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**MONDAY 31 JULY 2000**

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**THE HEARING RESUMED AT 10.05 AM**

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**CHAIR ADDRESSES INQUIRY**

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**CHAIR:** This morning we are to hear from Dr Bottrill. Dr Bottrill is

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coming to the Inquiry to give evidence at his choice. He has not been

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compelled to do so and I would emphasise that he is under no obligation to

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give evidence before this Inquiry. That he is giving evidence is a matter of

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his choice. As a witness before this Inquiry, he is entitled to give his

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evidence in the same circumstances as any other witness. It is important to

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ensure that the process of this Inquiry is conducted fairly, that Dr Bottrill's

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evidence is not given in circumstances which differ from that of other

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witnesses. This means that he should give evidence where members of the

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public are quiet, do not interject, comment, during the course of his

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evidence, or in any other way by their conduct such as standing and turning

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their backs on him or cause any discomfort to him during the course of his

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evidence. He is not on trial here. The purpose of the Inquiry is not to lay

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any blame at Dr Bottrill's door, and I emphasise that this is not a trial by

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ordeal for Dr Bottrill. If at any time the public conducts itself in such a way,

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by either interjecting or conducting itself in any manner different to that

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under which other witnesses have given their evidence, we will adjourn and

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the remainder of Dr Bottrill's evidence will be given in private without the

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public being present. Members of the press will stay and in that way his

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evidence can be made public. Ultimately, whether or not the public remain

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for the entirety of Dr Bottrill's evidence is a matter for them and will depend

1 entirely upon their conduct. Now, Mr Hodson, will you please call Dr  
2 Bottrill.

3 MR HODSON: Before I do so, it's usual for counsel on these occasions to  
4 open.

5 CHAIR: Yes

6 MR HODSON: I don't intend to take any time at all but I think it's worth  
7 making three points: two of them of a general nature, and one with direct  
8 reference to Dr Bottrill. The first point I make of a general nature is that  
9 when this Inquiry first convened in Wellington, we knew the results of the  
10 Sydney re-read and we were able to compare those results with the results  
11 of all other laboratories in New Zealand. I drew attention then to the vary  
12 marked disparity, to the very much greater proportion of abnormal smears  
13 found by Sydney to that of any other laboratory in New Zealand – either  
14 three or five times – I don't remember the exact figure, the New Zealand  
15 average. It is regrettable, in my submission, that at this stage of the Inquiry  
16 that concern remains. The second observation of a general nature is that it  
17 has been a theme throughout this Inquiry that TELARC accreditation would  
18 have prevented what is said to have occurred here, and great emphasis has  
19 been put, and much evidence has been heard, on the benefits of TELARC  
20 accreditation. All I need to say about that is that there is no simple answer to  
21 this Inquiry and that on all the available evidence, plus what is common  
22 knowledge of what has occurred outside, and which will not directly  
23 influence you at all, TELARC accreditation is not the only answer and  
24 clearly you will have to look further afield than that. My third opening point  
25 is with direct reference to Dr Bottrill. I am very grateful to you ma'am for  
26 making it clear that he has turned up today to give evidence of his own  
27 volition. He lives in this community. He has lived here all his life and he

1 feels, and has instructed me very clearly, that it is his duty to come forward  
2 and offer such assistance as he can. We said at the beginning of the Inquiry  
3 he would do that, and today is the day. I do not intend to say anything about  
4 the contents of his brief because, of course, everybody interested has had the  
5 opportunity to read that. I will say that his position is, and always has been,  
6 that he practised for many years in Gisborne in good faith, in the belief that  
7 he was serving the people of the district well and to the best of his ability. I  
8 now call Dr Bottrill. Come forward, please, Dr Bottrill.

9

10 **MR HODSON called –**

11 **MICHAEL BERNARD BOTTRILL (Sworn)**

12 MR HODSON: Madam Registrar, if Dr Bottrill could be supplied with a  
13 copy of his brief and the amended page 9 which I distributed. Your full  
14 name is Michael Bernard Bottrill, you are a retired pathologist, you reside in  
15 Gisborne and you have before you a brief of your evidence to this inquiry.

16 A: I have

17 Q: And are the contents of that brief true and correct

18 A: They are.

19 Q: Dr Bottrill, before I invite the panel to render your position open to  
20 cross ex-examination and questions there are some additional matters that  
21 have risen from the evidence given largely since that brief of evidence was  
22 prepared which I would like you to cover for the Inquiry. We will go  
23 through the evidence, the relevant parts of the evidence of Mr Morris, Dr  
24 Linehan and Miss Wilson in particular. In no particular order, but as the  
25 points arise. Now in respect of the evidence of Mr Morris, I think you knew  
26 Dr Padwell when he was a pathologist at the hospital?

27 A: I did

1 Q: Did you make arrangements before you went away in 1993 from time to  
2 time for him to review slides.

3 A: That is correct

4 Q: Had you made a similar arrangement with other pathologists at  
5 Gisborne Hospital?

6 A: Yes

7 Q: Why did you do that?

8 A: Various reasons. One was on occasions I found that the volume of work  
9 was rather more than I was happy to undertake, but more importantly  
10 pathologists in the hospital tended not to stay very long and by suggesting to  
11 them that they might like to take part in a little extra work. I hoped that they  
12 would retain an interest because I have always hoped that the two  
13 laboratories in this city could be reunited because it would be a much more  
14 efficient and altogether better way of dealing with things rather than two  
15 separate laboratories.

16 Q: So that how did occasional slide reading or reference to slides to these  
17 pathologists assist in that concept.

18 A: Well, so little cytology came from the hospital practice and I thought it  
19 would be a good idea to give the people at the hospital a little interest in  
20 routine cytology.

21 Q: In 1993 I think you were away from your practice for some 5 weeks.

22 A: Yes

23 Q: And during that time, Dr Padwell was contracted to read slides on  
24 behalf of your laboratory.

25 A: He was.

26 Q: Had you any awareness at the time of what procedure he would  
27 undertake to do that.

1 A: Well no, I mean, he was a qualified pathologist in his own right and he  
2 was to examine the slides and I was in no position to declare to him how he  
3 examined the slides.

4 Q: Mr Morris told us that he observed Dr Padwell to have taken slides and  
5 we assume it's the same period, we don't know - to have taken slides,  
6 essentially home for home screening after hours. Did you have any idea of  
7 that

8 A. No the first time I heard about this was reading it in the local paper on  
9 Saturday.

10 Q: Did you ever have any occasion to become concerned at the quality of  
11 Dr Padwell's reading of slides?

12 A: No.

13 Q: Now in your brief of evidence you mention a personal conversation  
14 rather with Dr Linehan in which the subject to TELARC accreditation came  
15 up. Do you remember the year in which that came up or the occasion?

16 A: No but it would have been very shortly after the accreditation started  
17 in this country.

18 Q: With reference to that –

19 A: Early 80s I really don't remember.

20 Q: Dr Linehan's evidence on that was that firstly that he would have  
21 encouraged you of the idea that accreditation was desirable. Do you  
22 remember any such view being put forward?

23 A: I don't think there's any doubt that accreditation would be good for  
24 all laboratories.

25 Q: He went on to say that he sympathised with you on the question of  
26 cost, can you make any comment on that?

1 A: I don't think cost is all that important. It was far more a question of  
2 the gigantic amount of work which would be involved in organising the  
3 documentation and organisation of the laboratory.

4 Q: If you were going to be accredited only at least initially in the depts of  
5 cytology and histology would the whole laboratory have been involved in  
6 paperwork?

7 A: Yes.

8 Q: Would you have also to gain accreditation have had to involve  
9 yourself in external quality assurance in cytology?

10 A: I believe so.

11 Q: Was the laboratory already involved in external quality assurance  
12 programmes in other depts?

13 A: Yes it was.

14 Q: In particular we've had mentioned the Wellcome Murax programme  
15 are you familiar with that?

16 A: Yes.

17 Q: What dept did that involve?

18 A: That was biochemistry.

19 Q: And can you tell us anything about that programme?

20 A: It was a programme where we were supplied by the Murax people  
21 with a series of freeze dried serum samples which were reconstituted about  
22 once a week and ran as unknowns with our other tests. The results were  
23 correlated, sent at the end of I think three month period to the Murax people,  
24 they then did whatever they did with their computers and compared your  
25 results with those of people who were using similar methods and also with  
26 those of people using different methods for particular tests.

27 Q: And do you remember how your laboratory stood in the comparisons.

1 A: Yes generally speaking we did extraordinarily well.

2 Q: Can you quantify that out of all the laboratories in New Zealand.

3 A: No I can't now, I remember one or two occasions being delighted to  
4 find that for specific tests we were number 1 but I'm afraid I can't remember  
5 the overall ratings so to speak.

6 Q: A great deal of time was spent, perhaps not on the scale of this  
7 inquiry but certainly over the last few days, in considering how your  
8 indexing and data recording systems in relation to cytology were established  
9 and worked and I'd like to take you through that now. Initially we are told  
10 that cytology slides, and we'll talk about them in particular but of course all  
11 materials derived in the same way, would arrive in the laboratory and first  
12 there would be an entry in the day book.

13 A: Correct.

14 Q: And that entry would include a laboratory number not just a cytology  
15 number.

16 A: No every specimen which came in was allotted a number regardless  
17 of what it was.

18 Q: And then your staff would give a cytology number starting with the  
19 year and then the consecutive number for that year to the slide and etch it on  
20 with a diamond pencil.

21 A: That's correct.

22 Q: And the same number would go on to the request form.

23 A: Yes.

24 Q: Then the slide would be stained, coverslipped, prepared, put in your  
25 room with the request form for you to read?

26 A: Yes.

1 Q: Now at some stage you acquired a computer which amongst other  
2 duties no doubt contained information relative to cytology.

3 A: Yes.

4 Q: Can you tell us roughly when you acquired that computer?

5 A: The first computer we had in the laboratory was way back in 1982 but  
6 I think it was about 1989 or 1990 before I started to do anything with  
7 cytology on the computer.

8 Q: By the time that you sold the laboratory what information did the  
9 computer have about any particular patient or slide?

10 A: It would have name, age, not address, cytology number and Bethesda  
11 Coding for the particular slide.

12 Q: Would it have also the smear-taker or person to whom the report was  
13 to go?

14 A: Oh yes.

15 Q: And did the original laboratory number get entered on to it?

16 A: I don't think it did no.

17 Q: Now how did the details apart from your reading report get entered  
18 into the computer?

19 A: When the specimens arrived, were given cytology numbers, the forms  
20 were then transferred to our office where one of the clerical staff would  
21 enter them into the computer.

22 Q: So a member of the clerical staff in your office entering those details  
23 into the computer before you read the slides.

24 A: Yes. If they were busy I'd do it myself but usually they did.

25 Q: Having read the slide what were you required to do to have the  
26 computer produce the form?

1 A: At the beginning of the session I would type in the cytology number  
2 for the first specimen that I wanted to examine and the name and age and so  
3 on would come up on the screen. I would then examine the slide into the  
4 appropriate Bethesda Codes and the computer would present me with the  
5 next consecutive number. If I didn't want that one I would type in the  
6 number I did want.

7 Q: And I think you said you printed your reports generally at the end of a  
8 session of reading?

9 A: Yes. I had a particularly noisy dot matrix printer which meant that I  
10 didn't want it going off all the time I waited until the end of the session yes.

11 Q: And then you would associate the report with the request and the  
12 slide.

13 A: Yes.

14 Q: How many copies of the report did the computer print?

15 A: Well a minimum of 2, very often the smear-taker would request a  
16 copy to be sent to some other person so very often 3 or even 4 depending on  
17 how many reports were required.

18 Q: So sufficient to send reports to those who needed to see them  
19 externally.

20 A: And a copy for our file.

21 Q: And how were those copies filed?

22 A: The copies of the reports were filed numerically. The original request  
23 forms were filed alphabetically.

24 Q: Lets say in 1995 your report showed that the smear was abnormal,  
25 what was your practice in respect of the patient whose smear you were  
26 reading as abnormal.

1 A: Well I had, we'll call a card index system, whereby abnormal smears  
2 were recorded by me and put in a box on top of the filing cabinet so that  
3 when I found an abnormal smear I would check to see if we'd had an  
4 abnormal smear before from this person. This to my mind was the easiest  
5 way of doing it. We're dealing with small numbers you understanding.

6 Q: What information would you put on the card relating to each person?

7 A: Name, age, the number of the cytology specimen and the coding for  
8 the report and date of course.

9 Q: Were you able at least by 1995 to use the computer to look back at  
10 any individual patient?

11 A: Yes I could.

12 Q: And how would you do that?

13 A: It wasn't a very sophisticated system I must admit, it was home made,  
14 but I would enter the name and the computer would present me with a series  
15 of names with the first three letters of the surname going back for up to 5  
16 years. I would find the one I wanted and the computer would then give me  
17 the records for that particular person. If the spelling was the same that it was  
18 every time.

