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WEDNESDAY 27 SEPTEMBER 2000

THE HEARING RESUMED AT 10.07 A.M.

CHAIR: Mr Murray, last night I asked if you could provide me with a copy of the Bill.

MR MURRAY: Yes, and I've passed that to the Registrar this morning to copy and it's probably just being actioned now.

CHAIR: Thank you very much. The committee's decision on going to the High Court won't be released until we've had time to consider the new legislation and any impact that might have on Inquiry powers.

MR MURRAY: Sure.

CHAIR: Ms Gibson, do we hear from you next?

MS GIBSON: Yes, ma'am, if that's suitable to the committee.

CHAIR: Yes.

CLOSING SUBMISSIONS MS GIBSON:

The way I intend to deal with matters this morning ma'am, is simply to go through submissions that have been made that are critical to Dr Bottrill under certain headings, which I'll do in a minute. First I wanted to address term of reference 1. Our submissions, I think Mr Grieve put, are "somewhat equivocal" on the matter and I have to say that that is the position. However, I have read the submissions of other counsel. With respect to my friends who are representing the Ministry, I think that their submissions best sum up the evidence in relation to the level of under-reporting and the unacceptability aspect of it. I don't intend to go through

1 those submissions or those of any other party who have made submissions
2 suggesting that there is an unacceptable level of under-reporting. Dr Bottrill
3 acknowledged in his evidence that the level of under-reporting was
4 unacceptable to him. Those are his instructions. I submit that there is
5 probably sufficient evidence for the committee to draw a conclusion on that
6 matter. The course of the evidence was such that it developed over time, so
7 I also appreciate that evidence that was discussed between Professor
8 Duggan and Dr Farnsworth wasn't available with Dr McGoogan gave her
9 evidence, for example. There is a body of opinion there, and that is clear,
10 and I accept that there is sufficient evidence for the committee to make a
11 decision in that regard.

12

13 CHAIR: When you say you consider there is sufficient evidence for the
14 committee to make a decision, do you consider that the evidence is
15 sufficient for the committee to conclude that there has been an unacceptable
16 level of under-reporting by Dr Bottrill?

17 MS GIBSON: Well, certainly Dr Bottrill's view is that there was, and as
18 counsel I accept that view and I accept the development of the evidence has
19 been such that that is an option open to the committee.

20 CHAIR: And do you accept the evidence of the witnesses we've heard
21 from – I'm actually looking as a quick reference at the Ministry's index
22 where they've got Professor Skegg headed what is unacceptable; Dr
23 McGoogan, Tracey Mellor, Dr Farnsworth, Dr Wayne. Just taking those
24 persons' evidence, do you accept their evidence?

25 MS GIBSON: Well, I think there's two limbs to that ma'am. The
26 unacceptability that Professor Skegg and perhaps Dr Wayne were looking at
27 was in terms of the effect on women to their health of this matter, and I
28 certainly accept that Professor Skegg has amended his view subsequent to

1 knowing the statistical synopsis discussed by Professor Duggan and Dr
2 Farnsworth. Dr Farnsworth's evidence was fairly clear. The difficulty that
3 has been identified with that, in our submissions, is that it identifies a rate of
4 calling of high grade lesions that was significantly different from any other
5 NZ laboratory – particularly given average figures, and it's a little hard to
6 work out why that might be in the context of this Inquiry.

7 CHAIR: Well, the only average figures we have, and I stand to be
8 corrected here by you, are the statistics that were sent out I think in 1996
9 showing what laboratory reporting rates were in 94.

10 MS GIBSON: Yes.

11 CHAIR: Is there anything else that you are aware of?

12 MS GIBSON: The du Rose study, and I may be corrected if I'm wrong,
13 retrospectively looked back over those figures and averaged them out to be
14 about 1% I think per year of finding high grade lesions. I'm not critical of
15 Dr Farnsworth's evidence ma'am, and it certainly wasn't put to her on that
16 basis. So in terms of the persons that you have listed, I don't wish to
17 challenge, in submission –

18 CHAIR: You don't challenge their evidence?

19 MS GIBSON: No, anything that they have put before you.

20 CHAIR: Right. Because it would seem to me that if you don't challenge
21 their evidence, and given the concession you make that there is sufficient
22 evidence before the committee to come to a conclusion on term of reference
23 1, then the logical consequence of that is that the committee should find that
24 the has been an unacceptable level of under-reporting in Gisborne.

25 MS GIBSON: I'm certainly not in a position to argue to the contrary,
26 ma'am.

27 CHAIR: Thank you.

1 MS GIBSON: And to be fair, that was Dr Bottrill's frank
2 acknowledgement.

3 CHAIR: Yes.

4

5 MS GIBSON: So I turn, ma'am, to matters that are raised in relation to
6 term of reference 2. In particular, firstly, I would like to deal with the issue
7 of fault which has been raised in Mr Corkill's submissions at p38 and Mr
8 Grieve's submissions at para 3.3 and 3.5.

9 CHAIR: I will just get those submissions.

10 MS GIBSON: I have a reasonably short point to make about them, ma'am.
11 There was an invitation in those submissions for the committee to lay blame,
12 and I would respectfully remind the committee of Madam Chair's note
13 before Dr Bottrill gave evidence, which is at B3055, lines 18 – 20, where
14 you said, Madam Chair, that "*He is not on trial here. The purpose of the*
15 *Inquiry is not to lay any blame at Dr Bottrill's door, and I emphasise that*
16 *this is not a trial by ordeal for Dr Bottrill.*" I've also heard counsels'
17 discussions with you on the point about laying blame, and I accept, in
18 submission, that that is an appropriate way to look at matters, that there can
19 be matters that are identified as causing or leading to under-reporting but
20 that blame does not have to be laid, and this is not the way that the Inquiry
21 has conducted itself throughout.

22 CHAIR: No, so you will probably recall the discussion I had, I think
23 mainly with Mr Corkill – certainly I picked up from his submissions at p39
24 where he refers to the High Court decision in *Davies v Transport Accident*
25 *Investigation Commission*.

26 MS GIBSON: Yes, ma'am.

27 CHAIR: It seems there is a difference between making express findings of
28 blame, which the committee's view is it's not here to do, as opposed to

1 making findings on the cause of what went wrong which may well give rise
2 to inferences of blame.

3 MS GIBSON: Yes, and I certainly accept that it's more than appropriate
4 for the committee to do that.

5 CHAIR: That's fine.

6

7 MS GIBSON: I note in regard to the issue of fault and blame that Dr
8 Bottrill was not summonsed to give evidence here, he gave it of his own
9 accord. He did so because he said through counsel that he felt, among other
10 matters, that he had a duty to assist the Inquiry, and in my submission it
11 wouldn't be appropriate to attach blame where the basis has been laid
12 throughout the Inquiry and throughout the submissions that that is not the
13 position of the committee. I would like to turn now, ma'am, to interaction
14 with the programme, and particularly to address the Ministry's submissions
15 at paragraph 9, p6, and paragraph 124, p38, that Dr Bottrill failed the
16 fledgling programme. Now, in my submission, ma'am, that can only be a
17 submission that is made with the benefit of hindsight. The best evidence of
18 Dr Bottrill's assistance to the programme was given by Ms Reid when she
19 appeared to give her evidence, and I would refer you to her brief of
20 evidence, particularly at paragraphs 23 and 25. If I could just read those out
21 to the committee: *"Dr Bottrill was very supportive and helpful to me and
22 the National Cervical Screening Programme. I thoroughly enjoyed the
23 working relationship I had with him. From the National Cervical
24 Screening Programme perspective, the service he provided in terms of
25 reporting times was exemplary, not only from a local viewpoint but from a
26 National one as well."* And then she goes on to say: *"I was very grateful
27 for Dr Bottrill's support. Another example of this was when he gave me his
28 own software to use to get his smear results in an electronic format from the
29 Gisborne Hospital laboratory. The contemporaneous evidence of his*

1 *support of the programme, therefore, does not bear out the suggestion that*
2 *he failed the fledgling problem at the time.:*

3

4 CHAIR: Well, doesn't it really depend on what you mean by "support".
5 Someone – and I'm not talking about Dr Bottrill here, I'm talking in
6 principle – someone could give very well meaning support but if it is not
7 helpful support, if it is in fact incompetent in some way, it's not really
8 support in a true sense.

9 MS GIBSON: I accept that, ma'am. The point that I'm trying to make,
10 and perhaps badly, is that there have been many unfounded submissions, or
11 unfounded allegations, in my submission, of cover-up not in relation to Dr
12 Bottrill I have to say but in relation to other persons. In relation to Dr
13 Bottrill's interaction with the programme, that is an allegation that could
14 never be levelled at him. He was totally open and honest with the Ministry
15 at all times through all the interactions that we've seen, with the exception of
16 the Mules exhibit in 1993, where he obviously under-estimated what was
17 required to apply to TELARC. He has at no stage been duplicitous or had
18 any problem in telling the Ministry exactly how his laboratory ran, and that
19 was the case with Ms Reid as well, who was the National Cervical
20 Screening Programme co-ordinator. Her evidence was that he discussed
21 TELARC registration with her, she found him to be very supportive of her.
22 It's not a situation where Dr Bottrill wasn't well motivated towards the
23 programme, this is a situation where he did not understand or know of the
24 problems that have subsequently arisen. And in that regard, ma'am, the
25 programme in some ways has failed everyone who's come in contact with it,
26 and I would refer particularly to Ms Reid's paragraph 22 regarding the QOS
27 reports and their usefulness. She provided them, after 1991, on a regular
28 basis, but she admitted that without comparative National data they would

1 have been useless in assisting Dr Bottrill to learn that he wasn't reporting
2 cervical cytology correctly.

3

4 CHAIR: Well, also, there's the statistics that came out showing what the
5 reporting rate was up to 1994 which showed his reporting rate as being
6 within the average.

7 MS GIBSON: That's exactly right, ma'am.

8 CHAIR: And if he had – I know he had actually retired when those
9 statistics came out, but if he'd still been in practice the only impression he
10 would have got from those statistics is that his performance was much the
11 same as other laboratories.

12 MS GIBSON: Yes, that's absolutely correct, ma'am.

13

14 MS GIBSON: Just carrying on this theme for a moment, there's been some
15 submissions made by Mr Grieve about Dr Bottrill's attitudes in relation to
16 matters. He's noted at paragraph 1.5 and paragraph 5.8 "*a cavalier attitude*
17 *and arrogant.*" In my submission there is no contemporaneous material to
18 support those allegations. There may have been conclusions that Mr Grieve
19 drew from Dr Bottrill's evidence, but I would suggest to you ma'am that
20 giving evidence 6 years after an event, or 5 to 6 years after an event when
21 you have had significant memory problems subsequently, would be a very
22 stressful event in any forum, and this is a very public forum. And I don't
23 accept, and I would submit it's not appropriate to accept, those allegations
24 about Dr Bottrill's attitude as being contemporaneous.

25 CHAIR: Is there any evidence at all before the committee as to what his
26 perceived attitude was at the time he was practising?

1 MS GIBSON: No, I don't believe there is ma'am. I'm going to forget the
2 Patient number, and I don't know whether she's got name suppression, but
3 there was a patient that worked briefly at Dr Bottrill's laboratory who did
4 give some evidence, which was admitted by way of brief, about his
5 disposition. But certainly that didn't support those types of allegations
6 being made.

7

8 MS GIBSON: The next heading that I wanted to address, ma'am, was
9 financial aspects. There's been a number of submissions, both from Mr
10 Grieve and from the Women's Health and Information Resource Trust
11 regarding alleged financial motivations, and those submissions are found in
12 Mr Grieve's submissions from paragraph 5.9 – 5.10 and in the Women's
13 Health and Information Resource Trust's submissions at 2.43, 2.50, 2.51,
14 2.56 and 2.57.

15 I would like to remind the committee of a further ruling that was made in the
16 course of the Inquiry, and that's set out in the transcript at B2992, line 11 –
17 it's a ruling of yours Madam Chair and it says: *"Price motivation is not a*
18 *relevant factor. The purpose of this Inquiry is not focused on laying blame*
19 *on Dr Bottrill. This is not a hearing for punitive damages."* Then at
20 B2994, line 15, you went on to say: *"Given the criticism to Dr Bottrill that*
21 *attaches to that, I think it has to be done using primary evidence and that*
22 *certainly can be pursued with him."* I accept, ma'am, that matters of
23 goodwill were pursued with Dr Bottrill. There were no questions, however,
24 relating to any other financial matters put to him. In any event, his
25 evidence was –

26 CHAIR: I'm just trying to find the ruling. You said it was at B2992?

27 MS GIBSON: Yes, 2992, it's during an interchange between Mr Grieve
28 and Dr Linehan I believe.

1 CHAIR: It's just my 2992 is dated 29 July.

2 MS GIBSON: Sorry, ma'am, some of the page numbers got a bit –

3 CHAIR: Are you working from the internet transcript, I'm working from
4 the official transcript and the numbers might be different. I have found it
5 now, it's 2990.

6 MS GIBSON: 2990, I do beg your pardon, ma'am. In any event, ma'am,
7 Dr Bottrill's consistent evidence on goodwill – and it was put to him on
8 three separate occasions that I can find during his transcript, and I'll give
9 you those references if that would assist. They are at B3068, lines 12 – 21,
10 B3075, lines 21 – 27, and B138, lines 7 – 11. His consistent position under
11 cross-examination was that money was not the primary consideration then
12 and money was not the primary consideration later.

13 CHAIR: Ms Gibson, just to go back to the ruling I made at 2990, which is
14 more an interchange with Mr Grieve over the course of his questions, I
15 notice no-one else was heard on it. I've said there that one of the factors we
16 had to look at was how the under-reporting happened, what contributed to it,
17 and I then said, *"If it turns out Dr Bottrill's practices were sub-standard"* –
18 that's what it should be, other than "subsequent" standard – *"that's enough.*
19 *The reason for why they were sub-standard and whether one would wish to*
20 *take a dim view of the reasons which motivated him are not for this Inquiry.*
21 *We cannot, for example, in the report embark on criticising Dr Bottrill on*
22 *the basis he continued to work in circumstances when he shouldn't because*
23 *he was price motivated."* Now, do you accept that's a correct view of the
24 terms of reference or not?

25 MS GIBSON: Yes, I do, ma'am.

26 CHAIR: It's just that because you've then gone into the evidence, are you
27 dealing with this issue on the basis of, firstly, it's not within the terms of

1 reference; secondly, if it is the evidence answers it in a way that is
2 favourable to Dr Bottrill?

3 MS GIBSON: Yes, ma'am. I don't accept that it's relevant to the terms of
4 reference, but it has been raised on a number of occasions by other parties
5 and other people making submissions. And the point I merely wish to make
6 is that Dr Bottrill's consistent evidence was that the effect on goodwill did
7 not provide any motivation for him in relation to keeping cytology in that
8 1995 period.

9 CHAIR: Right.

10 MS GIBSON: I also would note in that regard, ma'am, that the Women's
11 Health and Information Resource Trust made some submissions regarding
12 profitability analysis at 2.46, and I think my friend Mr Rennie has already
13 dealt with that matter and I don't propose to go through that.

14 CHAIR: Right.

15

16 MS GIBSON: I would then like to address the committee on TELARC
17 accreditation and the state of Dr Bottrill's laboratory. This matter was
18 particularly dealt with in the Women's Health and Information Resource
19 Trust's submissions at 2.34 – 2.41. In my submission, ma'am, a lot of the
20 criticism regarding the state of Dr Bottrill's laboratory rests on Mr Walker's
21 evidence, and my submission is it was borne out by cross-examination of Mr
22 Walker that his memory of his visits in 1993 and 1994 were confused. That
23 was clear from the criticisms that he made of the equipment that was
24 available. He seemed not to understand that at a later stage further
25 equipment had been bought, that he must have been aware of from his visit
26 in October 1994, and that he had not taken into account when he presented
27 his somewhat retrospective analysis to this committee. While he accepted –
28 at the transcript B507 to 508, lines 25 to line 5 of B508 – that it was not his

1 responsibility as a member of TELARC to critically review technical
2 equipment, he nevertheless saw fit to make criticisms of that technical
3 equipment in his brief which subsequently weren't borne out by factual
4 evidence from Dr Linehan, in particular, about what was available in the
5 laboratory at that time.

6 Mr Walker was also inconsistent in his evidence. He agreed early on in
7 cross-examination from Mr Hodson that it was not unusual for a laboratory
8 manager to be the point of contact, or the authorised representative of a
9 laboratory, and then subsequently did a turnaround on that matter later,
10 under cross-examination from Mr Grieve, where he said it was unusual.

11 Dr Linehan's view of the evidence, which we put in our submissions, was
12 that Mr Walker had confused his visits in his brief.

13

14 CHAIR: Would you accept, though, that the state of the laboratory was
15 such that it was going to require considerable time and effort to bring it up
16 to the standard of TELARC accreditation?

17 MS GIBSON: I certainly accept, ma'am, that there was a lot of work to do,
18 and I don't think anyone would deny that. I also would submit, though, that
19 it's highly likely from the evidence that neither Dr Bottrill nor Mr Reeve
20 realised the amount of work that would be needed to bring the laboratory up
21 to a TELARC accreditation standard. And I'm not talking merely, ma'am,
22 in terms of equipment, I'm really focused on the written material that was
23 available to them and that they had produced.

24 CHAIR: Well, it seems that if you look at what Mr Morris said, and Dr
25 Linehan in terms of procedures, there was very little in terms of quality
26 manuals, textbooks, documentation of procedures.

27 MS GIBSON: Yes, and my submission would be, ma'am, that those
28 matters did need to have some substantial work on them and they quite

1 possibly were under-estimated. To be fair, however, in my submission to
2 both Mr Reeve and Dr Bottrill, while Mr Walker's evidence was that he
3 thought that both of those parties, or particularly Mr Reeve, had under-
4 estimated the amount of work that would be required it's nowhere clear in
5 his evidence that he advised them exactly of the amounts that would be
6 required. He certainly advised them of the various headings and things that
7 they had to follow, but he never discussed with them his views of the
8 laboratory, and that is quite clear in the evidence from Dr Bottrill.

9 CHAIR: It seems that we do not have an accurate picture of what the
10 laboratory was like while Dr Bottrill was working there.

11 MS GIBSON: Yes.

12 CHAIR: It also seems, though, we know that a lot of work was going to be
13 needed to bring it up to TELARC accreditation. The real issue is whether
14 or not bringing a laboratory up to TELARC accreditation is going to reduce
15 the likelihood of under-reporting.

16 MS GIBSON: Yes, well ma'am, there are some submissions on that in our
17 submission. It is accepted that it certainly would have identified the fact
18 that Dr Bottrill was acting as a primary screener. But I note with some
19 concern that Mr duRose's study of laboratories that are all TELARC
20 registered still included a laboratory that was performing home screening in
21 the year 2000, or in the year 1999 to be fair, which was a practise that was
22 questionable in the early 90s as there has been evidence of. It's also
23 important to note, ma'am, that Dr Linehan's view of Dr Bottrill's laboratory
24 was that the aesthetic efficiencies that Mr Walker noted were a matter of
25 aesthetics rather than standards.

26 CHAIR: Well, we are looking purely at cytology, not the laboratory
27 generally.

28 MS GIBSON: Yes, certainly.

1 CHAIR: And from the perspective of carrying out good cytology it would
2 seem that you would need a good microscope and a good record filing
3 system so that it was quite clear that when slides came in you knew whose
4 slides they were and also you had a record system that would allow a ready
5 look back.

6 MS GIBSON: Yes.

7 CHAIR: So you could go over earlier slides to check the results of those
8 slides. Then, of course, you get into the other issues of how many
9 cytoscreeners do you have, and those things, but in terms of laboratory
10 equipment and methods that is probably a greater priority than the aesthetic
11 environment in which you're working.

12 MS GIBSON: I certainly accept that, ma'am. And we've heard evidence
13 about the microscope, that it's still in use. The record system seems to be
14 more problematic in terms of while it is certainly clear that Dr Bottrill was
15 operating the software, because Ms Reed refers to it and presumably she
16 was using software that she thought would be useful for Gisborne Hospital
17 laboratory when she borrowed it from Dr Bottrill, I appreciate that his
18 evidence in that regard was that he didn't regularly go back over a woman's
19 cervical cytology reports to look back.

20 CHAIR: Well, that is more to do with the practices he followed than the
21 state of his laboratory. I suppose the advantage of an accreditation process
22 is where your methods are documented it's going to cause you to consider
23 your methods and perhaps when you're faced with them set out in black and
24 white you may well give further consideration to what is a good process to
25 adopt rather than just what you are doing on a day to day basis.

26 MS GIBSON: Yes, I certainly accept that, ma'am.

27

1 PROFESSOR DUGGAN: As well, Ms Gibson, Dr Bottrill did say to me
2 that he didn't have a process in place in his laboratory to ensure that there
3 wasn't a mix-up between requisition forms and slides.

4 MS GIBSON: Yes, I re-read that discussion that you had with him
5 recently, Professor Duggan. It wasn't clear to me whether he thought that
6 he was checking as he went, but he certainly acknowledged that he had no
7 process for that in place in his laboratory.

8 PROFESSOR DUGGAN: This is a very risky part of laboratory practice
9 because it is very easy to mix up requisition forms and slides, and you will
10 recall I asked Ms Wilson in great detail how they avoided this. As well she
11 told me they didn't have a documented process to avoid it.

12 MS GIBSON: Yes, I certainly accept that.

13 PROFESSOR DUGGAN: So the point is one may have good equipment in
14 the laboratory but without good procedures the laboratory may not be good.

15 MS GIBSON: Yes. To reduce the possibilities of that, though, it was
16 principally that the slide was handled between Dr Bottrill's assistant and
17 himself – there weren't a plethora of people handling that. I accept there's
18 no documented procedure about it, but I also accept that Dr Bottrill in the
19 year 2000 said that he couldn't remember his procedure. The inference
20 from his evidence seemed to be –

21 PROFESSOR DUGGAN: I think he said to me he didn't have one.

22 MS GIBSON: Didn't have one. The inference seemed to be, though, that
23 it was a fundamental part of slide reading that he would be checking
24 numbers as he went. I don't know if that allays any concerns at all that you
25 hold in that regard, and there doesn't seem to be any evidence that the
26 reasons for the under-reporting were that he mixed up slides all the time. I
27 have seen no evidence of that before the Inquiry as opposed to a misreading.
28 That's unfortunately as far as I can take that.

1

2 CHAIR: It would seem that the essentials of a laboratory would be good
3 equipment, good procedures and competent persons to carry out the work?

4 MS GIBSON: Yes, I don't think there's any doubt about that, ma'am.

5

6 PROFESSOR DUGGAN: As well as good records?

7 MS GIBSON: Yes. And in relation to Professor Duggan's points, some
8 ability to analyse statistics seems to be helpful.

9

10 CHAIR: Yes, well, first of all, you have to get the information to be able to
11 do the analysis.

12 MS GIBSON: Yes, I appreciate that as well.

13

14 PROFESSOR DUGGAN: Actually, there are several issues here, but the
15 ability to understand the data and what to do with the data.

16 MS GIBSON: Certainly.

17

18 MS GIBSON: There have been allegations made, and I turn now to Mr
19 Grieve's principal allegations of incompetence and the Women's Health and
20 Information Resource Trust's allegations in that regard. Given the Inquiry's
21 focus has not been to lay blame, I do not see, with respect to my friends, that
22 there is a necessity to put a label on the behaviour, but I would also note that
23 Professor Skegg in his discussion confirmed that – there's a lengthy
24 discussion by him at B2303, lines 20 onwards about the results that
25 Professor Duggan discussed with Dr Farnsworth and what that meant. He
26 concluded that he didn't think that Dr Bottrill was a totally incompetent

1 pathologist because when he called something positive it was as positive as
2 often the Sydney statistics were. He further on said that he would have
3 expected someone who was untrained to have a high false positive rate and a
4 high false positive rate and that he wasn't behaving in the way of someone
5 who was completely untrained or completely incompetent may be expected
6 to do. Now that's a comment, ma'am, only in terms of the submissions that
7 my friends have made. Of course Dr Bottrill has already accepted the
8 unacceptable nature of the under-reporting.

