under questioning Mrs Skinner virtually said that she had no involvement or control over the private sector and

she just sort of cast it aside. Can you bring us up to date on what has happened with the Macquarie University patients?

Ms DAWSON: Yes, certainly. In relation to Macquarie University patients—I just want to be abundantly clear and not mislead you, so I will refer to my documentation—the Macquarie University complaint that we are investigating relates to 21 patients and their treatment with carboplatin across a range of different cancers.

The Hon. WALT SECORD: You made reference to 148 or 150 patients.

Ms DAWSON: Roughly 149, but say 150 for the sake of argument.

The Hon. WALT SECORD: Of those, how many are still with us, still alive?

Ms DAWSON: I have not done that breakdown, I am sorry, Mr Secord, but we can certainly take that on notice and provide you with that information.

The Hon. WALT SECORD: Of the patients or their families that you have made contact with, in the Central West there was concern, from evidence that we received and in the public arena, that there was a lack of materials available. What have you found in your investigations in the Central West?

Ms DAWSON: A lack of materials available in relation to records, data?

The Hon. WALT SECORD: Yes.

Ms DAWSON: I might get Mr Kofkin to articulate what some of our constraints have been in relation to western New South Wales, because there have been challenges both with what data is available up to 2010 and also as the investigation has involved the availability of prescribing records for other patients.

Mr KOFKIN: In relation to the 23 patients which formed the complaints which we received, we have complete records in relation to that and the prescribing data. I know the LHD have been conducting a very wide scoping examination of all PBS Medicare data in relation to Dr Grygiel's prescribing of chemotherapy to those patients, and I know from a recent update that there has been significant progress made in relation to that, and there may be—it has not been confirmed—further records or further complaints that come to the Commission in relation to that.

The Hon. WALT SECORD: Ms Dawson, can you give us the timetable on when you deliver a final report? Do you deliver a final report?

Ms DAWSON: We complete an investigation and then, depending on whether that investigation report identifies departures in the care and treatment, if that is the case there is then a next process of the deliberations of the independent Director of Proceedings. So I can say to you in relation to the completion of the investigations that we have regarding Dr Grygiel that we anticipate those will be completed in the middle of this calendar year—so July 2017. In relation to Dr Phadke, it is a little bit dependent on the factors of the timing of some input that we are still requiring from the local health district in relation to their look back and their governance review, both of which are quite critical to us coming to grips with the scope and the spectrum of the patients.

The Hon. WALT SECORD: Were you able to go over the section 122 inquiries into the Central West and to St Vincent's that were called? Were you able to go over those inquiries?

Ms DAWSON: Go over those inquiries?

The Hon. WALT SECORD: Did you examine those inquiries? Because there was some concern that they did not interview all the witnesses, did not compel witnesses.

The Hon. TREVOR KHAN: They could not.

The Hon. WALT SECORD: That was a bit of a debate at the Committee hearing. You are right, they could not.

Ms DAWSON: What I can tell you is that we have examined all of the transcripts of the interviews that were undertaken, and the purpose of that is for deciding whether we need to undertake more interviews to satisfy ourselves about the issues that may relate to consenting or so on. That may or may not be necessary. But our reading of those inquiry interviews is that they were very thorough and they did deal with the wide spectrum of questions.

The Hon. WALT SECORD: Have you interviewed the medical staff, the doctors and the staff who did not agree or did not consent to interviews with the section 122 inquiries?

Ms DAWSON: We have.

The Hon. WALT SECORD: You have interviewed all of them?

Ms DAWSON: Interviewed them, sorry—

The Hon. WALT SECORD: Maybe I will just summarise it. I want to find out what happened to the witnesses who refused to cooperate with the Department of Health investigations.

Ms DAWSON: Can I just deal with that at a headline level and then Mr Kofkin may wish to elaborate? For the four people who did not elect to participate in the section 122 inquiry we have sent a notice to all of those seeking a statement—so all four—and in a couple of cases we have also interviewed.

Mr KOFKIN: Just to confirm that, three practitioners who were junior—

The Hon. WALT SECORD: Doctors.

Mr KOFKIN: Yes—we served them a section 34A coercive notice and we asked them to provide us with a statement of information, and there was a number of questions that we asked, and we received fulsome responses from those three. One of the individuals, we took the decision that we wanted that individual to attend the Commission and provide all evidence. So again we issued a section 34A coercive notice for that individual to attend the Commission. He was interviewed by me and one of my colleagues.

The Hon. TREVOR KHAN: Do I take it if you have issued a notice for them to provide answers that you still have the capacity to issue a further notice to require them to attend then?

Ms DAWSON: Completely.

Mr KOFKIN: Absolutely, yes, and there are occasions when we will serve a notice for information if we are not entirely satisfied with the responses we are obtaining, so therefore we decide that perhaps we need to ask the individual to attend or coerce the individual to attend to give more evidence.

The Hon. TREVOR KHAN: Bring them in and give them a prod.

Mr KOFKIN: Absolutely.

The Hon. DANIEL MOOKHEY: In respect to these four, did you give them the opportunity to appear or provide a statement prior to you issuing a section 34, as on a voluntary basis?

Mr KOFKIN: No, we issued a notice because quite clearly the individuals had decided not to cooperate with a section 122 inquiry. We took that as an indication that perhaps they would not want to cooperate with a Commission inquiry, so we went straight to issue the notice. We do not always do that, but we did in this case.

The CHAIR: Can I ask about the findings? Will you be making findings towards Dr Grygiel or towards the affected doctors or will you be also considering making findings against the hospitals?

Ms DAWSON: The investigation powers allow us to do both. We can make findings relating to individual practitioners as they present during the course of the investigation and we can also make recommendations to health organisations under the legislation.

The Hon. TREVOR KHAN: If we talk about Dr Grygiel, by the middle of the year you expect to have essentially completed your investigation; is that right?

Ms DAWSON: Correct.

The Hon. TREVOR KHAN: Do you produce a document?

Ms DAWSON: Yes, we do.

The Hon. TREVOR KHAN: What do you do with the document?

Ms DAWSON: Under the statute, the first thing we are obliged to do with the document, if we are proposing any action in relation to that practitioner, is to provide that practitioner with our findings and to give them an opportunity to make submissions under section 40 of our legislation.

The Hon. TREVOR KHAN: We will not talk in respect of Dr Grygiel; we will talk in respect of Dr X. Let us suppose that in July you have come to a conclusion that Dr X has done a variety of things. You forward to him a copy of your document, which makes those determinations, and you give him or her how long?

Ms DAWSON: I will ask Mr Kofkin to run through two critical things. One is what would that document look like, so you get a feel for that, and then what our statutory rules are in relation to time frames for responses.

Mr KOFKIN: That document would be an extensive letter with the substance of the grounds for the Commission's proposed action. Together with that letter would be our independent export report and copies of all of the material which was provided to the expert when the expert was compiling his or her report. That would be served on the practitioner, or their lawyer, and at the point of receipt they have 28 days to provide a response to the Commission. After those 28 days, the Commission may need to make some further inquiries. For clinical matters, on the majority of occasions, if we receive detailed submissions, we will go back to our expert to make sure that the expert's opinion has not changed as a result of those further submissions. The Commission then needs to consult with the relevant professional council. In this case it would be the Medical Council. Therefore, we consult with the Council in relation to the Commission's proposed outcome.

The Hon. TREVOR KHAN: Is there a time frame that applies for that period of consultation?

Mr KOFKIN: It is normally the first available consult and the conduct committee of the Council meet every month, but in more serious matters we can do that out of session. In this matter, or other similar matters in the past, that is what we have done; we have consulted out of session. When it comes to that consultation process between the Commission and the Council, the Commission has the final say in respect of what the outcome is. The Council may disagree or may agree but, regardless, it would be the Commission's decision. In relation to what the Commission was talking about so far as what happens next, for instance, Dr X has a consultation that there is going to be a referral of the matter to the Director of Proceedings. My division would then compile an extensive brief of evidence to provide to the independent Director of Proceedings, and then it is her decision in respect of what action to take.