19 Q: Would it give you the age?

20 A: Yes it would.

21 Q: Would it give you the cytology number of the previous slides?

22 A: Yes.

23 Q: Would it give you the Bethesda coding?

24 A: Yes.

25 Q: Have you any idea what happened to that computer when you left the  
26 practice?

1 A: It was quite an old computer. I remember discussing whether – the  
2 new owners did not require it. I remember discussing what to do with it. It  
3 was offered to me to take home but what actually happened to it I'm not  
4 really sure.

5 Q: Do you know whether or not you left it in the laboratory or took it  
6 home.

7 A: I really don't know. Well if it had been at home –

8 Q: Did you take it home?

9 A: No.

10 Q: Was any inquiry made of you by the new owners about extracting  
11 information from that computer?

12 A: I can't recall anything.

13 Q: What happened to the box of cards?

14 A: Well to the best of my knowledge it should still be sitting on top of  
15 the filing cabinet.

16 Q: Why did you keep two systems going side by side?

17 A: Well the computer one was sort of a long term project. The numbers  
18 of smears involved was only up to 5,000 a year and with the computer  
19 system I had it was much easier to riffle through the reports of request forms  
20 than it was to stop whatever I was doing on my computer, start again and  
21 make this query and the other point is that so many people particularly in this  
22 part of the country do tend to change their names rather frequently and the  
23 person who comes – quite apart from spelling mistakes it's quite common for  
24 people to use different names at different times depending on presumably  
25 who their relations are. I'm not just talking about marriage it's just one of  
26 the strange things that happens.

1 Q: Having looked up either in the card or in the computer and found that  
2 there were previous slides from that particular patient where you'd just read  
3 an abnormal, what if anything would you do next?

4 A: Oh dear that would depend on so many different factors. If was  
5 necessary to look back at the old ones in my opinion at that particular time I  
6 would do so, but I can't give you a list of conditions under which I would  
7 look and conditions under which I would not look.

8 Q: Do you recollect ever being concerned that on review of a previous  
9 slide you might not agree with the report that you had originally made?

10 A: I can't recall that, no it's much too vague I'm sorry.

11 Q: Going on to another topic, you did not engage in external quality  
12 assurance in cytology during your time in practice either by participation in  
13 the Royal College of Pathologists of Australasia Programme or by regular  
14 exchange of slides with other laboratory or laboratories did you?

15 A: No.

16 Q: What was your philosophy about not participating in the Royal  
17 College of Pathologists of Australasia programme?

18 A: I was rather put off the Royal College of Pathologists of Australasia  
19 Programme because when it first started, my colleagues at the larger  
20 laboratories took the first one of these and perhaps the second ones and they  
21 were less than enthusiastic about the programme for reasons which I can  
22 only remember one or two now, one was that the Australian's use a rather  
23 different method of reporting and the second was that the results took so  
24 long to come back that no-one could ever remember what it was all about  
25 and had lost interest by the time they got the results. There may have been  
26 others but those are the ones I remember so it was not altogether  
27 encouraging.

1 Q: Apart from that, would it have been possible to have set out some  
2 kind of informal arrangement of exchanging slides with other laboratories?

3 A: Well it would have been a good idea.

4 Q: Was it ever done?

5 A: To the best of my knowledge, no-one ever thought of it and even if  
6 they did they probably would have had difficulty in finding someone who  
7 would take the time and trouble to coordinate, there would have been quite a  
8 considerable effort, this idea comes new to me so I haven't really analysed it  
9 in any detail at all.

10 Q: We've heard that in 1995 when patient 1's complaint first came to  
11 light you wrote to Dr Teague and asked him if he could inform you of how  
12 your results compared with other laboratories?

13 A: Yes.

14 Q: I don't think you were ever told.

15 A: No there was no feedback on that at all.

16 Q: While the review of patient's 1 slides was being set up, you and Dr  
17 Teague had a number of conversations.

18 A: Yes.

19 Q: Remember any suggestion by Dr Teague relative to your cytology  
20 practice?

21 A: Well we did discuss the disadvantages of single handed practice. I  
22 mentioned to him at one stage that because of the upset involved in  
23 discovering that I'd made a major error, that my confidence was slipping  
24 rather and he suggested that if my confidence was slipping perhaps I could  
25 send the slides to his laboratory for them to look at.

26

27 CHAIR ADDRESSES MR HODSON

1 CHAIR: Pause there. Mr Hodson I note that this is covered in  
2 paragraph 43 of the brief. There is a bit of extra being added buy as you  
3 know briefs are accepted as read unless you want to make a special  
4 application to have the existing brief read out.

5 MR HODSON: I'm quite happy to leave it at that. It may take some  
6 priority later. I think the one aspect of that that should be covered is the  
7 question of the sale and it's relevance.

8 CHAIR: Yes anything new in addition to what's in the brief.  
9

10 MR HODSON CONTINUES XXN OF WITNESS

11 MR HODSON: Now that suggestion and your lack of confidence, was  
12 that made after the results of the independent review were made known to  
13 you?

14 A: No I think it was before, I think it was when we were organising the  
15 review of the slides. By that time I had looked at them.

16 Q: And seen for yourself.

17 A: I had not come to the same conclusions I had the first time I looked at  
18 them.

19 Q: Now at that stage were you and Mr Reeve in negotiation with the  
20 hospital for purchase of your laboratory by the hospital company?

21 A: Yes.

22 Q: Did that state of affairs, the progress of the negotiations, relate to  
23 your views on whether or not you should send the cytology elsewhere?

24 A: Only indirectly. One I didn't want to send the cytology elsewhere,  
25 I've always been interested in the subject, in the speciality. The other point  
26 is that it's always been policy to give as comprehensive a laboratory service  
27 as possible and by cutting off part of it it would detract from the goodwill

1 certainly, but that was not the major consideration but thinking about it it  
2 would certainly have made a difference.

3 Q: You can say that now, did you think about that at the time?

4 A: No I don't think I did. I should have done.

5 Q: A quite separate topic raised in connection with the 1994  
6 correspondence with Midland Regional Health Authority I wonder if Madam  
7 Registrar, Dr Bottrill could be shown Mr Mules exhibits 24 and 25. Now  
8 you will remember that in 1994 Dr Malpass had written to all laboratories in  
9 connection with the affair at Whanganui and you had responded. This letter  
10 number 24 is from Mr Mules and appears to have also gone to all  
11 laboratories under 25, there's an indication it went to you. Do you recollect  
12 receiving that letter?

13 A: No but I have seen it since.

14 Q: No trace of any response by you has been found can you comment on  
15 that?

16 A: No I can't. You see 1994, again we were thinking of retiring so any  
17 comments we had to make were going to be of long standing importance to  
18 laboratories in this country and it was probably not reasonable to make  
19 comments which would inflict draconian measures of quality control on  
20 other people. It's not meant to be flippant it's just how it came out.

21 Q: You mean how it came out when you saw it.

22 A: When I said draconian measures I just meant inflicting conditions on  
23 other people.

24 Q: Do you now recollect seeing that letter in 1994?

25 A: Not really, no.

26 Thank you, that's all I have, ma'am.

27 CHAIR: Thank you Mr Hodson. Any questions?

1 [Mr Grieve and Mr Kirton indicate their intention to cross-examine, Mr  
2 Grieve to lead]

3

4 XXN MR GRIEVE:

5 Q: Just following on from that, Dr Bottrill, do I take it from your last  
6 response that you regarded the imposition of quality control measures as  
7 being draconian?

8 A: Certainly not.

9 Q: Well, in what context did you use that word a moment ago?

10 A: I simply used it, as I hoped I'd explained later, to indicate measures  
11 which would not affect me at all but might affect other people.

12 Q: And which, although affecting other people, you regard it as draconian;  
13 is that the gist of it?

14 A: They could have been draconian.

15 Q: "They", being quality control measures?

16 A: No – well, yes, the conditions which would be inflicted on the people  
17 who were the subject of the draconian methods, conditions.

18 Q: Did you think, at the time, back in 1994, that moves by ACL, your  
19 association, to have members participate in accreditation and quality control,  
20 did you think that those measures were a matter of being inflicted on you,  
21 did you?

22 A: No.

23 Q: So in what sense did you use the word "inflicted" a moment ago?

24 A: Well, we didn't do it, did we? We did not put forward our proposals or  
25 our submissions with regard to how other people should conduct their  
26 laboratories or their business.

27 Q: Or how you should conduct your laboratory, didn't that concern you?

1 A: I'm sorry, I don't quite see the relevance of that.

2 Q: You see, I suggest to you that even back in those days it was apparent  
3 to many of your colleagues, and I suggest to you as well, that issues such as  
4 TELARC accreditation, quality control and quality assurance were measures  
5 that were being recommended to ensure as far as possible good laboratory  
6 standards. Was that your understanding at the time?

7 A: Yes.

8 Q: And you, of course, as we know, undertook none of those measures did  
9 you?

10 A: No.

11 Q: And I put it to you that it was because you regarded them as  
12 unnecessary, is that right?

13 A: No.

14 Q: Well if you didn't regard them as unnecessary, why didn't you institute  
15 them at your laboratory?

16 A: Nobody would doubt that the achieving of uniformity of ways of doing  
17 things would be a good idea. What I do believe, however, is that this  
18 accreditation system whereby everything which is done has to be fully  
19 documented at all times so that, in theory at least, any person can come  
20 along and do almost any job is obviously of great value in the big  
21 laboratories where you have hundreds of people. It is of less value, in my  
22 opinion, in the small ones where you have only very few people and there is  
23 much closer supervision of what goes on and what comes out of the  
24 laboratory.

25 Q: But quality of output and, as far as is possible, reasonable accuracy of  
26 results, is as important in a small laboratory just as it is in a big laboratory,  
27 don't you agree?

1 A: Oh, I agree with that.

2 Q: And you have to agree with that, don't you, because behind all this is  
3 the issue of the health and safety of the women whose cytology smears are  
4 being examined, is that correct?

5 A: Obviously.

6 Q: In making these decisions back at the time not to participate in these,  
7 what I will call globally safety measures, I suggest to you you paid no regard  
8 to the health of the women whose smears you were examining; what do you  
9 say to that?

10 A: I say to that that there were numerous laboratories in this country,  
11 particularly the small ones, which had not got around to these measures.  
12 Like me, they probably intended to. But I don't really accept that by  
13 becoming accredited you immediately improve the quality of the results that  
14 go out.

15 Q: And what –

16 A: You could improve perhaps the methods by which the specimens are  
17 handled, but you'd still get the same opinion on the slides regardless of how  
18 meticulous your preparation had been.

19 Q: so is it your view that quality control, external quality assurance, played  
20 no part in ensuring accuracy of smear-reporting as far as you were  
21 concerned; is that your position?

22 A: My position is that all external quality controls –

23 Q: I don't want to interrupt, but I'm asking you about was that your  
24 position back at the time; would you just focus on that, please.

25 A: I'm not quite sure where we are. What was my view about?

1 Q: I'll put it to you again doctor. Was it your view at the time that  
2 measures such as external quality assurance and quality control systems  
3 played no part in affecting your standard of smear-reading?

4 A: Yes.

5 Q: So you didn't think they would help your accuracy, is that right?

6 A: I think that is correct, yes.

7 Q: Now a moment ago also you were asked about why you didn't send  
8 your cytology smears elsewhere when that suggestion was made to you by  
9 Dr Teague, and you gave, as I've noted it, two reasons: one, that as a matter  
10 of personal choice – and that's my phrase – you didn't want to send your  
11 cytology elsewhere; is that the situation?

12 A: Yes.

13 Q: Secondly, as a matter of policy, you wanted to provide a comprehensive  
14 laboratory service. That was the second reason wasn't it?

15 A: Yes.

16 Q: And in explaining that, you referred to the fact that if you didn't  
17 continue to maintain a comprehensive laboratory service, it would detract  
18 from the goodwill, you said that didn't you.

19 A: I did.

20 Q: Meaning price that you were going to get on sale.

21 A: Yes.

22 Q: So that, I just want to get it clear, I know at the time we're talking  
23 July/August 1995 you had had sale in mind for some time. You said yourself  
24 that at this time you felt your confidence was slipping that's right too isn't it.

25 A: Yes I did express that opinion.

26 Q: To Dr Teague.

27 A: Yes.

1 Q: And yet despite that for price reasons in part you decided that you  
2 would not take his advice and send these smears elsewhere correct?  
3

4 MR HODSON INTERJECTS

5 MR HODSON: He expressly discounted the price factor in the  
6 questioning that I made of him.

7 CHAIR: Yes I know that but Mr Grieve is entitled to go back over that  
8 ground Mr Hodson and if he gets a different answer you can re-examine and  
9 we will have the task of deciding which answer ultimately we are persuaded  
10 to accept.

11 MR HODSON: Yes ma'am.  
12

13 MR GRIEVE CONTINUES XXN OF WITNESS

14 MR GRIEVE: You understand don't you Dr Bottrill what I am putting  
15 to you? What I am suggesting to you, and I'll put it bluntly, I accept that it  
16 was one of the reasons, but the effect of it is that for a price reason as being  
17 a factor in the eventual sale, you decided not to send your cytology  
18 elsewhere as advised by Dr Teague.