9 I would like to turn briefly to the 1995 year, and in particular what Dr
10 Bottrill actually knew had occurred during that year. To set a background,
11 in the year 93/94 there was obviously considerable discussion between
12 pathologists – and Dr Bottrill was aware of it – of the necessity to become
13 TELARC accredited. Dr Beer's evidence was that there was also some
14 concerns amongst laboratories about the 1993 cutoff date for applying to
15 TELARC and that the date was flexible, it wasn't set in stone. Dr Bottrill
16 had long thought that he was going to retire, and I don't say that as any
17 justification for not pursuing standards at all, but that is the practical reality
18 of the matter.

19 In 1995 he was advised of a patient, Patient One, who he had misread
20 smears. The letter to ACC, which is in Dr Thompson's brief, from a
21 cytopathologist in Auckland who'd been retained by Patient One looked at
22 the four smears. He agreed with the first reading. He disagreed with the
23 second reading, he said it was CIN II. In relation to the third smear he said
24 it was CIN 1, with small clusters of cells which were CIN II, and he read the
25 fourth smear in contrast to Dr Bottrill's high grade reading as being
26 predictive of abnormal squamous cell carcinoma. Dr Bottrill's reading of
27 the fourth smear had been confirmed by colposcopy at Gisborne Hospital as
28 being CIN III. So from Dr Bottrill's knowledge he had four smears, one of
29 which the other cytopathologist agreed with, one of which has been

1 confirmed on colposcopy, and two which he acknowledged when he re-read
2 them he had misread. Now in relation to the third smear, the evidence from
3 Dr Teague, which was given somewhat later but consistently with the
4 Auckland cytopathologist's advice, was that it was difficult to see the
5 cellular material indicative of CIN III. There's a synopsis of that ma'am –
6 I'll just give you a reference for the transcript, it's KGT/MCNZ/008 at p202.

7 CHAIR: The second slide which Dr Bottrill read as CIN III and which was
8 confirmed as that by colposcopy, do you have a reference in the evidence
9 for that?

10 MS GIBSON: Yes, I haven't been through Patient One's notes. I know
11 that from the High Court documents. I can look and see if that has been
12 confirmed, but it was definitely –

13 CHAIR: That would be helpful, we can do that, we've got her notes so we
14 can do it.

15 MS GIBSON: It was definitely confirmed on colposcopy from Gisborne
16 Hospital as being CIN III and not invasion.

17 CHAIR: So you would say out of four slides 50% he would have seen as
18 reading them correctly, and –

19 MS GIBSON: Yes. It wasn't quite the straightforward ? I have for
20 cervical smears which were misread which has been put previously to you.

21

22 PROFESSOR DUGGAN: We will accept that with the knowledge that
23 there is a certain sampling error associated with colposcopic directed
24 biopsies?

25 MS GIBSON: Absolutely, ma'am. There is no dispute about that.
26 Colposcopy has its own difficulties.

1 PROFESSOR DUGGAN: So the colposcopy could have missed invasive
2 disease?

3 MS GIBSON: Yes. I'm not attempting to suggest that it wasn't present
4 ma'am. All I'm saying is from Dr Bottrill's perspective, with what he knew
5 at the time, it was confirmed by Gisborne Hospital.

6

7 CHAIR: And I suppose, given the importance placed on the cyto-
8 histological correlation, one would expect that when he saw the results that
9 the histology confirmed his reading that he would accept that rather than
10 think in the way that Dr Duggan has suggested now that it could be a
11 situation where the colposcopy was also inaccurate?

12 MS GIBSON: Yes, well there's no evidence on what he thought, ma'am,
13 but that's certainly a possibility.

14 CHAIR: It's an inference that could be drawn?

15 MS GIBSON: Yes, certainly.

16

17 MS GIBSON: And I would seek to remind the committee in submission
18 that at the time Dr Bottrill asked for his figures to be checked he wasn't
19 blasé about it, he didn't think that it was something that didn't bother him.
20 He admitted that he had lost confidence as a result of these matters being
21 brought to his attention, and that they were the first matters that were
22 brought to his attention, so he did the appropriate thing, he asked for his
23 figures to be checked in terms of other laboratories. And those
24 unfortunately never came back to him. Well, not until August 1996.

25 CHAIR: So what you are saying is given the results he got back from the
26 re-read there was nothing there to discourage him from continuing in
27 practice?

1 MS GIBSON: Yes, ma'am, because as we've heard, cytology is an art form
2 and we would all hope for a very good artist, I'm sure, but there are
3 subjective readings both at the higher end – and I accept that the evidence is
4 that that's much less – and at the lower end. I have listened to my friends
5 submissions about false negative mindsets but the fact is that there is a false
6 negative rate in cytopathology.

7 CHAIR: What about, though, the advice he got from Dr Teague to become
8 TELARC accredited and to send his cytology elsewhere?

9 MS GIBSON: Yes, well, Dr Bottrill's evidence was he couldn't remember
10 the TELARC accredited part of it. But certainly he viewed Dr Teague's
11 suggestion that he send it elsewhere as an offer, he didn't view it as a
12 direction or even a critique I think. His evidence was that he viewed it as
13 an offer and he thought that –

14 CHAIR: But you'd have to say to yourself, why was the offer being made?
15 Why would someone like Dr Teague say to another competent pathologist
16 who was reading cytology, receiving government funding for doing so, stop
17 doing it and send it off to another pathologist? You would only make that
18 offer to someone if implicit in the offer was your view that Dr Bottrill
19 shouldn't continue.

20 MS GIBSON: Yes, although Dr Teague's evidence isn't that, though, is it
21 ma'am? His evidence is that at the time he didn't see that there was a
22 problem. Dr Bottrill's evidence was that he told Dr Teague that he had lost
23 confidence as a result, he couldn't perform the rapid re-screening that Dr
24 Teague was talking about, and Dr Teague then suggested that he could do it
25 at his laboratory, or send it off. Dr Bottrill's view was, and the evidence
26 wasn't challenged that that was an offer, and that's the evidence before the
27 committee. I accept, ma'am, it's for you to draw a conclusion on that
28 matter. But I wish to clear up the point that it wasn't quite as clear-cut as
29 I've got – one patient with four misread smears.

1 CHAIR: Yes. So from your perspective you're saying all he knew at the
2 time was out of four slides he'd read two correctly, the third slide he'd been
3 advised that it was a difficult slide to read, and he'd received an offer from
4 Dr Teague to have his cytology read by Dr Teague's laboratory or another
5 laboratory?

6 MS GIBSON: Yes.

7 CHAIR: And those factors alone obviously were not sufficient to cause
8 him to stop working?

9 MS GIBSON: No, ma'am.

10

11 MS GIBSON: That was as far as I wanted to take the matters in relation to
12 rebuttal. In terms of the future issues, I just thought I would, with the
13 committee's leave, address a few points. There was a discussion between
14 yourself, ma'am, and Mr Grieve about exemplary damages proceedings and
15 the benefits of them. If I can adopt a word that my friend Mr Murray's
16 used, I would submit that exemplary damages proceedings would be a
17 particularly blunt instrument for trying to assess doctors competency or
18 having matters out in the public forum.

19

20 CHAIR: There is no suggestion that they were an effective means of
21 dealing with issues at all. What was behind the discussion was a
22 consideration of how could you get an issue ventilated in a public forum,
23 because obviously in a public forum – particularly a court where there are
24 powers to compel information and where information can be looked at
25 publicly subject to questioning, cross-examination, most lawyers believe
26 that is the best way of discovering what has gone wrong. And given that in
27 NZ actions for compensatory damages are not available, the only way –
28 what I was discussing was is there any alternative way of bringing these

1 issues out into a forum where they can be looked at in an open, transparent
2 manner, which we as lawyers are familiar with. And certainly the
3 exemplary damages case brought by Patient One did arouse interest. In a
4 sense it became a catalyst for people responding. It may be that by bringing
5 out a problem into the public, which also exposes it to media interest, that is
6 more likely to galvanise persons who can do something about the problem
7 into taking some action. That is the course of the discussion I was having
8 with Mr Grieve, it wasn't the outcome of getting an award of exemplary
9 damages but rather than at least a court case seeking exemplary damages
10 brought the matter to the public's attention.

11 MS GIBSON: Well, ma'am, since the advent of the Medical Practitioners
12 Act 1955, all disciplinary matters are heard in a public forum and the same
13 rules as to names, suppression and private forums apply as they would in the
14 criminal courts. So with a couple of exceptions, most of the proceedings
15 before the Tribunal have been conducted in public except when the
16 complainant requires her evidence to be heard in private. So that's a
17 change from the previous system.

18 CHAIR: Yes, the difficulty with that, as I understand, is that the process
19 has to go before the Health and Disability Commissioner first and there can
20 be delays there.

21 MS GIBSON: Yes, there certainly has been delays, ma'am, and they've
22 been commented on in the media. I think the new Health and Disability
23 Commissioner is hopeful that those delays will no longer be.

24 CHAIR: Also the process is in the hands of a third party, it's not in the
25 hands of the women concerned.

26 MS GIBSON: It's in the hands of a third party insofar as it's the Director
27 of Proceedings who prosecutes. There is, however, always open to a
28 patient the option of going to the Complaints Review Tribunal, which is not

1 a matter which is necessarily determined by the Director of Proceedings,
2 and the Complaints Review Tribunal is a specialist body. It's set up with a
3 barrister and solicitor as the Chair, it has a panel of people who the Ministry
4 appoints, who have particular expertise in certain areas, and those areas are
5 human rights, the medical matters that come from the Health and Disability
6 Commissioner, and the Privacy Commissioner's office. So that forum
7 covers those three areas. The situation with that is that in the Health and
8 Disability Commissioner forum if the Director of Proceedings does not wish
9 to take a damages claim to the Complaints Review Tribunal, then the patient
10 can take that directly. They are not restricted to take that through the
11 Director of Proceedings and there have been a number of cases where, in all
12 of those forums, claimants have taken their claims directly. That isn't a
13 compensation Tribunal in the strict sense of the word because of course the
14 ACC bar applies, but it has a jurisdiction of up to \$200,000 to compensate
15 for, amongst other things, stress and humiliation and grief.

16 CHAIR: Even if there's been a physical injury or a medical misadventure?

17 MS GIBSON: Yes. It doesn't matter, you can still take it to the
18 Complaints Review Tribunal, you are not barred from coverage of those
19 types of matters simply because of an ACC – they would bar a physical
20 injury but it does not bar nervous-shock-type aspects.

21 CHAIR: I know it wouldn't bar nervous shock, but by my understanding of
22 the ACC legislation is if you suffer a medical misadventure which, as part of
23 the injury involves mental injury, humiliation etc., you are still barred from
24 recovering for the mental injury. The only way you can recover from
25 mental injury is if you can show that there is no physical injury covered
26 which would bring you within the scope of the ACC Act.

27 MS GIBSON: Yes, certainly, I accept that ma'am, but the compensation is
28 there for humiliation, distress and it's not required to be consequent on a
29 physical injury.

1 CHAIR: The other point is that with a tort action of course you can look
2 further afield. You've talked about the Medical Disciplinary Tribunal which
3 would focus on the clinician or the medical practitioner who had dealt with a
4 patient. If a patient considered that the injury he/she suffered related to
5 more systemic issues that Tribunal wouldn't be of any assistance there.
6 Any evidence of systemic issues wouldn't be relevant to a complaint against
7 a doctor.

8 MS GIBSON: No, I accept that, ma'am. The point I was making is that in
9 terms of public awareness of these matters, with the advent of public
10 hearings and the Medical Practitioners Disciplinary Tribunal there has
11 certainly been, in a number of cases where doctors have appeared, a lot of
12 publicity. So it's not a closed forum.

13 CHAIR: No. In terms of looking at the wider systemic issues which may
14 relate to delivery of health services by persons other than medical
15 practitioners, does the Health and Disability Commissioner look at those
16 issues if a complaint is made to him?

17 MS GIBSON: Yes, certainly. Certainly the Health and Disability
18 Commissioner does, and I think the Health and Disability Commissioner's
19 investigation into PSA testing at Gisborne Hospital would be testimony to
20 that, although my friend Mr Ross may like to address that some more.

21 CHAIR: So if the Act relating to the Health and Disability Commissioner
22 establishing his office, etc., had been in force at the relevant time that we
23 have been looking at the women concerned could have complained to him
24 and he could have made enquiries?

25 MS GIBSON: Certainly.

26

27 MS GIBSON: The other thing about the Health and Disability
28 Commissioner's office ma'am is they have an educative function under their

1 role. They're not merely there to investigate complaints, they are there to
2 assess and assist with health and disability services, and under s14 I think of
3 their Act certainly one of their functions is education but also bringing wider
4 systemic issues into play. Certainly I made some reference to the
5 Christchurch Hospital investigation by the Health and Disability
6 Commissioner, which was prefaced on complaints I accept, but it also
7 contained an analysis of the systems in operation at that hospital at the time.

8 The other matter, ma'am, because our submissions do address the Medical
9 Council on competence, I would just like to go through briefly with you
10 some of the evidence in Ms Jones' brief of evidence – the Registrar of the
11 Medical Council, because there's quite wide competence powers now in
12 existence under the Medical Practitioners Act that weren't available to the
13 Medical Council at this time. There's a particularly interesting exhibit from
14 that perspective – it's exhibit 2, p33, which sets out the competence
15 referrals between 1 July 1996 and 3 May 2000. Now Ms Jones accepted in
16 her evidence that there was a significant delay in starting up this procedure
17 of competence reviews, but the competence referral sources shown in that
18 exhibit showed that of the 125 referrals to date 14 have come from the
19 public, one from the police, two from the doctors themselves rather
20 interestingly, and the rest of them have all come from either peers or
21 medically associated bodies. So in terms of a non-disciplinary way to deal
22 with competence issues, the particular sections in the Medical Practitioners
23 Act that relate to that are a very strong power and I accept that the Medical
24 Council has asked for amendments to those to include suspension. The fact
25 that those, in my submission, can be applied at random and there need not
26 be any concerns, they can randomly competence review any doctor in this
27 country at any given time, those are very wide powers if the Medical
28 Council chooses to use them.

1 Those are the submissions that I have, ma'am. If there are any questions I
2 would be happy to attempt to answer them.

3

4 PROFESSOR DUGGAN: Ms Gibson, I would like to practise some
5 inference.

6 MS GIBSON: That sounds ominous.

7 PROFESSOR DUGGAN: It's got to do with this; you were querying I
8 think the contribution of slide mix-up to the situation.

9 MS GIBSON: Certainly.

10 PROFESSOR DUGGAN: Assuming there is a situation. I've just been
11 drafting a few scenarios here. Professor Skegg made the point that Dr
12 Bottrill was not incompetent but he was economical when he made his
13 diagnosis.

14 MS GIBSON: Yes, certainly.

15 PROFESSOR DUGGAN: So, the inference there is that when Dr Bottrill
16 saw something abnormal he called it but he didn't call it very often.

17 MS GIBSON: No, I accept that.

18 PROFESSOR DUGGAN: So if you don't call it very often you've got to
19 think why isn't he calling it very often. Well, one solution is he's not seeing
20 it. So if he's not seeing it it's because either a) he doesn't it; or b) it's not
21 there, right?

22 MS GIBSON: Yes.

23 PROFESSOR DUGGAN: So if it's not there you've got to think, okay,
24 why isn't it there. Well, one approach to that is he has picked up the slide
25 belonging to somebody else and he has read that slide and formulated a
26 report and given all of that information to another woman. That's the
27 importance of the slide mix-up. So you could have Patient A, who has

1 disease, and Patient B who has no disease. If you pick up Patient A's slide
2 and you screen it, and you screen it properly but you don't report it, you
3 report it as normal, well then you've mixed everything up.

4 MS GIBSON: Hmm.

5 PROFESSOR DUGGAN: So that's why it's important to have procedures
6 in place to prevent that happening?

7 MS GIBSON: I certainly accept that.

8 PROFESSOR DUGGAN: And it may account for why Dr Bottrill,
9 although not incompetent, was economical because it could account for
10 some instances of false negative reporting – many instances of false
11 negative reporting, and it could also account for instances of false positive
12 reporting.

13 MS GIBSON: Yes, I can certainly follow that, Professor Duggan. I
14 suppose the inference that we take at the present time is that it was there, but
15 the inference from Professor Skegg's evidence is that it was there but it was
16 not recognised to a sufficiently high threshold of suspicion, if you like.

17 PROFESSOR DUGGAN: That's one way. We would have to accept
18 that's one way of looking at it, but the other is that he did see it but didn't
19 report it properly.

20 MS GIBSON: Yes, I accept both of those inferences can be drawn. In
21 terms of the women's evidence that we have seen, the more likely
22 conclusion I would submit is that the threshold was too high because there's
23 a number of matters that have been read as normal by Dr Bottrill that have
24 been read as low grade by Sydney. A number of low grades have been read
25 as high grades. It seems, in my submission, to flow from the predication
26 that there was too high a level of suspicion before it kicked in to front a
27 report, if you like. But I accept that both inferences are concludeable from
28 the scenario that you've put. I have a little difficulty with the evidential

1 basis for this second, except for Dr Bottrill's frank admission that he didn't
2 have any procedures in place. Does that assist?

3 PROFESSOR DUGGAN: It's just an inference that underscores the
4 importance of good laboratory procedures.

5 MS GIBSON: Yes.

6

7 CHAIR: Following on from that, it would seem procedures are important
8 because it would allow you to have a better idea of what had gone wrong
9 because –

10 MS GIBSON: Oh, I don't think there's any debate about the importance of
11 procedures, ma'am, and certainly as we stand here in the year 2000 they
12 look to be absolutely imperative.

13 CHAIR: Yes, and we know from the evidence which you accept, that there
14 was an unacceptable level of under-reporting by Dr Bottrill. Really, we've
15 got no clear evidence as to why that was. We know it happened, we know
16 what the consequences of that are, but how it came to be we don't know.

17 MS GIBSON: No, I agree.

18 CHAIR: Thank you very much, I have no further questions.

19 MS GIBSON: Thank you.

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21 CHAIR: Now is it Tairawhiti next?

22

23 MR ROSS: Thank you ma'am.

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CLOSING SUBMISSIONS MR ROSS:

Ma'am, I don't have anything to add to the written submissions unless there are particular questions arising out of them, with one exception, and that is Mr Kirton approached me this morning about my comment in paragraph 19. It may be that I had misunderstood a line of his questioning concerning looking back and correlating colposcopy and cytology. Mr Kirton informed me this morning that what he was trying to put to Dr Van de Mark was the opportunity for peer review in a remote area, and perhaps I had misunderstood his line of questioning of other experts as being intended to comment on her. So if I have misunderstood it I'm happy to withdraw the paragraph, but sometimes I've not been sure what the particular purpose of the questioning has been of some of the Tairawhiti witnesses. I do, however, have some comments on submissions of other counsel if I may just turn to that orally.

CHAIR: Yes, certainly.

MR ROSS: And I've tried to divide it up into general topic. The first topic is a suggestion that other health professionals knew about the circumstances in which Dr Bottrill was reading smears. Now I heard the discussion that you had with my learned friend about what do we really know about the state of the laboratory. I don't want to enter into the facts of it but there have been submissions that the THL pathologists – I'll use THL for Tairawhiti – knew the circumstances in which Dr Bottrill was reading cervical smears. In my submission there is in fact no evidence before the Tribunal about that matter. In fact none of the local pathologists have been here. That was a comment in Mr Grieve's submission at paragraph 7.8. He similarly commented at paragraph 8.3, or a rhetorical question: "*What were the other health professionals involved in treating women in the Tairawhiti area doing to question smear reports consistent with symptoms.*" I'm just submitting there, with respect, that we need to be careful about who we're

1 pointing fingers at specifically in this Inquiry. There are a lot of health
2 professionals who have been at the coal face in treating a number of these
3 women – many of them are GP's, it's not just of course THL specialists, and
4 we should be careful about pointing the finger at those people unless they've
5 had an opportunity to have their say in respect of particular patients or
6 treatments that they've undertaken.

7 My learned friend Mr Corkill's submission again refers to other THL
8 pathologists – that's at paragraph 25, and in his paragraph 25 he refers to
9 Patients 6, 7, 9, 10 and 12. I'm going to come back to those references to
10 those patients because he refers to unacceptable under-reporting by others so
11 I want to deal with that later. The point is the same here as the one that I've
12 made in relation to Mr Grieve's submission.

13 It's also suggested in paragraph 254 of Mr Corkill's submission, particularly
14 Sharon Reid knew about circumstances and did not take proper steps. I
15 think the discussion was about Patient One, although she didn't know that it
16 was about Patient One at the time because she was not told of the person's
17 name. In my submission that is an unfair criticism to level at Sharon Reid.
18 She was told about one incident of a patient whose name she didn't know.
19 It's not reasonable to expect a person in her position, let alone even a health
20 professional, to take that matter further – particularly when she was aware
21 that other people had the matter in their hands at the time, including, I
22 understand, a High Court proceeding.

23 In a similar vein in Mr Corkill's submission, a few paragraphs on, paragraph
24 258, he mentions that there were other factors which should have led people
25 at THL or elsewhere to take further steps and those factors were the
26 knowledge that Dr Bottrill was proposing to retire, the fact that he was not
27 TELARC accredited and that they'd recently had the Burkenshaw incident
28 at Good Health Wanganui. In my submission, none of that in itself is a
29 reason to put up one's hand and say, "we're aware of a problem in our

1 particular area". And I think the comment has been made often in the
2 evidence that it was understood that there was monitoring of this programme
3 going on in different places. So if there had been evidence of some
4 systematic under-reporting, then I would certainly accept that it is a health
5 professional's responsibility to do something about it to protect the patients
6 or the public. But in the absence of that sort of information, I'm not sure
7 that one can go with the benefit of hindsight and say it was someone's
8 obligation at the time to do something more just because of those
9 surrounding factors.

10

11 CHAIR: What attitude does Tairawhiti have to the committee making a
12 recommendation that the programme and those responsible for it should be
13 all housed under one unit so that rather than a regional co-ordinator being
14 employed by Tairawhiti the regional personnel associated with the
15 programme would be employed by the programme, wherever that was
16 housed. If it was housed with the Ministry of Health they would be
17 employed by the Ministry of Health but working in a region with the local
18 CHE or HSS.

19 MR ROSS: Or DHB as it's about to be.

20 CHAIR: Yes.

21 MR ROSS: I don't have instructions on that. If I may just observe that
22 that makes better sense from an accountability perspective. The only issue
23 arising for the DHB (as it will be) will be what claims does that person have
24 on the resources of the DHB and how is that worked out. Presumably that
25 can be done by agreement with the central agency. That's just dealing with
26 cervical screening. If there are other programmes, then I guess these people
27 will find that there are a lot of people not actually employed by the DHB
28 who are involved in the DHB's work one way or the other and those two

1 will have to be co-ordinated. So it will replace one problem with perhaps
2 other issues.

3

4 MR ROSS: Just completing that point about Sharon Reid, I think I
5 remember her using the words that “bigger people would be involved in the
6 matter”, and of course she was right, because at the time the Medical
7 Council was involved with the complaint. In an Inquiry where there have
8 been few bouquets thrown, I want to grab a couple that have been thrown to
9 THL in the submissions of the Ministry. There are comments made about
10 the emphasis that was put on the enrollment of large numbers of women in
11 the review, and certainly Tairawhiti is grateful to accept the bouquet of the
12 efforts that were put into enrolling women and certainly wouldn't want to
13 have lost in this Inquiry the benefit that women do get from participation in
14 the programme. Not responding to a criticism, of course.

15 I want to come to another subject heading, which is a suggestion that
16 Gisborne Hospital has been involved in unacceptable under-reporting.

17

18 CHAIR: Well, there's no evidence one way or the other because at the
19 moment the study which we wanted to have carried out by Professor Skegg
20 isn't happening. We initially contemplated it including the Tairawhiti
21 region to look at reporting by Gisborne laboratories because we had seen
22 instances where women had had smears read by Gisborne laboratories
23 sandwiched in between smear-reading events by Dr Bottrill and Gisborne
24 laboratories had also read the smears as normal. Subsequently, we knew Dr
25 Bottrill's normal readings had been found to be high grade, or abnormal
26 anyway by the Sydney re-read, and that caused some concern. But the
27 group of women, I understand, is about 14, and really we're not sure

1 whether the Skegg Study is even going to get off the ground now because of
2 the delays.