The Hon. WALT SECORD: In respect of your investigation of Dr Grygiel and Dr Phadke, has it given rise to any other investigations, or is it limited to Dr Phadke and Dr Grygiel?

Ms DAWSON: The investigations that are on foot raise a range of different issues. They stem beyond the clinical actions of Dr Grygiel and Dr Phadke. They touch on some more systemic issues, as you would imagine, such as mandatory reporting, informed consent, the operation of multidisciplinary teams, education and training and culture. So our investigations have the opportunity to deal with that full spectrum of issues.

The Hon. WALT SECORD: Did you find you had any legislative constraints or a lack of any powers that you felt had limited your investigations?

Ms DAWSON: No, I have to say, as I said in my opening statement, the spectrum of our powers for the Commission is very powerful.

Mr JEREMY BUCKINGHAM: I take it from your evidence that the HCCC has the powers it needs to investigate matters as they emerge? If there are particular matters that emerge during an investigation of one issue, they can be fully explored and you can make recommendations and take actions, et cetera, on the basis of that?

Ms DAWSON: That is correct. We are statutorily obliged to keep our complaints under review and the scope of them throughout the course of the complaint, therefore, through the assessment process and the investigation process. We have the capacity to add either providers or issues as the investigation proceeds.

Mr JEREMY BUCKINGHAM: You do not have to refer back to a complainant, or you can do that of your own volition?

Ms DAWSON: There are processes that apply to adding practitioners or issues. There is no constraint on us doing that, it is just a matter of us following those.

Mr JEREMY BUCKINGHAM: What about time—I apologise for being late. I may have misheard you. Did you say you were investigating the role of the Ministry of Health subsequent to the calling of section 122? Are you investigating the role of the Ministry and the department generally, free of limitations of time?

Ms DAWSON: No. I will clarify what that reference was, Mr Buckingham. What I was referring to is that as part of our investigation we have sought advice from the Secretary for Health about the progress with implementing the recommendations of the section 122 inquiry and whether, in their view, there are other aspects that we could usefully turn our mind to in the investigation. No, we are not investigating NSW Health.

Mr JEREMY BUCKINGHAM: You do not investigate the role and you are not investigating the role of senior bureaucrats or Ministers? You are limited to only practitioners?

Ms DAWSON: We are investigating the care, treatment and conduct of the individual practitioners involved in these issues, and we are able to look at whether there are any systemic issues that arise where improvements would lead to better protection of public health and safety.

The CHAIR: I would like to clarify your last question, which was a specific question. Can you and do you have the powers to investigate the Department of Health?

Ms DAWSON: We have the powers to raise investigations relating to matters in the public health system or relating to treatment provided in the NSW Health system with a set of steps about notifying the Secretary where we intend to do that. That is a statement of the powers under the legislation.

Mr JEREMY BUCKINGHAM: To be clear, does that mean you cannot investigate the role, hypothetically, of the Chief Health Officer in this matter, or any matter? You are limited to the function of a particular practitioner and a particular hospital, but not the bureaucratic side of the Ministry of Health?

Ms DAWSON: The administrative practices of NSW Health are not matters that we advert to.

The CHAIR: To be clear, if there was a systemic governance breakdown from the Secretary of Health through a system, you are not empowered to investigate that?

Ms DAWSON: What I have said is that we, through this investigation, will identify weaknesses relating to the actions of a health organisation or a health practitioner, not of NSW Health.

Mr JEREMY BUCKINGHAM: For the record, what is the HCCC's definition of a health organisation?

Ms DAWSON: I think that the statute offers the definition and we could go to that if you like, but from our point of view it is a hospital or a facility that delivers health care and treatment.

Mr JEREMY BUCKINGHAM: If there is an interaction between a hospital or a facility and the ministry you do not investigate that element of it?

Ms DAWSON: I do not know that I can add anything more to what I have already said. I have the statute here that I can refer to.

The Hon. DANIEL MOOKHEY: Is the Ministry a health organisation?

Ms DAWSON: Not for the purposes of this investigation, no.

Mr KOFKIN: Certainly the Commission will look at the interactions between chief executives or senior executives of health organisations and what interactions they may have had with senior members of the ministry.

The Hon. TREVOR KHAN: Or did not have.

Mr KOFKIN: But the Commission investigates health practitioners who provide health services and health organisations who provide health services whether or not they are public or private or your local beauty salon which is offering Botox, which is providing a health service. It is very, very broad. We are not investigating the Ministry of Health. We have no jurisdiction in terms of senior members of the Ministry of Health. It does not mean that there is not relevant material or relevant evidence which we have heard during this inquiry.

Mr JEREMY BUCKINGHAM: But you cannot make findings or recommendations in relation to them or those parts of the Ministry?

Ms DAWSON: Let me be clear on this, if I may. The scope of our jurisdiction relates to the activities associated with the delivery of a health service. An administrative or executive member who may be performing other advisory functions is not within the purview of a health service for the purposes of our Act.

The Hon. DANIEL MOOKHEY: I have a couple of questions related to various choices in your investigation method. You mentioned that under your notice to produce powers you have 81 patient records or thereabouts?

Mr KOFKIN: We have 149 patient records, to be precise.

The Hon. DANIEL MOOKHEY: Do your powers give you the opportunity to obtain that from anyone who has legal ownership or legal custody? You get the distinction.

Mr KOFKIN: Yes. Basically anybody who has ownership of those records, we can serve a notice on them and ask them to provide them so long as they are relevant.

The Hon. TREVOR KHAN: Ownership or possession, I take it?

Mr KOFKIN: Yes, so long as they are relevant, of course. There always needs to be relevance if the Commission is making any requests or if it is using its coercive powers.

The Hon. DANIEL MOOKHEY: Who has legal ownership of those 149 records?

Ms DAWSON: The medical record is owned by the practitioner that generates that record.

The Hon. DANIEL MOOKHEY: Does the local health district own them or have possession?

Ms DAWSON: Part of the reason why we have had to issue notices is that those records may be held by Genesis.

Mr KOFKIN: Yes, the records may be held by the hospital, they may be held by other private organisations such as Genesis CancerCare.

The Hon. DANIEL MOOKHEY: I am sorry to quibble but when you say "held" do you mean owned or possessed?

Mr KOFKIN: I think it would be a combination of the two, really. For example, if a GP is working in a practice and he is completing a record the records are his. If he leaves and takes the patients with him I think he will take the patients or if he leaves the practice then the records will stay with the practice.

The Hon. DANIEL MOOKHEY: Did you give the opportunity to these organisations or people to hand these records over voluntarily?

Ms DAWSON: We find that for abundance of clarity as to what we seek and to ensure that organisations are clear about the terms on which they can transmit records they actually take a great deal of confidence from the careful articulation of that for the purpose of exercising the powers of our Act. It is protective in a sense for those who we are seeking the information from.

The Hon. TREVOR KHAN: It resolves issues of confidentiality and all those sorts of things.

Mr KOFKIN: Completely.

The Hon. DANIEL MOOKHEY: I am not quibbling with the decision; I am trying to understand that documents were obtained for the reasons you just mentioned as opposed to there being an attempt not to hand them over.

Ms DAWSON: No, there was no resistance. In fact, this was just what we see as good practice for clarity and resolution of those sorts of issues.

Mr KOFKIN: When the Commission is serving coercive notices there is another reason why we serve those notices. It is because for the individual who is providing the evidence there are inbuilt protections in the notice that the evidence they provide cannot be used for any civil or criminal proceedings, it is only for Commission purposes.

The CHAIR: What is the patient's right to have access to or a copy of those records?

Mr KOFKIN: The records we obtain we do not ordinarily provide those to the patient. If the patient wants a copy of their own record they go to the practice.

The CHAIR: What are the obligations on the practitioner to give them?