19 A: I was not advised by Dr Teague to send the specimens elsewhere for a  
20 start.

21 Q: That's what he suggested.

22 A: He offered, that is all.

23 Q: He has said in evidence and I'll find the passage if necessary that  
24 when he was discussing the review of patient 1's smears with you he told  
25 you two things. In short get accredited and secondly send your cytology  
26 elsewhere. Do you now disagree with that do you?

27 A: I do yes. I have no recollection of anything of that sort.

1

2 CHAIR INTERJECTS

3 CHAIR: It might be better Mr Grieve just for precision sake if we find  
4 the passage in the transcript and read it out to Dr Bottrill and see what he  
5 says. I think 1301 might be a page your interested in.

6 MR GRIEVE: Yes 1301 line 6 and 7. Thank you Madam Chair.

7

8 MR GRIEVE CONTINUES XXN OF WITNESS

9 MR GRIEVE: Now this is the passage Dr Bottrill page B1301 line 6  
10 through to 11. It was put to him that in 1995 when Dr Teague received the  
11 results from the cytology review panel he knew that your laboratory was not  
12 TELARC accredited and he then said, and this is his answer, yes I believe  
13 that when he rang me I ascertained that his laboratory was not TELARC  
14 registered and I suggested that he should either send his cytology elsewhere  
15 or get registered. That was his evidence. Do you say now that that did not  
16 happen or is it your position that you don't remember it happening?

17 A: My position is that I have related to you my recollection of the  
18 conversations which I had with Dr Teague. And that really is all.

19 Q: Well you refer to this you see in your brief of evidence at paragraph  
20 43.

21 A: Yes.

22 Q: I'll quote it. You say at the top of page 11 of your brief, do you have  
23 it there?

24 A: I have.

25 Q: That at the time of forwarding the smears you can recall talking with  
26 Dr Teague that's the first point. He told you that his laboratory had  
27 introduced rapid re-screening, you said it would be difficult for your

1 laboratory. Dr Teague said that I could always send the smears to his  
2 laboratory and that they could read them. Correct?

3 A: Yes.

4 Q: So you had a conversation along those lines with Dr Teague which  
5 you obviously recalled at the time your brief was prepared correct?

6 A: Yes.

7 Q: And the effect of that suggestion was that you could send your  
8 cytology out with the additional suggestion to Dr Teague correct?

9 A: Yes.

10 Q: But, and I come back to it, it seems that one of the reasons why you  
11 elected not to follow that recommendation was that you didn't want to  
12 detract from the potential goodwill that you might receive on sale correct?

13 A: That is correct, however, I believe that it occurred to me considerably  
14 later.

15 Q: So that's your memory now.

16 A: My memory now is that yes.

17 Q: I see. You had told Dr Teague that your confidence was slipping  
18 correct?

19 A: Yes.

20 Q: You at the time of this conversation knew that at least as far as one  
21 patient was concerned your accuracy was in question didn't you?

22 A: Yes.

23 Q: But I put it to you that despite those factors and the suggestion made  
24 to you by Dr Teague, you were more interested in the price that you were  
25 going to receive for your laboratory and you therefore decided not to send  
26 the cytology elsewhere. That's the reality, isn't it?

1 A: I think this concentration on money is probably unwarranted. We all  
2 aim for perfection. We know in our hearts that we're not going to be able to  
3 achieve it, unless of course we're either misleading ourselves or we are liars.  
4 When one finds that one has made a mistake it is a very distressing  
5 circumstance, but we do know that these things happen. And I don't wish  
6 to sound flippant, but it is in some ways equivalent to when you fall off a  
7 horse you've got to get straight on again and get your confidence back  
8 interest his case.

9 Q: One of the ways you might have recovered your confidence was to  
10 decide there and then to, for example embark on some sort of quality  
11 assurance exercise, but you didn't do that, did you?

12 A: No, no formal quality control exercise, no.

13 Q: Well, what informal quality control exercise did you follow after that?

14 A: Well before that and after that, interesting specimens were shown to,  
15 and discussed with, the only colleague I had handy at the hospital and that  
16 could, I believe, be considered to be an informal quality control measure.

17 Q: And what did that involve exactly, how did it work?

18 A: Looking at slides together and talking about them.

19 Q: where did you do that?

20 A: Oh, I usually did it at the hospital because they had a microscope with  
21 two heads on it there, you could look at the same slides simultaneously – the  
22 same fields simultaneously.

23 Q: since this Inquiry has begun, have you, with the assistance of your  
24 counsel, been following the proceedings and taking note of significant  
25 evidence that's been given?

26 A: Yes.

1 Q: Are you aware of the evidence given by Dr Farnsworth quite recently,  
2 where she was asked to produce and analyse some figures taken from  
3 exhibits produced by Ms Mellor from the Health Funding Authority?

4 A: I certainly remember reading them, I'm not sure which particular you're  
5 referring to at present.

6 Q: So you've had the opportunity to give some consideration to the  
7 evidence of that type, have you?

8 A: Yes.

9 Q: And do you recall that the figures show that the false negative rate of  
10 your laboratory compared to the results from Sydney, that the rate indicates  
11 something in excess of 80%; are you aware of that?

12 A: I remember those figures, yes.

13 Q: That figure's derived by looking at the % of smears that you correctly  
14 identified as either high grade squamous intraepithelial lesion or cancerous  
15 compared to the findings on histology; you understand that I take it, do you?

16 A: Yes, thank you.

17 Q: And the figure for that was 17%, which taken from 100 leaves 83%  
18 error rate; did you understand that?

19 A: I had great difficulty in analysing those results from Ms Mellor, but I  
20 understand that that is the conclusion that some people have come to  
21 regarding those figures.

22 Q: Do you now accept that that error rate is correct?

23 A: I can't offer any alternative figures. If that in fact is true, well I accept  
24 it.

25 Q: Do you recall Dr Farnsworth giving evidence and commenting on that  
26 error rate? Were you shown that evidence?

27 A: I did see her brief, yes.

1 Q: I'm referring Madam Chair to p1869, beginning at about line 13. She  
2 was asked – i.e. Dr Farnsworth was asked how she would describe it – very  
3 low, through to high etc., and she said: “The 17% rate – i.e. the accuracy  
4 rate – was extremely low.” She was asked: “unacceptably low”, she said  
5 “yes”, and then she was asked, “why” she thought it was unacceptably low,  
6 and among other things, she said at line 25: “These are the lesions we are  
7 actually looking for because it's these lesions that by finding them at this  
8 stage you can remove and actually prevent cancer. It would seem to me that  
9 if you're picking up such a small % of the actual disease that exists in that  
10 community of screened women, then basically you shouldn't have a  
11 screening programme at all because it's not doing any good.” Do you  
12 remember that?

13 A: I'm sure I read it but I can't recall it at present, no.

14

15 MR HODSON: I am just reminded in this line of questioning – it's entirely  
16 for you because I can't object to it as a formal matter of inadmissibility –  
17 there was an indication from you on Friday or Saturday that Dr Bottrill  
18 would not be in a position to assist you on term of reference 1 and that you  
19 would not expect questioning on those lines.

20 CHAIR: Well, when I said that, what I meant, Mr Hodson, was that I  
21 considered that the Inquiry had sufficient evidence before it to deal with  
22 term of reference 1 in view of comments you had made without the need to  
23 hear from Dr Bottrill. But equally if he is able to give evidence that assists  
24 in answering term of reference 1, then that can be pursued with him.

25 MR HODSON: Well, ma'am, I would simply leave it to you, if I may, to  
26 determine at which point you are assisted or are not assisted.

1 CHAIR: Yes, the only point at which we would intervene would be if we  
2 considered that we'd already heard so much evidence that it was really  
3 unnecessary for us to hear any more.

4 MR HODSON: I'm quite happy to leave it to you, ma'am.

5 CHAIR: Thank you. Mr Grieve, I've got no objection to you pursuing this  
6 line of questioning at the moment, but what the committee is particularly  
7 interested in from this witness is term of reference 2 in terms of practices,  
8 because -

9 MR GRIEVE: Ma'am, I will put something that hopefully will resolve it.

10 CHAIR: Perhaps you could round it up quite generally.

11 MR GRIEVE: I will do that. I want you to listen to this question carefully  
12 please Dr Bottrill if you would. Do you now accept, from what you've  
13 seen, read of the evidence that's been given, that during the period 1991 to  
14 March 1996, there has been an unacceptable level of under-reporting of  
15 cervical smears in the Gisborne region as a consequence of your misreading  
16 and/or mis-reporting of those smears?

17 A: Regretfully yes.

18 Q: Do you now accept that at the time you should have known that this  
19 would be a consequence, that is the under-reporting which you've now  
20 acknowledged would be a consequence of lack of proper training either as a  
21 cytopathologist or as a primary screener do you accept that?

22 A: No.

23 Q: Do you accept that it's a consequence of lack of appropriate continue  
24 education?

25 A: No.

26 Q: Do you accept that it's a consequence of failure to take timely steps to  
27 have your laboratory accredited?

1 A: No.

2 Q: Do you accept that it was a consequence of your failure to institute  
3 appropriate quality control measures?

4 A: No.

5 Q: Including peer review with proper records of that and a systematic  
6 look back review system of patient smears? Do you accept that that failure  
7 was a consequence which lead to mis-reporting and under-reporting by you?

8 A: That's hard - I think it would still say no.

9 Q: And do you accept that the under-reporting you've acknowledged  
10 was also a consequence of your failure to participate in an appropriate  
11 external quality assurance programme?

12 A: No.

13 Q: Do you accept that as a result of the failure of yours to undertake the  
14 matters just put to you, that you failed to discharge your ethical obligations  
15 to your patients?

16 A: Certainly not.

17 Q: Could you look please at paragraph 5 of your brief?  
18

19 CHAIR INTERJECTS

20 CHAIR: Are you moving on to a new topic?

21 MR GRIEVE: Yes Madam Chair.  
22

23 CHAIR REPLIES & XXN WITNESS

24 CHAIR: Just before you do that, Dr Bottrill the committee of inquiry  
25 has listened with interest to your evidence and your statement that you  
26 accept that there has been an unacceptable level of under-reporting in  
27 Gisborne as a result of your misreading or mis-reporting smears. Since the

1 time when you have come to this knowledge, has it been of concern to you  
2 that this has occurred?

3 A: That Madam is a great understatement. I have been absolutely  
4 devastated of the discovery during the last 12 months that these things have  
5 happened.

6 Q: Have you therefore had cause to consider, just for yourself, how it  
7 could be that misreading at such a level could have occurred?

8 A: I've obviously given an awful lot of thought to this. Certainly I have  
9 ideas but they're pure supposition and I honestly feel they have no place in a  
10 place like this.

11 Q: Well Mr Grieve has put to you a series of matters which most persons  
12 might think would lead to under-reporting and you have denied that that was  
13 so in your case. Therefore the committee would be most interested to hear  
14 from you now as to what you think the reasons are for you misreading so  
15 many smears.

16 A: This is a terribly difficult question. I believe that prior to 1990 there  
17 was no problem. Now my reason for thinking that is that I had been  
18 practicing here for something like 25 years and if the local doctors had been  
19 in any way concerned at the failure of diagnosis of cervical cancer I would  
20 like to think that either directly or indirectly I would have had some  
21 feedback. Talking about negatives is really very very difficult, that is how I  
22 believe –

23 Q: You told me that you have felt devastated.

24 A: Yes.

25 Q: By the under-reporting. Therefore if you have felt devastated by it,  
26 you must at times have tried to work out for yourself how it is that you could  
27 have mis-reported slides to the level at which you now accept you did and I

1 am most interested to hear from you what you think could have caused you  
2 to have misread slides to this degree.

3 A: As I said before pure supposition. I do know that following my  
4 coronary by pass surgery, I did have problem with my memory. Since we've  
5 been talking about all this business I have had the terrible feeling that it may  
6 be that there was some other effect which was not recognised associated  
7 with this, for example, either a form of attention deficit or possibility lack of  
8 concentration, but that's as far as I can go.

9 Q: After your coronary by pass did you have a full medical examination  
10 with a view to seeing whether or not you were fit to resume your work as a  
11 pathologist.

12 A: Yes.

13 Q: Are you required to undertake such an examination by the Medical  
14 Council in those circumstances, or whatever the –

15 A: I wouldn't think so, not for something just like a coronary by pass I  
16 wouldn't think. If you'd had a stroke or something associated with the brain  
17 or nervous system I would have expected it yes. That's just my opinion.

18 Q: Right. And those two matters that you've just referred to are the only  
19 two matters that you can think of which could have caused you to misread so  
20 many slides.

21 A: There the only ones that occur to me, but they didn't occur to me until  
22 very recently.

23 Q: Have you checked these ideas out with any of your medical advisors  
24 in respect of your heart condition?

25 A: Yes with really unsatisfactory sort of results in that I have since been  
26 told that ah yes well some people believe that there is a thing called a post by  
27 pass syndrome which nobody knew about in 1990 which some specialists

1 believe in now and some don't. It's the old story, I think most of the  
2 physicians believe in it and the surgeons don't.