3 MR ROSS: Yes, well, that was a submission I was going to make to you.
4 We will find examples of under-reporting. The question of whether it is
5 unacceptable, there have been weeks and weeks of evidence determining
6 just that issue in respect of one practitioner.

7 CHAIR: Well, we are not determining it in respect of a practitioner, we
8 have to look at whether there has been an unacceptable level of under-
9 reporting in consequence of misreading and/or mis-reporting of
10 abnormalities in cervical smears in the Gisborne region. We're not looking
11 at individual laboratories. So it's a question of making that assessment in
12 respect of the Gisborne region and, given that that is term of reference 1,
13 there was a concern to look at the other laboratory as well as Dr Bottrill's.

14 MR ROSS: I understand the point you make, Madam Chair. What I was
15 trying to say was that we will find under-reports, the question is how are we
16 going to do the analysis for each one of those pathologists who did that
17 report; was that in itself unacceptable, because we all know it is going to be
18 there?

19 CHAIR: Well, that would fall back very much on the protocol of the study.
20 We've heard a lot in the course of this Inquiry about types of abnormalities
21 on slides and how some are classically obvious as being high grade
22 abnormalities, others are difficult to read, so we will probably require a slide
23 review and some qualitative assessment made of the slide

24 MR ROSS: Yes, I understand the point.

25

26 MR ROSS: Mr Corkill raised an issue at Patient 10 as part of the
27 suggestion of THL involvement in under-reporting. Patient 10 we don't
28 know anything about, there's been no brief of evidence, Dr Wayne hasn't

1 reviewed her notes. So I'm inviting the Inquiry really to look at that sort of
2 evidence, effectively from the Bar, carefully.

3 Patient 12, in his submissions Mr Corkill says at paragraph 12.4 that
4 medical records have been lost by the public health unit for Patient 12.
5 That does not appear in the patient's brief of evidence, it just appears in the
6 submission. Certainly, my instructions are the public health unit knows
7 nothing of this issue at all and hasn't been in a position to investigate or
8 respond.

9 Paragraph 33 of Mr Corkill's submissions, he does again refer to
10 unacceptable under-reporting by others. We've already discussed whether
11 there's any evidence of that, but he does refer to specific patients – Patient 6,
12 Patient 7, Patient 9 and Patient 12. Patient 6 was a patient whose smear was
13 read by Dr Padwell. The result of the smear was blood-stained, no other
14 abnormality seen, repeat in 3 years. A subsequent re-read I think
15 determined that that was "insufficient cells, repeat in 3 months". But it's not
16 a missing of a high grade smear.

17 Patient 7 is not a THL patient so we're not sure why that patient is in Mr
18 Corkill's list.

19 Patient 9, in my submission, the THL's response in that patient's case was
20 appropriate, it was a "repeat in 6 months" smear recommendation.

21 And Patient 12 we have no information on, so it's hard to respond to these
22 allegations which we see now coming through in the submissions.

23

24 CHAIR: There is one patient which the Gisborne Hospital Laboratory
25 wrote to the patient about the misreading of the smear.

26 MR ROSS: It's probably that patient, patient 6.

27 CHAIR: Patient 7.

1 MR ROSS: I think it would be 6 because it was acknowledged that on the
2 re-read was different and so it was appropriate to respond to that and
3 acknowledge it.

4

5 MR ROSS: There has been discussion about blame. I don't want to say
6 anything more therefore on that subject. I have no other submissions in
7 response.

8

9 CHAIR: Paragraph 11 of your submission, which I've read. I don't know
10 whether you've misunderstood the thrust of the questioning of Dr Duncan
11 because the committee's concern was to ensure that he as a Medical Health
12 Officer did receive information which could provide him with the means to
13 be more alert to health concerns in the region and his evidence was that, no,
14 he hadn't received the material. He was aware of the high incidence of
15 cancer because there is a graph which I think shows the cancer mortality in
16 Gisborne at about 89. We've got that in evidence so he would have had
17 that.

18 MR ROSS: Yes, and it was Midland statistics I believe too.

19 CHAIR: No, this is a Department of Health statistic that came out in about
20 88/89 and I think it's in Dr Boyd's exhibits. It's very early on but it shows
21 that Tairawhiti has the second highest cervical cancer mortality. I note you
22 say the discussion was outside the terms of reference. I'm interested in that
23 because the provision of information to various health professionals
24 associated with the programme so that they might be able to carry out their
25 role better seems to fall within the terms of reference, particularly when you
26 look down the later ones from 4 onwards.

27 MR ROSS: That's my poor mode of expression. I was really referring to
28 the timeframe and if there was a suggestion that Dr Duncan some time in

1 1998 or 1999 was supposed to be understanding things from statistics from
2 previous periods then that would be beyond the scope. I simply wanted to
3 look after Dr Duncan.

4 CHAIR: Well, we had the greatest sympathy for Dr Duncan, I think. We
5 wanted to find out what information was available to him.

6 MR ROSS: And I'm happy to resile from the propositions in paragraph 11
7 if that assists.

8 CHAIR: Very well. Are there any questions?
9

10 PROFESSOR DUGGAN: I'd like to follow through on Mr Kirton's
11 questioning of Dr Van de Mark. My interpretation of what Mr Kirton was
12 pursuing was that he was raising some concern about professional isolation
13 – not just her but all professionals in this region, because during her
14 evidence it was asked if she had discussed this unusual pattern of cervical
15 cancer incidence with other OBGYN colleagues, and she hadn't. It
16 transpired that she doesn't have much contact with other colleagues because
17 of a) her work commitments; and b), I think she is the only OBGYN
18 employed at the hospital.

19 MR ROSS: I think that, if I remember the evidence correctly, it was that at
20 one stage there were two of them. She was at that stage focused on getting
21 her waiting list down and in that particular year when she had another
22 colleague she didn't go to the annual meeting, her colleague did. I recall
23 her evidence as being that she has been supported in getting locums in so
24 that she can attend conferences and other relevant peer gatherings and that it
25 has been possible for her to do, and that she has done that annually apart
26 from that particular year. That's as I remember her evidence. But I would
27 certainly accept the proposition that in an area like this, where often you are

1 the only specialist, or one of two, it is much more difficult to stay in touch
2 with your colleagues than it would be in a major centre.

3 PROFESSOR DUGGAN: It's probably also easy to let it slide because
4 there are competing priorities and Tairawhiti Health Limited –

5 MR ROSS: For now.

6 PROFESSOR DUGGAN: - would need to do more than just support,
7 ensure that her maintenance of competence and continuing education
8 continues, although I do know that this is now mandated essentially through
9 the Practitioner Acts. These comments would also apply to all practitioners
10 in this region because obviously dialogue between practitioners could
11 identify problems much earlier.

12 MR ROSS: Yes, I accept that proposition. It may be of some interest to
13 the panel, I don't know whether it's been discussed yet, that there is a
14 working party on accreditation for senior medical specialists in all public,
15 and possibly other, hospitals which involves looking at these very issues and
16 establishing accreditation processes that are ongoing. Not simply on
17 appointment of medical staff but ensuring that certain things are done
18 annually and are done properly. As I understand it, it is standard practice in
19 NZ hospitals that senior specialists are encouraged to make sure that they
20 have the time to stay up with their areas of discipline. I'm not sure whether
21 it is mandatory or not, and certainly for THL I would have to check before
22 advising them.

23 PROFESSOR DUGGAN: And the final point – I believe I asked Dr Van
24 de Mark this, was in regard to her orientation to health care services policy
25 and procedure in a new region. This was a physician trained overseas, who
26 came back to this area, and based on her evidence and some of the
27 questioning, I was left with the impression that she really didn't know how
28 things worked. She didn't know how the Cervical Cancer Screening

1 Programme worked and how an organised programme differed to what she
2 was used to in the United States.

3 MR ROSS: Yes, I do remember that line of questioning and I remember
4 her saying that when she came she had a huge pile of paper to work through
5 to get up to speed, along with her clinical responsibilities, and I think she
6 observed that it took about 6 months for her to feel comfortable, you know,
7 practising in the new environment. On the question of the orientation to the
8 programme I'm not sure that her evidence is the end of the story because she
9 was asked about whether she remembered Sharon Reid specifically making
10 an appointment to come and speak with her about it and talk with her about
11 it. She said it may have happened, she wasn't sure. Sharon Reid, on the
12 other hand, was quite clear that she did make a special effort to do that and
13 remained in contact with her and had meetings with her and made times to
14 do that and went over to the colposcopy clinics to do that. So it may be that
15 memories are fading about what occurred in those early times.

16 PROFESSOR DUGGAN: One thing that was clear was that Dr Van de
17 Mark was not receiving the smearer report. She used the smearer and
18 she was not getting any report.

19 MR ROSS: Yes, I think she said that happened intermittently, that was my
20 recollection of her evidence.

21 PROFESSOR DUGGAN: I think she's getting them now.

22 MR ROSS: Yes.

23 PROFESSOR DUGGAN: But during the observation period when she was
24 observing all of these cases of cervical cancer and was extremely worried
25 about it, I don't think she was receiving – that was her evidence.

26 MR ROSS: I think that is correct and I think she said in a number of cases
27 she asked for it.

1 PROFESSOR DUGGAN: Yes. So it begs the question, you know, if you
2 have been orientated to the programme and you're aware of all the things the
3 programme can do for you, why wasn't she getting smertaker reports?

4 MR ROSS: I can't answer the question.

5 PROFESSOR DUGGAN: And why wasn't she getting previous histories
6 of the women who were being referred for colposcopy?

7 MR ROSS: I'm afraid I cannot answer that questioning further than what
8 we have heard in evidence.

9 PROFESSOR DUGGAN: But it does suggest lack of communication or
10 mis-communication between Dr Van de Mark and the screening programme
11 with regard to what the programme can offer her as a physician?

12 MR ROSS: Yes, it does suggest that – it either suggests the information
13 wasn't given or that if it was given it wasn't really taken on board. I accept
14 that.

15 PROFESSOR DUGGAN: All right.

16

17 CHAIR: Mr Kirton, you have something to raise, because if you do it's just
18 we've gone beyond 11.30 and we will adjourn and come back at 11.45.

19 MR KIRTON: Madam Chair, I wish to raise with you my indication earlier
20 this week with regard to the suppression order on the financial information.
21 Perhaps if I left that until after the break?

22 CHAIR: Yes, we will.

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24 **INQUIRY ADJOURNS AT 11.34 AM**

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INQUIRY RESUMES AT 11.55 A.M.

CHAIR: Mr Kirton, what I will do is I will just finished questions first and then we will deal with your application. I have one further question. In paragraph 5 of your submission, when you're dealing with issues which could have led to under-reporting being discovered earlier, you've said it has no relevance to factors that are likely to have led to under-reporting – it's term of reference 2, which is correct, but do you see it as having relevance to others terms of reference?

MR ROSS: I would need to refresh my memory on those terms of reference.

CHAIR: It's just that the committee was thinking that factors which could have led to under-reporting being detected earlier on were matters that should be considered in the context of terms of reference 4 onwards – in other words, we'd look to see changes already made and other changes. If you look at term of reference 6 “all relevant proposals that could ameliorate any risk of under-reporting abnormalities and identify whether these are covered earlier”, we saw that as reducing risk of under-reporting as including early detection of it.

MR ROSS: I entirely accept that as a prospective exercise rather than a retrospective exercise, yes.

CHAIR: Yes, but what would need to be done is to identify what did occur at the relevant time, what opportunities were lost, if any, and then from there to extrapolate and say, “Well, this shows us for the future various steps should be taken.”

MR ROSS: I can see the argument. In other words, instead of having to deal with hypothetical possibilities we have an actual situation which can

1 guide us for the future without any necessary adverse comment about that
2 past.

3 CHAIR: That's right.

4 MR ROSS: Yes, I accept that.

5 CHAIR: Thank you, that's fine. Are there any further questions?

6

7 MRS BARRETT: Good morning Mr Ross. I wanted to take you to
8 paragraph 8 of your submission where you talked about the criticism that
9 was directed at Sharon Reid. Perhaps I should take you back a little bit
10 more. Were you able to read the Cancer Society submissions Part I and II?

11 MR ROSS: I've had a very quick read of those submissions, but if you're
12 taking me to a specific section that would be helpful.

13 MRS BARRETT: I just really want to take you to the recommendations in
14 Part II of the Cancer Society submissions, p142, paragraph 20 where in their
15 submissions they've made a recommendation about protocols for concerns
16 and incidence. Would you agree from THL's point of view that in view of
17 paragraph 8 of your submission, if that was in place or to be intended, that
18 the criticism may not have been directed at Sharon Reid?

19 MR ROSS: I'm not sure that I do agree with that. I don't necessarily
20 accept that the suggestion in paragraph 20 would actually result in anything
21 significantly different from what Sharon Reid could have been in a position
22 to do had names been discussed in this particular case. So that a patient
23 needs to be able to say, "these are my details and I would like this
24 investigated". As I understand and read paragraph 20, the recommendation,
25 that is that their name doesn't get bandied about other than specifically for
26 the purpose of identifying whether there's an underlying problem with that
27 [inaudible] and whether that leads anywhere else. That would inevitably
28 mean others would need to know that patient's name for that purpose but it

1 wouldn't be able to be passed on for any other purpose. Otherwise I can't
2 see how an investigation could be done.

3 MRS BARRETT: What I did was take you straight to the recommendation.
4 When Ms Marshall gave her submission yesterday she talked about how a
5 regional person or a person that would be responsible to the National
6 programme could be in that kind of position to avoid situations like this.
7 And I would say that's a follow on of the recommendation that they are
8 making. I just wondered what your view, from THL, would have been in
9 view of what the Cancer Society was recommending there.

10 MR ROSS: I think that anything that would encourage people to come
11 forward with concerns and be assured that those concerns are going to be
12 dealt with properly, and as is suggested there "in confidence", needs to be
13 supported. I'm not sure whether I can take the matter any further except to
14 say if this programme does become a centralised programme and the staff
15 involved in the regional co-ordinator's roles leave the local institutions to
16 become, if you like, part of the national institution, we'd need to make sure
17 that all the usual processes that apply with the service providers at the
18 moment – the complaints processes, ways of bringing forward concerns
19 about the manner in which you've been treated – applied equally to the new
20 national system that's being set up for it. And the identification of a
21 particular process for raising concerns seems to me a sensible proposition if
22 people know where to go when they have a concern. There are already
23 avenues. This would add another one.

24 MRS BARRETT: Well, I think the affected women, or women who want
25 to make their views known, if they looked at a regional person that could
26 direct them in that area you would agree that sometimes, you know, women
27 do have problems in trying to look for the right person to look at protocols
28 and incidence. I just really wanted to bring that to your attention, whether in
29 fact THL had looked at that.

1 MR ROSS: I can't tell you that I have instructions on that particular point.
2 I would add, though, that the Health and Disability Commissioner process is
3 itself a way of making confidential complaints about matters and every
4 health provider has a responsibility, a legal responsibility, to tell consumers
5 of health care services that they have the right to take matters to the Health
6 and Disability Commissioner. So there are mechanisms in place. There is
7 a worry, of course, the more mechanisms you have for this sort of thing the
8 more difficult it is to co-ordinate.

9 MRS BARRETT: I think we in this Inquiry would fully understand what
10 you're talking about Mr Ross, but I think if you went and asked somebody
11 on the street about that they wouldn't have the slightest idea. That's really
12 the point I was trying to make.

13 MR ROSS: That may well be so.

14 MRS BARRETT: Thank you.

15

16 CHAIR: Thank you Mr Ross.

17 MR ROSS: Thank you, ma'am.

18

19 CHAIR: Mr Kirton?

20 MR KIRTON: Madam Chair, I would like to seek your leave to make
21 application for the lifting of a suppression order and I just wanted to submit
22 to you that at two levels there is good cause to in fact raise the suppression.
23 The first level, I would question the approach – if it is the approach of
24 Tairawhiti Healthcare Limited, to appeal to the commercial sensitivity
25 issues given that the latest piece of information within the documents relate
26 to prior to 1996 and therefore the commercial imperatives are most likely to
27 have been extinguished by now. I appreciate your ruling on the suppression

1 in the first instance and your further deliberation on the relevance of the
2 financial information, however I would put to you that there has been a wide
3 range of personal information submitted to the Inquiry. The identification,
4 for example, is the only suppression applying to that with regard to the
5 women affected, and included amongst that is some financial information
6 particularly relating to Patient One. At that level, therefore, in my first
7 submission to you, there is a public interest at stake. This is, I submit,
8 public money – whichever form you look at it in terms of Tairawhiti
9 Healthcare Limited's interest – a directly owned public body, but further,
10 there is the public funding, if you like, of the laboratory service in Gisborne,
11 and you will be well aware in the political environment of the \$89 pair of
12 underpants which created a scenario for NZ with regard to how much
13 information the public is entitled to know about downstream expenditures
14 on this. So in that regard, I put to you that there is debate about the public
15 interest at that level.

16 At the second level of submission I make to you, and that is the level of
17 relevance which I suspect will be your highest priority, I put it to you that
18 there was raised throughout the Inquiry issues to do with – for example
19 we've had discussion about the goodwill issue in relation to Dr Bottrill;
20 we've had in Dr Linehan's submission the issues about the cost of quality
21 assurance, and, in Mr Mules, his reference to financial issues with regard to
22 negotiation of contracts with the pathologists; and at a broader sense still,
23 we have the issues raised – specifically in Dr Lambie's brief – when you
24 consider the priorities and tradeoffs and the market styled health service
25 environment in the period which the Inquiry is considering was actually
26 operating in. So what I'm putting to you is that there is a residual, a
27 collateral, if you like, discussion and evaluation of economic issues in
28 addition to the public interest invocation that I put before you. So in
29 summary, they're the two grounds on which I seek the suppression to be
30 lifted.

1 CHAIR: Thank you. Mr Ross?

2

3 MR ROSS: Ma'am, I'd be more than happy to give my learned friend an
4 undertaking that there are no "underpants" budgets in those numbers, but in
5 my submission there's no reason that's been advanced to change the order
6 that was made originally. I don't accept my learned friend's submissions
7 about the relevance of this material, I'm more than happy to address you in
8 detail on it but I know other counsel have views on this as well and perhaps
9 we will re-visit it then.

10 CHAIR: Right. Ms Gibson?

11

12 MS GIBSON: Thank you ma'am. I'm slightly at a disadvantage because I
13 wasn't present when the suppression order details were agreed to in May,
14 but it was certainly made, and my friend Ms Janes may be able to help us
15 with that. Basically, ma'am, my submissions are two: there's no public
16 interest in this material, in terms of it's never been put to Dr Bottrill
17 throughout the course of this Inquiry. There has been questions put to him
18 about goodwill and he has answered those. But this material was available
19 to counsel to put and it was not put. Secondly, we've discussed this this
20 morning -

21

22 CHAIR: Well, in that sense, he's never been asked to confirm whether it's
23 correct or not, has he?

24 MS GIBSON: No, he hasn't, ma'am.

25 CHAIR: Because it's Tairawhiti's information about his practice when
26 they were looking at purchasing it, isn't it?

27 MS GIBSON: That's correct.

1 CHAIR: So without having his comment on it, we don't know whether or
2 not he accepts it as an accurate reflection of his laboratory's profitability?

3 MS GIBSON: That's completely my submission, ma'am. The second
4 matter is it's not relevant to this Inquiry. We've had a discussion this
5 morning already about price motivation, financial motivation and the
6 relevance of it. You have ruled on that separately, and if it's not relevant,
7 then in my submission there can be then no public interest in it. And I do
8 not accept that it's appropriate at this late stage to be lifting a suppression
9 order that was not objected to at the time. I know Ms Janes can probably
10 help on the basis that the documents were entered in the first place.

11 CHAIR: Yes, well it seems any submission which would want to use this
12 price information which wasn't put to Dr Bottrill would be doing so on the
13 basis of attempting to establish a motivation for him remaining in business.
14 Now so far we haven't had any of those submissions because although Mr
15 Kirton did start out making those submissions they were amended to refer
16 purely to the goodwill of the business, and equally, I've already said, putting
17 aside how the under-reporting happened, why it happened and what was
18 motivating Dr Bottrill is really not for us it's really a matter of looking at did
19 it happen rather than how did it happen and the motivation behind that.

20 MS GIBSON: I certainly agree with all those matters, ma'am.

21

22 CHAIR: Does anyone else wish to be heard? Ms Janes?

23

24 MS JANES: Ma'am, just very briefly. If I can submit that these things
25 may well be interesting to the public but do not fall into the public interest
26 element, in that neither were they put to Tairawhiti Healthcare Limited to
27 confirm, nor were they put to Dr Bottrill, and not only did you rule when Mr
28 Grieve was talking about the financial motive was not relevant but that was

1 reinforced in his closing submissions that those were issues that the
2 committee did not feel that it was necessary to pursue. Just very briefly
3 clarifying how those documents came into evidence, it was agreed that there
4 were issues that counsel for women affected and also counsel assisting were
5 wishing to pursue in the event they were ruled to not be relevant to the
6 Inquiry, thought was given as to whether full documents should be provided
7 or whether just the actual text should be provided. In the interests of the
8 approach that's been taken by all counsel of putting in full documents they
9 were put in but those suppressions were sought because they were not
10 relevant to the issues before the Inquiry, and no objection was taken to that
11 stance at that time. So I would really just support the submissions that
12 suppression should not be lifted at this stage because they have not been
13 able to be commented on by the parties affected by those orders.

14

15 CHAIR: Thank you. Do you wish to be heard in reply Mr Kirton?

16

17 MR KIRTON: Yes, I do Madam Chair. I would submit, in conclusion, that
18 there has been a wide range of evidence put to the Inquiry which was not put
19 to the witnesses themselves.

20 CHAIR: I hope not Mr Kirton. I would be very worried if that was so. I
21 thought we'd done quite well there, but I might be tempting fate to say so.
22 The point is, if witnesses haven't had an opportunity to comment on
23 evidence which could ultimately be accepted by the committee in the report
24 and which might reflect adversely on the witness concerned who didn't have
25 the opportunity to comment, that would be a breach of natural justice.

26 MR KIRTON: Well, Madam Chair, perhaps I should be more expansive on
27 that point. When I say "evidence", I'm referring to – for example there's a
28 wide swathe of evidence given by various TELARC commentators to the

1 Inquiry, or given in evidence, which was taken, put into evidence, various
2 documentations for example around 93/94 with regard to Dr Bottrill's
3 laboratory. Those specific documents were not specifically put to Dr
4 Bottrill and yet they were accepted as a public record. So what I'm saying
5 is that there are a wide range of materials that have come in that are
6 available for scrutiny by the public should they so wish, and I question
7 whether in fact, because this is a specific piece of financial information, why
8 some sort of imperative should be held over that information versus a vast
9 array of others that a suppression order has not been sought and has been
10 considered to be in the public interest to allow that to stand. On that basis I
11 question why this specific piece of information should be withheld from the
12 public.

13

14 CHAIR: Well, having heard everyone, there doesn't seem to be any reason
15 to change the order. There is no new fresh material before the committee
16 which would justify a change. Certainly, it's clear at the time the
17 information was first before the committee a suppression order was
18 obtained. After that the information was not put to the two important
19 parties – Dr Bottrill or Tairawhiti Health representatives to comment on the
20 accuracy of the information as it was seen to be irrelevant. So in that sense
21 it is untested information; we don't know for sure how accurate it is. It
22 probably is, but it hasn't been tested.

23 The other point is that the committee has already ruled that the motivation
24 for continuing to practise is not in itself relevant because the committee is
25 not here to pass judgment on Dr Bottrill. It is not a question of did he
26 intentionally carry on acting in the way that he did or not, and did he do it
27 for good reasons or bad reasons. The only issue before the committee is
28 while he was practising at a certain point in time did his practice amount to
29 under-reporting at an unacceptable level, and once we've reached that

1 conclusion it's then a matter of looking at what are the factors that have led
2 to the under-reporting.