Mr KOFKIN: They have to give them but there are at times issues where there is an administrative cost to that. But the patient is fully entitled to gain access to their records.

The CHAIR: Are patients able to see their medical files at any time?

Mr KOFKIN: Depending obviously on logistics, but they are certainly entitled to have a copy of their medical record.

Ms DAWSON: Bear in mind just the fact that practitioners are only required to hold those records for the statutory period of time. It might depend on how long ago they wish to have their records for. They may simply not have been kept.

The CHAIR: Is it seven years?

Ms DAWSON: That is correct.

The Hon. TREVOR KHAN: Are you able to tell us when St Vincent's Hospital lodged its complaint?

Ms DAWSON: Yes, I am. I believe it was 19 February 2016.

The Hon. TREVOR KHAN: What a surprise.

The Hon. WALT SECORD: From memory, was that the day after the *7.30* report?

The Hon. BRONNIE TAYLOR: That would be the day after.

Mr JEREMY BUCKINGHAM: Are you able to request or compel, coercively or not, Federal agencies such as Medicare for records?

Mr KOFKIN: Our legislation means we can only use our coercive powers within the State of New South Wales, but the Commission does have very good working relationships with Medicare. Therefore, whenever we request information from Medicare they provide it to us and we have an memorandum of understanding with Medicare.

The Hon. WALT SECORD: Did the investigation or the publicity relating to Dr Phadke and Dr Grygiel bring to your attention any concerns involving hospitals that were not in the public arena like St Vincent's, St George, Macquarie University or Western Local Health District were? Did any other hospitals or patients come to your attention or make complaints unrelated to the districts that were in the public arena?

Ms DAWSON: Not to my knowledge.

The CHAIR: In regard to sample size, there is a percentage of patients who love the doctor, there is a percentage who hate the doctor and there is a percentage of patients who just go to the doctor. Is there any benchmarking or sampling that shows there is a portion of patients who are averse to the doctor? Are you aware of anything like that in your history of investigating medical officers?

Ms DAWSON: Can I just ask for a bit of clarification? I am not quite sure I have caught that one.

The Hon. TREVOR KHAN: You can hate your doctor and it does not mean that the doctor is incompetent.

The CHAIR: That is what I am asking. Because you are an investigating body I would imagine you get different complaints and all sorts of feedback about doctors that you have to investigate.

The Hon. WALT SECORD: Are you trying to get context?

The CHAIR: Yes. Is there any benchmarking to show there is a portion of patients who are normally for the doctor and a portion who are normally against the doctor?

Ms DAWSON: I am not aware of any such benchmarks, no. I think there is a wide experience of patients and the experience of a patient can change over time depending on their own clinical journey and depending on whether there are any confounding factors. They may have a mental health issue that may affect their experience and their perspective on their doctor and so on. I do not think there is any benchmarking that we are aware of.

The CHAIR: They have benchmarked politicians. I think it is 90 per cent adverse.

Mr JEREMY BUCKINGHAM: I have one more question. I am not a health professional. The section 122 inquiry used a particular methodology for assessing the various cohorts of patients to assess the probable rates of recurrence and people who may or may not have been impacted by these practices. Do you review that methodology in that section 122 to assess whether the numbers of people who may or may not have been treated in this particular way are reflected accurately?

Ms DAWSON: No, that is not part of the scope of our investigative work. What that is part of is the section 122 inquiry itself. It has made a range of recommendations about lookbacks and the random sample and so on. That is really the mechanism for drilling down further into recurrence rates and so on. It is a separate process.

Mr JEREMY BUCKINGHAM: But you will be relying on the recommendations that fall out of that methodology.

Ms DAWSON: NSW Health is monitoring and overseeing that implementation. That is not within our purview.

The CHAIR: Would you like to make any further comment you would like to make before we close?

Ms DAWSON: No, thank you.

The CHAIR: There being no further comment, I thank you for appearing today. It has been very helpful. I think it will be quite strategic in the recommendations for us. Members may have further questions that arise from the hearing. You will have 21 days to provide written answers to those. The secretariat will help you out if that happens. Otherwise, thank you. Have a very good day.

Ms DAWSON: We appreciate the opportunity.

(The witnesses withdrew)

GREG KESBY, President, Medical Council of New South Wales, sworn and examined

The CHAIR: Dr Kesby, thanks for coming today. You might want to introduce the person that is here as your adviser even though she will not be going formally on the record.

The Hon. TREVOR KHAN: Or indeed participating.

Dr KESBY: I have with me Caroline Lamb, the executive officer of the Medical Council of New South Wales, to hopefully fill in any gaps that I may need filled.

The CHAIR: Do you have an opening statement that you would like to present.

Dr KESBY: I do, thank you. These proceedings are understandably very distressing for those who feel adversely affected by the matters that are under inquiry. I am hoping that by giving an overview of the Medical Council it may assist you and the observing public in understanding our work. The Medical Council has 19 members from across the profession and the community. Twelve are medical practitioners of experience and standing who are appointed by way of nomination by the various specialist medical colleges, the Australian Medical Association and universities, but the other seven members are appointed by the Minister and drawn from the broader community. They include a nominee of the Community Relations Commission and a member with legal qualifications.

We regulate about 7,000 medical students and 33,000 practicing doctors in New South Wales and we have responsibility over that. That is about one-third of Australia's medical student and medical professional population. Thankfully most of those doctors will practice in a manner that clearly reflects the requisite professional attributes of integrity, competence, high ethical standards, altruism and respect for patient autonomy—the things that underpin the high level of trust that the public has in the profession. But there are doctors who fail to live up to these expectations. Most often they will display deficiencies in their clinical performance but sometimes they may exhibit inappropriate conduct. Some of them will sadly be affected or impaired by their own personal health issues. It is this group of doctors that comes to the attention of the Medical Council either by way of a complaint or by a notification.

The Medical Council of New South Wales is a statutory body established under the Health Practitioner Regulation National Law. Essentially we are charged with ensuring that a doctor is fit to practice in the profession. The law that governs our activities is not punitive. It is protective. We focus therefore on promoting ongoing safety and health of the public, promoting the trust of the public in the profession and one of the governance structures that underpins trust in the broader healthcare system of New South Wales. Essentially our role is to remediate and monitor. The investigation and prosecution is the domain of our co-regulatory party authority—as you have heard, the Health Care Complaints Commission.

In New South Wales every complaint or notification about a medical practitioner is jointly considered by the commission and the council. It is a good governance structure. It works very effectively. It has been copied by other jurisdictions with the recent changes you may have noted in Queensland. To give some indication of volume, in the last year, 2015-2016, we considered more than 3,000 complaints together. Of those, 2,230 were new complaints. More than 500 were assessed as raising enough concern that they should be investigated or referred to the council for management through its conduct, performance or health pathways. When the council receives a referral from the commission, in all of the committees, all of the interviews and all of the hearings that we conduct in managing those matters we involve both community members and medical members. They adjudicate and participate on equal terms. This is a culture very deeply embedded in our process and highly valued by all concerned.

Finally, the Health Practitioner Regulation National Law recognises that in the setting of serious complaints a requirement for thorough investigation and examination of evidence to inform a decision as to whether to prosecute or remediate takes time. Section 150 of that law provides a mechanism for protecting the public while these important investigative and related processes occur. Section 150 is a power given to the council. It obliges us to suspend or impose conditions on a practitioner's registration if at any time we are satisfied that it is appropriate to do so for the protection of the health or safety of any person or if we are satisfied the action is otherwise in the public interest. We therefore use this power fairly liberally at the beginning of serious complaints, recognising that there might be quite a significant amount of time pass before the investigation is completed and the matter is concluded. Any conditions or suspensions we put in place will stay in place until the conclusion of the matter or until it has been appealed or lifted by council process.