3 Q: But otherwise if I understand your evidence you are at a loss to  
4 provide any explanation to the committee for why you could have misread so  
5 many slides between 1990-1996?

6 A: Yes, ma'am.

7 Thank you.

8

9 MR GRIEVE: You realised quite shortly after your by-pass that you were  
10 having problems with your memory, didn't you?

11 A: Yes.

12 Q: Because you had to make notes to remind yourself of things?

13 A: Yes.

14 Q: And at some point I think you have said you gave up forensic pathology  
15 because you were encountering difficulty with giving evidence in criminal  
16 trials, is that right?

17 A: Yes.

18 Q: When was that?

19 A: That was 1990.

20 Q: do you accept that as a medical practitioner, if you have reason to  
21 believe that you may in some way be incapacitated, that your ethical  
22 obligation is to put the health of your patients first and, in an extreme case,  
23 stop practising?

24 A: Yes.

25 Q: And in 1990 you desisted from part of your practice?

26 A: Yes.

27 Q: For that reason?

1 A: Yes.

2 Q: Did you not consider that you should – i.e. back then – look carefully at  
3 your ability to carry on reading cytology smears for the same reason?

4 A: I maintain that there's no connection whatever between the reasons why  
5 I decided to desist from forensic pathology and reading of cytology smears.

6 Q: So is it only now that the extent of the errors has been revealed that you  
7 have come upon this as a possible reason?

8 A: Yes. Why I stopped the forensic pathology was that I was slightly  
9 worried because sometimes it's anything up to 9 months or a year after a  
10 homicide, for example, before the case comes to trial. And it's one thing to  
11 go into court and say "may I refer to my notes" and use those to supplement  
12 your memory. It's completely another one to find that you are relying  
13 entirely on your notes to tell you what went on. That is why, because I  
14 thought it was unfair, both to me and to the accused, if there was an accused,  
15 that I should no longer do this. Cytology, on the other hand, I had no doubts  
16 that I was as competent as I had been before.

17 Q: Well, we'll explore that. One of the first matters that I put to you as  
18 being a reason which you disagreed with was lack of proper training.

19 A: Yes.

20 Q: In para 5 of your brief you refer to having the opportunity to study  
21 gynaecological cytology during the course of your pathology training.

22 A: Yes.

23 Q: Have you got that there?

24 A: Yes.

25 Q: And do you recall that opportunity was during the years, or between the  
26 years March 1957 and September 1961.

27 A: Yes.

1 Q: Would you look, please, at an exhibit – it's McGoogan 8, which is the  
2 Royal College record of your application for Fellowship and it contains  
3 details of your experience in medicine and pathology. If you look at the  
4 third page of that, do you see that?

5 A: yes.

6 Q: In your brief you say, at para 5, that "this opportunity to study was in  
7 Leeds".

8 A: Yes.

9 Q: And if you look at p3 of the exhibit can you indicate when it was that  
10 that opportunity presented itself?

11 A: Yes. It was during the time when I was working in the microbiology  
12 department.

13 Q: So that's between the period of it must be March 1958 – i.e. after your  
14 first year, so it's between march 58 and December 60, is that right?

15 A: I guess so, yeah.

16 Q: All right. Now what did that opportunity consist of?

17 A: It consisted of a pathologist at one of the hospitals who was interested –  
18 becoming interested in exfoliate cytology. I went along and looked at slides  
19 with him.

20 Q: So is that sort of process what you refer to when you say "part time for  
21 3 months"?

22 A: Yes.

23 Q: So there was no formal training?

24 A: Oh, no!

25 Q: So this was just someone who became, or was becoming, interested in  
26 gynaecological cytology; is that right ?

27 A: Yes.

1 Q: And you, with him, did the sort of thing that you've referred to earlier  
2 when you go down to Gisborne Hospital with a slide that's of interest, that  
3 sort of thing?

4 A: What I would like to say is that this 3 months that I said that I was  
5 engaged in part time exfoliate cytology would be almost exactly 3 months  
6 longer than any of my contemporaries who trained at the same time. The  
7 training for cytology just did not exist in the 50s.

8 Q: All right, but it existed later, didn't it?

9 A: Yes.

10 Q: And I suggest to you that you at no stage undertook any formal training  
11 of any sort in gynaecological cytology; is that correct?

12 A: That is correct.

13 Q: So even the 3 months that you mention was informal, correct?

14 A: Of necessity.

15 Q: Looking at slides that this colleague thought were of interest; that's all,  
16 isn't it?

17 A: Yes.

18 Q: No examination, oral or written?

19 A: No, no examiners either.

20 Q: So that following on from that, this training such as it is, as you've  
21 described, concluding at the latest, some time before December 1960, you  
22 then came to New Zealand went to Whangerei Hospital and then came to  
23 Gisborne in 1967.

24 A: 1966.

25

26 CHAIR INTERJECTS

27 CHAIR: Mr Grieve if you could pick a convenient time.

1 MR GRIEVE: Thank you Madam Chair I'll just finish this.

2

3 MR GRIEVE CONTINUES XXN OF WITNESS

4 MR GRIEVE: So there was then a 6 or 7 year gap during which time  
5 you undertook no gynecological cytology at all did you?

6 A: Not so far as I remember but I would like to stress the word  
7 gynecological because all histopathologists have been engaged in a form of  
8 cytology for generations and then recognition of abnormal cells, although  
9 there are some factors which are peculiar to exfoliate cytology and  
10 gynecological pathology in particular, the general principals of recognising  
11 normal from abnormal cells is not limited to cytopathologists.

12 Q: But the short point is doctor that you had done no cytology virtually  
13 at all while you were at Whangarei so there was a 6 or 7 year gap until you  
14 started doing cytology here in Gisborne that's right isn't it.

15

16 MR GRIEVE ADDRESSES CHAIR

17 MR GRIEVE: This would be a convenient point Madam Chair.

18 CHAIR: Very well we will adjourn until 11:45.

19

20 INQUIRY ADJOURNS UNTIL 11:45 A.M.

1

2

## INQUIRY RESUMES AT 11:54 A.M.

3

4 MR GRIEVE: Dr Bottrill, in para 8 of your brief you say that you had a  
5 special interest in cytology – the top of p4, see that?

6 A: Yes.

7 Q: And you said just before the break, when I was asking you about the  
8 nature of your training, that there was no training available at the time that  
9 you did your specialist training in pathology. Were you aware that in 1973,  
10 which is the year you obtained your Fellowship, that the College – i.e. the  
11 RCPA – offered an examination in anatomical pathology slanted towards  
12 cytopathology; were you aware of that?

13 A: I was certainly aware of it since then. I'm not sure if I was at the time.  
14 I've never regarded myself as a cytopathologist.

15 Q: Well, at para 7.4.3 of the College statement, I'll just read you what they  
16 say about it, and I quote: "The College, since 1973, has offered examination  
17 for fellowship in anatomical pathology slanted towards cytopathology. This  
18 examination is considered appropriate for those Fellows with a particular  
19 interest in cytopathology or who are contemplating a career specifically in  
20 cytopathology." Now I know you will say, because of the amount of  
21 cytopathology you were doing, that your career was not specifically directed  
22 in that regard, but you did have a particular interest in it, didn't you?

23 A: I thought it was a very valuable specialty, yes.

24 Q: Bearing in mind the difficulty you had during your training in getting  
25 any training in cytopathology, did you not, in 1973, when you were  
26 considering Fellowship, think it appropriate to embark on a specialist course  
27 that was available then?

1 A: In my opinion, a specialist course of this sort would be quite unsuitable  
2 for a person in my position who was, in ever sense of the word, a general  
3 pathologist.

4 Q: But effectively at this time you must have realised that you were  
5 reading cytology smears without any formal training at all; that's the  
6 position, isn't it?

7 A: I had no more and no less training than a large majority of my  
8 colleagues in other parts of the country.

9 Q: In addition though, you had some added disadvantages, didn't you; you  
10 were the sole pathologist in your laboratory, correct?

11 A: Yes.

12 Q: And also, you were the primary screener, weren't you?

13 A: Yes.

14 Q: Now, you understand, don't you, that as far as screening is concerned  
15 the primary screeners require significantly more specialised training than  
16 cytopathologists who don't do primary screening?

17 A: Well, yes.

18 Q: And did you understand that at the time?

19 A: Well, a pathologist already has a training in histopathology. They  
20 don't need to be taught to recognise an abnormal cell when they see it.

21 Q: Are you saying now that at this time say from the 1970's onwards when  
22 you began to read, when you had been reading for some time, the Gisborne  
23 cytology that you thought you were adequately qualified because you had  
24 done histology. Is that what you're saying?

25 A: I am saying that the average histopathologist should be able to  
26 produce a reasonable competence in cytopathology yes.

1 Q: Have you been shown the evidence of at least 3 witnesses who have  
2 referred to the training necessary to become competent as a primary screener  
3 and I refer to Professor McGoogan, Dr Farnsworth and Dr Teague. Do you  
4 recall their evidence about that or not?

5 A: I'm sure I read it but I don't recall it at this moment but I will accept  
6 what they say.

7 Q: Do you remember that when asked Dr Teague himself acknowledged  
8 that he was not competent, he didn't consider himself competent to primary  
9 screen, do you remember that?

10 A: No I don't. But again I will accept that.

11 Q: You'll accept it. And indeed Dr McGoogan expressed similar  
12 reservations about her competence to do that do you remember that?

13 A: Yes.

14 Q: Where you aware during the relevant time that is between 1990 and  
15 1996 that your training was totally inadequate for the task of primary  
16 screening?

17 A: No.

18 Q: Dr McGoogan told us page 940 beginning at about line 5 that in the  
19 UK they have two grades of staff employed for primary screening. She went  
20 on to say at line 13 that the training period has a minimum of 2 years with a  
21 minimum of 5,000 slides having been primary screened by that individual  
22 after which they are eligible to sit the exit examination, it's a national  
23 examination, only then are they allowed to sign out negative an inadequate  
24 smears. You hadn't had any training that fitted you for that task had you?

25 A: No.

1 Q: And do you say that at no stage during this period did it occur to you  
2 that you simply hadn't had the training to carry out the work that you were  
3 doing in cytology?

4 A: I don't accept this you know.

5 Q: What don't you accept doctor.

6 A: Well I don't accept this assumption that a pathologist is incompetent  
7 when it comes to screening cytology.

8 Q: So are you saying that despite what Dr McGoogan said, you think that  
9 your training fitted you for that task, is that your position now in the face of  
10 the evidence that we've heard?

11 A: My position is really associated with the history of cytopathology. In  
12 the beginning it was the duty of the pathologists initially, histopathologists  
13 later perhaps, people with a special interest in cytology and finally in people  
14 who specialised in cytopathology. At some stage the practice of exfoliative  
15 cytology became sufficiently valuable for the volume of work to increase to  
16 such an extent that the pathologist found it was difficult to continue looking  
17 at all the slides. They then started to train people who were not medically  
18 qualified to look at the slides and I suspect much to their surprise they found  
19 that these non-medically qualified people were often better at it than they  
20 were themselves. We now come to the stage were as you are alleging,  
21 because I have not had two years training in screening, I'm no good at  
22 screening slides, I think that's a non sequitae.

23 Q: Well at page 942 line 21 Dr McGoogan was asked this by Professor  
24 Duggan. Could I ask you for your own personal opinion on whether  
25 pathologists who have not been trained in the skills of primary screening  
26 should function as a primary screener and Dr McGoogan said this, I have a  
27 very high regard for the skills of primary screeners. It is an exceptionally

1 difficult skill to develop and maintain day in day out. It is not a skill which I  
2 have as an individual. I would have to undertake a similar training and  
3 concentrate my training in that area to achieve the same skill. And then she  
4 was asked, you as an acknowledged expert in cytopathology do not consider  
5 you should function as a primary screener and Dr McGoogan said yes, I  
6 agree. What is your comment on that evidence?

7 A: My comment on that evidence is that I am not in a position to  
8 disagree with it. On the other hand I also say that should one concentrate all  
9 the cytopathology in the country in one, two or three centres, or should we  
10 continue to do what we have had to do up until now, all do our own  
11 cytopathology. The ideal in Scotland is not necessarily the best that we can  
12 manage in New Zealand.

13 Q: A few pages on at page 943 Madam Chair asked Dr McGoogan this  
14 at line 14. Do you consider it good practice for a pathologist who has not  
15 been trained as a primary reader of smear tests, to nevertheless do the job of  
16 primary screening, and the answer was, I think for anyone to do the task of  
17 primary screening without proper training and evidence of competence is  
18 bad practice. That was Dr McGoogan's expert opinion what do you say  
19 about that?

20 A: I can't comment on that.

21 Q: Well what she is saying in effect I put to you is that in your situation  
22 given the training, limited training that you had in primary screening, you  
23 weren't competent to do it. What do you say about that?