3

4 MR KIRTON: Thank you for your wise consideration, Madam Chair.

5

6 CHAIR: Before Health starts, Mr Murray, can you help me with
7 something. When the Cartwright Inquiry commenced, and I also know this
8 from the Inquiry I was involved in at Carrington Hospital, the Minister at
9 the time made a ruling – I think it was under either s60 or 62 of the
10 Hospitals Act, which allowed certain named persons (which was the
11 committee and counsel assisting, often) to have access to hospital records
12 because the main part of s60 or 62 contains a protection of information but
13 there was always a power where the Minister could direct that certain
14 persons could have access to the material. Now I understand that power has
15 gone. I did ask Ms Janes if she could look at it, but maybe you can help too,
16 because for the purposes of looking at whether there is any benefit in
17 appointing the independent audit team as a Committee of Inquiry there's
18 been a lot of talk about how do they get access to medical records. In the
19 Inquiry I was involved in earlier, and in the Cartwright Inquiry, there was no
20 difficulty in getting access to hospital records without consent because the
21 Minister exercise the power then available. Whether a similar power is still
22 available in existing health legislation or not I don't know, but if it was, it
23 would be another benefit of appointing the audit team as a Committee of
24 Inquiry.

25 MR MURRAY: Yes, we did have a quick look to see what had happened
26 to s62 just during the morning adjournment. I didn't get my mind around
27 where it got to, the section's gone so we've gone in to look at the history. I
28 think over the lunch break counsel assisting are going to see if they can

1 tackle it and I'm happy to have a look at it as well to see whether the same
2 sort of provisions ended up somewhere else in the health legislation.

3 CHAIR: Yes, it seems that the whole sense of provision in the Hospitals
4 Act was one to protect hospital information except in limited circumstances
5 and then, of course, recognising that s13 of the Hospitals Act allow for
6 inquiries to be set up, there was a provision in the s64K I think it was that
7 allowed the Minister to direct that certain persons could get access to
8 information in the sense that the information protections in the body of s60
9 were to be said not to apply to these specific named persons. It was done
10 by notice in the Gazette. So it did allow any Committee of Inquiry set up,
11 certainly under the Hospitals Act, to have a free reign at getting access to
12 medical information in a hospital.

13 MR MURRAY: Yes. All right, well we will see where that gets to.

14

15 CHAIR: Yes, Mr Hindle.

16 MR HINDLE: We are sort of on the trail. The Act was amended by the
17 Hospitals Amendment Act 1993 and with Ms Anderson's good offices we
18 are going to go to her library at lunchtime and see if we can find it.

19 Just an update on Ms Thorpe and the Tairāwhiti Regional Ethics
20 Committees, I've spoken to her this morning and she doesn't think she'll
21 want to be heard but was taking final instructions and was going to let me
22 know at lunchtime. I think she's the only person outstanding then apart
23 from Health.

24 CHAIR: Well, as she's not here now, I think we shall just embark on
25 hearing from Health and she will have to be fitted in once Health has
26 finished.

27 MR HINDLE: I think it's unlikely she'll want to say anything.

1 CHAIR: Right.

2

3 CHAIR: Mr Murray?

4

5 MR MURRAY: Now the way we've decided to deal with final
6 submissions, Madam Chair and members of the panel, is that I'll just speak
7 to Health Funding Authority and Midland RHA issues and my friend Mrs
8 Sholtens will deal with Ministry of Health issues. Having said that, I don't
9 need too much time to elaborate on many points. I'd like to leave most of
10 the time for Mrs Sholtens to speak about Ministry issues, and the
11 programme in particular, and I'm conscious that the panel's probably heard
12 enough from me as the Inquiry's been going on

13 If I can just start with referring to the introduction of the combined
14 submission.

15

16 CHAIR: Yes. Could you just as a housekeeping matter tell us when the
17 other submissions are going to be ready because we'd like to be able to plan
18 our evening.

19 MR MURRAY: Well, we really haven't prepared a written version. What
20 I'd like to do is speak to term of reference 1. I'd like to speak to the
21 introduction to our submission, term of reference 1 very briefly, term of
22 reference 2 on Midland RHA issues. I have a few points on terms of
23 reference 3 and the others, just to simply indicate the structure, and I would
24 like the leave of the Inquiry to write up some of the detail on that, which I
25 just haven't had a chance to do. It's not contentious but I just haven't been
26 able to write it during the Inquiry process. And then leave the balance of
27 our submissions for Mrs Sholtens to deal with – mainly term of reference 2.

1 Most of our 100 page submission is on term of reference 2 and Mrs Sholtens
2 has got quite a lot of material she'd like to cover on that.

3 CHAIR: And what about term of reference 3?

4 MR MURRAY: Yes, that's the one that I'd just like to make some brief
5 comments about the structure, how we approach it, and just seek the
6 Inquiry's leave to write some of that down with some references to the du
7 Rose material. Because we called Mr duRose, I'd like time just to address
8 that in a bit more detail. I haven't had a chance to study counsel assisting's
9 submission on that, it takes quite a critical approach. I would just like from
10 the Health Funding Authority's point of view to I think sit down and write
11 some of that up. It's not controversial, it's more an analysis that's required
12 I think.

13 CHAIR: In some ways this issue runs into the issue we are grappling with
14 over the referral to the High Court because what had prompted it was our
15 wish to have a study, first of all to answer term of reference 1, and then it
16 became clear there was no need for the study for that purpose. It seemed
17 that a study particularly looking in other regions – the three other regions
18 just as examples – may assist us in determining whether or not there is a
19 systemic issue.

20 Now depending on the attitude you take, given the lateness with which we
21 are now faced with getting information, and given that if the study were still
22 to go ahead we would have to wait on: one, a ruling from the High Court;
23 two, it would depend on whether the Minister was prepared to accept a
24 report which did not give her final comments on term of reference 3, and so
25 it may be the study started and then stopped because the Minister just
26 wanted to stop things as at 20 December. So in some ways the attitude that
27 you now take to whether or not there is a systemic issue could well
28 influence us in terms of how strongly do we pursue the study.

1 MR MURRAY: Yes, I'm conscious of that Madam Chair, and that's why
2 earlier I made a submission on term of reference 3 orally because I was
3 aware that it goes right into the question of pursuing some of these other
4 studies. I'm happy to pick up that issue after I've dealt with speaking to a
5 few points in term of reference 1 and 2, comment on some points in other
6 submissions by way of reply, and then come to term of reference 3, and I
7 hope that my submission on that will actually make the panel's decision
8 about whether to pursue other studies a bit easier. I'm well aware of that.
9 I flagged there was an interpretation issue with term of reference 3.

10 CHAIR: Yes, well I'm happy to be assisted on that because so far no-one
11 has really gone into the terms of reference and made submissions on their
12 interpretation, and that would be helpful too – particularly because at the
13 moment the committee is reading them but if it doesn't hear from others then
14 it may well be that others have a different interpretation and we don't know
15 of it. So we do need to know how they're interpreted by you.

16

17 MR MURRAY: Well, I'll just make a start if I can by referring to the
18 introduction to the Health submissions, I'll call them, because they are a
19 combined submission. If I could just raise an important point there and that
20 is we have tended to become very negative in the Inquiry, and
21 understandably, because we are focusing on Gisborne and the terms of
22 reference require us to do that to make a start on the other terms of
23 reference. It's just a plea really, not entirely in defence of the Health bodies
24 but on behalf of the screening programme and the importance of it, that any
25 Inquiry report not just concentrate on what's gone wrong but balance that by
26 the achievements of the programme. We have in the submission referred to
27 Professor Skegg's evidence. For obvious reasons he was the expert witness
28 called by the Inquiry, and although Professor Skegg, of course, was quite
29 critical of many aspects of the programme and the Ministry, his criticism

1 was well balanced because he pointed out that we have a programme that
2 has actually saved many lives. So while, of course, we feel the pain of lives
3 lost, I think it's important to get that balance. The submission quotes
4 Professor Skegg but the other reference I would refer the Inquiry to would
5 be Ms Glackin's brief of evidence and at the last part of her evidence she set
6 out the targets that had been fixed for incidence and mortality, and it's
7 interesting that the targets have been modest but achieved and so higher
8 targets seem to have been set and achieved as well ahead of time. So that
9 my strong plea, really, is that if any report is going to be written that
10 explains what has gone wrong with Gisborne, let's balance it with the
11 outcomes of the programme. Where the balance is struck, of course, is for
12 the Inquiry and I can't –

13 CHAIR: I accept everything you say, Mr Murray, and if the Inquiry was an
14 Inquiry looking into the overall effectiveness of the programme on a
15 national basis, then everything you say is absolutely correct, and certainly
16 any report would have to balance the bad incidence with the good. The
17 difficulty is that there we have terms of reference requiring us to look at
18 what has happened in Gisborne, and this is where we come back to
19 interpreting the terms of reference because I see the core issue as being
20 looking at “has there been an unacceptable level of under-reporting in
21 consequence of misreading”, and once you accept that, you then look at
22 what led to the under-reporting. So in that sense term of reference 1 and 2
23 are negative because in term of reference 2 you are saying “how did this
24 come about”, so you're looking at negative factors. Once you establish that
25 there has been unacceptable level of under-reporting in term of reference 3,
26 you then have to say, “well, is it isolated” – in other words, does it just relate
27 to Gisborne, or is it evidence of a systemic issue for the programme. And if
28 you're looking at is the unacceptable level of under-reporting evidence of a
29 systemic issue for the programme, again it seems to me you're looking at
30 negative features.

1 MR MURRAY: You've gone right into the interpretation issues and
2 foreshadowed where I was going, so I'll touch on it now and we can come
3 back to it later as well if necessary. In my submission these terms of
4 reference have a pattern to them. It starts off with the bad news, if you like,
5 which is the Gisborne situation. One gets to term of reference 3, which I
6 submitted before was a pivotal one because you deal with systemic issues,
7 and as Professor Duggan has pointed out, it's the only one that actually
8 refers to the screening programme and systemic issues. Just pausing there,
9 in my submission the systemic issues have to be looked at in two
10 departments. Historical systemic issues and current systemic issues.

11 CHAIR: Yes, I agree.

12 MR MURRAY: And if I can just go to my opening address that Mrs
13 Sholtens and I presented, if I can just find the way I put it right at the
14 beginning. It is in the opening submission. I foreshadowed this because
15 normally with these types of Inquiry you look at what's gone wrong, what
16 are the systemic issues so that they don't happen again in the future – that's
17 the whole process. So when you look at term of reference 3 there may be
18 many systemic issues that in the early part of the 1990s were very serious,
19 but in the second half of the 1990s you may see a pattern of diminishing
20 concerns. In my submission that's what the evidence shows. As various
21 things happened, your concern about system issues can be reduced. Section
22 74A enacted national reconfiguration of the Register, achievement of
23 TELARC accreditation, cytology standards being applied.

24 So my submission is that the historic systemic issues are not the main focus.
25 It's important to identify them, but in the opening address Mrs Sholtens and
26 I included paragraph 11 which said that essentially the Inquiry is into what
27 went wrong with cervical screening in Gisborne in the early 90s in order to
28 find out whether anything arising out of that situation still contains lessons

1 for the way in which the screening programme operates today. That's the
2 heart of the exercise.

3 CHAIR: When you say "systemic issues" here, I had seen the systemic
4 issues we were to look for as relating to under-reporting. In other words, if
5 we decided the under-reporting was not simply isolated we were to look at
6 was there under-reporting in the rest of the country. It didn't seem to me
7 that, for example, it was part of our role – if we decided there were systemic
8 issues – that we should go into systemic issues that went beyond smear
9 reporting. In other words, smear-taking for example.

10 MR MURRAY: I think, though, that the panel has inevitably got into
11 systemic issues, not because you start with the whole programme but you
12 start with Dr Bottrill and it's like a funnel and you go out wider.

13 CHAIR: That's right.

14 MR MURRAY: And the submission that I would make, still focusing on
15 the introductory part of our written submission, is that we really have a
16 situation where if I can just try and encapsulate this in a few words, you
17 have a screening programme that focused upon enrolling large numbers of
18 women – should we continue Madam Chair – I'm happy to continue.

19 CHAIR: Everything is being tape recorded so it can be read, so in that
20 sense what you are saying is not being lost. No, we will continue unless
21 you would rather we stopped.

22 MR MURRAY: No, I'm happy to continue and use the time. In my
23 submission, it goes to this concern I think that we can become very negative
24 and lose the balance here. The way I would –

25 CHAIR: Actually, I think it might be better, given that the Ministry is
26 concerned about potential criticism and given that it's not evidence but
27 submission, even though it can be read, often submission given orally is
28 more persuasive. So I think, yes, we will just wait.

1 MR MURRAY: Yes, thank you.

2 CHAIR: We will adjourn for 10 minutes.

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4

5 **THE HEARING ADJOURNED AT 12.35 PM AND RESUMES AT**

6 **12.44PM**

7

8 MR MURRAY: I think where we were getting to was this submission that
9 I was making about balance in the report. Madam Chair you made the
10 point, well what's the basis for writing up the successful parts of the
11 programme if the terms of reference don't invite that approach.

12 CHAIR: Yes.

13 MR MURRAY: And my answer is that I think there's plenty of scope for
14 that, the way the terms of reference are constructed, because one starts off
15 with the small issues – if you like the focused issues around Dr Bottrill and
16 Tairawhiti and this region, and one broadens out to the extent that the issues
17 identified are systemic and take you into the programme. We, therefore,
18 get into the concept that the screening programme is a pathway. We do not
19 need to deal with every point on the pathway but we do need to deal with
20 the concept of cervical screening being a pathway. Where I was going was
21 to make the submission that there's need for balance because the screening
22 programme has been focused, if you like, on the front of the programme and
23 the back of the programme. The front of the programme being enrolling
24 large numbers of women and having access to colposcopy and treatment
25 services in a timely fashion for women who have abnormalities detected
26 from the tests. In my submission that part of the programme has been done
27 well. Clearly the evidence showed high coverage and concentration on
28 colposcopy services and waiting times, and the panel will recall the

1 evidence when we started looking at monitoring that those were the two
2 indicators that seemed to be emphasised, even through the health
3 restructuring in 1993. I don't want to go into the detail of that, simply to
4 emphasise that that was the focus of the programme, it was the front of the
5 programme, and those two indicators were monitored.

6 CHAIR: It seems, though, that that in a sense can also be a factor for
7 criticism because from a very early time, from the experts group, from
8 CSAC, the Ministry was being advised that all aspects of the programme
9 were just as important and it was wrong to have the emphasis on the front
10 end, so to speak, that you had to have the emphasis everywhere of equal
11 weight. And following on from that it could be said, well, it's fine to
12 encourage large numbers of women to enrol but if the quality of the smear
13 taken, when it gets to the laboratory if it is not being read properly, then all
14 the numbers of women in the programme is not really going to be beneficial
15 if their smears are not being accurately and competently read.

16 MR MURRAY: That's what I'm coming to, that there was this weakness in
17 the middle of the screening pathway. But the way I've put it, or the way
18 that we've put it in the introduction to our submissions is that because there
19 was a focus on the success of the programme the results were looking good
20 – if I can put it that way. The outcome of the screening programme tended
21 to indicate it was very successful. You had high coverage, impressive
22 reductions in the incidence and mortality of cervical cancer, and Ms
23 Glackin's evidence indicates what the targets were, that they were being
24 achieved, and Professor Skegg indicated that even targets for 2005 have
25 already been achieved. Unfortunately those good aspects of the programme
26 have been let down by the weakness in the middle of the programme. So
27 it's quite right, and the Ministry and all concerned will have to accept
28 responsibility, to the extent that it's appropriate, that all those elements were
29 not of an equally high quality at the start of the programme and monitored

1 and failures detected. And all I'm doing is saying when the Inquiry panel is
2 writing out the bad news about the smear-reading part of the programme and
3 the pathway, it needs to be balanced by the fact that it is a pathway and
4 some parts were done very well, and that indeed the success of the
5 programme may have camouflaged the weaknesses of the programme.

6 CHAIR: Yes, well, I certainly understand the point you make. However,
7 when I look at the terms of reference, 4, 5 and 6 refer to under-reporting,
8 and although you've said, well, there are other aspects of the programme
9 that are good, we actually haven't gone into those aspects in great detail.
10 Indeed, although we've touched on them, I was always concerned, if we
11 seemed to be going in too far, to pull back because if there were concerns
12 about the clinical management of the women, the quality of colposcopy –
13 and you will recall there has been some questioning about colposcopy and I
14 can remember a little booklet that Mr Kirton was questioning people on
15 (which is another part of the programme pathway in a sense), and smear-
16 taking – use of lay smertakers – those aspects have come up but I've always
17 been quite vigilant not to ensure that we got into it in too great a detail. So
18 what this means is that in terms of the other pathways we haven't looked at
19 them in a comprehensive sense and so were not in a position really to say,
20 well, is it good, is it bad. It appears to be good, but then again anyone
21 looking at the programme from the outset would have said the entire
22 programme appeared to be good, and looking at the laboratory statistics, for
23 example, that were sent out to the laboratories, things looked to be good.
24 We've now learnt that they weren't as good as they first appeared, so I'm
25 sort of concerned. I don't know whether the same will apply to other parts
26 or not. We're really in a position where we don't know.

27 MR MURRAY: Well, I don't want to invite the Inquiry into trying to look
28 at each step in the screening path, indeed in the opening submissions we

1 indicated that we didn't see that that was what the term of reference
2 required.

3 CHAIR: That's right.

4 MR MURRAY: And all I'm submitting is that the Inquiry does have a fair
5 amount of discretion in the way it writes up its report, so it's really a style
6 and balance issue that I'm addressing, and that when one gets right down to
7 the end of these terms of reference to comment on any other issue the
8 Inquiry team believes to be of particular relevance. For example, that is an
9 opportunity to reassure women that although there've been some
10 unsatisfactory things discovered along the way, I mean, they're written up in
11 the Inquiry report, nevertheless the target, the outcome target, seemed to
12 have been achieved and reduced cervical cancer in NZ so that one doesn't
13 end up with a report that discourages everyone, which may be a very poor
14 outcome in terms of encouraging women to subscribe.

15 CHAIR: Well, I see what you mean there, but I think one has to be honest
16 to women as well. It's all very well to say, "Well, we're afraid women will
17 lose confidence in the programme." You can't falsely create a sense of
18 confidence, and I think women do need to know certain aspects about this
19 programme, and although you've pointed to statistical achievements in
20 terms of reduction in rates of cancer, for all we know they may well have
21 been reduced further if there had been no under-reporting. Secondly, I'm
22 sure that the women of Gisborne, from their perspective, would not be
23 comforted from knowing that the rates of cancer overall have dropped.

24 MR MURRAY: We accept that. Look, there's no question that this is no
25 comfort to the Gisborne women. No question at all.

26 CHAIR: And the other point is I think the main thing too is that women do
27 need to know that at the moment this programme has not, in terms of the
28 quality of the smear-reading, been evaluated. And the gold standard for the
29 programme, and I know I keep harping on about this, but the gold standard

1 for the programme which will tell us whether it is working or not hasn't
2 been carried out and we do not know – we're waiting to hear from you on
3 this point, but at the moment it is hard to say whether or not there is a
4 systemic issue. Now if under-reporting is a systemic issue for the
5 programme, that is something I think that women need to know.

6 MR MURRAY: Yes. I don't want to go into the detail of evaluation
7 because Mrs Sholtens can address some of these topics, but just focusing on
8 these terms of reference, in my submission one has to deal with the past, the
9 present and the future. The past is showing a very sad situation in Gisborne
10 and systemic issues. The present is showing that Dr Peters is about to
11 launch national policy and quality standards and performance indicators and
12 independent monitoring that seem to be of international standing in
13 accordance with the evidence we heard about the European guidelines, so
14 that the future looks good. What we don't know is –

15 CHAIR: I'm not sure about whether the future does look good, because I'm
16 told it's going to happen. A lot of things in the past have been said to be
17 going to happen. TELARC accreditation was going to happen in 95 and 94,
18 it didn't happen until 97, and in terms of what Dr Peters has done it's a
19 superb job but it's not in place, and secondly, in terms of a lot of the
20 gathering of the information that is needed in terms of the independent
21 monitoring, I've yet to see how legally it can happen, given the difficulties
22 we face now the law is still the same. I haven't seen any evidence of a
23 change in law. So I can't see how Dr Peters' independent monitoring team
24 is going to be any better placed than the evaluation which is still waiting to
25 be finished by Doctors Cox and Richardson.

26 MR MURRAY: I think I'm really trying not to buy into these issues which
27 are well known and we've covered in evidence. I'm just trying at this stage
28 to indicate the structure of the terms of reference enable the Inquiry to deal

1 with past, present and future. One of the topics within the past is the fact
2 that the national evaluation wasn't done.

3 CHAIR: Well, it's not in the past, it's in the present because it still isn't
4 done.

5 MR MURRAY: Yes, but it shows you information about performance
6 prior to the date that it's done. So that one has to say, in my submission I
7 just draw it together by saying this, that the screening programme outcomes
8 seem to have been successful – and Mrs Sholtens can refer to some of the
9 international benchmarks one looks at for outcomes, but the evaluation may
10 show that it's not as successful as it could have been because if there have
11 been failures at various points in the pathway that evaluation should pick
12 them up.

13 CHAIR: Yes.

14 MR MURRAY: And that's the measure we don't have. Success, but we
15 may have saved more lives if it had been more successful. That's how I
16 would like to submit –

17 CHAIR: Yes, I see that and I suppose you have to ask yourself, well, if you
18 have a programme that is in operation and during the course of the
19 programme a doctor in one specific area is between – I think it's 1990 to
20 1996 – carrying out an unacceptable level of reporting of cervical smears
21 you have to say what does that say about our programme, because during
22 that period it wasn't picked up. And there's no evidence to show that there
23 was anything to do with the programme which picked it up, because I think
24 you would accept the ideal programme should be constructed in such a way
25 that it has processes built into it which would pick up under-reporting. It
26 might not do it immediately, but over a given period of time it would pick it
27 up. Here you have had under-reporting from 1990 to 1996, when it was

1 finally picked up after that period of time it was not picked up by the
2 programme.

3 MR MURRAY: Oh, that is so. A lot of this we're not debating, I don't
4 think it's contentious.

5 CHAIR: No.

6 MR MURRAY: I think Mrs Sholtens would like to make submissions
7 about how that came about and the timeliness of the way the programme
8 evolved. Clearly as different elements of the programme evolved the
9 prospects of this thing not happening, or being detected, improved. But I
10 don't there's much between us. I think a lot of the evidence is not in
11 contention. We know factually what happened. We know there was a
12 unacceptable level of under-reporting, but what one then has to do is make
13 an assessment of how did that come about and, given the various elements
14 that one now recognises should be in a programme, why weren't they there
15 to start with. Professor Skegg, and I think Dr Medley, seemed to indicate,
16 well, you wouldn't wait, you'd get started, but some of these other things
17 should have been implemented in a more timely way. And that's I think
18 where the Inquiry panel's judgment – we are all in the Inquiry panel's hands
19 on those judgment calls.

20 CHAIR: Yes. We will break for lunch soon, but what we also really are
21 interested to know is we've seen the documents prepared by Dr Peters, and
22 they look good, but we need to be persuaded as to how they will actually
23 work, because being confronted with excellent plans is not itself going to
24 persuade us that they will happen and we need to know they can happen.
25 That's basically because there are obstacles in the path of – and I'm getting
26 back to the evaluation exercise, but there are obstacles in its path still and
27 unless those obstacles are cleared, and we haven't seen evidence of how
28 they're going to be cleared, any new plans are going to run into the same
29 problems.

1

2 PROFESSOR DUGGAN: Also, could I make a comment. If you could
3 perhaps make some reference in your comments to the following context.
4 Cervical cancer from the point of initiation, the initiating agent takes 15 to
5 20 years to develop. We tend to look on the programme as having a past, a
6 present and a future, but the disease is 15 to 20 years long. So somebody
7 initiates the disease in 1990, it may not declare itself until 2005/2010.
8 That's the disease, it's not the future.