I hope that these comments have assisted you in understanding the role of the council in its regulatory activity. We appreciate the opportunity to appear today and to explain our role. As president I will endeavour to

help you as much as I can. I am mindful that the complaints regarding the medical practitioners of interest to this inquiry remain under investigation by the commission. We will need to be formally consulted by the commission at the conclusion of its investigation to consider a pathway forward. To ensure the integrity of that process is maintained you will appreciate that I may need to exercise great caution in expressing a personal opinion or an opinion on behalf of the council regarding specific practitioners.

The Hon. BRONNIE TAYLOR: Dr Kesby, when you talk about the medical council where the cases come before you and you are making decisions, you said that consisted of community and medical practitioners, how many people and what is the ratio? How many community representatives and doctors?

Dr KESBY: The council itself has 19 members. It is a big council because there is a lot of work that needs to be conducted in committee. On the council are 12 medical practitioners who are drawn from the specialist colleges, the Australian Medical Association and universities, and seven are from the community appointed by the Minister. One is from the community relations commission and one is a member with legal expertise. A lot of the work of the council is done in committee by the health committee, the conduct committee and the performance committee, depending on the nature and dimensions of the complaint. I have been focused on making sure that every committee has at least a third, sometimes more, lay involvement, and that there is an appropriate mix and diversity in each committee. When doctors are called in for hearings, be they section 150 hearings or other interviews, the interview panel will generally be comprised of a lay member and at least a peer and in many cases a third.

The Hon. BRONNIE TAYLOR: When that review happens, you get a complaint and it goes to the specific committee, but I presume it then comes back to the entire medical council of 19 members for a decision as to what the action would be?

Dr KESBY: No. A complaint is received by the council, it is then jointly considered at a weekly meeting of the commission with delegates of the council, who is usually a senior medical officer. The commissioner takes advice from the council about how we view that the complaint should be triaged, but she will make a call as to whether it is investigated or referred to us for remedial action. If it is referred to us for remedial action we will then apply our remedial, supportive, re-educative processes to the practitioner.

The Hon. BRONNIE TAYLOR: Re-educative?

Dr KESBY: If there is a performance deficiency we will make sure they are brought up to speed.

The Hon. BRONNIE TAYLOR: You said there were 500 investigated in the 2015-16 year that you thought required investigation. Out of those 500 how many did you take action on?

Dr KESBY: The wording was that there were 500 of significant enough concern that they were either investigated or referred to the council. The figures may be available to me here. Are you looking to see how many ended up in a disciplinary outcome?

The Hon. BRONNIE TAYLOR: Yes.

The CHAIR: How many were immediately restricted in service until the investigation is finished?

Dr KESBY: We held approximately 100 urgent action hearings where we thought that this may have dimensions of seriousness where there may be ongoing risk. In about two thirds to three quarters it may have had an outcome of having interim conditions or suspension in place. Those are rough figures. The matters that are referred through to investigation and were then referred to the commission will be in our annual report. I am trying to find the figures for you. Seventeen?

The Hon. BRONNIE TAYLOR: Seventeen?

Dr KESBY: More than that went through to the commission.

The Hon. WALT SECORD: What is the ultimate sanction?

Dr KESBY: Let me give you some figures. Approximately 60 matters were referred for disciplinary hearing in 2015-16 and the outcome of those disciplinary hearings can include suspension or cancellation of a practitioner's registration. The outcome was that in 21 NSW Civil and Administrative Tribunal [NCAT] hearings the doctor's registration was suspended or cancelled and about another 17 doctors under investigation I believe surrendered their registration in the interim.

The Hon. WALT SECORD: There were 17—and what was the previous figure? So 21 had their licences taken away?

Dr KESBY: Of the investigations that occur about 65 per cent will go through to the director of proceedings who will independently determine whether the matter is to be prosecuted before a professional standards committee or before NCAT.

The Hon. WALT SECORD: Of those figures, out of 500 cases 38 doctors either voluntarily gave up their licence or had their licences taken away?

Dr KESBY: Yes. About 21 were removed by NCAT and 17 surrendered their registration.

The Hon. WALT SECORD: It is rare to have your licence taken away?

Dr KESBY: And it should be. A profession that is functioning at high standard should have a very uncommon incidence of doctors who are so egregious in their behaviour that they should have their licence removed.

The Hon. WALT SECORD: They have to be really egregious to take away their licence?

The Hon. TREVOR KHAN: You do not take away the licence?

Dr KESBY: NCAT make that decision. NCAT is a forum where there is the judicial knowledge of a district court judge or equivalent and testing of the evidence. It does need to be serious to have your licence to practice medicine removed, mindful of considerations about whether deficiencies in the doctor's performance or conduct could be remediated.

The Hon. TREVOR KHAN: A whole series of other restrictions could be placed on a practitioner's right to practice, is that right?

Dr KESBY: That is right.

The Hon. TREVOR KHAN: What areas they can practice in, for instance?

Dr KESBY: They can limit the scope of practice and direct them to do specific courses or continuing professional development [CPD] activities.

The Hon. TREVOR KHAN: And restrict where they practice?

Dr KESBY: Yes. One of the common mechanisms to add security and mitigate risk is to bring doctors who may be in solo practice into group practice or under other peer review structures.

The Hon. TREVOR KHAN: There is a degree of supervision or oversight of the practitioners?

Dr KESBY: Yes. We use supervisors near universally when conditions are imposed and we make use of mentors as well.

The Hon. TREVOR KHAN: On notice are you able to provide a breakdown? So we are not only talking about those struck-off but the other forms of restrictions that are placed upon practitioners out of the number dealt with each year. It might be in your annual report.

Dr KESBY: It is in the annual report which I will make available.

The Hon. BRONNIE TAYLOR: If you have decided that someone is not quite right and is under supervision, is the patient informed of the fact that the doctor they are seeing is under supervision?

Dr KESBY: Each patient individually would not be informed but it does appear as a condition on the public register.

The Hon. DANIEL MOOKHEY: There is no requirement for that to be displayed at the practice?

Dr KESBY: There is no requirement to display. At the end of an outcome where there may be a requirement for a doctor's practice to be supervised, that does not necessarily translate into the fact that the doctor is functioning deficiently, it is more a protective oversight to ensure the protection of the public. If you are trying to say should a patient be informed that a doctor is required to meet monthly or weekly with his supervisor that brings with it a connotation that that doctor is very deficient in their practice. It may well be that they have been remediated and we are keeping in place a process of oversight to ensure that that is sustained. Those conditions will usually, eventually fall away.

The Hon. TREVOR KHAN: For instance, it may be that the doctor is in some way unwell?

Dr KESBY: It could be that the doctor is unwell.

The Hon. WALT SECORD: What is the current status of Dr Grygiel's licence in New South Wales?

Dr KESBY: He is subject to conditions on his practice that were imposed under a section 150 hearing by the council. The more substantive parts of those conditions are that he is permitted to practice as long as he—

The Hon. WALT SECORD: He is permitted to practice?

Dr KESBY: He is permitted to practice as long as he adheres to eviQ guidelines and he would practice under supervision and monitoring.

The Hon. WALT SECORD: So what do you have to do in New South Wales to get rid of your licence?

Dr KESBY: Excuse me?

The Hon. WALT SECORD: Dr Grygiel can still practice in New South Wales?

Dr KESBY: He has a potential to practice.

The Hon. WALT SECORD: What do you have to do in New South Wales as a doctor to lose your licence?

The Hon. TREVOR KHAN: Go to a hearing before the NSW Civil and Administrative Tribunal [NCAT].

The Hon. WALT SECORD: What is the test or the level? I am not a barrister or solicitor.

The Hon. TREVOR KHAN: I know what you are doing, but you need to go to a hearing before NCAT. The matter is under investigation.

The Hon. DANIEL MOOKHEY: That is not technically true. Can I follow up on that question?

Dr KESBY: Can I answer the question?

The CHAIR: Order! The witness will be allowed to answer the question.

The Hon. WALT SECORD: Can you answer the question about Dr Grygiel?