24 A: I say as I've said before that I'm sure I was at least as competent as  
25 my colleagues. Never having had the luxury of a screener available to me  
26 it's very hard for me to comment further.

1 Q: Well, I know that in your brief you referred to the unavailability of a  
2 cyto-screener, but also in your brief you comment that there wasn't  
3 sufficient work to warrant you employing a cyto-screener. So what I  
4 suggest to you is that there was a financial reason for not employing a cyto-  
5 screener as well. What do you say about that?

6 A: What I say about that is that there was insufficient work for a full-time  
7 screener, which meant that there was no point whatever in my engaging  
8 someone, sending them for training and bringing them back because there  
9 would never be enough work for them to work full-time in my department.  
10 If, however, there had been a young woman, perhaps with a child, who used  
11 to be a screener and who would like to work for 2 or 3 or perhaps 4 hours a  
12 day, I would have been only too pleased to employ her. I say "her" because  
13 most of the screeners are women.

14 Q: Dr Farnsworth was another expert who expressed similar views, so Dr  
15 McGoogan was not alone in this. The consensus of these experts, including  
16 Dr Teague, was that without specialised training, pathologists should not  
17 work as primary screeners. Now, do you accept that now or not?

18 A: There's a lot of hindsight going into this, isn't there? What is  
19 recommended as being ideal for the 1990s has very little relevance to what  
20 was done in the 1970s, in Gisborne, or Hamilton, or Tauranga and so on.

21 Q: Well, I'm going to suggest to you that, in fact, this knowledge isn't  
22 new; that it was available in the relevant period, and that you simply  
23 ignored it.

24 A: What are we talking about? – the availability of screeners?

25 Q: The need to have training to undertake work as a primary screener.  
26 I'm suggesting to you that you knew about it but went ahead anyway.  
27 What's your comment?

1 A: My comment is that if you don't have a screener and you've been doing  
2 the job for years you might just as well go on doing the job.

3 Q: And what about the health and safety of the women whose smears  
4 you're reading?

5 A: Well, I'm big headed enough to think that the health and safety of the  
6 women is probably better after they've been screened than before.

7 Q: Pig headed enough to think that –

8 A: Big headed enough.

9 Q: Pardon?

10 A: Big headed.

11 Q: What, big headed about your own ability, without training?

12 A: I do resent this “without training” business.

13 Q: Well, Dr Bottrill, you tell me, in your own words, in the way in which  
14 you consider you had adequate training to undertake the reading of cytology  
15 smears?

16

17 CHAIR: Do you mean primary screening?

18 MR GRIEVE: Yes.

19

20 CHAIR: With that added qualification to the question Dr Bottrill.

21 A: Well, we're really coming back, madam, to the question of what one  
22 does when there is no primary screener available, as there hasn't been here  
23 ever.

24 Q: Well, did you contemplate sending the work elsewhere, that is what  
25 occurs at the present time.

26 A: Yes, but again Gisborne's a long way from anywhere else and there's  
27 terrific satisfaction in providing as comprehensive a service as you can for

1 the people in the area. You know, this question of “should have known that  
2 I was not trained in screening” is all very well, but how does one find out  
3 these things? I’m not alone in doing this.

4 Q: Dr Bottrill, Dr Gabrielle Medley has given evidence to us, and I note  
5 from her curriculum vitae, which is in duRose exhibit 11, she was born in  
6 1935, which is reasonably close to your birth date, she became a FRCP of  
7 Australia in 1973 (which is about the same time as you did), and she's  
8 practised in Victoria, which is at least closer to NZ than Scotland is. In her  
9 evidence at p2687, lines 20, she said: “I think one of the most important  
10 things in cervical cytology, which is a very subjective discipline, is the  
11 opportunity to have more than one pair of eyes on a slide and more than one  
12 brain to discuss a slide. So I guess one of the most important areas of this  
13 questionnaire to me” - this was a questionnaire to look at other laboratories –  
14 “was where the sole practitioners and were there sole practitioners who were  
15 actually screening slides because it’s my belief that under usual  
16 circumstances pathologists are not trained screeners. So to me, I suppose, I  
17 ranked the different areas of the questionnaire in terms of what I considered  
18 to be the greatest risk, and to me, that was the single greatest risk and that  
19 was not the case for any other practice. So I think, I guess, that’s what I  
20 mean when I say that I was looking at the questions in the questionnaire as  
21 to how they impinged on the risk to women whose smears were being  
22 looked at.” And when I then asked her to sum up her answer: “Is what  
23 you're saying that, given the absence of any standards or benchmarks in NZ,  
24 you had to fall back on looking at the practice from the perspective of very  
25 fundamental standards which most pathologists would adhere to throughout  
26 the world in terms of standards of practice, and for you, one of those is that  
27 there should be more than one pair of eyes and more than one brain to

1 discuss a slide and that a pathologist during primary screening, working on  
2 his own, is in a risky position or in a position that might place women at  
3 risk.” And her answer was: “I believe so.” Do you have any comment to  
4 make on that?

5 A: I certainly can't argue with her conclusions. I have never pretended  
6 that sole practice is an ideal situation. In fact, I think there's only some  
7 people are, by nature, able to do it. I've worked in University departments,  
8 I've worked in large hospitals and I've worked in small hospitals. Given the  
9 choice I would work in a large hospital where you have various colleagues  
10 with various expertises in various specialties. But – I come back to what I  
11 was saying before: either you don't have a pathology service in a place like  
12 Gisborne, which I suspect is what's going to happen in the future; or, you  
13 do the best you can under the circumstances in which you find yourself.

14 Q: Well, we have learnt that Dr Lapham, who was one of the locums at  
15 Gisborne Hospital laboratory, who was a pathologist who had worked in a  
16 large laboratory in Houston, Texas, when she came to the Gisborne Hospital  
17 laboratory and realised that there was no cyto-screener there at the time of  
18 her arrival and that the laboratory was only reading 2,000 smears/annum, she  
19 refused to do the work and sent it elsewhere to Palmerston North on the  
20 basis, she considered, she could not retain her competency at reading smears  
21 in those circumstances. Do you think that that might have been an  
22 appropriate course of action for you to take to send the smears coming to  
23 Gisborne laboratory elsewhere for reading?

24 A: I can't argue with that but I can only come back to one of the things  
25 that I said in my brief here that I liked cytology, I was interested in cytology  
26 and to the best of my knowledge I was quite good at it until recently

27

1 MR GRIEVE CONTINUES XXN OF WITNESS

2 MR GRIEVE: One of the issues I suggest to you that impacts on all  
3 this as well, and you've referred to it, is that you were practicing on your  
4 own without that second pair of eyes to review your work weren't you?

5 A: I was.

6 Q: Do you recall someone showing you the evidence or drawing your  
7 attention to the evidence that Dr McGoogan gave about the risks of a sole  
8 pathologist doing primary screening do you remember that evidence? I'll  
9 take you to it if you wish.

10 A: No ... Yeah OK I'll accept it.

11 Q: I'm referring Madam Chair to page 939 of Dr McGoogan's evidence.  
12 It was put to Dr McGoogan by Madam Chair at line 7, she was asked about a  
13 small laboratory, one pathologist, no-one else employed full or part time  
14 with approximately 5,000 smears per annum, single pathologist doing all the  
15 screening and then she's asked can she, that is Dr McGoogan, formulate an  
16 opinion. She commented that it was a very unusual situation, that it would  
17 be extremely difficult and would require exceptional measures to be put in  
18 place. She was then asked to describe how it might be done and she said if  
19 you're really asking me how I would want to set up a bad service how I  
20 would do it with the least risk to women and she then went on to describe six  
21 measures that she regarded as essential in those circumstances. You would  
22 accept that the circumstances to you were those that pertained to your  
23 method of practice wouldn't you?

24 A: Yes.

25 Q: Professor McGoogan said there would have to be frequent and good  
26 interaction with pathologists in another laboratory whereby there was an  
27 exchange of work between the two laboratories or at least in one direction

1 from the single handed laboratory to the other for quality control, internal  
2 quality control. Now what she was referring to there was a situation  
3 whereby on a regular basis you would have given a quantity of your cytology  
4 to the Gisborne hospital laboratory to check your work. You didn't do that  
5 did you?

6 A: No.

7 Q: Professor McGoogan said there would have to be a well documented  
8 processes and data collected for that quality control. There was none of that  
9 in your laboratory was there?

10 A: What does that mean?

11 Q: Records kept of the quality control measures taken.

12 A: Ah, no.

13 Q: None of that.

14 A: Correct.

15 Q: The third thing she mentioned was biopsy smear correlation would be  
16 imperative so that the pathologist knew that the patients that he was  
17 recommending be referred for colposcopy had been appropriately referred,  
18 that the majority of those patients did have disease, and that that biopsy  
19 reflected the disease he suspected in his smear report. Let me ask you this.  
20 What steps did you take to put in your records that you've described this  
21 morning, the results of biopsies taken from patients whose smears you read  
22 as high grade or cancerous.

23 A: If you're talking about records, apart from an entry on this card  
24 system that I had, the answer is none. If you're talking about ensuring that  
25 grossly abnormal smears were given the attention they deserved and the  
26 people concerned had the appropriate investigations, the answer is most of

1 the time I did because I talked to the doctors. When it comes to correlation  
2 between cytology and histology I can confirm that this was done.

3 Q: What records did you keep of it.

4 A: Well when I examined the histology I kept a histology record.

5

6 CHAIR INTERJECTS

7 CHAIR: Can I just ask Dr Bottrill how often did you do cervical  
8 histology?

9 A: It varied from time to time Madam but there was a reasonable amount  
10 after one of the gynecologist's here bought her own colposcope.

11 Q: And if a woman was sent to Gisborne hospital for a colposcopy  
12 examination was it the hospital laboratory that did the histology reading?

13 A: Yes it was.

14 Q: If the Gisborne hospital laboratory did a histology reading, did they  
15 send you the information as well so that you could correlation that with the  
16 cytology you might have done on the woman?

17 A: No but I could find out about it. We come to a rather strange  
18 situation here. In the past when I found a smear which I didn't like and the  
19 recommendation was for biopsy or colposcopy I would let the  
20 histotechnologist at the hospital know the name of the person so that when a  
21 biopsy came up I could be informed and I could see it and we could correlate  
22 them. Unfortunately with the Privacy Act it was interpreted extremely  
23 rigidly by the hospital authorities and it was extraordinarily difficult to get  
24 any information at all about any of their patients which was a source of  
25 considerable frustration. I have to admit that I did have ways of getting  
26 around this but they were not official channels.

1 Q: But apart from relying on a relationship you'd developed with the  
2 hospital there was no formal communication to you of the histology results if  
3 the histology was read in a laboratory other than your own?

4 A: No, none at all.

5

6 MR GRIEVE CONTINUES XXN OF WITNESS

7 MR GRIEVE: Had you thought it appropriate, you could have  
8 approached the referred GP for permission to get the patient's histology  
9 results couldn't you?

10 A: I could yes.

11 Q: Did you do that?

12 A: No.

13 Q: And did you then in the cases where you did have some information  
14 about the histology results, what steps did you take to associate that with  
15 your records of cytology?

16 A: Apart from a little comment on that index that I had of abnormal  
17 cytology, nothing.

18 Q: And I take it that, therefore, you had no ongoing statistical record  
19 available to you to give you some indication of your accuracy, based on the  
20 histology information that you were gathering?

21 A: I had no further information except that if a biopsy, for example,  
22 required more serious surgery I would probably, with a bit of luck, find out  
23 what the histology was of a cone biopsy or a hysterectomy or whatever was  
24 required. But I don't think I was in a position to demand this information,  
25 and if people didn't see fit to give it to me I did not see my position being  
26 one to ask for it.

1 Q: You see, what Professor McGoogan is saying is that in the situation in  
2 which you practised this was essential to give you some feedback on the  
3 degree of accuracy of your cytology reading. Do I take it from what you've  
4 said that effectively, for whatever reason, you were denied that opportunity?

5 A: On occasion, yes.

6 Q: Professor McGoogan also said that someone practising in the situation  
7 put to her, which was akin to yours, that they should frequently participate in  
8 external quality assurance – well, we know you didn't do any of that,  
9 correct?

10 A: That's correct, yes.

11 Q: That you should frequently attend meetings of cytologists pertaining to  
12 cervical screening. Now you didn't do that either, did you?

13 A: Well, I think I did, yes.

14 Q: What sort of meetings?

15 A: Meetings of the Society of Cytology and their workshops and slide  
16 seminars and such which they had from time to time.

17 Q: Whereabouts?

18 A: Oh! Various parts of the country. I remember them in Wellington,  
19 Tauranga, at least two in Rotorua – no, that's all I can remember at the  
20 moment.

21 Q: Are these the cytology sessions about every 2 years from 1968 to 1993  
22 referred to in para 56 of your brief?

23 A: What I was thinking of at the time when I said this was, I attended NZ  
24 Society of Cytology meetings on numerous occasions, the last being in 1992  
25 in Rotorua. Those would be the meetings of the Society of Cytology. They  
26 also, when they had visiting specialists of one sort of another, used to

1 organise these either slide seminars or lectures or so on, and I would make  
2 an attempt to attend those too.