9 MR MURRAY: Yes, and the programme should be sufficiently robust to
10 pick it up. If not the first smear, the second smear and if not the second one
11 at least the third.

12 PROFESSOR DUGGAN: Yes, but in the first 6 years of this programme
13 women had only two opportunities. Sometimes three opportunities to have
14 their disease detected because you're on a 3 year screening frequency.

15 MR MURRAY: Yes. And that was the tragedy that happened in Gisborne
16 because women on two cycles went to the same laboratory, it was a
17 repetitive situation. And that is the challenge, to make sure that that is
18 detected. It shouldn't occur, but if it does occur, the programme systems
19 detect it before it becomes a cancer that cannot be resolved.

20 PROFESSOR DUGGAN: So your approach really I think has to take into
21 account this long natural history of the disease?

22 MR MURRAY: Yes.

23 PROFESSOR DUGGAN: Anywhere from 15 to 20 years?

24 MR MURRAY: Yes, and I think Dr Medley's evidence touched on this. I
25 won't deal with this at any length now, but sometimes you get to a point
26 when you look at a situation like Gisborne and the things that have gone
27 wrong, the improvements that have been made subsequently, but you do
28 have to draw a line in the sand and say, "Let's make sure the programme is

1 working correctly now, because women who then participate will actually
2 have smears read by good laboratories within the next 3 years". So that I
3 think that was a point that she seemed to be saying, that you can't always be
4 looking back and re-read something like 2 million or 2 billion slides. I
5 think it's that temporal aspect that we are struggling with a bit in the terms
6 of reference. If I could just pick up a point, though. Of course the Inquiry
7 is rightly concerned about implementation of the Peters work, but of course
8 even having heard that evidence it's relevant to term of reference 5 which is
9 to identify other changes agreed to be implemented. So, I think we get 5
10 out of 10 if we can get something into that term of reference and I'd like to
11 say we'll get the other 5 out of 10 if within the life of this Inquiry it is
12 implemented. That's what a lot of work has been done on, and that's
13 outside the Inquiry's evidence at the moment, so I can understand the
14 confidence issue that you need.

15

16 CHAIR: We will adjourn until 2.15.

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19 **THE HEARING ADJOURNED AT 1.05 P.M.**

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THE HEARING RESUMES AT 2.15 PM

PROFESSOR DUGGAN: What I was trying to solicit opinion from you on was your approach to looking at the programme in terms of past, present and future and, my concern in terms of women, that cervical cancer has a natural disease history of 20 to 25 years, so if the programme is only 10 years old you can't really dismiss that 10 year history and move forward because you have women enrolled for that 10 year period.

MR MURRAY: Yes.

PROFESSOR DUGGAN: And there's 50 more years to run in the cycle of the disease.

MR MURRAY: Yes. If you had a situation like Gisborne Laboratories Limited that carried on and you had a poor programme that didn't have monitoring and evaluation, it's conceivable that it would not be picked up. So that is a real concern, and probably leaping ahead, but that's where at the end of the day you have to do a risk assessment, I think, and that's what Dr Medley was talking about. She said, "Well, as a pathologist, I had a level of comfort and decided you could draw a line in the sand and move on." Now, that's a judgment call for experts to make, but my understanding of Dr Medley's evidence and her participation in the national laboratory review was that "we are at that time", because they didn't discover any other situation like Dr Bottrill – sole practitioner, isolated from his peer group, no quality assurance and so on. What they couldn't be conclusive about was whether there was some under-reporting. Now, I'm leaping ahead here, but my submission really on term of reference 3 is that – part of it is that you take Dr McGoogan's evidence, and she said "the problem with cytology is you don't have definite benchmarks." Even internationally it's very hard to find something that you can say is universally accepted as your benchmark

1 for specificity, but what you can do is you can look at the standards at which
2 a laboratory is practising and if they don't have quality control and they
3 don't have smear-reading, cytoscreeners, you are left thinking "this is a
4 risk". On the other hand, if they do have accreditation, internal/external
5 quality control and so on, you can get a level of comfort that that type of
6 laboratory is likely to have a good level of accuracy. It's not definitive but
7 I'm taking Dr McGoogan's evidence at her word, bringing it over to the
8 national laboratory review and saying for all its lack of science it was an
9 attempt to look at laboratory practice over a 10 year period. And you can
10 be critical (as counsel assisting has done in picking up Professor Skegg's
11 evidence) of the science. But in the real world – if you go out and do that
12 and you don't find any glaring example like Gisborne Laboratories Limited
13 – as a matter of risk assessment you can say, "Well, that's some comfort".
14 You can also say, "On the other hand, we can't rule out under-reporting."
15 So judgment call. Do we do another slide re-reading, and the Health
16 Funding Authority's assessment after doing the national laboratory review
17 was no, we don't go and re-read another 30,000 slides in another region.
18 Obviously there were some concerns with other regions, that some
19 laboratories over that time had had coding errors and possibly under-
20 reporting, but there was nothing that stood out as another Gisborne
21 laboratories situation that would warrant a massive re-reading exercise. It's
22 a matter of expert judgment then, in my submission.

23

24 CHAIR: Just help me. I'm just trying to recall now with the du Rose
25 study. Did it use the Screening Register?

26 MR MURRAY: Yes, they used data from the Screening Register.

27 CHAIR: Of identifiable women?

28 MR MURRAY: I don't believe so, no, I think it was data.

1 CHAIR: The reason I say that is because the one laboratory which seems to
2 have been the laboratory in Northland, if you look at the description, was
3 recorded as having under-reporting up to 95 I think and then after 95 things
4 improved. Now if you had looked at the Screening Register for the names
5 of women and if you made sure that women subsequently had smears that
6 were being read and what they were being read as, you could say, "Well, if
7 there was a woman whose smear was under-reported, in the sense they had a
8 very low rate of reporting abnormal given the cancer incidence there, that
9 it's been picked up subsequently in the cycle. But if you didn't actually
10 check with the Register for all you know – particularly given the long period
11 of the disease – there could be women whose smears were not read
12 accurately before 95 who either have left the district or haven't had regular
13 smears or in some way it hasn't been picked up. I can't help, I have to say
14 we read the papers, we see in the "Herald" reference to a woman in
15 Northland who out of 8 smears is supposed to have 7 read as normal. Now
16 that certainly is not enough on its own to carry any weight with us other than
17 to make us think our study that we wanted to have carried out to see whether
18 or not there was a systemic issue by looking at the other areas with a high
19 incidence of cancer seems to be called for, because it's only by carrying out
20 that type of study that you can be sure that there hasn't been under-
21 reporting.

22 MR MURRAY: In my submission the problem with doing the four region
23 study is that it might confirm there's under-reporting, but we know there's
24 under-reporting in Gisborne so we've got one example, so we've got a
25 systemic problem because of how that situation came about. I suppose,
26 again moving ahead to term of reference 3, but why not, my submission is
27 you probably don't need to identify another region if the region you've
28 already identified is unacceptable under-reporting shows you the systemic
29 issues because you have to go and fix the systemic issues. You don't need
30 another case to make that call.

1 CHAIR: Well I suppose the only thing is at what point do you draw the
2 line on getting evidence of system issues, because if we looked further afield
3 we might find evidence of other systemic issues that hasn't come to light
4 here. There is that possibility. I haven't carefully read our terms of
5 reference to see whether or not the benefit of looking for systemic issues
6 elsewhere in terms of revealing to the women affected in those other regions
7 that they too have a problem falls within our terms of reference. But I'm
8 sure that women of NZ, if they thought that the Inquiry had identified
9 systemic issues in Gisborne which were seen as representative of systemic
10 issues in other parts of the country, would want to have their concerns about
11 whether or not they had been detrimentally affected by these systemic
12 issues.

13 MR MURRAY: Yes, you see I'm making breath-taking submission again,
14 that there's only so much that can be done within the Inquiry. If that
15 approach was pursued to its logical conclusion you would say, "Well four
16 regions is not enough, we might miss the fifth region where there's another
17 Gisborne laboratories type of situation."

18 CHAIR: Well, can I take it then – I don't want to rush you with your
19 submissions at all, just so that you can allay some concerns of mine – that
20 the Ministry agrees that the evidence we have heard to date points to
21 evidence of systemic issues for the programme?

22 MR MURRAY: Yes.

23 CHAIR: Right. Dr Duggan has just discussed with me, she has concerns
24 about what you mean by "systemic issues". We're getting back to
25 interpreting the terms of reference. She sees systemic issues as geographic
26 issues. I must say I've seen systemic issues as issues relating to the systems
27 within the programme and in that sense they will affect the country
28 nationally because it is a national programme. I haven't seen the word

1 “systemic” as equating geographic, but just related to the systems within the
2 programme.

3

4 PROFESSOR DUGGAN: Let me clarify. When I read terms of reference
5 I took that to mean that if there was under-reporting in the Gisborne region
6 we were to determine if this was an isolated event or was this occurring
7 some place else – was there under-reporting occurring some place else in
8 NZ for the programme. That’s how I read it.

9 MR MURRAY: No, in my submission that’s not legally correct. The
10 whole approach to systemic analysis is you find a problem and see whether
11 there are underlying factors that you can extrapolate out of that to the
12 subject matter you're looking at. I’m more used to aircraft accident disasters
13 and you don’t deal with it on a geographic basis, you deal with the aviation
14 systems. The whole structure of operating a system, right from the
15 operational end of it, right back through to the board of management and the
16 company that runs the airline then back into the safety regulator. It’s a total
17 system approach but it’s not related to the geography of where things might
18 happen.

19 PROFESSOR DUGGAN: When, then, did you do the laboratory review?

20 MR MURRAY: Because it was – well, that’s the distinction between the
21 Health Funding Authority’s responsibility and this Inquiry’s role, and that’s
22 a very important distinction to make.

23 PROFESSOR DUGGAN: Could you expand on that for me, please.

24 MR MURRAY: Yes, the evidence of Mr duRose was that when the high
25 level of high grade results started being reported by Sydney the Health
26 Funding Authority was concerned that there could be risk to other women in
27 other parts of NZ and that required the Health Funding Authority to do
28 something to try and identify that situation. Because if so, the Health

1 Funding Authority's responsibility was to put in place safety measures
2 immediately. This is where, I think, the national laboratory review has
3 been looked at – I think the Inquiry's actually aware of this, that it was done
4 for that purpose because the Health Funding Authority had a specific
5 responsibility for the health of the women in NZ. That study's now been
6 brought over into this Inquiry. I think perhaps I'd better go – because this
7 is I think so fundamental, if I can just go straight to it. The way I see the
8 national laboratory review is that it helps you really on four points. It helps
9 you work out whether it was an isolated case or not – or at least it goes to
10 that issue. It helps you with identifying whether there's systemic issues
11 over the last decade. It helps you with a risk assessment as at today and it
12 gives you a bridge towards implementing the new policy standards because
13 you know where laboratories are at now and you know what they have to do
14 when you issue your national contract with standards attached. Now, just
15 taking the first of those points – whether it's an isolated case or not, it's
16 actually that laboratory review has been seized upon to help with term of
17 reference 3. That's why I say that whether or not this was an isolated case
18 is a relatively low threshold because the point is if you are not satisfied you
19 may have no evidence – if that laboratory review hadn't been done you may
20 have no evidence about whether it was an isolated case or not; you couldn't
21 be satisfied it was an isolated case so you would have to go on and address
22 systemic issues. Now, if the laboratory review itself shows systemic issues
23 you add those to the ones you've already discovered with Gisborne and
24 you've got in to systemic issues relating to the screening programme. So
25 we've already got a raft of systemic issues that have come out of Gisborne,
26 we've got a few more systemic issues that have come out of the national
27 laboratory review, so you don't need to go on studying other geographic
28 regions. You go into the purposes of this Inquiry, which is to address the
29 systemic issues, because those are the ones that the government has to fix.
30 And that's the nature of an accident and emergency type of Inquiry like this.

1 So I've only addressed one of the four, but in my submission that's the
2 trigger for systemic analysis.

3

4 CHAIR: Do you see our role as part of making recommendations to come
5 up with solutions to the systemic issues we do identify?

6 MR MURRAY: Yes, the way I read the terms of reference there's a logic
7 to them and you might end up as you go through them recording problems,
8 changes already made, changes agreed to be made but residual concerns,
9 therefore recommendations have to be made to complete the analysis and
10 complete the safeguards.

11 CHAIR: Should we, therefore, once we are aware of certain system
12 problems, struggle to find a solution to them?

13 MR MURRAY: No. In my submission, the value of these inquiries is that
14 they focus on this topic. In fact it becomes excruciating because you pick a
15 narrow area of human activity and you focus just on that. But the power of
16 an Inquiry is to identify the problems and make recommendations and pass
17 the ball back to those responsible. That's the real power that an Inquiry
18 has, because then it puts the pressure on the decision-makers to do
19 something about it.

20 CHAIR: Well, in terms of making recommendations, should the
21 recommendations go so far as to say, "this is a problem, we recommend it
22 be fixed." Do we go further and say, "We recommend it be fixed by doing
23 X."

24 MR MURRAY: Yes, that is still within the terms of reference if you've
25 heard evidence about it sufficient to go that far, but the Inquiry, in my
26 submission, has a great deal of flexibility about how far it goes. It may be
27 with some topics you have got as far as identifying a serious issue but

1 haven't got the evidence to say what the solution is. But having identified
2 the problem is a powerful advance in itself.

3 CHAIR: We need to just discuss further this issue of system issues because
4 Dr Duggan is having some concerns. My understanding – I accept what you
5 say about systemic issues, but I saw systemic issues as being, for the
6 programme, in relation to under-reporting and therefore in the course of the
7 Inquiry it has looked at what systemic issues are there in the programme
8 which might give rise or allow under-reporting to happen or to go
9 undetected. Dr Duggan is concerned because she sees, I think as a result of
10 your submission, systemic issues as including any systemic issue in relation
11 to the programme because she has had concerns about quality of
12 colposcopy, for example, which I have thought shouldn't be pursued because
13 I didn't see us as being here to look into colposcopy but rather laboratory
14 reporting. Now how do you see, when you say that a systemic issue goes
15 right into the system – the whole system of the programme – would you,
16 therefore, read our term of reference as allowing enquiry into the way in
17 which smears are taken, colposcopy, access and acceptability, or how
18 acceptable is the programme.

19 MR MURRAY: Yes. Well, my submission about that is that both
20 approaches are right because the focus of the Inquiry is under-reporting, but
21 under-reporting leads you to ask, well how would you detect under-
22 reporting.

23 CHAIR: That's right.

24 MR MURRAY: You have to have standards.

25 CHAIR: Yes.

26 MR MURRAY: You have to have monitoring.

27 CHAIR: That's right.

28 MR MURRAY: You have to have evaluation.

1 CHAIR: Exactly.

2 MR MURRAY: And that, then, leads you into issues for the screening
3 programme and that may mean those same issues could affect smear-taking.

4 CHAIR: I agree with you there, but we don't need to then go into smear-
5 taking and look at how that is working or not working and equally how is
6 colposcopy working or not working.

7 MR MURRAY: No, we don't, but the residual discretion that the Inquiry
8 has is if the evidence and this process we are involved in showed a concern
9 about colposcopy, there is no reason why the Inquiry shouldn't report it
10 within term of reference 7.

11 CHAIR: Yes, well the way the Inquiry's been structured, we left term of
12 reference 7 to the side. If you recall at the very beginning a ruling was made
13 that we would concentrate on the specific terms of reference first because of
14 concerns about time and then deal with term of reference 7 later, and of
15 course we've run out of time because people wanted to raise a number of
16 topics within term of reference 7. But it would seem that whether one is
17 looking at an isolated case or systemic issues, it is really looking at it from
18 the perspective of laboratory reporting of cervical smear tests.

19 MR MURRAY: Yes. And I don't believe the Minister, in setting these
20 terms of reference, would have required this Inquiry to go into evidence on
21 all the different steps of the screening pathway.

22 CHAIR: No.

23 MR MURRAY: That would have been such a huge undertaking, it can't
24 have been contemplated.

25 CHAIR: That is right. Well, that would be looking at the entire
26 programme, which you had said in your opening we were not to do. What,
27 I suppose, could be said is that the same lack of standards, monitoring and
28 evaluation in relation to laboratory reporting, if it is clear from the

1 documents before us that there has been a sufficient absence of those factors
2 in other areas of the programme we can point to that as well, if we're going
3 to go into that, and say, well, just as we have evidence that there are no
4 standards, no monitoring and evaluation of laboratory smear-reporting,
5 equally this doesn't happen in other areas well.

6 MR MURRAY: And that is the purpose of the systemic analysis, it leads
7 you to some fundamental repairs that have to be made, and term of reference
8 3 of course refers to the programme and this seems to distinguish between
9 the other terms of reference which are more specific.

10 CHAIR: One of the problems I have when I was asking you about whether
11 or not we should go so far as to search for solutions and you said, "yes, if we
12 could, in making recommendations", and I know this is actually being very
13 unfair to you, but I'm sure you'll handle this well. In **Douglas v**
14 **Pinlington** it does say it is the duty of the commission to pursue all lines of
15 enquiry that appear promising – even if those lines may not in the end prove
16 productive. And given the sort of encouragement from **Douglas v**
17 **Pinlington** about the duties of Committees of Inquiry, and given what
18 you've said about coming up with solutions if we can – and this is getting
19 back of course to this vexed question of evaluation and the High Court
20 ruling, just one of the ways of offering solutions here is if we knew where
21 we stood on 74A in terms of the regulation-making power and the meaning
22 of the words "persons studying cancer" – if we knew for sure whether that
23 applied or not; if we could then say it does apply therefore the Ministry
24 should be looking at making regulations because parliament has provided a
25 way for it to – it's not even to overcome this prohibition on information but
26 rather parliament has chosen to protect information to a limited degree but
27 equally to allow it to be available through regulations being made for proper
28 monitoring and evaluation. We could say that we if we knew for sure that
29 that section in the Act applied, and we won't know that until we hear from

1 the High Court. Equally if we knew that it didn't, we then could say, "Well,
2 you should be looking at amending the Act". The other solution was the
3 solution I had of appointing Doctors Cox and Richardson themselves under
4 s47, which we know already in fact would allow them to get access to the
5 Cancer Register because we've had access to the Cancer Register exercising
6 the 4D power, and we know the limits on medical privilege in terms of s32.
7 I was refreshing my memory on that reading Mr Collins' text and it's clear
8 physical examinations, etc., aren't covered by the protection – doctor's notes
9 aren't, it's the communication the patient makes. So you could get some
10 way certainly in looking at records. We could actually make that
11 recommendation now and it still could be carried out. The only drawback
12 is the impact of s74A because if we knew that the 4D power over-rode 74A,
13 then that really would be a clear ticket to the Cox/Richardson team if they
14 were appointed under these provisions to get access to everything just about
15 that they wanted. But we can't actually make the recommendation with any
16 confidence if we aren't clear on the law.

17 MR MURRAY: Well, just picking up two points there, one on **Douglas v**
18 **Pinlington**, if I was wrong about my interpretation of term of reference 3
19 and you had to go geographically around the country to answer term of
20 reference 3 and make sure you picked all the ones where there was a real
21 risk, you would have a duty to pursue the summons, pursue the information
22 and so on. I think there's possibly a distinction to be made between a
23 commission as in **Douglas v Pinlington** and a ministerial Inquiry that's
24 been given the powers, but I find it hard to work out what the distinction is.

25 CHAIR: No, I don't think there's a distinction.

26 MR MURRAY: Anyway, put that to one side.

27 CHAIR: Can I perhaps say, then, that there's a distinction between us and
28 the Erebus Commission and we don't have to be so careful about fair
29 process?

1 MR MURRAY: No, I'm not. That's definitely wrong. In my submission
2 on that first point, the **Douglas v Pinlington** point, I don't think the Inquiry
3 should feel it has not discharged a duty. In my submission the evidence
4 that we've heard has been extremely broad and persistent and relevant to the
5 terms of reference and I don't think the Inquiry should feel under any
6 obligation to get more evidence. And that brings me to the second point
7 that the power of the Inquiry is to stop when it's identified the problem,
8 write it up and make sure that those responsible for the solutions are aware
9 of it. So, it's not for counsel to make these judgments, all I can do is make
10 a submission and say that for the Ministry my submission would be the
11 Inquiry has already identified some powerful issues and the sooner they are
12 written up in the report and passed to the people who have to fix them the
13 sooner we'll get a solution. And I think that's the difference between us on
14 the High Court. I've got instructions, but my instructions are ones that I'm
15 comfortable with because I do believe the Inquiry should not feel that it is
16 stopped short of doing something that it could have done. I have no doubt
17 that the Inquiry would have fulfilled its obligation if it wrote up the
18 difficulties that have been encountered, and that's why I made the
19 submission that you Madam Chair have all the expertise in the law, you just
20 don't have the authority to give a definitive ruling. But your appointment
21 to this Inquiry and your expertise in the areas of law that we're actually
22 talking about is of itself of high value and if it's captured in the report that
23 provides the way out. I think that's where we're getting to on the High
24 Court, and I'm trying my hardest to persuade the Inquiry that it may or it
25 may not give us something, but it's not necessary to go down that route if
26 the Inquiry feels that it has enough to write a powerful report that says it
27 cannot be good enough to set up a programme and have a whole bunch of
28 legal issues that stop you achieving the purpose. We've all identified that
29 and the ball needs to be passed back to those who are responsible for finding
30 a solution. And it seems on the evidence that, to be fair to the Ministry,

1 there seems to have evolved – it seems that we had Cartwright, we had
2 confidentiality, we had s74, we have known that one of the benefits of the
3 screening programme is that you do an evaluation, but that side of it doesn't
4 seem to have come to the top and been explored until finally the evaluation
5 protocol said, “Actually, we would like information off the Screening
6 Register, we would like women’s names”, and then there was a second
7 element to it, “and we also would like to go and find the women and their
8 clinical records”. And the value of this Inquiry is it’s now identified that,
9 it’s heard evidence about it, it’s heard expert evidence from Professor Skegg
10 and others, and once that’s in the report it means the government has the
11 platform for saying, “all right, well if we need legislation to override the
12 confidentiality of the screening programme and personal privacy we will
13 promote the legislation and the balance will be struck”, and it may well be
14 that you would override privacy in the case of women who can't give their
15 consent – the deceased women or women who can't be contacted. I’m just
16 hypothesising where the balance might be struck. But that’s something that
17 a court can't decide by the legislature can. And I suppose that’s why we've
18 been so keen to persuade the Inquiry to write it up and then pass it to the
19 Minister and say “this has got to be fixed.” And as Cartwright was, a very
20 powerful and authoritative report, this Inquiry itself will be very
21 authoritative in that respect. I have no doubt about that.

22 CHAIR: Yes, well the concern was if we were able to get an authoritative
23 ruling on a way which you could cut through the obstacles now – whether
24 the Minister chose to use it or not would be another story, but it would be
25 there for her to use if she wanted to direct that it be used. So in that sense
26 we would have done the utmost we could by identifying something which
27 was in existence which could be called upon straight away. The alternative
28 in terms of making recommendations, I haven't made any assessment of it
29 but there have been submissions from others that not all the
30 recommendations of Cartwright were followed through in the way that were

1 recommended. And a lot of the things that, you know, you say about the
2 programme which would pick up under-reporting, the need for monitoring,
3 evaluation etc., standards, the CSAC report of 1994 was saying much the
4 same thing, and earlier on with the Ministerial Review Committee with the
5 experts group a lot of the things that have come out in this Inquiry where
6 you would now say, “Well, yes, we realise these were systemic issues were
7 being identified by others at a very early point in time – in fact, all along the
8 pathway of the programme”, and yet it didn't happen. I suppose that is why
9 the committee has some concerns about making recommendations which are
10 dependent on other actions or other changes before something can be done,
11 whereas if we find a way to allow the evaluation to go ahead now, getting
12 through these legal obstacles, at least it will be there – whether it's used or
13 not is another matter.

14 MR MURRAY: If that technique of solving a problem was considered by
15 the Ministry to be valuable we would be submitting that that be done, we
16 really would. And in my submission the Inquiry does not need to feel under
17 an obligation to go that far because if that is the solution the Ministry should
18 be pursuing it and asking the Inquiry to state a case rather than it coming the
19 other way.