Dr KESBY: Complaints or concerns were raised about Dr Grygiel that are under investigation. Whilst those matters are under investigation an assessment of possible risk was made by the council, and that was addressed by a hearing under section 150. That hearing was conducted by the deputy president, a non-medical legal member and an oncologist. The assessment was made, in carrying out our legislative responsibility of protecting the public, that that could be effected by ensuring conditions were placed on his registration that he practised in accordance with eviQ guidelines and that he was kept under supervision and review. That is still ongoing.

The Hon. WALT SECORD: Do you not think that it is an absurd situation that Dr Grygiel can still practice in New South Wales?

Dr KESBY: There has been no finding about Dr Grygiel—

The Hon. TREVOR KHAN: Point of order: The witness has already indicated that he needs to be constrained in what he says because matters will be referred back to the council in due course. I would be concerned if we caused the whole process of investigation to go off queue by the witness inadvertently answering the question in some way.

The CHAIR: I think everyone understands the point the member is making. Mr Mookhey, do you wish to ask a question?

The Hon. DANIEL MOOKHEY: Does a section 150 hearing allow the council, for want of a better term, interim powers before NCAT hearings?

Dr KESBY: It allows the council to place conditions on a practitioner or to suspend registration at any time. We tend to activate it on receipt of serious complaints that we know will be required to be investigated and that will take time.

The Hon. DANIEL MOOKHEY: Would you describe the current restrictions on Dr Grygiel as "interim"?

Dr KESBY: They are interim and the section 150 conditions will fall away after investigation and conclusion of the matter. If the matter goes to a prosecutorial level, they may or may not be replaced by other conditions.

The Hon. DANIEL MOOKHEY: When do you consider a matter to be concluded?

Dr KESBY: A matter is concluded, from our point of view, when it has either gone through a determination by the commissioner that it be referred to council and council has completed its processes or it has gone through the joint consideration and referral to the DP and the DP has taken action. That may be that it is heard before a disciplinary body, a performance standards committee or NCAT and they have made their final determination.

The Hon. DANIEL MOOKHEY: There is a window between should the matter proceed further in a prosecutorial sense, as you put it, and the completion of those prosecutorial proceedings where the section 150 current conditions will fall away?

Dr KESBY: No, they will only fall away at the conclusion of the prosecutorial hearing.

The Hon. DANIEL MOOKHEY: You said that you generally receive 500 complaints per year?

Dr KESBY: No. We received about 2,230 complaints last year. A lot of the complaints may be: "I was charged too much. He only spent five minutes with me." A lot of the complaints were dismissed but about 500 had enough characteristics about them that they required a deeper dive, in terms of investigation, because it may have come to a level of concern that required prosecution. Others were referred directly across to council, recognising the council's regulatory role of overseeing appropriate levels of performance, conduct and health.

The Hon. WALT SECORD: Can Dr Grygiel still prescribe in the current situation?

Dr KESBY: He can prescribe. In terms of prescribing chemotherapy, he is restricted to prescribing and keeping within eviQ guidelines. Any individualisation of care under eviQ guidelines is to be clearly documented and then subject to review by a supervisor.

The CHAIR: It still leaves a bit of a hole there. There has been a systemic governance breakdown—this got through multi-disciplinary team reviews. I am concerned that Dr Grygiel can still prescribe.

Dr KESBY: I do not understand what you mean by a "governance breakdown". Are you referring to the medical council?

The CHAIR: Not by the council, but generally within the hospital system as to the way in which a doctor prescribes. It appears there are holes along the way because it was never picked up that this low chemotherapy dosing was happening. How do we know that case Dr Grygiel will abide by the prescribed system, given that to date there have been occasions when he has not done so? Is someone checking what he is prescribing every time? If so, who is doing that?

Dr KESBY: There are a few layers to that question. At the moment Dr Grygiel is not practising but he has got the capacity to practice under those conditions. Those conditions require, as I said, that he maintains prescribing in this regard to eviQ protocol. He is not employed at any institution at present, I believe, either. We also have in place monitoring conditions where the supervisor is tasked with overseeing the prescribing behaviour of Dr Grygiel should he practice. There is an expectation that that supervisor would also report to the medical council. We also have a provision to audit Dr Grygiel's records. The concern you raise I understand fully but we are certainly satisfied that we have in place, particularly given all the other activity that has occurred in this space, that we can be confident that should he return to practice, should he prescribe, we would be able to effectively monitor that.

The CHAIR: Are the supervisors, for instance, supervising him daily, weekly or monthly? What are they reviewing and how often are they doing it?

Dr KESBY: At the moment he is not practising.

The CHAIR: But if they were, what would the expectation be of the supervisor?

Dr KESBY: They would met monthly but the council at any time can review his records.

The Hon. TREVOR KHAN: Do I take it that if Dr Grygiel were to practice then he would be under an obligation to immediately notify the council that he is recommencing practice?

Dr KESBY: He must notify us I think it is seven days before he recommences practice.

The Hon. TREVOR KHAN: So there are a series of procedural steps to be followed that keep an eye on what he or any other doctor in a similar circumstance would do?

Dr KESBY: In protecting the public we must maintain a watching brief on any doctor that comes to our attention. And we do that.

The Hon. DANIEL MOOKHEY: Are there any restrictions on the number of patients he could see in a month?

Dr KESBY: I do not believe so, no.

The Hon. DANIEL MOOKHEY: So it is possible that if he is operating on a calendar of 10-minute appointments that he could see a number of patients—

The Hon. TREVOR KHAN: He is a specialist oncologist; not a general practitioner.

The Hon. DANIEL MOOKHEY: Okay. Hypothetically we will go to a broader timescale but my general point is—

The Hon. NATASHA MACLAREN-JONES: Point of order: We cannot have hypothetical questions. It is already been explained that he is not practising.

The CHAIR: The Hon. Natasha Maclaren-Jones has a question.

The Hon. NATASHA MACLAREN-JONES: I ask about the complaints that come through and whether any analysis is done on it from the perspective of a series of complaints about not one practitioner but perhaps a hospital or region. Do you analyse that at over either a 12-month or five-year period?

Dr KESBY: That is not the remit of the Medical Council. That would be the remit of the NSW Health Care Complaints Commission.

The Hon. NATASHA MACLAREN-JONES: You mentioned that you are looking at performance and governance. Do you have any jurisdiction when it comes to hospitals or is it purely over the medical practitioner?

Dr KESBY: On the medical practitioner purely. The power to look at hospitals resides with the commission. Remember, at the moment the Medical Council's involvement in this space has been to put in place interim orders to protect the public. We are still awaiting the investigative outcome of the Health Care Complaints Commission. If the decision of the commission is that Grygiel or Phadke is to be referred to the council, we would then take up our performance pathways more intensely.

The CHAIR: Can you give us a snapshot of where Dr Phadke is in the system?

Dr KESBY: Dr Phadke is not practising at the moment either. He is suspended from the St George Hospital, but we keep an active watch, and our inquiries as recently as last week were that he has not been practising since late last year.

The Hon. DANIEL MOOKHEY: Have you imposed restrictions on his practising?

Dr KESBY: He has conditions on his practice.

The Hon. DANIEL MOOKHEY: When you say suspended, you mean from his employment.

Dr KESBY: He is suspended from, I think, the St George Hospital.

The Hon. DANIEL MOOKHEY: As an employee.

Dr KESBY: As an employee. But he does practise under conditions. Again, the substantive conditions are that he is to be supervised, that he does not see any new haematology patients and that the patients he does see are brought to the attention of a multidisciplinary team review, which is another sort of level of security in terms of oversight of patients with cancers.

The CHAIR: When would one expect the investigations into Dr Phadke's case to be concluded? Is that months away or has it been concluded?

Dr KESBY: That is purely in the hands of the commission.

The Hon. DANIEL MOOKHEY: I want to return to the interim powers you have. How many doctors are currently subject to an interim suspension of their licence?