3 Q: And the final thing that Professor McGoogan mentioned was that the  
4 laboratory should meet all external accreditation procedures and processes  
5 that were available, and we know that you didn't do that, don't we?

6 A: We do, yes. My reasons for that are in my brief.

7 Q: You knew about accreditation being available in NZ from the early 90s  
8 didn't you?

9 A: Yes

10 Q: And you were aware that your Association of Community laboratories  
11 in 1993 had passed a rule making it mandatory for members who wished to  
12 retain their membership to become TELARC accredited; you knew that  
13 didn't you?

14 A: Yes. And that is one of the reasons why we took steps to become  
15 accredited.

16 Q: Well, of course, you took some steps but never achieved it, did you?

17 A: No, we didn't. Again, I think that has been explained.

18 Q: Do I take it now that you don't dispute the value of accreditation?

19 A: My views on the value of accreditation are as I've stated before, that it's  
20 obviously valuable, but I still believe that it is more valuable in larger than  
21 small laboratories.

22 Q: You see we've heard evidence from various witnesses about this.  
23 Recently Dr de Beer from ACL told us that – and this is p1053 on 12 July,  
24 beginning line 3 – he referred to accreditation and participation in external  
25 quality assurance programmes; he also mentioned internal quality assurance  
26 programmes and went on and said: “that sort of discipline is absolutely  
27 essential for the practise of medical laboratory medicine these days, and in

1 this particular decade TELARC accreditation has become the benchmark to  
2 achieve, and if a laboratory was not intending to achieve that, I would be  
3 very concerned about the safety of the patients that laboratory was dealing  
4 with.” So, you see, that’s his opinion about these measures, and in  
5 particular TELARC accreditation. Do you accept that as being a correct  
6 view?

7 A: Oh, yes, that’s definitely the correct view in the year 2000. I can't tell  
8 you what year Dr Beere’s laboratories were, or was, accredited.

9 CHAIR: 1988.

10 A: that’s quite early on.

11 CHAIR: It’s p1052.

12 MR GRIEVE: Well, he was also talking about that answer, he referred to  
13 “this decade” – namely the 1990s. And what I’m suggesting to you is that it  
14 was well known amongst your colleagues, and I suggest well known to you,  
15 that TELARC accreditation and the associated procedures were something  
16 that should have been undertaken. What do you say about that?

17 A: I say that certainly it would have been ideal, and if I’d been thinking of  
18 continuing in practice for much longer, it would have actually been – we  
19 would have been accredited.

20

21 CHAIR: Was that because you considered it necessary or because you were  
22 aware that the Health Funding Authority was moving to a position whereby  
23 it would only contract with laboratories to do cytology if they had TELARC  
24 accreditation?

25 A: It was becoming obvious that this accreditation was going to be  
26 universal.

27 Q: Mandatory?

1 A: Mandatory, yes, or desirable (as well as being mandatory). It was a  
2 good thing, but it was not mandatory at the time when we were hoping to  
3 retire and hoping to sell the laboratory.

4 Q: You applied for accreditation but apart from putting an application in  
5 and having a visit from Mr Walker, I haven't seen much evidence of any  
6 attempt to advance the accreditation process.

7 A: No. In Dr Linehan's exhibits there is the general purpose – I can't get  
8 the right word – preliminary statements with regard to accreditation and  
9 things that were necessary for getting accreditation. I'm a bit lost for words  
10 at the moment, but we got as far as that, I started on getting some detailed  
11 methodologies ready for the cytology and histology depts but that was the  
12 point at which it looked as if we were going to be retiring very shortly and it  
13 was suggested to us by, I think it was Mr Jack who was negotiating on  
14 behalf of the CHE, that if they were going to be taking over it was a waste of  
15 time to continue.

16 Q: Yes but my understanding of your evidence, I haven't found the exact  
17 passage yet, is that the whole issue of your negotiations with the Tairawhiti  
18 CHE dragged on for some time.

19 A: It did indeed.

20 Q: No at some point in time you must have realised that it was either a  
21 matter of doing something about your laboratories accreditation or sending  
22 work elsewhere.

23 A: This was around about the 1993/1994 when we hoped that we were  
24 rapidly going to come to some kind of arrangement with them but as you've  
25 said it dragged on for another 18 months, 2 years before they finally decided  
26 not to take over.

1 Q: And in the meantime, in terms of what you did in the laboratory  
2 because you had it in mind that the laboratory was going to be sold, did you  
3 just leave it in a state of limbo in terms of maintaining it?

4 A: No not in a state of limbo but we didn't replace capital equipment  
5 unless it was really run down and was not working efficiently. Prior to that  
6 we had tried to keep our capital equipment up to date but to that extent yes  
7 we did let it run down.

8 Q: I understand you were using a domestic pressure cooker instead of an  
9 autoclave to sterilize instruments is that correct?

10 A: That's right yes. There's essentially no difference between an  
11 autoclave and a pressure cooker except of course that even the big pressure  
12 cookers are rather small compared with the gigantic ovens which are used in  
13 the big hospitals but it worked quite well.

14

15 MR GRIEVE CONTINUES XXN OF WITNESS

16 MR GRIEVE: Do I understand you to say that you left the dealings  
17 with the TELARC people and in relation to accreditation largely to Mr  
18 Reeve?

19 A: Yes.

20 Q: But you must accept that you had a responsibility in that area as well  
21 don't you?

22 A: I do yes.

23 Q: Because of course had you got accredited, that would have imposed  
24 standards upon your methods of practice too wouldn't it.

25 A: Yes.

26 Q: Are you aware of Mr Reeve's evidence that in his opinion your  
27 laboratory and the standards of it ...

1

2 MR HODSON INTERJECTS

3 MR HODSON: Not Mr Reeve.

4

5 MR GRIEVE CONTINUES XXN OF WITNESS

6 MR GRIEVE: Sorry Mr Walker's evidence that your laboratory and  
7 it's standards were one of the worst that he had ever seen on his preliminary  
8 inspection in 1994?

9 A: Yes I was very surprised to read that recently. It's a pity he couldn't  
10 have told us.

11 Q: So are you saying that you had no knowledge of that.

12 A: Certainly no knowledge of that no. He did give us a letter saying  
13 some of the things he thought would be required before we could become  
14 accredited.

15 Q: You knew didn't you that lack of TELARC accreditation had a  
16 negative effect on your laboratory in that the Tairawhiti hospital laboratory  
17 would not send you any cytology because you weren't accredited.

18 A: I don't think those two things are connected. I would never have  
19 expected to receive any cytology from the hospital.

20 Q: Well Mr Morris told you that when the occasion arose that required  
21 them to send cytology out they sent it elsewhere, not to your laboratory  
22 because you were not TELARC accredited, did you know that?

23

24 MR HODSON INTERJECTS

25 MR HODSON: He told the inquiry ma'am, he never told Dr Bottrill  
26 that.

27 CHAIR: No I think it was a slip of the tongue by Mr Grieve.

1

2 MR GRIEVE CONTINUES XXN OF WITNESS

3 MR GRIEVE: You heard that evidence, it was drawn to your attention  
4 was it doctor?

5 A: Yes I don't know if it's right or not.

6

7 CHAIR INTERJECTS

8 CHAIR: My understanding of Mr Morris' evidence was that the  
9 Gisborne laboratory would have lost it's accreditation from TELARC if it  
10 had sent it's work out to be done at a laboratory that was not also TELARC  
11 accredited. Where you aware of that?

12 A: No I wasn't.

13

14 MR GRIEVE CONTINUES XXN OF WITNESS

15 MR GRIEVE: Do you say that notwithstanding your almost daily  
16 visits to the hospital laboratory which you refer to in your brief of evidence,  
17 you were never told by anybody there that you weren't getting any work  
18 from them because you weren't accredited?

19 A: Absolutely not.

20 Q: Now you refer in your brief to preparing some documentation for  
21 accreditation, this is at paragraph 48 of your brief. You commenced work  
22 on some of the documentation.

23 A: Yes.

24 Q: Now we've had produced by Dr Linehan in a supplementary book of  
25 exhibits and we'll get you to look at that if you would please as pages 1  
26 through to 64 of the supplementary exhibit.

27 A: Yes.

1 Q: What we're told is a draft quality manual.

2 A: Yes.

3 Q: Did you have any role in preparing that.

4 A: Not much no. I had a role in the part at the end where they are  
5 talking about accidents and treatment for various things which are likely to  
6 occur which I don't really remember. But for the technical part of it, no.

7 Q: However you say not much, you were obviously aware that it was  
8 being prepared.

9 A: Oh yes.

10 Q: By Janet Wilson.

11 A: And Mr Reeve.

12 Q: What in 1994?

13 A: I'm not sure when they started. Probably earlier than that I would  
14 think. It took a long time to do as a part-time activity.

15 Q: It's apparent from this document that, although it's in draft, there was  
16 going to be it would appear, a laboratory manager, a quality manager, a  
17 technical manager and that those people were going to have specialist  
18 qualifications as a pathologist.

19 A: Oh no.

20 Q: So what was this –

21 A: Not as a pathologist.

22 Q: What was this a sort of a wish list was it?

23 A: No these people are not supposed to be medically qualified.

24 Q: Well if you look please - We will go to the page and have a look at  
25 the – look with me first at p9, you'll see it's been number stamped in the top  
26 right hand corner.

27 A: Yes.

1 Q: And you'll see down in the chain in the organisation chart there there's  
2 going to be a Laboratory Manager, Pathologist and laboratory Manager are  
3 owners, and under that there's going to be a Quality Manager and a  
4 Technical Manager; do you see that?

5 A: Yes.

6 Q: Now first of all, on this organisation chart you were the pathologist  
7 weren't you?

8 A: Yes.

9 Q: and then across to one side there's the laboratory manager, was that Mr  
10 Reeves?

11 A: Yes.

12 Q: And then below him, or reporting to him I assume from the lines that  
13 we see there, was the technical manager; see that?

14 A: Yes.

15 Q: Turn over the page if you would to para 3.3.2 and you'll see that the  
16 technical manager had to be either a registered pathologist or a medical  
17 laboratory scientist, correct?

18 A: Yes.

19 Q: In 1993 or 1994 when this document was being prepared did you have  
20 anybody in that position?

21 A: No, I don't think so. We'd filled the other two, obviously.

22 Q: So this was a proposal was it?

23 A: Yes.

24 Q: Then you see on the –

25 MR HODSON: We can save much time later if my friend directs the  
26 witness's attention to the footnote at the bottom of page [inaudible]

27 A: Oh, yes.

1 MR GRIEVE: You will see that there's a reference on p9 to quality  
2 manager, see that?

3 A: Yes.

4 Q: And on p11 the quality manager was supposed to be, or would be, it was  
5 envisaged it would appear, a registered pathologist or medical laboratory  
6 scientist; see that?

7 A: Yes.

8 Q: Now the quality manager, in fact, isn't referred to in the footnote that  
9 Mr Hodson seems to rely on. Did you have a quality manager at the time?

10 A: Now, that is, I think, in here somewhere. I'm not quite sure at the  
11 moment. You can probably tell me what the designation of Janet Wilson  
12 was in this preparation. She probably fulfilled that position – quality  
13 manager, JA Wilson.

14 Q: Where's that, doctor?

15 A: Page 5.

16 Q: So what were her qualifications?

17 A: She was a qualified medical laboratory technologist. I can't remember  
18 what her specialist qualification was, I think it was in haematology.

19 Q: Now it's also apparent from this material, and if you look at p64  
20 through to 69, you'll see that the first document is a memorandum from a  
21 person by the name of Shurich in Hamilton Medlab to Dr Linehan, but let  
22 me ask you this first of all: Have you had this documentation shown to you  
23 before?

24 A: Yes.

25 Q: The attached action plan appears to be Hamilton Medlab's assessment  
26 of what was required to achieve accreditation, were you aware of that?

1 A: I think – I mean, I can't tell what was in the mind of the person who did  
2 this.

3 Q: I accept that.

4 A: But it would appear to be the steps which they were proposing to make  
5 to tie the Gisborne Medlab in with the Hamilton one.

6 Q: The fact is, I suggest to you, that it's quite apparent from this  
7 documentation that Hamilton Medlab regarded it as a lengthy task to get  
8 your laboratory, which you'd just transferred to them, up to TELARC  
9 accreditation standard. Do you accept that that was the position?

10 A: I'm not sure that I read that into it. It was obviously a complicated  
11 business to integrate the running of the two laboratories at a distance of  
12 goodness how many kilometers. I'm prepared to accept that it's to do with  
13 TELARC accreditation, if you can show it to me, but otherwise I think it's  
14 just changes that they wanted to make once they took the laboratory over.

15 Q: All right. There's been some dispute about the meaning, and it will be  
16 for the Committee of Inquiry to make its mind up what it takes from the  
17 document, but did you see the reference to the moving of your laboratory  
18 from the 60s into the 90s in one of the memoranda?