20 CHAIR: Yes.

21 MR MURRAY: Perhaps just while I'm on that, I said in the opening
22 address that the government can't wait for the Inquiry's report to find
23 solutions. It's not sitting back and saying, “Well, there's an Inquiry going
24 on, we won't do anything in the meantime.” As you know, both the Health
25 Funding Authority and the Ministry have had to carry on working. Where
26 we've got to – just a quick assessment – we've got a Cox/Richardson
27 evaluation: The first limb is done and needs to be written up by Dr Cox;
28 the second limb is underway because Dr Peters has seconded in the people
29 to make sure that the letters can go and the consents can be obtained; the

1 third limb struck problems with the Cancer Registry and the Ethics
2 Committee. On the Ethics Committee approach outside this room they're
3 looking at withdrawing the application – I think it may have actually been
4 withdrawn, it's been re-cast, it's going to be submitted to the Privacy
5 Commissioner and the Health and Disability Commissioner to get an
6 approval for the course that they now want to take, and then it's going to be
7 put back before the Ethics Committee because the researchers – whatever
8 you call them – do want Ethics Committee sign-off. It's not a question of
9 whether it's a good thing or a bad thing – they want it because it gives them
10 the comfort that they need for the type of work they're doing. And as for
11 the other side of the equation, the stumbling block was access to information
12 on the Cancer Registry. We've already had in evidence the Curran? Exhibit
13 2 which was the protocol that the NZHIS had as a guide to the Privacy Act,
14 and Madam Chair you've pointed out quite rightly that, hang on, it's not just
15 one Act there's two Acts here, and if I can say from the Bar that Mrs
16 Sholtens and I have seen the problem, we've gone back to the Ministry, that
17 protocol has become a bit of a diversion. Somebody's got to actually look
18 at the two statutes. If there is a request under the Official Information Act
19 from third parties outside the Ministry, that Act has to be properly applied.
20 If the Ministry wants to release information it has to observe the Privacy
21 Act. Those two different concepts have to be correctly applied within each
22 statute. It's actually quite difficult for lawyers, but you can imagine how
23 difficult it is for health professionals.

24 CHAIR: Yes.

25 MR MURRAY: That side of it we are confident will not be a problem.

26 CHAIR: Tell me this: From the Ministry's perspective, if the members of
27 an independent audit team apply under the Official Information Act
28 (because they can do that) is that how they will be treated – to the Cancer
29 Register?

1 MR MURRAY: Yes. Section 9 applies. Although there may be a “no” in
2 terms of privacy under s9(2)A, public interest may well cancel that out.

3 CHAIR: Exactly, because it seemed to me that with the Cox/Richardson
4 study if they could have applied under the Official Information Act, got the
5 release of the information from the Cancer Register, got the names, they
6 would have been in a position to go to the women (however they chose to
7 approach it) to get their consent and the whole issue with the Ethics
8 Committee and that dreadful catch-22 they got themselves into would have
9 been avoided?

10 MR MURRAY: Very annoying to see sometimes those things happening
11 when just a bit of legal advice could have cracked it open.

12 CHAIR: I must say have you got any submissions on – is that a systemic
13 issue for the programme, the quality of the legal advice – excluding
14 yourselves? I don’t include you in that.

15 MR MURRAY: I've been a legal adviser in a ministry and I would be the
16 last one to be critical. I think sometimes the problems are not exposed so
17 the legal solutions are not obtained either. I actually think that’s a different
18 topic, I really do. There's no shortage of access to legal services. No
19 matter how big or difficult the problem the Ministry has the resources of its
20 internal legal department, the Crown Law Office and external counsel.

21

22 PROFESSOR DUGGAN: We’re coming back to standards, monitoring
23 and evaluation of the legal profession.

24 MR MURRAY: Yes.

25

26 CHAIR: Well, after what I've seen I'm just worried that I’m not under
27 some internal moral obligation to go off and report it!

1 MR MURRAY: Don't go there. But we will. I mean, those are areas
2 that, I think as counsel, we can advise on issues that have come out of an
3 Inquiry such as this – and we do, of course.

4

5 PROFESSOR DUGGAN: It would appear Mr Murray that there is
6 sufficient access to the legal advice but it's the quality of the legal advice
7 may have been a barrier?

8 MR MURRAY: Yes, I'm just very reluctant to cast a stone –

9 PROFESSOR DUGGAN: It's sort of like access to a laboratory.

10

11 CHAIR: Are you in the “there but the grace of God go I camp” are you?

12 MR MURRAY: I think these things become easier after a two and a half
13 month Commission of Inquiry or Ministerial Inquiry, and I'm going to move
14 on to concepts of blame and hindsight bias. Therefore, if I'm to apply the
15 submissions I'm about to make I would not be critical of my legal
16 colleagues, but if there was a problem I would look to “resolving it”, is I
17 think how I would put it. It's an objective stance that one takes with an
18 Inquiry. I'm in the Inquiry's hands but I can go on to my second point.

19 CHAIR: Yes.

20 MR MURRAY: It was just that Mr Corkill made a submission about how
21 you approach this concept of identifying causes and problems in answering
22 the term of reference and yet not blaming people. This is a tension that has
23 caused a lot of difficulty, and for Mr Corkill's perspective I think he was
24 concerned that the Inquiry might feel inhibited that it had got to a certain
25 point and because of this concept it had to stop short of writing up the report
26 the way it would like to. In my submission, the Inquiry need have no
27 concern about that. The **Davies** case that Mr Corkill referred to is a good

1 example of that. You have a minimum safe altitude for pilots in the law, so
2 that's the standard. The investigation showed a pilot that did not comply
3 with that minimum safe altitude. There are risks involved in that that led to
4 an accident. The Transport Accident Commission was duty bound under its
5 statute to catalogue all that, write it up, but it did it for the purpose of
6 finding out the causes and circumstances so that other pilots didn't have the
7 same accidents. So the purpose of this Inquiry is to be free to write up what
8 it's found in an objective manner to avoid a similar Gisborne in the future.
9 The effect of doing that may be that blame is attributed. It may well be that
10 when the Inquiry report is delivered blame will be attributed, and that's why
11 natural justice is so important in these Inquiries, and it's that tension I think
12 that somehow seems to dog this process but it's not that complex in the
13 **Davies** case which is a good example and authority for the approach that the
14 Transport Accident Commission took.

15 CHAIR: So you would go along with what Mr Corkill says – I think it's on
16 p39 of his submission – that's where he refers to the **Davies** case, under the
17 heading "Blame" – 39 to 40.

18 MR MURRAY: I don't think, with respect to Mr Corkill, he quite got it
19 right with the sentence "any distinction in 64". "*Any distinction between*
20 *determining causation and attributing blame is more apparent than real.*" I
21 just think that that might be a bit of a gloss.

22 CHAIR: Well, it seems to me if you're attributing blame that is what you
23 are looking for in the course of your Inquiry and so anything you write is
24 leading to that end, whereas if you're trying to determine causes you're
25 looking for what caused the incident, you will identify what caused the
26 incident, so I suppose anyone who reads what you write about that will
27 therefore sit back and think, "Ah ha, so and so's to blame because they are
28 behind the causes" –

29 MR MURRAY: Exactly.

1 CHAIR: – but the actual writer is not focusing on the person but rather
2 than the causes, including their conduct which has led to the incident.

3 MR MURRAY: Yes, and you will find flags to this concept. You will see
4 in some of the submissions that judgmental terms are used – outrageous or
5 unconscionable or unforgivable. These are the concepts of blame and they
6 are warning signs that the person saying that has moved over from an
7 objective analysis into attributing fault and it's where the Inquiry does not
8 go.

9 CHAIR: no.

10 MR MURRAY: But it's uninhibited in writing up its findings in an
11 objective way. If it's done well that has more power than attributing
12 blame.

13 CHAIR: That's right. Well, I think that logical analysis ultimately is
14 always more persuasive in the sense it's more reliable than emotive
15 statements.

16 MR MURRAY: Yes, and that's why I referred to some of the big inquiries
17 in NZ where – I don't want to go into it, but you can see that possibly they
18 were affected in part by crossing over into feelings of indignation – how
19 could that have been done so badly, and then objectivity is lost and the
20 purpose of the Inquiry is not fully achieved because we were all deflected
21 into who to blame rather than what went wrong and how to fix it in the
22 future. That then brings me to my third submission about hindsight bias
23 and I know the Inquiry panel will quite rightly pick me up very early on in
24 this analysis and say, “Oh, well, it's not hindsight bias because look advice
25 was given about these things at the time.” And that's true. The point I'm
26 making about the concept is one always has to check on any topic – hang
27 on, we know it now, but what was the fact situation at the time, and this is
28 touched on in our submissions at p42 where Mrs Sholtens found this article

1 that we've quoted at paragraph 134. It's an article by Fishhoff?, published in
2 the Chicago Law Review. Rather than try and explain in my own words
3 what this is about, if we go to the James Reason material –

4 CHAIR: The what, sorry?

5 MR MURRAY: It's the book that James, Professor Reason wrote –

6 CHAIR: But what are you looking at, I don't think I've got it.

7 MR MURRAY: Yes, it's in Mr Corkill's cases and materials.

8 CHAIR: I'm not that familiar with Mr Corkill's cases and materials yet.

9 MR MURRAY: It's a natural springboard from our submission at
10 paragraph 134 where we have picked up this writing on hindsight bias and
11 we are going into the Professor Reason article, which is pages 1 to 28, and
12 the passages I'd like to refer to are starting at p23. There's a postscript to
13 this article. Professor Reason I think is sort of seized upon by all disaster
14 analysts and particularly in the aviation field, but the postscript has got some
15 wonderful writing there. It says, for example in the second paragraph:
16 *“For those who pick over the bones of other people's disasters, it often*
17 *seems incredible that these warnings and human failures, seemingly so*
18 *obvious in retrospect, should have gone unnoticed at the time. Being*
19 *blessed with both uninvolved and hindsight, it's a great temptation for*
20 *retrospective observers to slip into a censorious frame of mind and to*
21 *wonder at how these people should have been so blind, stupid, arrogant,*
22 *ignorant or reckless.”* And it goes on, one purpose of this concluding
23 section that he's writing about is to *caution strongly against adopting such a*
24 *judgmental stance. No less than the accident producing errors themselves,*
25 *the apparent clarity of retrospection springs in part from the shortcomings*
26 *of human cognition. The perceptual biases and strong but wrong beliefs*
27 *that make incipient disaster so hard to detect by those on the spot also make*
28 *it difficult for an analyst to be truly wise after the event. Unless we*

1 *appreciate the potency of these retroactive distortions, we will never truly*
2 *understand the realities of the past nor learn the appropriate remedial*
3 *lessons. There's one obvious but psychologically significant between*
4 *ourselves, the retrospective judges and the people whose decisions, actions*
5 *or inactions led to disaster. And that is we know how things were going to*
6 *turn out. They did not.”* And then Professor Reason cites the article that
7 we've got in our submissions by Fishoff? and further down, just to conclude
8 at the bottom of 215: *“Outcome knowledge dominates our perceptions of*
9 *the past yet we remain largely unaware of its influence. For those striving*
10 *to make sense of complex historical events familiarity with how things*
11 *turned out imposes a definite but unconscious structure upon the antecedent*
12 *actions and conditions. Prior facts are assimilated into the schemer to*
13 *make a coherent cause or story. A process similar to that observed by*
14 *Bartlett in 1932 in his studies. But to those involved at the time these same*
15 *events would have had no such deterministic logic. Each participant's view*
16 *of the future would have been bounded by local concern. Instead of one*
17 *grand convergent narrative there would have been a multitude of individual*
18 *stories running on in parallel towards the expected attainment of various,*
19 *distinct and personal goals.”* It goes on and the passages over the page are
20 equally powerful, the last paragraph in particular at p24 of the volume. For
21 example, it starts: *“The concurrence of a manmade disaster leads inevitably*
22 *to a search for human culprits.”* I just cite all that because it's all part of
23 striking the balance when we're assessing the failures of complex systems
24 and assessing the responsibility of the humanbeings that were part of those
25 systems.

26 CHAIR: Yes. One thing, in some ways I will be guided by you on this,
27 but it seems to me since you've raised this issue of hindsight bias, to give
28 you an opportunity to deal with the issues I can go over documents that I've
29 read which suggest to me that people were saying things at a very early
30 point in time, or I can just leave you to make submissions and then deal with

1 that later. I would feel more comfortable about taking the time to actually
2 go over it with you because I then get the opportunity of hearing what you
3 have to say about it.

4 MR MURRAY: Can I just say that I think Mrs Sholtens is anticipating this
5 and possibly has the same list of topics.

6 CHAIR: You're just doing the introduction.

7 MR MURRAY: Yes.

8 CHAIR: I'd feel more comfortable if I could take it up with one of you
9 because since you've raised this concept of hindsight bias it does seem to
10 me from what I've heard from I think Dr Cox's evidence, but also from what
11 I've read in the CSAC report of 94 and the experts group report and I think
12 the Ministerial report, they all seem to be singing the same tune about what
13 was needed to be done. Certainly, no-one was saying – well, there were
14 noises in the CALC minutes about there had been difficulties in Australia, it
15 could happen here, but apart from that no-one was saying we're going to
16 have a disaster on our hands if we don't do this, but certainly all the experts
17 were saying "this is what should be done for a programme" and it wasn't
18 happening.

19 MR MURRAY: Yes. I know Mrs Sholtens would like to speak to those
20 topics.

21 CHAIR: That's fine.

22 MR MURRAY: And has more knowledge actually of those events, too, I
23 must say. Yes, I think just on that hindsight bias, Mr Corkill's submissions
24 were obviously very impressive and valuable, but you can see that he's put
25 all these warnings signs in a line and of course you read all that and you say,
26 "well, of course, how stupid, why didn't people do something", and that's
27 where the James Reason material, in my submission, just infuses a paradigm
28 for analysis because all that information was never held within one brain at

1 one time and that brain didn't actually know what the disaster that's
2 occurred. Or the brains didn't know that. But it's just a matter of
3 perception. I'm not being critical of the submission, I'm just simply
4 indicating that there's a balance to be struck. Just pursuing that, to an
5 example, there was quite some formidable cross-examination of Mr Mules –
6 well you knew and you knew that and you knew that so why didn't you do
7 more – why didn't you go that one step further and go out and see Dr
8 Bottrill. And of course Mr Mules himself said, yes, with hindsight I put too
9 much reliance on this reference to TELARC accreditation. That's an
10 example where one can be critical or not. One has to go back and say,
11 “Well, these were the factors that were applying at that time.”

12 CHAIR: It seemed to me actually when you looked at that correspondence
13 that Dr Malpass was the person who was the most concerned, and in fact if
14 anything what it suggested to me is the benefit of having a medical
15 practitioner involved in the sense that I just wondered perhaps a medical
16 practitioner is a better person to make assessments of, is what's going on
17 here something of real concern as opposed to something that is not the best
18 but still acceptable.

19 MR MURRAY: Yes, it's interesting to see that Dr Malpass was really
20 concerned, and he wasn't a cytopathologist he was just, I think he was
21 surgical services advisor in Midland actually.

22 CHAIR: Yes, that's right, whereas Mr Mules, not being a medical
23 practitioner, may well have looked at it and thought, well yes, there's a
24 concern here but it seems to be answered on the paper, I won't take it any
25 further.

26 MR MURRAY: And he had in his mind a different framework for
27 analysing these situations because he had a health structure which consisted
28 of s51 notices, minimal quality controls, and to him, “Well, what could I do”
29 – he's a registered medical practitioner, he's a Fellow of the Royal College,

1 there hasn't been any complaint about him – “so I will do what I as a health
2 manager would do, I'll make sure there's some standards and better
3 contracts and I'll weed these problems out”, whereas a medical person
4 might have said, “no, no, you go out there and fix it.”

5 CHAIR: Well, it's a bit like lawyers, if you encounter someone else's legal
6 advice you're in a better position I think to make an assessment of whether
7 it's acceptable or not, does it raise issues, than a lay person is. It shows the
8 reliance lay people have on professionals.

9 MR MURRAY: Yes. In my submission, Midland was clearly focused on
10 quality but they were focused on systems, getting the quality right across the
11 board in a generic sense, and it just obviously, with hindsight, what a shame
12 that in 1994 the Dr Burkenshaw situation didn't result in somebody going
13 out to Dr Bottrill and stopping it just a few years before he retired, which
14 wouldn't have solved the problem of course but it would have stopped it 2
15 years earlier.

16 CHAIR: Yes, and may have identified existing problems 2 years earlier,
17 which could have quite an impact on the necessary clinical treatment of
18 women.

19 MR MURRAY: Yes, within that 2 year time period. Just before I leave
20 the sort of approach to these issues, in my submission when you look at the
21 Women's Health and Information Resource Trust submission you'll see that
22 falls into the traps of blame and hindsight bias. It's a very extreme
23 submission. Extreme submissions are often valuable because the truth lies
24 somewhere back from the extreme in my assessment, but you will see
25 language there that indicates blame and hindsight bias which in my
26 submission is detracting from the points that nevertheless may be very valid
27 but they're detracting from the substance of the problem. And that's to be
28 contrasted with the submissions of counsel assisting who strike a very
29 objective and neutral approach which has a very powerful way of bringing

1 out the problem, and much more difficult to reply to I might say,
2 unfortunately. But Mrs Sholtens will.

3 Just moving now to another point which is our submissions in paragraph
4 183. This is just a legal point about s19 of the Health and Disability
5 Services Act where that creates an obligation upon the Midland region at
6 that time, as an RHA, to purchase quality health services and Mr Corkill
7 made a submission about this at p99 of his submissions. At the bottom of
8 his p99 at his paragraph 237 he says: *“The RHA’s had an obligation under*
9 *s9 of the Health and Disability Services Act, which is headed Maintenance*
10 *of Appropriate Standards: Every purchaser shall purchase services only*
11 *from persons who maintain standards, including ethical standards, that the*
12 *purchaser considers appropriate for those services.”* That was put to Mr
13 Mules and we’ve quoted the Mules evidence at p54 in paragraph 183 of our
14 submission where he says: *“I would not agree with that.”* There was no
15 breach, in other words. He says: *“I think it’s very important to*
16 *acknowledge the context of what was going on at this time in the place of*
17 *s51 agreements. They were intended to roll over business as usual until*
18 *such time as contracts could be negotiated to replace them”* and so on.
19 And the only point I’d like to make about that is in my submission Mr
20 Mules’ evidence is consistent with the legal position. The Health and
21 Disability Services Act talks about, in the preamble, achieving things. Yes,
22 in the preamble, paragraph C of the original Act, I look at that because that’s
23 the one that as in place at the time and it says: *“Achieve appropriate*
24 *standards of health services and disability services”*, and then one goes to
25 s22.

26 CHAIR: What do you think that means “achieve appropriate standards” –
27 work towards rather than put in place?

28 MR MURRAY: Yes, that submission I’m making that parliament could
29 not possibly have envisaged that on the day the Act came into force higher

1 quality standards would have been achieved, it just is a non sequiter and
2 therefore the technique for achieving better services or higher quality
3 services was through s22 and other provisions which was to negotiate and
4 enter into purchase agreements. That was the technique and that's
5 consistent with the Midland evidence – namely, that on the day Midland was
6 born it had s51 notices to roll over the previous statutory regime and it was
7 then necessary to move forward by negotiating contracts with providers that
8 had quality provisions in them.

9 CHAIR: Also my reading of s19, it's a very general section and in some
10 ways quite meaningless because although it talks about maintenance of
11 appropriate standards it's standards that the purchaser considers appropriate
12 for those services; it doesn't refer to any objective standards, it's whatever
13 standards the purchaser considers appropriate. We've heard no evidence
14 from the RHA in the period prior to the contracts being entered into that it
15 had any services that it considered appropriate, it just rolled over the s51
16 notices with a view to working towards establishing contractual
17 arrangements which ultimately didn't happen, in the case of Midland RHA,
18 until March 97.

19 MR MURRAY: Well, I suppose the first point I should make is that prior
20 to this Act, throughout the health system there was just reliance upon
21 professional integrity and professional standards. There's a lot of criticism
22 of the so-called purchaser/provider split in the commercial model, or
23 whatever expression you like to use, but if one is going to be critical one
24 also has to acknowledge that this statute was the technique, the legal
25 machinery for creating a layer of standards by a regulator over and above
26 the health professionals. In the Midland region, when the Midland RHA
27 was formed, it was faced with the Mark I approach to health care, which as
28 the professional standards; it had s51 notices which incorporated all the
29 regulatory provisions but produced into a contractual type of notice, and

1 then it was asked to move out of that. When I say “asked”, it was required
2 by the Health and Disability Services Act to move from that point to achieve
3 negotiated contracts which had appropriate standards. And it was generic
4 because we've focused, of course, on purchasing laboratory services, but the
5 statute applied to the whole health sector so that when it was purchasing
6 both public and private health care and disability services it had to develop
7 standards appropriate to the particular health service it was purchasing.

8 CHAIR: When it started up it didn't have standards in place.

9 MR MURRAY: No.

10 CHAIR: As I said to you, although s19 talks about standards the purchaser
11 considers appropriate, I note from your submission, the first sentence at 184
12 you say, “Mr Mules explained the s51 notices were essentially introduced to
13 enable the current situation to continue”. In other words, a situation that
14 had been inherited where there were no standards but which was a holding
15 situation until the RHA had developed standards which were in place via the
16 contract system.

17 MR MURRAY: Yes, and I think just picking up Mr Corkill’s approach, I
18 think he’s critical of the Midland RHA from day one, but in my submission
19 the clock is ticking from day one and Midland should have been working
20 assiduously to move out of s51 notices for laboratory services so that it had
21 appropriate standards in a contract. So my submission is that one looks at
22 the time that was ticking by while the s51 notice prevailed.

23 CHAIR: How long was it – was it 6 years or 5?

24 MR MURRAY: No, Midland came into existence in I think 1 July 1993
25 and the period of time until a generic contract was agreed with the Midland
26 laboratories was until November 1996.

27 CHAIR: My understanding is it was signed off in March 97 but it was
28 backdated. Although it might have been backdated do you have to say,

1 well at what point in time was it signed and did it become legally
2 enforceable.

3 MR MURRAY: Yes, the evidence of Mr Mules was the deal was done in
4 November 1996. There was agreement, and I think that is the operative
5 date because that was the price increase, a small % price increase went from
6 that date. The actual signing was done in February and March the
7 following year and Mr Mules explains that.

8 CHAIR: So it's just over 3 years then, it could be 3½ years if you take it up
9 to March from July 93 to November 96.

10 MR MURRAY: Yes.

11 CHAIR: But if you take it from July 93 to March 97 –

12 MR MURRAY: Well, it was during that time and if one focuses on that
13 and says, “well, that was all the time that Dr Bottrill was reporting
14 unacceptably” and the Health and Disability Services Act didn't cause that.

15 CHAIR: No.

16 MR MURRAY: And it did provide the machinery for stopping it but it
17 didn't achieve that – the statutory objective wasn't achieved until those
18 contracts were entered into, and it's significant that that process seems to
19 have been influential in the TELARC accreditation starting to bite on
20 Gisborne Laboratories Limited and Dr Bottrill's own evidence – I can't
21 remember exactly how he put it but he was aware that he was going to have
22 to be TELARC accredited and by the time, of course, the contract was
23 agreed he'd already retired. So I suppose the process was working but it
24 just didn't work quick enough to stop the under-reporting as soon as we
25 probably all would have liked.

26 CHAIR: The other point which no-one has raised – probably because it's
27 not helpful to their position, is that given that Dr Bottrill all along had
28 received government funding for his laboratory, if there had been an attempt

1 by the RHA, and I raise it at that point in time because you're the one
2 principally addressing the RHA's position, if there'd been an attempt to use
3 the s51 of the Health and Disability Services Act sub-section 2 to give
4 notice of a change of conditions, because it says there you have to give 4
5 weeks notice. Yes, you give notice under sub-section 1 and then under sub-
6 section 2 you have to give 4 weeks notice of any amendment or revocation.
7 And others have suggested, well that was enough to allow Midland to
8 require Dr Bottrill to be TELARC accredited and to say well if you don't
9 we're not going to pay you, but it would seem to me that the RHA is subject
10 to administrative law principles and therefore any action by it introducing a
11 change would have been open to judicial review. Do you agree?