Dr KESBY: An interim suspension of their licence?

The Hon. DANIEL MOOKHEY: Yes. You said you had the opportunity under your interim powers to impose restrictions, which I think you described as either remediating or prohibitive.

Dr KESBY: If you want a figure as of today's date, I would have to take that on notice, but of the immediate action outcomes we undertook in 2015 and 2016, just to give you a flavour, we suspended the registration of just under 20 per cent, 18 doctors.

The Hon. DANIEL MOOKHEY: So 18 doctors had their registration suspended, but these two doctors have not. Why? What have those 18 doctors have done that is worse to justify that discrepancy? Clearly there are two thresholds here at an interim level. There is a category at the top with 18 doctors that the Medical Council has deemed oppose such a threat to the public that their registration is suspended, prior to NSW Civil and Administrative Tribunal or the Director of Proceedings of the NSW Health Care Complaints Commission having the opportunity to do so, but these two doctors are not in that category.

The Hon. TREVOR KHAN: There could have been a finding, for instance, by a court that would justify making an order. There is no such thing in this case.

The Hon. DANIEL MOOKHEY: I have no doubt that would be grounds, but I am asking the witness to provide that evidence. What does it take to get to the top?

Dr KESBY: I am being cautious in answering this because inherent in your question is your belief or your judgement that Dr Phadke and Dr Grygiel have transgressed so far that in your opinion they should be suspended.

The Hon. DANIEL MOOKHEY: Am I wrong?

Dr KESBY: I am not in a position to say. I need to await the outcome of the investigation and consultation with the commission.

The Hon. DANIEL MOOKHEY: I respect that, but I am not asking you to make this assessment in the abstract. The council has made this assessment that these doctors do not qualify on an interim basis for suspension. I am trying to understand contextually—

Dr KESBY: I would look at it the other way and say that the council has carried out its statutory duty to make sure that the public is protected by the imposition of conditions. I think that if you look at the conditions in effect, they do protect the public. It was unnecessary—but I will not even take it any further than that. In response to the question about what would warrant definite suspension, clearly a matter of a sexual nature would immediately result in suspension, but I do not want to start drawing parallels between those issues and the doctors of interest to you.

The CHAIR: We have come to the conclusion of this session of the hearing. Can we get some sort of flowchart of the way these disciplinary actions work? It would be very helpful to be aware of that.

Dr KESBY: It is terribly complex.

The CHAIR: Thank you for your evidence today. It has been most helpful for us to contextualise the broader things we need to consider in this inquiry. Given that some of us may want to ask further questions, the secretary will be here to help you. You have 21 days to answer questions on notice.

(The witness withdrew)

CAROL BRYANT, Chief Executive Officer, Macquarie University Hospital, sworn and examined

The CHAIR: Ms Bryant, I note for members that you have a legal advisor to help you in the procedure. She will not be a sworn witness but is here to advise you, so please introduce her after you introduce yourself.

Ms BRYANT: I am here in the capacity of Chief Executive Officer at Macquarie University Hospital. This is Suzanne Wallace, who is a partner at Moray and Agnew.

The CHAIR: Before I ask you whether you have an opening statement, I will just read a formal communication to you. I ask that you please be careful when using individuals' names during the hearing, in order to avoid unnecessary harm to people's reputation. Please ensure your comments are relevant to the terms of reference. I also 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 their evidence at this hearing. So I urge you to be careful about any comments you make to the media or to others after you complete your evidence here today, as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation. Do you have an opening statement that you would like to make?

Ms BRYANT: I do, thank you. I am the chief executive officer at Macquarie University Hospital, which opened in 2010, and I have held that position since May 2011. Dr Grygiel treated patients as a specialist oncologist in our hospital between June 2010 and October 2012, when he resigned. I am grateful for the opportunity to appear before the Committee today because I believe it is very important to acknowledge and learn from the vulnerabilities that we become aware of in our health care system so that we can continue to develop better and safer care for our patients. This process of reflection to learn from past mistakes is valuable for our patients, the hospital and its practitioners. It can sometimes be a painful process, but it remains an extremely important one.

In January 2012, I was made aware by hospital staff of conduct issues in relation to Dr Grygiel. I met with Dr Grygiel on 6 March to raise those issues raised directly with me. I should point out that these concerns raised with me were not specific concerns about chemotherapy treatment doses. I first learnt of concerns regarding Dr Grygiel's dosing practices from media reports in early 2016. Following these initial media reports we had an internal investigation and identified 21 patients at our hospital who had been prescribed a flat dose of carboplatin by Dr Grygiel. NSW Health was immediately informed of our preliminary and subsequent findings. After identifying that some patients had been prescribed with a flat dose of carboplatin, our chief priority was to contact them and/or their relatives in a considered and sensitive manner. We sought external advice and assistance to do this.

We accept that our handling of patient conduct could have been much quicker. This task was more difficult than expected and we regret any delays that may have added to our patients' and their families' concerns. I can confirm that all patients and/or their relatives have now been contacted, and we again extend our apologies to patients and their families.

The CHAIR: Were the delays because of legal representation and advice or was it just a systematic breakdown?

Ms BRYANT: They were not in relation to advice. The records were four years old—

The Hon. TREVOR KHAN: Finding people.

Ms BRYANT: Yes, that is right; so it was contacts. We had landlines that were out of date, all of those sorts of issues made it more difficult than we anticipated.

The Hon. WALT SECORD: I just could not hear the time line. When were the concerns raised with you about Dr Grygiel?

Ms BRYANT: That was in early 2016.

The Hon. WALT SECORD: The time line did not make sense to me.

The CHAIR: Can we go to your opening statement where you said a couple of dates? I thought you said January 2012 and then I think you said something about 6 March. Can you just go over that again?

The Hon. WALT SECORD: Can you say it again for us please—just the time line?

Ms BRYANT: In January 2012 I was made aware by hospital staff of conduct issues in relation to Dr Grygiel. I met with Dr Grygiel on 6 March 2012 to discuss those issues raised directly with me. I should point

out that those concerns raised with me were not specific concerns around chemotherapy treatment doses. I first learnt of concerns regarding Dr Grygiel's dosing practices from media reports in early 2016.

The Hon. TREVOR KHAN: About 18 February, I take it.

Ms BRYANT: Yes.

The Hon. WALT SECORD: So January 2012 the first issues were raised about the conduct issues involving Dr Grygiel; you met him on 6 March 2012 and he departed October 2012.

Ms BRYANT: Yes.

The Hon. WALT SECORD: What were those conduct issues related to?

Ms BRYANT: They were mostly around communications. We have an instant reporting system where all issues, whether they be clinical or non-clinical, are raised through those, and there were a number of incident reports and then a report from the nursing manager of the area, and they were around the communication between nurses and Dr Grygiel, mainly around a method of communication. There were other issues around trying to finalise specific procedures that he might want conducted—a lack of signing off on those. So I described them as conduct issues.

The Hon. TREVOR KHAN: Essentially, he was rude to nurses. Is that the general direction?

Ms BRYANT: That is correct.

The Hon. BRONNIE TAYLOR: When he was asked to do things that would be expected of him.

The Hon. WALT SECORD: But you also made reference to signing off. So as well as being rude, are you also talking about a lack of detail to paperwork?

Ms BRYANT: Not necessarily a lack of detail, but there was a particular issue that we were working on as far as standing orders. We had those orders, but it is really him signing off on those. So it was just that method of communication—he was difficult to get to comply with that sort of thing, and it was around communication: we would ask and he would be quite abrupt and abrasive.

The Hon. TREVOR KHAN: All the sorts of things that specialists are.

Ms BRYANT: I must say not all.

The CHAIR: Would you say that that would not be outside some specialists' responsiveness—that type of behaviour?

Ms BRYANT: Yes, I can confirm that that is the sort of behaviour that you do get from some individuals.

The Hon. WALT SECORD: Did you know about the chemotherapy underdosing before the *7.30 Report* was broadcast?