19 A: Yes, that was rude, wasn't it?

20 Q: I beg your pardon?

21 A: That was rude.

22 Q: Did you take that to be a reference to the need to bring your laboratory  
23 from 60s quality to 90s quality?

24 A: I was rather surprised at that. Mr Warren was trained at the Gisborne  
25 Hospital while I was there. I don't quite know why he would make a  
26 remark of that sort. I noted it but you don't expect me to agree with it, I  
27 hope.

1 Q: Well, the first question is, did you take it as being a reference to the  
2 standard of the laboratory?

3 A: Yes.

4 Q: And obviously it was Mr Warren's expression of opinion that this  
5 documentation that I referred you to was the sort of work necessary to get  
6 your laboratory from the 60s into the 90s, would you agree with that?

7 A: I have no way of knowing what he meant by that.

8 Q: All right. Now I've already asked you about the statements made by Dr  
9 McGoogan as to internal quality control. Do understand what you regarded  
10 as internal quality control was a process whereby you read 10% of all smears  
11 that you had reviewed?

12 A: Yes, that was the recommended procedure at that time.

13 Q: And you did that by selecting the smear numbers ending in a zero, is  
14 that right?

15 A: Yes

16 Q: Did you keep any records of that procedure?

17 A: No. No-one else would have been interested.

18 Q: You think that's a justification for not keeping records do you?

19 A: Well, yes I do, especially in things of this sort where all you're doing is  
20 checking.

21 Q: But if you didn't keep records, you wouldn't have the ability to look  
22 back, say 3 months hence, on results would you either?

23 A: I don't follow you.

24 Q: Well let me just start by asking you this. How often did you engage  
25 in this 10% review of smears?

26 A: Well purely for my own convenience, I put the smears I was going to  
27 look at again on one side as I've explained, that the arbitrary method I use

1 for deciding which ones was the ones with the zero at the end, put them in a  
2 slide tray and when I got to 10, I would sit down for a while on afternoon  
3 when I wasn't otherwise engaged and go over them again.

4 Q: So that would be about once a week would it.

5 A: Yes.

6 Q: And you would have the zero ending numbers in a tray and you  
7 would simply look at them again, putting them on the microscope and  
8 reviewing them?

9 A: Yes.

10 Q: Did you have with you the report form.

11 A: No. I would have waited until I found some abnormality and look it  
12 up to see if I had seen it before.

13 Q: So you –

14 A: Incidentally the serious abnormalities were excluded from this.

15 These were apparently normal or non neoplastic or briniaplastic?? smears,

16 Q: Right you kept the abnormalities separate but we're looking at slides  
17 then that you thought or you had originally read as normal is that right?

18 A: Yes non neoplastic.

19 Q: But you didn't compare on your second review against what you had  
20 the result of your original review did you?

21 A: No.

22 Q: And do I take it that at the end of this process every week or so, you  
23 simply looked but recorded nothing.

24 A: Correct.

25 Q: That would be a convenient time Madam Chair.

26

27 CHAIR REPLIES

31/07/00

B/3115

1 CHAIR: Very well we'll adjourn until 2:15

2

3

INQUIRY RETIRES UNTIL 2:15 P.M.

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INQUIRY RESUMES AT 02:18 P.M.

MR GRIEVE CONTINUES XXN OF WITNESS

MR GRIEVE: [recording missing] smear that in your opinion you had incorrectly read first time around?

A: The short answer to that question is no. I do however recall occasions when having reviewed the smear I might have made a slightly different report, for example I might have on the first time accepted a degree of inflammation which I would not have done when I went back but nothing from the point of view of normal to neoplastic.

Q: Well how would that work if when you were conducting this review of one in every ten you did not have with you your original reports?

A: I can't see it would have made any difference. When you find an abnormality you have a look and see what you would have said the first time.

Q: Yes but what I'm asking you about is whether you recall any occasion on your re-read of your 1 in 10 normals that your original read had been, you would have changed, and you said well no except for perhaps a change with regard to inflammation and my question to you is having earlier told us that when you were doing this 1 in 10 review you did not have with you the details of your original report, how are you now able to say that you would have or you can recall occasions when the report would have been different?

A: Well if you look at a smear and it's normal, I certainly didn't go back to see if I'd called it normal the first time. If however I found it abnormal or I had any question in my mind about it, then I would go back to the old one. I didn't routinely have the two side by side at all times.

1 Q: So were there occasions when you went back to the old, wait a  
2 minute, lets be careful here, it wasn't an old smear, it was the original report  
3 on the same smear wasn't it.

4 A: Yes that is what I was talking about.

5 Q: So there were occasions when you would as a result of your review  
6 operating group back to the original report.

7 A: Yes.

8 Q: And on those occasions did you ever find that a smear that you had  
9 originally reported as normal was in fact abnormal to some degree?

10 A: I don't recall any such occasion.

11 Q: Would you look please at this document that's now going to be shown  
12 to you. Madam Chair it's a new copy of Mules 43 which was the one where  
13 there was a question about the signature if you recall.

14

15 CHAIR REPLIES

16 CHAIR: Is this a document that makes it clearer what the situation is  
17 there?

18 MR GRIEVE: Yes it does Madam Chair and it's referred to in Dr  
19 Bottrill's evidence at paragraphs 49 & 50 in his brief.

20 CHAIR: Right.

21 MR GRIEVE: So I suggest that this be gives perhaps Mules 43A or B.

22 CHAIR: Yes that's a good idea. Madam Registrar make this Mules  
23 43A.

24

25 MR GRIEVE CONTINUES XXN OF WITNESS

1 MR GRIEVE: Now Dr Bottrill you'll see that, well first of all let me  
2 see if I can shorten it, this document has been shown to you by your Counsel  
3 relatively recently hasn't it.

4 A: Yes.

5 Q: And you will now then know that you have made the declaration on  
6 the last page at Gisborne on 12 May 1993?

7 A: Yes.

8 Q: You say in your brief that you now have no recollection of signing  
9 that document, tell me this though, was it your practice at the time when  
10 signing documents like this to read them through before you signed?

11 A: Yes.

12 Q: So is it fair to assume that when you signed, you were familiar with  
13 the contents?

14 A: Yes.

15 Q: And would you look please then at the third page in from the back  
16 which, it's a page headed about your quality see that?

17 A: Yes.

18 Q: Now although you mightn't have remembered it until shown it  
19 recently, from your recent look at the document it's apparent isn't it that this  
20 was a questionnaire sent out by Midland Health seeking information about  
21 your laboratory operation and you probably assume that it was sent to all  
22 laboratories in the Midland area wouldn't you.

23 A: I would think so yes.

24 Q: And so in that connection it was asking about your quality wasn't it?

25 A: Yes.

1 Q: And tell me this, you've talked about in your brief and we've already  
2 referred to it about the professional meetings that you attended, paragraph  
3 56, did Mr Reeve attend such meetings with you.

4 A: No.

5 Q: So where this document refers to attendance at meetings, that must be  
6 a reference to you must it?

7 A: I can't at this time recall what meetings he might have attended and  
8 what meetings he didn't attend. He would have certainly attended the  
9 annual meetings of the technologists.

10 Q: Right. It talks about as you will see, internal and external quality  
11 control programmes/regular review meetings. That would be a reference to  
12 your activities wouldn't it?

13 A: The laboratory this is.

14 Q: Sorry.

15 A: Their talking about the laboratory not me personally.

16 Q: So are you saying that statement refers to Mr Reeve's activities and  
17 not yours?

18 A: No I'm saying it's the laboratory.

19

20 CHAIR INTERJECTS AND XXN WITNESS

21 CHAIR: Perhaps we could deal with it this way Dr Bottrill, it has been  
22 ticked at paragraph 3.3 where the question has been asked do you have a  
23 quality review system, this may include a combination or selection of peer  
24 review, service audit, quality circles, review meetings and someone from the  
25 laboratory has ticked yes and then when you've been asked to list the key  
26 features of the system it says internal and external quality control

1 programmes regular review meetings. Now could you say please who  
2 attended the regular review meetings and what were they in respect of?

3 A: At this time I have difficulty in remembering exactly what they were.  
4 I suspect these meetings were between Mr Reeve and myself and between  
5 the heads of the depts concerned regarding the quality control in hematology  
6 and biochemistry which were the two dept we felt were most likely to cause  
7 trouble.

8 Q: What were the external quality control programmes that the  
9 laboratory participated in?

10 A: In biochemistry there's this one Liburas Wellcome which later  
11 became Murex. In hematology there was one the name of which I don't  
12 remember but it was supplied by the manufacturers of the hardware. For a  
13 long time the national health institute used to send out samples for  
14 microbiology testing and also serology testing of various things. Again I'm  
15 just a bit vague on the details now.

16 Q: What were the internal quality control programmes that the laboratory  
17 had in force?

18 A: Now those were associated with averages for apparently normal  
19 results.

20 Q: Of what department?

21 A: Well, biochemistry, haematology, to some extent microbiology, although  
22 it's more difficult to assess. If we found, for example, that we were making  
23 far fewer isolations of gonorrhoea than we had been, we'd wonder if our  
24 culture media were going off and we would take steps to check that.

25 Q: So the internal and external quality control programmes that are  
26 referred to in this document relate to departments in the laboratory other  
27 than cytology, is that correct or not?

1 A: Yes, this answer is concerning the laboratory. Histology and cytology  
2 were already my province and nobody else was really interested.

3

4 MR GRIEVE: So, you are saying, are you, that these answers relating to  
5 quality plans, quality review system, had no application to your department,  
6 have I got that correctly?

7 A: Well, we have already talked about the question of internal/external  
8 quality control for cytology, haven't we?

9 Q: Well, I understand that, but do I take it that in signing this document, as  
10 you've acknowledged, these answers were not intended to cover cytology or  
11 histology, is that right?

12 A: I don't really know.

13 Q: You can't tell at this stage?

14 A: I would think that – no, I can't tell at this stage, it was filled in mostly  
15 by Mr Reeve and he is the laboratory manager who would be talking about  
16 the laboratory.

17

18 CHAIR: So he would be talking about the things more in his province and  
19 histology and cytology were solely your province.

20 A: I think that is probably right.

21 Q: He's likely to be talking about the other laboratory departments?

22 A: Yes.

23

24 MR GRIEVE: Does the same apply to the answers over the page, 2.4 and  
25 2.5, where you are asked to list the key quality indicators you currently  
26 measure, accuracy and precision.

1 A: Yes. Again, particularly the sort of things you can measure, where you  
2 can measure the accuracy and precision.

3 Q: So, do you say that that wasn't intended to relate to cytology?

4 A: I very much doubt if the question of cytology came into anybody's  
5 consciousness when this was being filled out.

6 Q: What about –

7 A: this was a questionnaire about what we did in the laboratory and that's  
8 what we answered.

9 Q: Well, of course, that would cover cytology, though, wouldn't it, because  
10 you were doing that in the laboratory?

11 A: Well, yes, I know that now, but I don't think that we thought  
12 specifically of a particular sphere in which we did more quality control or  
13 less quality control than others.

14

15 CHAIR: How much, when you look at the laboratory work, how much time  
16 did histology and cytology take up in comparison with the other work done  
17 by the laboratory? I know you were the one solely working on  
18 cytology/histology, but just so I can get a clear picture of the way the  
19 laboratory worked, I know that there were a number of staff members doing  
20 other things – where was the bulk of its work being done?

21 A: The large majority of the work was done in the haematology and  
22 biochemistry departments, and also perhaps microbiology.

23 Thank you.

24

25 MR GRIEVE: When you signed this declaration did you realise that at para  
26 2.2 you were stating that application had been made for TELARC  
27 accreditation?

1 A: Yes.

2 Q: You realise now that that statement is incorrect, don't you?

3 A: Taken literally yes. We had, however, made steps towards  
4 investigating TELARC accreditation and we expected that that would be  
5 correct in the very near future. So I didn't correct it.

6 Q: So when you signed it you knew what steps had been taken, did you?

7 A: I expect so. I must have done, yes.

8 Q: Because we have it from Mr Walker and his exhibit 2, that it would  
9 appear that all that had been done at the time you signed this declaration was  
10 that some sort of enquiry had been made for information. Did you know  
11 that to be the position at the time?

12 A: I recall that there had been various phone calls and I think one letter  
13 regarding enquiries re TELARC accreditation, yes.

14 Q: Well, you see the first letter that we have is one from Mr Reeve to  
15 TELARC dated 14 June 1993, which is a month or so after you signed this  
16 declaration. Did you know that all that had happened prior to your  
17 signature was that there had been some telephone calls?

18 A: I have no idea. I think I must have done that.

19

20 CHAIR: In your was the making of telephone calls about TELARC  
21 accreditation the first step towards applying for accreditation? In other  
22 words, once you made the phone calls to find out about it, in your mind, in  
23 Mr Reeves mind, did you already see yourselves as starting off the  
24 application process for accreditation?

25 A: We were on the way to it.

26 Q: You were on the way to it, yes.

27

1 MR GRIEVE: Someone from Midland Health reading your answer might  
2 have thought that you were somewhat further down the track and that you'd  
3 actually made application, mightn't they?