12 MR MURRAY: No doubt and it has been. When the patience runs one
13 this technique is used and it usually results in judicial review.

14 CHAIR: Yes, and really the RHA would have had to have reasons for
15 making the change – in other words, it couldn't act irrationally, it couldn't
16 act arbitrarily, therefore there would have needed to have been sufficient
17 reason to tag payment to TELARC accreditation which would go far enough
18 to convince a High Court judge that this was not irrational conduct.

19 MR MURRAY: I think to be fair that if we had known then, if Midland
20 had known then what we know now they would not have been strung along
21 for as long as they were.

22 CHAIR: No, but what I'm thinking is knowing what they did know at the
23 time, because everyone knew TELARC accreditation was good but it had
24 never been introduced in a compulsory fashion in NZ and I was just thinking
25 if Midland had acted to require Dr Bottrill to become TELARC accredited
26 how they would have got on defending themselves in a judicial review. In
27 other words, was there enough known at the time about TELARC
28 accreditation to be able to say to a High Court judge "the fact that we've
29 been paying this man all along and now we're cutting off the money supply

1 because we want him to be TELARC accredited is a perfectly reasonable
2 thing to do” because he would no doubt say, “Well, I’m operating today in
3 the way that I did 10 years ago and it was fine then, what's the difference.”

4 MR MURRAY: Well, I’d like to think that if Midland had done that it
5 would have succeeded, I think. Even in those days one would have thought
6 the objective was a rational one – money was being paid for a service, the
7 statute provided for quality services to be provided. I think that legally the
8 technique was there. The implementation of the technique would have to
9 have been done carefully to withstand the inevitable challenge. If it had
10 been done carefully I think it would have succeeded.

11 CHAIR: So you don’t see any legal impediment at the time to the Midland
12 RHA requiring TELARC accreditation?

13 MR MURRAY: I don’t think I should go that far because I think I would
14 be guilty of hindsight bias, and all I’m saying is that I’m being neutral about
15 it. I’m not trying to claim it as something that – well, you could understand
16 why Midland didn't do it because they would have lost the case. I’m just
17 trying to be neutral about it in saying that legally the machinery was there, it
18 would have had to have been done carefully. What we now know – the
19 affidavits that would have been filed at that time would be nowhere near as
20 convincing as the ones we’d file now, but I also refer to Mr Mules’ evidence
21 where he emphasised that the focus under the Health and Disability Services
22 Act and the tier of documents under that Act – there was Crown objectives,
23 policy guidelines, funding agreements, and the whole focus was to move out
24 of s51 notices to achieve quality by agreement. And Mr Mules I think said
25 in evidence, if I recall it, “with quality we had to take people with us, it
26 wasn’t a matter of just imposing it or we might not achieve what we want.
27 We had to take them along with the policy debate.” Given that this focus on
28 quality over and above professional standards was introduced by the Act, in
29 my submission it was a reasonable approach to take for Midland to say, “We

1 had to get buy-in to the concepts of quality”, and I think the evidence that
2 Mr Mules gave covered not just the private laboratory contracts – remember
3 he found the missing file and he put in the CHE documents with the
4 Tairawhiti Healthcare Limited which was the other side of the screening
5 programme. It was all the regional services, and in my submission there
6 was quite good evidence there of Midland’s emphasis on quality control and
7 holding its contracted parties to documents that had performance reporting
8 requirements in them. Unfortunately one then comes to another system
9 issue because there was a change in the health system, the RHAs were
10 disbanded, the Transitional Health Authority was set up and the Health
11 Funding Authority was set up. But one can see that with that as an example
12 and the Sylvia Sax standards, one can see that there's been a lot of criticism
13 of this Act but one has to be careful because it was moving in the right
14 direction but everyone was restructured again.

15 CHAIR: Yes, and I suppose the Act itself did allow for quality standards to
16 be introduced via s51 and putting aside the issue we've been discussing
17 about TELARC accreditation and was there enough evidence to make a
18 move towards compulsory TELARC accreditation and appear reasonable in
19 judicial review terms, I suppose, too, what the RHA could have done is
20 pointed to the whole thrust of this Act and said to any court if it’s actions
21 were being challenged, “Well, the Act is aiming at introducing quality
22 standards into health care and this is what we’re doing, so although it’s a
23 departure from the past it is a departure contemplated by parliament.”

24 MR MURRAY: Yes.

25 CHAIR: So it’s not really the Act that is at fault so much as the way it was
26 used, though that of course could be subject to hindsight bias.

27 MR MURRAY: Yes.

28 CHAIR: Is this a convenient time?

1 MR MURRAY: Yes, it is. I will pick up that point after the break, too,
2 there's just one point about it I can add.

3 CHAIR: We can finish that now if you like.

4 MR MURRAY: Well, I was just going to make the point that the Inquiry's
5 been rightly cautious about the Peters standards. Because we have them,
6 they seem to be a model of the type because they seem to match with the
7 European guidelines, and we're all cautiously optimistic that they'll bite in
8 the near future. And I don't want to say too much from the Bar, but the
9 implementation is causing controversy and the laboratories are concerned
10 that that contract is going to be imposed on them and if they commence
11 legal proceedings we will be in exactly the situation that you have posed. It
12 will be almost like history repeating itself. There's not evidence of it but
13 the laboratories are concerned about having to compete with the hospitals,
14 so they may not object to the quality as such, but if there's something else
15 that the object to they may try and stop that being implemented and then one
16 has to go to court and argue that no, that was a reasonable exercise – either
17 the contracting power or the s51 power, and I think we'd be reasonably
18 confident that we'd win today.

19 CHAIR: Yes.

20 MR MURRAY: In fact very confident.

21 CHAIR: yes.

22 MR MURRAY: But that's the test of 84, 85, 86 compared to the position
23 today.

24 CHAIR: Yes, that is I suppose the difficulty with working in the public
25 area, you may introduce contracts but you either then do get into a true
26 commercial situation where you negotiate and then you are criticised for not
27 governing because you've negotiated away issues which the public think are
28 non-negotiable issues from the point of view of good government or

1 otherwise. In a public fashion you govern and then of course create
2 backlash from the people you are contracting with because they do not like
3 the coercion coming in and you are exposed to public law remedies. That's
4 life for government really, isn't it?

5 MR MURRAY: It is. Whichever way you go you are in trouble and it's a
6 matter of a high standard process if you're going to withstand the challenges.

7 CHAIR: Yes.

8 MR MURRAY: As you know Madam Chair.

9 CHAIR: Right, well we will adjourn now until 5 to 4. Yes, Ms Gibson.

10

11 MS GIBSON: I just wonder if I could seek leave to be excused at this time,
12 ma'am.

13 CHAIR: Oh, yes, certainly.

14 MS GIBSON: I've had an indication from my friends that there's nothing
15 further in relation to Dr Bottrill, but I would just like to reserve his position
16 if any new matters arise.

17 CHAIR: Certainly. Is counsel assisting going to look out for you on that
18 or?

19 MS GIBSON: I'm happy to look out on the transcript, ma'am, if that arises.

20 CHAIR: That's all right because I would be reluctant to take on that role.

21 MS GIBSON: No, I'm certainly happy to keep an eye out for that, but I am
22 grateful to my friends from Health, they have indicated that there would be
23 nothing new.

24 CHAIR: Yes, no you are excused, and certainly anyone else who's given
25 their submissions who would like to go feel free to go.

26 MS GIBSON: Thank you ma'am.

1 CHAIR: We will adjourn now until 5 to 4.

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MID-AFTERNOON ADJOURNMENT 3.40P.M

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THE HEARING RESUMED AT 4.00 P.M.

MR MURRAY: I think we'd got to the legal issue of implementing contracts under the Health and Disability Services Act and that's a convenient point to just refer to the cases that are cited in our submission at I think it's paragraph 187. I didn't photocopy these unreported judgments, partly Madam Chair because I thought they might actually be very familiar to you but if it would be of assistance I'm happy to make up a volume of those unreported cases. I don't think it's the complete list but it's the main cases that eventuated after the Health and Disability Services Act was passed. They tended to be interim order cases in the main to stop the RHAs proceeding with a proposed method of contracting.

CHAIR: Well, I'm familiar with the Wellington airport case, the decision by Blanchard J, the Northern Regional Health Authority case, the Napier City Council case. I'm not familiar with the one by Temm J and I'm not familiar with Bishop & ors or with Medlab Hamilton. But one thing, though, I would have thought from the cases I am familiar with is that the case law itself on consultation I think makes it clear what consultation is so that although we've heard evidence from a lot of people about consultation going on and on and on – the need for consultation legally – a consultation process can be carried out within a specific timeframe – 3 months, 6 months, it can vary, it can be even less than that. I'm using 3 months because the Resource Management Act specifies 3 months. But really it's a matter of hearing from people, keeping an open mind and then coming to a decision. It's not negotiation and it seems we've heard here evidence of attempts at consultation that have gone on for a considerable period of time.

MR MURRAY: It's the combination – the way I analyse the Health and Disability Services Act is there's a tension between public law consultation and private law contracting and it's fine for lawyers to stamp that analysis

1 on it but in the real world when health sector people have to move forward
2 it's not easy to say, "Well, when do we finish the consultation – and we're
3 bullet proof on that – now we can negotiate our contract." I think that's
4 been the tension with the process and the litigation has tended to highlight
5 that.

6 CHAIR: What is the provisions relating to the contracts because I would
7 have thought that once you consulted, then when you went into the
8 contractual phase, the fact that initially you have to consult would suggest
9 that you don't actually have to negotiate – in other words, you could go into
10 the contracting phase with certain key issues in mind which you were not
11 going to yield on, and presumably you reach a point in the contractual
12 process if the provider is saying, "No, we're not going to do these things",
13 where you just say, "Well, if you don't do it we're not going to purchase",
14 and if you are the sole purchaser then obviously that should bring the
15 provider around.

16 MR MURRAY: Yes, and some of these cases arose out of that where I
17 think it was the NZ Private Hospitals Association case where the Northern
18 RHA was moving to tendering out contracts – they implemented or they
19 were proposing to implement quality standards for private hospitals and they
20 were going to then ask for the private resthomes to put in bids. If they met
21 the quality and their price was good they'd get contracts and some would
22 miss out. In other words, there was an over-supply of beds so the idea was
23 that the lowest quality or the highest price would not get contracts.

24 CHAIR: My understanding is that the RHA won that case, I might be
25 wrong.

26 MR MURRAY: I think there were numerous causes of action and they
27 may have lost on consultation. They got home on Commerce Commission
28 and everything else.

1 CHAIR: Yes, and I think, too, the court found there was limited public law
2 review as well I think, but there was the requirement for consultation
3 because that was written into the Act so they had to do that but they tried
4 arguing – I think they tried legitimate expectation, or they tried arguing the
5 full gamut of public law, causes of action - Blanchard J said “no”, but there
6 is consultation because that’s written into the Act and you haven't consulted.

7 MR MURRAY: Yes. But the last case in that list, Medlab Hamilton, I've
8 lumped it in there but strictly speaking it’s not so much a case on
9 consultation but it’s a case that’s very relevant to this Inquiry in a way
10 because it relates to the laboratory contracts in the Midland region, the ones
11 that we know and have in evidence, and the Association of Community
12 laboratories representing these laboratories challenged the Midland RHA
13 and said that there was an obligation to review the contract annually because
14 they wanted a price increase. Then they applied for an interim order, a
15 mandatory interim order to require Midland to carry out a review of the
16 contract. Robertson J refused to make a mandatory order, partly because
17 the parties had not been very clear about whether there had to be a review
18 and what a review constituted, and in any event, even if there was a review
19 it didn't follow that there had to be a price increase so that the laboratories
20 failed. And it was obvious that the litigation was not going to succeed from
21 Robertson J’s judgment and the outcome of that was the settlement, the
22 laboratories and the Health Funding Authority by this stage which had
23 inherited the litigation settled the litigation and that resulted in the contract
24 variation that Ms Mellor produced which recorded the price increase to \$21
25 for the cytology test provided the laboratories agreed on an interim basis to
26 the standards that existed – the general laboratory standards, the Sax
27 standards and the draft Peters standards, and the Inquiry will recall that the
28 variation in variation document that we referred to in evidence and that Ms
29 Mellor produced was actually not signed, there was no signature on that one
30 page variation. That’s because that was an annexure to the deed of

1 settlement in that litigation and it was the deed that was signed rather than
2 the terms of the settlement. The terms of that settlement were applied
3 nationally and correspondence with the other laboratories was held to
4 evidence the same terms and conditions nationally. That then is the current
5 position before the national laboratory contract that I've mentioned is put in
6 place. So we go from that litigation to the variation and I hope to THE
7 definitive contract implementing the general laboratory standards and the
8 Peters standards.

9 I just want to move quickly to –

10 CHAIR: Just so I'm absolutely clear, are the Peters standards in the
11 contracts at the moment or is that which you're engaged in battle over at the
12 moment?

13 MR MURRAY: Actually, I believe that so far as the Health Funding
14 Authority and the laboratories are concerned there is a meeting of the minds
15 that that \$21 is paid on the condition that the laboratories comply with the
16 Sax standards and the Peters standards, but it was done on a very ad hoc
17 basis because both of those quality documents were still in draft and the
18 Inquiry panel rightly said, "Well, what is the binding force of draft
19 standards", and the Health Funding Authority of course is well aware of that
20 but they wanted to make sure that the laboratories accepted the deal, that
21 you get the money but you've got to lift your game.

22 CHAIR: Yes, because Mr duRose seemed to think it was going to be some
23 time before the standards were properly in place but that might have been
24 the timeline for the official version.

25 MR MURRAY: I don't think Mr duRose was the best witness on that, he
26 was on other things. You will recall the affidavit of Mr Walker that came
27 in that said TELARC itself has got sick of the general standards being
28 labelled draft so they've just taken the word "draft" off, they've just checked

1 the content and they've decided to adopt the Sax document as their
2 document and the Health Funding Authority and TELARC I understand
3 have communicated about that so that they're identifying that they're talking
4 about the same document and it's that document that they want to have in
5 the national contract. I hope we can come back with a short affidavit which
6 just annexes the contract, the TELARC accepted standards as well as the
7 Peters standards

8 CHAIR: It would be helpful to have that because really just from the
9 perspective of writing the report, when it comes to putting it down on paper
10 the issue is do we say the Sax and Peters standards are in force at this
11 moment by this mechanism, and we have to be precise and it is fuzzy still.
12 It may be that the best we can do is say that it is fuzzy, but it would be nice
13 to have some clarity. So if you could just make sure we know what is
14 actually in force and how that's achieved.

15 MR MURRAY: Apparently I've made myself very unpopular back at base
16 by explaining how important that is, and I think time is running – there's
17 about a 4 or 5 week period. They issued that document 1 or 2 weeks ago
18 and so we're into about a 5 week period which I think expires in early
19 November. Unless the laboratories can come back and say there's
20 something wrong with it, it's actually going to be applied, and if laboratories
21 don't like it after that they won't be paid.

22 CHAIR: And you're doing that using existing contractual powers under the
23 Act?

24 MR MURRAY: I think the intention is that the laboratories will agree
25 "time's up" and they'll all sign it. But the fallback position is if they don't
26 sign it too bad, it's what's going to apply.

27 CHAIR: And if you go to that fallback position, what section of the Act do
28 you rely on to do that?

1 MR MURRAY: Well, it's still s51 and time is running because they want
2 to make sure it's in place before the new legislation comes in and carries
3 everything over. It's got to be caught by the transitional mechanism into
4 the whole new brave world that we're going into

5 CHAIR: Yes, well the last thing you want is draft arrangements being
6 caught by a transitional mechanism. All right.

7

8 PROFESSOR DUGGAN: Mr Murray, when you say "laboratories" you're
9 talking about both the community laboratories and the hospital laboratories?

10 MR MURRAY: I should be a bit more clear because I've been talking
11 about the community private laboratories, but the same rules, the same
12 standards are going to be applied to the hospitals and I'm just not sure
13 whether it's going to be the rolling over of the main hospital contracts and
14 then it will be done or whether they're looking at trying to get them in by
15 variation to each of the hospital contracts.

16

17 CHAIR: When we talk about hospital laboratories my understanding has
18 always been there's no contract with a hospital laboratory but a general
19 contract with the hospital for all its services which would include within that
20 the laboratory service?

21 MR MURRAY: Yes, but the intention, I understand, is to have the same
22 quality standards so that the private and the public laboratories are on the
23 same standards and then if there's to be competition between the two of
24 them it's the same rules that will apply. And that does mean that there's
25 going to be quite a realignment of laboratory services because the 15,000
26 smear minima is going to apply to the private and the public laboratories.
27 There are a couple of other criteria, I've forgotten the numbers, but the

1 numbers also apply for the number of pathologists – you know, there are
2 two other –

3

4 PROFESSOR DUGGAN: There must be two pathologists, at least two
5 pathologists?

6 MR MURRAY: That's right, yes. So all that's going to hopefully be
7 implemented and that's going to force some of the hospital laboratories – I
8 understand they will be bitterly complaining but they'll probably have to
9 either get out of the business or gain new work if they're going to meet that
10 standard and compete with the private laboratories. And it is 15,000 as I
11 understand it. In the earlier Peters evidence it was 12,000 but it's gone to
12 15,000.

13 I'm just about to move on now to a related point, but it's just a point Mr
14 Corkill makes in his submission at his paragraph 126. That paragraph is
15 actually quite wrong in my submission because there's two factors operating
16 here. One was the requirement in the 1997 Midland RHA contract to be
17 TELARC accredited and the other was what standards applied. In this
18 paragraph there seems to be an assumption that the TELARC accreditation
19 wasn't mandatory because the Sax standards hadn't been completed and
20 made binding, but that's definitely not correct because you'll recall the
21 contract was quite clear that Midland would only purchase from laboratories
22 that achieved TELARC accreditation.

23 CHAIR: But presumably what Mr Corkill is getting at then is TELARC
24 accreditation but not in respect of the Sax standards?

25 MR MURRAY: Yes, and so if accreditation applied the standards were
26 actually annexed to the contract as a draft. You will recall Mr Mules
27 produced that contract, and TELARC evidence came along and said, "We
28 apply that document as part of our accreditation", so that in effect you

1 achieved mandatory accreditation and general medical laboratory standards
2 – namely the Sax standards. But it was achieved by a combination of the
3 Midland contract and the TELARC adoption of the standards.

4 CHAIR: Just to be precise about this, the Midland contract ensured that
5 there was general TELARC accreditation. At that point, though, the Sax
6 standards for cytology?

7 MR MURRAY: No.

8 CHAIR: They're general?

9 MR MURRAY: General medical laboratory standards.

10 CHAIR: Well, perhaps this is what Mr Corkill's getting at. If the Sax
11 standards were draft and he says they required ratification by the Royal
12 College, how would they be enforceable when it came to the crunch? In
13 other words, it's all very well to say to someone in a contract you have to be
14 TELARC accredited, but if the standards aren't in place you either can't do
15 it, you're in limbo, or you get TELARC accreditation but under the earlier
16 standards.

17 MR MURRAY: No, I'm just trying to recall the TELARC evidence, Mr
18 Walker's evidence, and my friend Ms Janes knows this evidence well
19 because she briefed it, but as I recall it TELARC had ISO documents which
20 they used and if somebody gave them a document like the Sax standards
21 they will apply that as well. If Midland RHA said, "right, our contracts
22 require TELARC accreditation" and then TELARC would come along to
23 accredit and they would apply their generic ISO documents, they would also
24 apply any industry documents like the Sax document, and then if you went
25 into the sub-branches or the sub-specialties of pathology and there was an
26 existing standards document they would apply that as well. And so it's
27 something that's been quite difficult to follow through the evidence, but –

1 CHAIR: Well, it's almost as if what happens is people just get tired of
2 waiting and just adopt drafts in the end – the different parties, so that
3 TELARC ultimately decides we've got to move here and so they adopt the
4 draft. So there's no clear fixed point in time when a standard is obviously
5 adopted for all purposes for all people.

6 MR MURRAY: I think TELARC has its own independent view on this but
7 where the Royal College of Pathologists and the RHAs get together and say
8 “this is a standards document that we've developed” TELARC is prepared to
9 pay a great deal of respect to that document and incorporate it into its own
10 accreditation requirements. That was Mr Walker's evidence. And so as at
11 1997, if we just take a snapshot at that time, you will remember we had the
12 1991 cytology standards, and it was actually printed as one page on
13 TELARC letterhead –

14

15 PROFESSOR DUGGAN: Recommendations Mr Murray.

16 MR MURRAY: Sorry, recommendations. And we had the Sax document
17 in its version at that stage, so when TELARC comes along to a laboratory
18 that's practising in cytology they're going to impose as a requirement of
19 accreditation their own ISO documents (which are generic and could be
20 applied to a lot of things), they're going to apply the 1991 cytology
21 recommendations and they're going to apply the Sylvia Sax general medical
22 laboratory standards.

23

24 CHAIR: It must be very hard for them.

25 MR MURRAY: Well, TELARC seems to have an easy facility with this
26 process that's a mystery to the rest of us.

27 CHAIR: Yes, but it is hard. Let's try to clear this one up because
28 TELARC is a separate entity. It's role is accreditation. One would

1 logically think that they would develop their standards, have their standards
2 which they would then apply rather than this process of taking on board
3 standards others have adopted and having a collection of standards which
4 apply.

5 MR MURRAY: I think Professor Duggan is going to –

6

7 PROFESSOR DUGGAN: Well, I was just going to say that ISO – I believe
8 I'm correct in this, that ISO doesn't have medical laboratory standards.

9 MR MURRAY: No.

10 PROFESSOR DUGGAN: And that's well known by those of us who
11 practise. I think in Mr Mules evidence there was a TELARC representative
12 involved in the development of medical laboratory standards when they
13 commenced that initiative.

14 MR MURRAY: Yes, I think that's right.

15 PROFESSOR DUGGAN: Because TELARC would have been interested
16 in this avenue and it would be a cooperative approach to the development of
17 something that they would embrace.

18 MR MURRAY: Yes. Before RHAs developed the national project, Sylvia
19 Sax co-ordinated it and they got experts from the Royal College and experts
20 from TELARC and that produced the Sax standards as we've referred to
21 them. They were virtually complete, ready to implement when the problem
22 of near patient testing become controversial and the pathologists therefore
23 wouldn't give it a final tick. Sadly that document lay with "draft" on it right
24 through until this year. They were still being applied by TELARC,
25 according to Mr Walker, but it was just untidy that they couldn't have just
26 finally put the seal of approval on it and put the TELARC letterhead on it.

27

1 CHAIR: It seems a point Mr Corkill is making is that the draft standards
2 were never completed because they required the Royal College's approval.
3 The first thing I'd like to know is why did the Royal College hold such an
4 influential position in the sense I would have thought that if the Health
5 Funding Authority wants providers to be TELARC accredited in case
6 laboratories and that accreditation process is going to be carried out by
7 TELARC, and sure there would be some consultation with the laboratories,
8 but I can't see – I'd like to know what this legal basis is for saying, "Well,
9 until the Royal College ratified these standards they were draft" and if you
10 accept Mr Corkill's submission they were legally incomplete and therefore
11 not enforceable.

12 MR MURRAY: No, the way I'm picking up Mr Corkill's submission is
13 he's confusing accreditation and standards and he's making the submission
14 that compulsory accreditation never happened in the period under
15 consideration. Well, compulsory accreditation was achieved in 1997 but
16 what was not achieved was the final resolution of the Sax standards as a –

17 CHAIR: But I think what he is saying, though, is that until you had final
18 resolution of the Sax standards you didn't have standards which you could
19 compel people to adhere to. That's the thrust I see of his submission, that
20 until those standards were ratified by all concerned, or by the Royal College,
21 the process was incomplete. So it's like a contract where you've agreed 9
22 out of 10 terms but you haven't agreed the 10th so you can't enforce it. That
23 is taking a very legalistic view and what I'm asking you, in order to counter
24 it, is to say well, you know, where does this notion come from that the
25 standards have no legal impact until ratified by the Royal College.