Ms BRYANT: No, we did not.

The Hon. WALT SECORD: When did you make contact with the Ministry of Health or the appropriate regulatory body?

Ms BRYANT: The exact time line: we started investigations, so we had to look at our medical records; we determined the number of patients who were treated by Dr Grygiel with carboplatin. Then, in consultation with one of our medical oncologists, they reviewed all the records. So it took it a number of weeks. We started contacting patients in early April.

The Hon. TREVOR KHAN: Did you contact the patients before or after you notified the ministry?

Ms BRYANT: I would have to check that time line. I am happy to bring that exactly back to you.

The Hon. TREVOR KHAN: If the contact was made with the ministry, was it in the nature of just a phone call, "Hey, Houston, we have a problem", or was it in some more formalised way?

Ms BRYANT: Yes, it was a written report to the ministry.

The Hon. DANIEL MOOKHEY: You said that 21 patients were identified. Out of how many?

Ms BRYANT: That was the total number of patients treated with carboplatin—the total number.

The Hon. TREVOR KHAN: On flat doses?

Ms BRYANT: On flat doses, that is correct.

The Hon. DANIEL MOOKHEY: Out of how many patients did he treat?

Ms BRYANT: I would have to get back to you on that. The majority of his patients were treated by carboplatin. His patient numbers were not great, but I am very happy to give you that detail.

The Hon. BRONNIE TAYLOR: I know that you did answer initially that you saw him about conduct issues. I have never been to Macquarie Hospital—I presume you have an oncology unit where you do the chemotherapy.

Ms BRYANT: We do.

The Hon. BRONNIE TAYLOR: And he has got his private consulting rooms at Macquarie Hospital.

Ms BRYANT: Yes. Most of his consulting was done at St Vincent's and he had some consulting space on one of our levels in the hospital.

The Hon. BRONNIE TAYLOR: So none of the nurses in the chemotherapy unit ever raised the issue with any senior staff that there was a medical oncologist that was just doing a generic flat dose of a drug like carboplatin?

Ms BRYANT: I can confirm that none of those issues were ever raised with me.

The Hon. BRONNIE TAYLOR: Never raised with you, but are you aware that they were raised with anyone else in a senior clinical position within Macquarie?

Ms BRYANT: No, I am not.

The Hon. TREVOR KHAN: Do you have multidisciplinary teams that operate within the hospital?

Ms BRYANT: We do. Probably a bit of context: The hospital opened in 2010, as I said, and the majority of those patients were treated in 2010 and 2011, a few in 2012—the last patient in April 2012. So the chemotherapy unit in itself was quite small and in its growing phase. We might have seen 80 to 100 patients a year; we are now seeing over 200 a month—so a lot of growing. Within that time we now have multidisciplinary teams across every cancer stream.

The Hon. TREVOR KHAN: The patients that he saw, were they head and neck cancers?

Ms BRYANT: The majority were head and neck, but all.

The Hon. TREVOR KHAN: I take it either you or your lawyer has seen the transcript of Dr Grygiel's evidence. Would that be right?

Ms BRYANT: Yes.

The Hon. TREVOR KHAN: Again, it is going over time and I am getting old, but I take it that essentially what Dr Grygiel would say is that he was treating some of his patients by flat dosing, they were head and neck patients, he came to a view that it was an appropriate form of treatment because it—sorry, I have forgotten the word—essentially it sensitised the patient for radiotherapy. What has perplexed me throughout this, and if I accept what he says, is how does an oncologist come to a decision to flat dose because it assists in radiotherapy, without having a discussion with the radiotherapist on that line of treatment? Is it a thought that has crossed your mind as to how this non-communication of a course of treatment does or does not come up?

Ms BRYANT: It would be difficult for me to answer that question; I am not a medical practitioner, even though I am a very experienced health administrator.

The Hon. TREVOR KHAN: I gathered that.

Ms BRYANT: All I do know is that he worked in a radiotherapy practice. I cannot comment on how or why that would not occur.

The Hon. TREVOR KHAN: It means that your doctors who operate within your system do not talk to each other. It is a problem that is not restricted to St Vincent's; it seems to be endemic amongst doctors that they do not talk about what seems to me is the most basic of things, such as, "We will give this one a low dose because they are in trouble and they will not take a high dose. We will press on with radiotherapy as the way of treating the patient." To me, that seems blindingly obvious as to what they would chat about.

Ms BRYANT: I cannot comment exactly on that situation, but I can say now that we have multidisciplinary teams [MDTs] across every cancer stream. They occur next to my office almost every morning

of the week. They look at breast cancer, melanoma cancer, lung cancer, colorectal cancer. It is a multidisciplinary team with a radiation oncologist.

The Hon. TREVOR KHAN: I have heard over and again that you have a multidisciplinary team.

The CHAIR: The problem is that they are dealing with the headlines.

The Hon. TREVOR KHAN: I am wondering what they talk about.

The CHAIR: No-one seems to know the dosage that the patients are on.

The Hon. BRONNIE TAYLOR: The evidence that has been given to the inquiry over the course of time would clearly demonstrate that the doses of chemotherapy, certainly what the oncologist shared within the multidisciplinary team, was not a dosage.

Ms BRYANT: That is my understanding.

The Hon. BRONNIE TAYLOR: With respect, Ms Bryant, you are saying that you have established MDTs because you have a greater volume of patients, that is fantastic, but the evidence we have heard clearly demonstrates that even with those MDTs in place, they were not dealing with the issue of the dosage.

The Hon. TREVOR KHAN: It is more than dosage. It is a different regime of treatment. It is using the chemotherapy—

The Hon. BRONNIE TAYLOR: To enhance.

The Hon. TREVOR KHAN: To enhance the radiotherapy. I would have thought that would be a fundamental issue for a multidisciplinary team to talk about.

Ms BRYANT: I would agree that it was not happening then, but there are many other ways in which outcomes are identified. For example, every specialty runs a mortality and morbidity meeting, which looks at outcomes. It looks at those who are outliers and they examine trends. Then there is incident reporting within the hospital when a certain clinical issue occurs. It is raised and they are discussed at various clinical meetings. There is a quality assurance level to making sure that things work properly because outliers are identified.

The Hon. TREVOR KHAN: St Vincent's have the same bodies in place, but the problem is, with respect, you can have all the bodies you look like, but if your specialists are not talking to each other, it does not matter what you have got.

Ms BRYANT: As a chief executive officer, I would disagree in multiple areas that the clinicians do not talk to each other. They definitely do.

The Hon. TREVOR KHAN: In this area, have you asked the question why the heck this was not discussed between the relevant specialties and, if not, why not?

The CHAIR: The evidence we have taken is that in some places nurses particularly pick up at the ward level that this is an inappropriate dose, and that hopefully works through the frameworks that are in place to set off the alarm bells.

Ms BRYANT: That is correct.

The CHAIR: It seems that all these alarm bells have been quietened, for whatever reason—systemic breakdown. One would have thought that the MDT, with allied health services being there—they still missed it.

Ms BRYANT: I reiterate that MDTs were not in place then. The eviQ guidelines were in their infancy, so they really only came into prominence in 2012. It was not until 2013 that there was a recommendation that they became national guidelines, so there was a lot of change in that area.

The Hon. BRONNIE TAYLOR: This dose was outside the stated eviQ guideline.

Ms BRYANT: It was, that is correct.

The Hon. BRONNIE TAYLOR: And as you just said, those guidelines came in in 2012.

Ms BRYANT: Yes.

The Hon. BRONNIE TAYLOR: I would imagine that every time your nurses were delivering chemotherapy, they were printing out the eviQ guideline and that they would check it religiously.

Ms BRYANT: They do.

The Hon. BRONNIE TAYLOR: Yes, perhaps the underdose flag was not in place then as it is now, but they would have known because they would have seen the guidelines.

The Hon. TREVOR KHAN: It is a regime of treatment.