26 MR MURRAY: Accreditation was achieved strictly in a legal sense at
27 1997 – mandatory accreditation in the contract.

28 CHAIR: But how can you accredit – if you are going to accredit you have
29 to have standards in place, don't you?

1 MR MURRAY: Well, TELARC of course had standards anyway.

2 CHAIR: So not the Sax standards?

3 MR MURRAY: Not the Sax standards, so you could say –

4 CHAIR: That's what I was coming at before.

5 MR MURRAY: Even without that Sax document you could have said,
6 “But you’ve got to have TELARC accreditation because TELARC had its
7 own generic systems – ISO documents – and therefore to add in the Sax
8 document was another standard, an additional one specifically designed for
9 pathology laboratories.

10 CHAIR: and what is the pivotal impact of the Royal College’s ratification.
11 Does it have any impact at all, or minimal impact – what is its role?

12 MR MURRAY: Actually, legally I don’t believe the RHAs needed to wait
13 for the Royal College.

14 CHAIR: It seems hard to imagine why they did legally.

15 MR MURRAY: That’s right, and it’s very well in hindsight, but they
16 shouldn't have let the pathologists deflect them into a dispute about near
17 patient testing, they just should have said, “Sorry, these are the standards,
18 we’re going to implement them, we’ve through a consultation period, we’re
19 satisfied that they can apply practically”, but unfortunately – this is where
20 we come to another system issue, you will recall that Ms Sylvia Sax went
21 off to another project and then the Transitional Health Authority was set up
22 so restructuring overtook that co-ordinated 4 RHA standards exercise. We
23 took the evidence as far as we could. We tried to track that through and we
24 got to a point where restructuring had overtaken and that seems to be the
25 reason why those standards were not signed off.

26 CHAIR: Apart from the restructuring does it seem to you, and I’ll focus on
27 this issue because it’s before us, that one possible systemic issue is a

1 tendency of those involved in the negotiation process to negotiate for too
2 long a period of time – in other words, instead of reaching a point of time
3 where they say, “Well, we've gone far enough, we've consulted, we have
4 rights here under the Act, we're going to apply the rights now and get
5 finality” – the process seems to go on and then, and then of course added on
6 top of that is a restructuring or change in personnel which causes another
7 problem. It seemed also to me that there was a mindset where people
8 thought, instead of suddenly realising, “Well, we're never going to get
9 agreement here, therefore we fall back – we either give it away or we fall
10 back on insisting upon it”. They would struggle to persuade and these
11 struggles to persuade went on and on.

12 MR MURRAY: Yes, you can see the human element here, the desire to be
13 inclusive, get the stakeholders to participate, try and get them all not just to
14 consult but to consult to the point of agreement and so that everyone goes
15 off with a willing heart to apply these wonderful documents.

16 CHAIR: yes.

17 MR MURRAY: Whereas from a safety regulatory point of view that
18 human element has got to be overridden at a certain point and it's the same
19 in many industries, in aviation where I'm familiar, you can't let the operators
20 string you out forever, you've got to say, “No, we're the safety regulator,
21 we've reached the point”. It's all very well for us lawyers to say that in
22 hindsight, but I think that's the explanation for it.

23 CHAIR: Well, if you did that with aircraft in terms of safety matters you
24 could end up with aircraft falling out of the sky, couldn't you?

25 MR MURRAY: It's so critical, yeah, but some of those principles are very
26 parallel in the health sector as well, I suggest.

27 CHAIR: And I suppose as lawyers we're more familiar with the exercise of
28 coercive powers?

1 MR MURRAY: Yes, I think there's a reluctance for the people in the
2 health sector to resort to lawyers and say, "Well, let's crack these guys."
3 As lawyers you wish why didn't they do it, if they'd come to us –

4 CHAIR: That's what comes from working in an adversary system, you see.

5 MR MURRAY: In NZ we have a very active administrative law system
6 and s34 in the Health and Disability Services Act is really just an example
7 of how if you put a section like that in an Act and you then apply our
8 administrative law system to it you've got to be mighty careful if you don't
9 comply because you're going to get tangled up in litigation for some time
10 and I know when I look at these problems I always say, "look, consult
11 beyond the point of risk because it's easier and cheaper to consult a bit
12 longer than litigate and lose", because then you've got to go right back to
13 the start. But that's a judgment call that lawyers have to advise their clients
14 on. In NZ we commence judicial review proceedings almost like a national
15 sport sometimes.

16 CHAIR: Yes, although a requirement to consult on a regular basis you
17 would think in some ways that health authorities would therefore become
18 used to the consultation process, work out the process and just go through
19 the process. I'm familiar with government departments that have to
20 consult, often on an annual basis, and there is a well worked out process for
21 consultation, you go through it and that's that. It can lead to litigation, it
22 often does, but the alternative is to really abdicate governing.

23 MR MURRAY: Well my submission, of course that's right, but there's a
24 particular problem with the wording of s34 because it says, if you take the
25 Wellington Airport case that was about landing charges and the airport was
26 going to make a decision and that decision about the charges was something
27 that the consultation was focused around. But when you try and apply it to
28 this section you say, "Well, what are we consulting about. We are
29 consulting about intentions relating to the purchase of services." Well,

1 that's quite a nebulous subject matter to be consulting on and I think that,
2 this is just a submission that I'm making really from experience because it's
3 quite hard to put pegs in the ground and say, "These are our intentions, we
4 are consulting on those intentions, and then we're going to contract",
5 because intentions by their nature keep changing.

6 CHAIR: Yes, well I suppose the section's been worded this way because
7 given that you can't come to a decision until after you've consulted, the
8 whole idea is to keep it open, so you can't say you must consult before you –
9 I suppose you will say consult before you act in a certain way, but by
10 referring to intentions I suppose it's a way of keeping it neutral and saying,
11 well before you come to a decision on anything you consult first. So you
12 are really consulting on your intended action, because having heard what
13 people have to say you then decide whether or not you will still carry out
14 your intended action, whether you will alter it in some way and carry it out
15 or whether you will abandon it.

16 MR MURRAY: Yes. And you can impose that structure on it but I do
17 believe that it's been a difficulty – particularly at the early stages of this act,
18 and the Northern RHA kept losing. Some of the other RHAs picked up the
19 process very quickly and either were not sued or were sued but succeeded
20 because they'd done it properly. I don't want to go on much longer but I
21 think I've already made the point that with the Women's Health and
22 Information Resource Trust that the defect in my submission is that there's a
23 lot of criticism of public servants and nowhere is the Health and Disability
24 Services Act incorporated into that framework and of course, as the panel
25 will know, public servants of course are bound by law and this whole
26 structure was imposed by parliament. In NZ we seem to elect the
27 governments who like to have their own platforms and the Health and
28 Disability Services Act was the fulfillment of one such political process and
29 if you're going to criticise the public servants you have to take account of

1 the fact that they're just applying the structures that are created by this Act
2 right from the Crown objectives through to the policy guidelines, funding
3 agreements, purchase contracts and accountability mechanisms back to the
4 Ministry of Health and that labyrinthine process was covered in evidence,
5 particularly by Dr Lambie at the end, and if you're going to criticise public
6 servants you have to realise that a) it's imposed by law; b) it applies across
7 the whole health sector; and c) the cervical screening programme was not
8 an easy fit with that system. So my submission and Mrs Sholtens can pick
9 this up in discreet topics, but my submission is it is very unfair to public
10 servants to single them out and say, "Well, look, you didn't quite get it right
11 because the complexity of it was quite amazing." In my submission when
12 you analyse the evidence it does have a coherence about it which actually is
13 a testament to the skill of the public sector officials who had to make it
14 work. If you look at the policy guideline documents and so on, although
15 you can find discrepancies, by and large there was a coherent structure there
16 and we just ended up, in my submission, with quite a complex situation with
17 screening because of the division that occurred between the Ministry policy
18 role and the RHA purchaser role.

19 CHAIR: Yes, certainly the Act itself does allow for what other parties have
20 been critical of in the sense that the contract model might well have
21 achieved something, it was just the way in which the contracts were written
22 – for example, the Act itself wouldn't have prevented compulsory TELARC
23 accreditation being required at an earlier time, in a sense the legal
24 mechanisms to do it were there. It wasn't as if the Act lacked the legal
25 mechanisms it was the way in which they were applied. And when you look
26 at the funding agreements between the Ministry and the RHA and this
27 notion of using reasonable endeavours to get TELARC accreditation, and
28 we heard from Dr Lambie there was best endeavours, reasonable
29 endeavours, TELARC accreditation was put at reasonable endeavours which
30 was a lower tier. The contract model would have allowed a funding

1 agreement to be drafted which said you must have TELARC accreditation in
2 place by X date.

3 MR MURRAY: There's no doubt the machinery was there.

4 CHAIR: And I think that's why the officials are criticising. You say well
5 they had this Act to work within and are critical of the Act, and certainly I
6 know some people have been critical of the Act and the purchaser funder
7 provider split, etc., but if you actually look at the Act it had mechanisms
8 which would allow you to do what everyone with the benefit of hindsight
9 say should have been done at a much earlier stage.

10 MR MURRAY: If you look at TELARC accreditation of course the focus
11 was on imposing, or reasonable endeavours through the funding agreement
12 on to the RHAs and purchasing under contracts. But that was all generic
13 and there were special circumstances relating to the screening programme
14 which probably down at the RHA level may not have been appreciated. I
15 think Mr Mules evidence was quite candid that, well, there were screening
16 programme issues that the Ministry was looking after and our focus was
17 using reasonable endeavours and trying to get those contracts in place with
18 laboratories. We didn't think that's very important for cervical screening
19 and the National screening programme because that was another specialised
20 area that didn't quite get linked into the urgency, if I can put it that way.

21 CHAIR: No, well, there was nothing to signal to the RHA and to Mr Mules
22 that it was urgent because the way the Ministry had structured the funding
23 agreement by structuring it as saying "reasonable endeavours" didn't signal
24 any great sense of urgency. The way to signal great sense of urgency
25 would have been said, "you must ensure you are purchasing the services of
26 laboratories that have TELARC accreditation by the year January 1995."
27 Now if that were there Mr Mules would then have known by January 1995
28 he had to be purchasing services from TELARC accredited laboratories only
29 and he would have done whatever he needed to do to ensure that happened.

1 He would have presumably used s51, given Dr Bottrill plenty of notice and
2 said, "This is what I'm required to do, you're on notice, you get TELARC
3 accredited or I'm going to have to go elsewhere."

4 MR MURRAY: Yes, that's right, and unfortunately the evidence never
5 quite got us as far as explaining why that reasonable endeavours ended up in
6 the funding agreements. We did hear evidence that the funding agreements
7 were negotiated. There was an active exchange between the RHAs and the
8 Ministry for that topic and reasonable endeavours ended up there but the
9 evidence didn't explain how that came about, and that was a great shame in
10 a way because we might have been assisted if somebody could say,
11 "Actually, there was a practical problem and that's why we couldn't impose
12 it."

13 CHAIR: You see, we heard from Dr Lambie, I think he said that they
14 would have upped the priority if they'd been notified, but he seemed to be
15 saying "no-one within the Ministry told me it was a high priority", whereas
16 when you looked at the policy documents from 91 onwards, the 91 policy
17 document said TELARC accreditation within 2 years. Two years is a
18 reasonable timeframe. So that was the mindset in those early days,
19 therefore you would have expected come 93, when it wasn't achieved then,
20 that someone from within the programme was knocking on the door of those
21 responsible for negotiating the agreements with the RHAs to say TELARC
22 accreditation was expected to be place in 93, it isn't, bear this in mind when
23 you negotiate the contracts. There is a gap there but there's no satisfactory
24 explanation, put it that way, from the Ministry.

25 MR MURRAY: I'm going to stop at that point because I think Mrs
26 Sholtens, tomorrow, wants to add just something about that topic and I don't
27 want to trample over that.

28 CHAIR: One thing I do want to hear from you because I'm conscious
29 you're acting for the Health Funding Authority is it became clear from Mr

1 Mules evidence, that's on my reading of it and I would like to be taken
2 through passages of it, that when the funding agreement was put to him -
3 apart from this clause relating to using reasonable endeavours to ensure
4 laboratories were TELARC accredited, there was a reference earlier on in
5 the funding agreement to the purchasing agreements between the RHA and
6 providers being consistent with the national policy. And I think under the
7 national policy it was the Ministry to monitor and evaluate the programme,
8 because the impression I got from Mr Mules is that he considered that it was
9 the Ministry's role to monitor and evaluate the programme and not the
10 RHAs. And I know there was Ms Glackin's evidence where she refers to it
11 in the document and says it could be read this way but we didn't have the
12 facilities to do it and so you got on the face of it a situation where, in terms
13 of the paper trail which set out how people were to work, the responsibility
14 was given to one body – namely the Ministry, therefore the RHA thought
15 the Ministry would carry out its role because it didn't have to but the
16 Ministry was saying, “Well, we weren't able to do it”, which then leaves you
17 to conclude does that mean that no-one was doing it.

18 MR MURRAY: Yes, we covered that in our evidence and the main
19 submissions have addressed this and a slightly different emphasis placed
20 upon that. Dr Lambie came back to say, “yes, but at the end of the day the
21 fundamental point was reasonable endeavours was imposed upon the RHAs
22 to engage TELARC accredited laboratories.”

23 CHAIR: yes, but you're getting back to TELARC accreditations not
24 TELARC accreditation. TELARC accreditation would have gone some
25 way towards ensuring quality assurance but it's this other aspect –

26 MR MURRAY: The policy.

27 CHAIR: it's actually best if you pull the documents out.

28 MR MURRAY: Can I leave that to Mrs Sholtens.

1 CHAIR: Is she going to speak on behalf of the Health Funding Authority
2 as well because I think there's a conflict in the sense that it is understandable
3 that the Health Funding Authority when reading a document which imposed
4 a responsibility on the Ministry, considering everyone was in the mode of
5 contracts. Normally when people are in a contractual mode your attitude is,
6 "Well this is my obligation under the contract, I'll carry out my obligations
7 and what's more I'll either see that you carry out your obligations or I'll
8 leave your obligations to you to carry out – I'm not going to adopt your
9 obligations as well as my own." That was the impression I got from Mr
10 Mules evidence, which is understandable, but how does that fit then with the
11 Ministry?

12 MR MURRAY: I think in the submission it goes through Mr Mules
13 evidence, then it moves more to the Ministry position. Mr Mules evidence
14 on that I thought was fairly clear, he did say "we contracted with
15 laboratories and we also contracted with the hospitals for the regional
16 services." And there was a Ministry policy document and it had in it two
17 clauses – one that laboratories should move towards TELARC accreditation
18 and another was the – there's 6 criteria for cytology practice.

19 CHAIR: And that's at the 4.1.2 to 4.1.4, but over the page, I think it's
20 clause 8, you get into the monitoring and evaluation, which is on the
21 Ministry to do.

22 MR MURRAY: Yes, and on the RHAs Mr Sholtens is pointing out. The
23 RHAs had to monitor through their contracting process and the Ministry had
24 a more generic monitoring process.

25 CHAIR: Well I'd like to hear about this because it seemed to me that there
26 were these general contracts which were generic, and certainly I think my
27 memory under the general contracts the RHA had some obligations in terms
28 of quality assurance and monitoring but insofar as the contracts related to
29 the National Cervical Screening Programme the funding contract referred

1 back to the policy that the funding contract was to be consistent with the
2 policy, and of course under the policy it's the Ministry that is responsible.
3 So you therefore had a tension between different contractual responsibilities.

4 MR MURRAY: Yes, Mrs Sholtens is pointing out that although the
5 funding agreements referred to the Ministry's policy document for the
6 Cervical Screening Programme when you go into that document policy
7 document itself discriminated between what the RHAs had to do and what
8 the Ministry had to do. It's in Mules but it's in other places as well. I've
9 got it at Mules exhibit 32.

10 CHAIR: I'm trying to find the policy document though, that's in Glackin.

11 MR MURRAY: It's in a number of places. If you're talking about the
12 updated October 1993 government policy for National cervical screening
13 Ministry of Health –

14 CHAIR: I'd rather look at Glackin just because I've got that one marked
15 up. It's at Glackin 6, that's the government policy for National cervical
16 screening.

17 MR MURRAY: Yes.

18 CHAIR: And then the Mules funding agreement that's in Mules what
19 volume?

20 MR MURRAY: Mules volume 2, exhibit 34 – exhibit 33 was the earliest
21 funding agreement and it wasn't very specific but the next one over, exhibit
22 34.

23 CHAIR: If you look at Mules it says at the bottom of p34: "The RHA in
24 conjunction with other RHAs is to purchase screening services and this
25 programme and the cervical screening services are to be consistent with
26 s74A and the government's 91 policy." So in terms of consistency with
27 that policy, and if you look at the Glackin document, p8 of the actual
28 document, 7.14, it says: "The national co-ordinator will be responsible for

1 ensuring the National Cervical Screening Programme is monitored and
2 evaluated nationally. Evaluation of projects and services nationally will be
3 co-ordinated by the Ministry of Health.” And then 8.1.1 you’ve got the
4 responsibilities of the Ministry of Health set out there. One of the bullet
5 points is “coordinate monitoring and evaluation of the programme”, and
6 then over the page at 8.1.3 it says, “the main responsibility for the RHAs
7 and one of them is to monitor and evaluate the programmes in the RHA
8 regions.”

9 MR MURRAY: Yes, and my submission is that both applied. Each had
10 their separate responsibilities and the funding agreement I think might have
11 deflected us all a little bit because it had these words “programme and
12 cervical screening services are to be consistent with s74A of the Health Act
13 and the government’s 91 policy”, but that’s a general statement, an
14 introduction to the various items which the RHAs have to purchase and then
15 that just sits with the policy because the RHAs obligations are set out in the
16 policy s well. So that I think there's some superficial ambiguity but I do
17 think when you say “right the policy applies” and you go into the policy the
18 policy discriminates between the Ministry and the RHAs and they both had
19 monitoring and evaluation obligations for their respective areas. Bearing in
20 mind that the RHAs had discreet purchasing responsibilities in their region
21 whereas the Ministry had national responsibilities for the screening
22 programme across all regions.

23 CHAIR: Also, if you look at 7.1.2 of the Glackin document it talks about
24 performance indicators. This is under the heading of Evaluation and
25 monitoring of the programme. “4 RHAs will be developed by the Ministry
26 of Health”. And I've left out the Public Health Commission just for ease of
27 reference, but again for the RHAs to monitor and evaluate there was this
28 expectation that there would be performance indicators developed by the
29 Ministry of Health.

1 MR MURRAY: And there were two key performance indicators.

2 CHAIR: That's right, colposcopy times and –

3 MR MURRAY: Enrollment coverage and colposcopy waiting times. That
4 goes right back to my opening submissions this afternoon how at the front of
5 the programme those two performance indicators were seen as the most
6 important elements of the programme. I mean, now, of course we say,
7 “goodness gracious why didn't you go on and put all the other ones in”, but
8 anyway the other ones were regarded as exception monitoring in the jargon
9 of the Ministry, the two I've referred to were built in.

10 CHAIR: It seems to me from the perspective of the RHA it would be
11 difficult to be critical. Just looking at the two bodies as separate entities for
12 now, to say, “Well the RHA should have been monitoring and evaluating in
13 its region and therefore Midland should as a result of its own monitoring and
14 evaluation have discovered the under-reporting because until performance
15 indicators were set by the Ministry of Health, which would have allowed
16 Midland to monitor and evaluate for the purposes of detecting under-
17 reporting of smears, it wasn't in a position to do so.

18 MR MURRAY: No, and Mr Mules, his evidence about that was, “well, we
19 looked after our job which was the performance indicators that were given
20 to us. We routinely reported back to the Ministry on coverage and
21 colposcopy waiting times and the Ministry had a whole department, which
22 Dr Lambie was in, to make sure that the generic process was working, if you
23 like, the accountability was there.” And it does seem as if Midland was
24 quite efficient because they did monitor those two performance indicators
25 right through to Tairawhiti and imposed quite strict reporting requirements
26 on them. Where it broke down, in my submission, is if the Ministry had
27 had another performance indicator there which was laboratory specificity
28 and that was built in to the purchasing contract with the laboratory and the
29 hospital contract with the hospital laboratory, then Midland's monitoring

1 obligations would have ideally picked that up and said, “Oh, we've got a
2 problem here”, but that’s why I say the programme was good at the front,
3 good at the back but the indicators that we now know from Dr Peters
4 evidence that there's got to be indicators all along and they just weren't
5 there.

6 CHAIR: Yes, well, that’s not Midland’s fault in a sense. The difficulty is
7 the programme ultimately was the responsibility of the Ministry. Under the
8 policy document it was for the Ministry to develop the indicators and where
9 the vacuum arises is that there was a sort of hole which could have been
10 filled by the Ministry putting in place various things and they didn't.

11 MR MURRAY: No, and I think that’s obviously a given, and I know Mrs
12 Sholtens would like to explain how you assess that situation. We know the
13 programme evolved. We know expert advice was given. We know there's
14 criticism of the delays in implementing expert advice. In my submission
15 most of it was implemented – possibly not all of it, but one looks at the
16 timing and asks how come so long, and I know Mrs Sholtens who has
17 analysed the Ministry evidence more closely can just I think put it in context
18 because it comes back to the hindsight bias, you have a complex system,
19 highly complex process going on and you tend to be very critical. The
20 advice was given, why wasn’t it implemented? Of course there's a whole
21 host of reasons why humanbeings in a complex structure either don’t or
22 won't or can't, and so in this Inquiry we've been listening to all this barrage
23 of criticism – well, it was identified then, the advice was clear, but the
24 danger is saying, “Well, it’s obviously a failing that anyone with half a brain
25 could have acted on”, and of course it’s never that simple. I think I should
26 stop there because Mrs Sholtens can just perhaps put some of those early
27 days of the programme into context. I hope the Inquiry will not be quite as
28 harsh, as I detect it might have been, listening to some of the evidence. I do
29 think that in the mix there there's a balance and that's why you do clearly

1 have a programme that's evolved – that doesn't seem to be unusual when
2 you look at other jurisdictions, and then you have to say if it had evolved
3 faster it may have saved even more lives than it did. That's how I would
4 like to put it because it clearly was a complex process and Dr Wayne, I
5 remember asking him, “Do you think people realise when they create these
6 screening programmes the complexities” and he said “No, they don't even
7 understand that now.” That's why, at the end of the day, the Inquiry panel
8 has to assess that factual position, and it's a difficult job because we weren't
9 there, and it became politicised, and I believe that you have to see there's
10 three components in my analysis anyway: you had the political input; you
11 had the Ministry input and you had the external stakeholder input, and
12 because the screening programme became politicised everyone focuses on
13 the Ministry and says, “Well, look, that's where it's all gone wrong”. But
14 you have to say, “Goodness gracious, it's not a Ministry of screening, it's a
15 Ministry of Health, huge competing demands on a complex bureaucracy,
16 limited funding and we here have had the luxury of just picking out a tiny
17 part of that process and subjecting it to a minute examination.” I believe
18 when you do that sort of analysis that Professor Reason, or the way he
19 explains it, you can see why things could have been done better but there are
20 reasons why they weren't. Just to take one example with opt-on, opt-off,
21 sure it may not have been the right way to do it but to do it the right way
22 required legislation. So no public servant could instantly say, “Well, it's
23 going to happen because it just required a legislative process”, and when
24 you think about it, if the programme started in 91, with a number of givens
25 that were wrong, it took until 93 to get that legislation through, which in our
26 NZ system is probably not bad going.

27 CHAIR: It doesn't give much hope for the legislative solution to 74A does
28 it?

1 MR MURRAY: Well, I think we're partly down the track there anyway, so
2 some time has run hopefully. I think that's by way of introduction to some
3 of the discreet topics that Mrs Sholtens would like to cover.

4 CHAIR: All right, well we will adjourn until 10.00 a.m. tomorrow.

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THE HEARING ADJOURNED AT 5.05 P.M.

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TO RESUME AT 10.00 A.M.

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THURSDAY 28 SEPTEMBER 2000

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