Ms BRYANT: On looking back, our investigation showed that nurses were doing as exactly what you said. They were checking the dose against the prescription and then administering at that dose; they were not questioning it. I have spent a lot of time looking back. It has been very informative for me and I have tested all of the procedures. I know now that that is absolutely not the case. EviQ guidelines are available on an app, they are available on a shortcut on the computer top, they are available within the record, so there are multiple checks by the nurses, by the pharmacists as that prescription comes in before it is ever administered, so things have changed. Not only have those processes changed, but there has been a real focus on changing culture. You only have to look at the recent guidelines that the College of Surgeons have put out for harassment and bullying. Within our own hospital we measure our culture every two years.

The Hon. BRONNIE TAYLOR: I am pleased to hear that. From 2012 you had pharmacists, and other people were administering chemotherapy doses that were against the eviQ guidelines and you say that no-one raised it with you?

Ms BRYANT: That is correct.

The Hon. BRONNIE TAYLOR: No senior people in the hospital? I find that quite alarming.

Ms BRYANT: I would go back to saying that, while it is not an excuse, the patient numbers are very small.

The Hon. BRONNIE TAYLOR: That is even more reason, respectfully—

Ms BRYANT: I agree with that. I reiterate, I know that the nurses then—I am a patient and I am ordered 10 milligrams of morphine. That would be checked five times before that finally comes to me between two nurses.

The Hon. TREVOR KHAN: Absolutely. They were doing that with me.

Ms BRYANT: That is what was done. The prescription was written clearly, there was consent for treatment from the patient, and the nurses were checking the prescription against the drug that was sent up to them.

The CHAIR: You said you measure culture every two years. Can you submit to the Committee how you do that and what you do to achieve that?

Ms BRYANT: Certainly.

The Hon. WALT SECORD: Can you tell me what is the status of the 21 patients who were at Macquarie University Private Hospital?

Ms BRYANT: Yes. Ten of those patients are well and have had no recurrence. Seven patients are, sadly, deceased—five were deceased at the time that we started ringing and speaking to patients—and the other four have had recurrences.

The Hon. WALT SECORD: So seven people have died since this has become public?

Ms BRYANT: Yes, at the time it was noticed five were already deceased and two have died since we found that out.

The Hon. WALT SECORD: Have you discussed compensation with the families or those surviving patients?

Ms BRYANT: No, we have not. Our focus has been talking to the patients, making sure they are informed, apologising, offering them an oncologist review, if they like, and, in most cases, we have given our details. I think all of the patients have written back and asked for a copy of the review that has been done, and we have sent that out.

The Hon. BRONNIE TAYLOR: Were all 21 of those people who received carboplatin head and neck patients?

Ms BRYANT: No, they were not.

The CHAIR: Was the cause of death of those seven patients cancer-related?

Ms BRYANT: I could not—

The CHAIR: Because it may not be.

Ms BRYANT: Yes, it may not.

The Hon. TREVOR KHAN: That is right, there may be a variety of causative factors.

The CHAIR: It could have been their heart—a stroke—or a whole bunch of things.

Ms BRYANT: Yes, old age, or whatever.

The Hon. DANIEL MOOKHEY: Has the hospital obtained advice on any liability it might have? I am not asking for the advice.

The Hon. TREVOR KHAN: There is probably legal professional privilege, but there is a lawyer sitting at the table with her, so I would be amazed if you have not had a chat over a cup of tea.

The Hon. DANIEL MOOKHEY: You are saying you have not obtained any advice as to any liability arising out of the aspects of this episode?

Ms BRYANT: Not specifically, no.

The Hon. DANIEL MOOKHEY: How was Dr Grygiel employed?

Ms BRYANT: He was an accredited practitioner, so the traditional model of doctors working within a private facility are appointed through an accreditation process.

The Hon. DANIEL MOOKHEY: What does that process involve?

Ms BRYANT: The process involves completion of an application which requires a curriculum vitae, Australian Health Practitioner Regulation Agency registration, insurance references. Once that application is completed it goes to the Medical Advisory Committee. The Medical Advisory Committee is set up in craft groups so that same specialties review same specialties. That is then reviewed by the specialists within the Medical Advisory Committee. The Medical Advisory Committee as a group endorse all of the people who are applying for accreditation and make a recommendation to the board and the board then sign off on the accreditation. All papers are available for the board members. We give lists and detail and they are able to review anything they wish to review before they make the accreditation permanent

The Hon. DANIEL MOOKHEY: There were no deviations from that procedure in respect to the accreditation or employment of Dr Grygiel?

Ms BRYANT: No, there was not.

The Hon. DANIEL MOOKHEY: Has that process been reviewed since this has happened?

Ms BRYANT: Yes. We operate with a system of bylaws and the bylaws have been reviewed in that period. Actually, it was reviewed twice in that period.

The Hon. DANIEL MOOKHEY: I understand that you operate under a system of bylaws. Has the hospital reviewed the application process to ensure that the assessment at all levels—as in the first disclosures by Dr Grygiel, the assessment by the medical committees, the referral to the board and the board decision itself—in respect to the specific circumstance has been reviewed and have any deficiencies been identified? I am talking about the process and not the bylaws that govern it.

Ms BRYANT: It has been reviewed as part of the bylaws review. I know that sounds complicated, but the application form also forms part of the bylaws. We reviewed the whole process including the application process. We are also accredited against the Australian quality in health care standards. The issue of accreditation of all medical practitioners, nursing practitioners and clinicians is reviewed at that time. I can show evidence, if you wish to see it, of our accreditation which shows the review of our accreditation process.

The Hon. DANIEL MOOKHEY: Your evidence is that as far as you can tell there were no deficiencies in the procedure that was used to select Dr Grygiel in the first place?

Ms BRYANT: That is correct.

The CHAIR: Have you put in place any other changes that you have not stated already to prevent this from happening again?

Ms BRYANT: I think that there are some general changes that go to changing culture that I would like to comment on. About 12 months ago we did a review of quality and safety in the organisation. We employed an external consultant to look at quality and safety across Australia and the world and come up with a recommendation. We are right in the process now of making organisational changes to reflect that. We have set

up two governance committees; one IT governance and the other patient safety and quality governance. Macquarie University is creating an academic health science centre. These committees sit across the faculty and the hospital. We are interviewing next week. In the next two weeks we will be appointing a director of patient safety and quality and a director of nursing. We have also added to our executive a director of medical services. I think we have really as an organisation elevated quality and safety to an appropriate position based on best practice around the world.

The CHAIR: Finally, have you any recommendations as to how New South Wales Ministry of Health oversight and support could improve to perhaps help your hospital?

Ms BRYANT: I do not think I could consider any recommendations. The ministry came out and reviewed part of our licensing which was around reporting, so I guess they have given us some sort of assurance that the way we conduct ourselves is well done against the licensing standards.

The Hon. TREVOR KHAN: When you made the report to the ministry did you deem what you had discovered as a critical incident?

Ms BRYANT: Yes. Well, that is by definition. Anything we would report to the ministry is at various levels. It was not a severity assessment code [SAC] 1 where it caused death to a patient that we knew of, but, yes, it was raised along the serious incident—

The Hon. TREVOR KHAN: So that it was reported as such?

Ms BRYANT: Yes. If I can just add one comment? On a yearly basis we check all registration against the Australian Health Practitioners Registration Authority [AHPRA]. AHPRA take all of our doctors and they send us back a report that shows where there are any limitations. All hospitals where doctors work are informed of those limitations when they occur. So we have that ability that is very high visibly on an annual basis and we require people to inform us of those during the definition process.

The CHAIR: I thank you are your adviser for coming today. The evidence has been very helpful. We may have further questions for you and you will 21 days to answer any questions on notice. The secretariat will be glad to help you. Thank you again for contributing to this inquiry.

Ms BRYANT: Glad to be part of it. Thank you.

(The witness withdrew)

(The Committee adjourned at 12.55 p.m.)