4 A: Yes.

5 Q: Now you've told us this morning something about your system. One  
6 of the issues that was covered was the question of the smears that you  
7 arranged or contracted to have read by Dr Padwell, and you said that you  
8 simply made the arrangement to have him read them and were unaware of  
9 the means that he was going to employ to carry out that task. Am I right that  
10 when he read those smears for a 5 wk period that you told us about this  
11 morning, when you got back you took no steps to review his work?

12 A: That's correct.

13 Q: So does that mean that you did not subject that work to a 10% review?

14 A: Now that I can't remember. I think probably not.

15 Q: Why not?

16 A: Because I think he was responsible for the reports that he put out. I  
17 wouldn't expect somebody else to go over what I'd been doing if I was  
18 doing it for them. Especially on a long term basis like that.

19 Q: Well of course that goes right against the Dr Medley two pairs of eyes  
20 and two brains view of things doesn't it?

21 A: We've already said that we can't double check all the specimens, we  
22 couldn't then and I don't think we can now. It would double the time  
23 involvement for testing and probably – oh I don't know – in those days

24

25 MR HODSON INTERJECTS

26 MR HODSON: Something wrong with Dr Padwell's reporting, I don't  
27 quite see what effect Dr Bottrill reviewing it would depend on anything.

1 CHAIR: Well we don't know and I mean we don't know to what degree  
2 the slides read by locums were under-reporting because the Sydney re-read  
3 went through all the slides and the other thing is it's really looking at the  
4 practices being followed in the laboratory and whether or not there was an  
5 adherence to a practice which involved random screening 10% of the slides.

6

7 CHAIR CONTINUES XXN OF WITNESS

8 CHAIR: Dr Bottrill did you think that without the approval of a  
9 colleague such as Dr Padwell who was reading slides for you that it  
10 wouldn't have been appropriate to rescreen slides that he had read. Did you  
11 feel inhibited in that way?

12 A: I wouldn't put it as strongly as that but I don't think it was – I  
13 wouldn't expect somebody else to do that to me.

14 Q: Right so was it something you felt uncomfortable about doing would  
15 that be a way of describing it.

16 A: I think I would have done yes.

17 Q: You would have felt uncomfortable about it.

18 A: Sorry to keep saying I think but it's a little difficult at this stage to be  
19 certain what I was thinking 7 years ago.

20 Q: And certainly you'd never discussed with Dr Padwell the possibility  
21 of you rescreening a random selection of his slides.

22 A: No he was a colleague, I trusted him to look at the slides.

23

24 MR GRIEVE CONTINUES XXN OF WITNESS

25 MR GRIEVE: You said that at around 1989 or 1990 you began to  
26 utilise a computer for cytology and that by the time of the sale of the

1 laboratory that would bring up patient identification details plus cytology  
2 number and so forth.

3 A: Yes.

4 Q: And you went on to say that at the end of 1995 if you got an abnormal  
5 report you could go back and review earlier smear reports is that right?

6 A: Yes.

7 Q: When did you begin the process of loading smear reports into this  
8 computer database?

9 A: Well I started this particular programme about 1992 I believe but I  
10 had had a rather simpler system going before that and by the time I retired I  
11 could recall records back to 1990.

12 Q: So does that mean that at some point you loaded historic information  
13 onto the computer database?

14 A: I transferred files from one medium to another which is not quite the  
15 same thing.

16 Q: Well if you began loading data in 1992, then presumably that began  
17 with current reports as they were completed.

18 A: Yes.

19 Q: But if as you say by the time you retired you could look back as far as  
20 1990, it means that at some point you went and loaded historic data from  
21 1992 backwards through to 1990 doesn't it.

22 A: No what I said was we had a simpler system earlier with information  
23 on the database but in a slightly different format and I could only look at one  
24 year at a time under that. What I did later was to transfer them to the new  
25 programme in such a way that I could if I needed to go right back to 1990.

1 Q: I see. So does that mean that once you had achieved that  
2 programming function you were able to accept all smears that you had read  
3 going as far back as 1990 and forward from there?

4 A: In theory at least I'm pretty sure we could.

5 Q: Well once you had this system up and running at some point what in  
6 1995 was it?

7 A: Yes.

8 Q: If you had all the records on the computer going back to and  
9 including 1990 what was the need to maintain your manual card index  
10 system?

11 A: Well as I've said before the copies of the reports had to be kept  
12 anyway and it was much easier just to refer to the hard copy than it was to go  
13 into the computer and get all this stuff on a day to day basis.

14 Q: So does that mean that despite the computer system your preference  
15 was to revert to the manual system for looking back on historic smears?

16 A: Yes I'm beginning to wonder why I bothered to archive all that  
17 material.

18 Q: Well there was a very important purpose behind it wasn't there, or  
19 there ought to have been.

20 A: Well as you've said the manual technique was obviously working  
21 quite well and I could check on names and I could check on numbers.

22 Q: Well let me just ask you about the manual technique. Janet Wilson  
23 has told us that the manual records were filed alphabetically on a year by  
24 year basis is that correct?

25 A: Yes.

1 Q: So that if patient A came in at the beginning of any given year and  
2 then came back again at the end of the same year, one would expect to find  
3 in that year's box her record for the original smear correct?

4 A: Yes.

5 Q: But of course the cycle assuming no abnormality was intended to be 3  
6 yearly wasn't it?

7 A: Yes.

8 Q: So with a manual filing system in the way you've described, if patient  
9 A came in in 1990 and again in 1995, and she had had in 1994 an abnormal  
10 smear, by what process would you have looked up her earlier smear in 1990?

11 A: Well, you go back to the 1990 file and look it up.

12 Q: But how would you know that she'd had a smear in 1990?

13 A: I suppose you wouldn't unless the doctor said so.

14 Q: Exactly, so what system did you have to tell you, independent of what  
15 either patient or Dr might tell you, that you held a woman's smears over a  
16 period of years?

17 A: Nothing.

18 Q: Nothing.

19

20 CHAIR: Were you getting any computer printouts from the screening  
21 programme Registry recording a woman's smear history?

22 A: No.

23

24 MR GRIEVE: Did you realise the shortcomings of your manual system  
25 doctor?

26 A: Not in so many words, no I didn't.

1 Q: If you couldn't look back, if there was no record of a woman's history  
2 over a period of years, what was the point of keeping those records?

3 A: I do agree with you, it could be argued that there wasn't any. It's a god  
4 old laboratory custom to maintain records that go back a long time.

5 Q: the purpose of it, doctor, was to enable you to look back on a woman's  
6 history and you were required, in order to do that, to maintain a system –  
7 manual or otherwise – which enabled you to look back, surely?

8 A: Yes, this has only just occurred to me that there is this disadvantage in  
9 the system I had.

10

11 CHAIR: Dr Bottrill, my understanding is that you filed the patients records  
12 alphabetically according to the year in which their smear was read by you.

13 A: Correct, ma'am.

14 Q: so if you were reading a smear in 96 for a woman and you did want to  
15 look back at past records, there was the very cumbersome process by which  
16 you could have just gone to each year and looked for the woman's surname,  
17 and provided the surname hadn't changed and you had read her smear in the  
18 past, you ultimately would have come to the record would you or not?

19 A: It's not so cumbersome, no, because with a mere 5,000 smears/year, a  
20 year would occupy two file cabinet drawers. So if you wanted, say, A-L  
21 and K-Z, and you wanted to go back 3 years you only had to look in 3  
22 drawers.

23 Q: My understanding of looking at patient records from the weekend, there  
24 was one patient, the first patient we saw, she seemed to have had a smear  
25 ever year whereas others had them 3 years and others had them at greater  
26 different, varying intervals. So it wasn't as if you could automatically  
27 assume, because I've got a smear for 1996 it's a matter of going to the year

1 1993 and if this patient came to me before she'll be there, was it? In other  
2 words, there is variation?

3 A: Oh, yes.

4 Q: And because of that variation did you, as a matter of practice, regularly  
5 go back through all the years to see whether or not a patient's name  
6 appeared in one of those years or did you just focus on the current smear that  
7 you had to read?

8 A: No, I focused on the current smears. Again retrospectoscopes come  
9 into it. I thought that what I was doing was adequate for the job in hand.

10

11 MR HODSON: Ma'am, I'm very concerned unless an impression which  
12 isn't accurate be given, and I know my friend won't much enjoy my saying  
13 this, but I would like to say it. The manual system as I understand the  
14 evidence was a backup. If you wanted to look back, and certainly the last 6  
15 years of the practice I think his primary resort was to the computer which  
16 gave it to him.

17 CHAIR: Well, we don't know that. That's not the way the evidence is  
18 coming out, Mr Hodson, and it will have to be explored.

19 MR HODSON: I thought he said that this morning.

20

21 MR GRIEVE: This manual system Dr Bottrill, if you were to look back on  
22 a woman's smear history over a period of years, depended for its operation  
23 on your memory, didn't it?

24 A: In what way?

25 Q: Well, who else knew from personal knowledge whether there were  
26 smears going back over a period of years?

1 A: Well, the computer knew and the filing cabinets knew. I could refer to  
2 either of those.

3

4 CHAIR: I think the evidence is you've got a whole filing cabinet,  
5 everything's filed by the year, you just simply go through each year.

6 MR GRIEVE: Right.

7 CHAIR: It's a question of whether you take the time to do it, but it can be  
8 done.

9 MR GRIEVE: Exactly.

10 A: There's not a great chore.

11 MR GRIEVE: But you've just said you didn't take the time to do it, did  
12 you?

13 A: Have I?

14 Q: That's what you said to Madam Chair a minute ago.

15 A: I think we must have some misunderstanding here, I'm not quite sure  
16 where we are.

17 Q: I wonder Madam Chair –

18 A: I said I didn't take the trouble to go back? – no. This sounds awful,  
19 Madam Chair, but what did I say?

20 CHAIR: Well, Madam Registrar, what is the situation with the transcript?

21 MR HODSON: Rather than do that process which involves at least the  
22 stress of being thought one is being caught out, it would be more appropriate  
23 I suggest if we just get him to – Dr Bottrill just to re-state what he did as  
24 clearly as he can.

25 CHAIR: The problem is that if it's going to vary all the time, the committee  
26 isn't going to know what version to rely on, that's the problem. Dr Bottrill,

1 when you were reading smears for a patient, did you at all go back and look  
2 at their past history?

3 A: No.

4 Thank you. That was the answer I got before. We got it again. I think we  
5 will only get confusion if we keep on this area.

6

7 MR GRIEVE: I accept that Madam Chair. Dr Bottrill, can you just  
8 describe for me, please, the method you employed to screen a cytology  
9 smear?

10 A: The method I employed?

11 Q: The method you employed to screen a smear.

12 A: Right. You place the slide in the microscope with the label to the  
13 right. You then used to go to the bottom right, which on the microscope  
14 looked like the top left, went along the slide, down and back again in a –  
15 what do you call it, not “S”, but –

16 CHAIR: Z?

17 A: Yes, fashion, until I came to the opposite corner, or end.

18 MR GRIEVE: You've said –

19

20 PROFESSOR DUGGAN: Excuse me. Dr Bottrill what did you do then?  
21 Is that how you screen the slide?

22 A: Used the length of it and then down one field and then back again,  
23 down one field and back again.

24 Q: And how many times did you do that?

25 A: Oh, until I came to the other side of the slide.

26 Q: Is that how you screened the slide?

1 A: The length of it and then down one field and back again, down one  
2 field and back again.

3 Q: And how many times did you do that?

4 A: Till I came to the other side of the slide.

5 Q: Do you use a microscope stage?

6 A: Yes.

7 Q: OK.

8

9 MR GRIEVE CONTINUES XXN OF WITNESS

10 MR GRIEVE: You've referred in your evidence to the text book Cox.  
11 I want to show you some material from that text book. This is Cos on  
12 diagnostic cytology. It's the 2<sup>nd</sup> edition which is 1968 and you will see if you  
13 turn over the pages from the coversheet that I've had photocopies part of  
14 chapter 26 which deals with the screening and marking of smears do you see  
15 that?

16 A: Yes.

17 Q: And you'll see there that it describes the process for the correct  
18 screening of smears, Cos seems to recommend that you screen up and down  
19 the narrow width of the slide, or you screen up and down the vertical access  
20 rather than along the horizontal. Are you aware of any reasons why one  
21 should be preferred to the other?

22 A: I'm not now.

23 Q: Who taught you screening method?

24 A: Well a doctor whose name I can't remember in Leeds.

25 Q: And were you taught the importance of making sure that you viewed  
26 all available cellular material by making sure that when you move the stage

1 or the slide on the stage, that the fields overlapped? Were you aware of  
2 that?

3 A: I don't recall that.

4 Q: Well if you didn't ensure that the fields overlapped as you moved the  
5 slide, you could miss cellular material couldn't you.

6 A: That's possible .

7 Q: Do you accept that from the procedure you employed that you might  
8 have done that?

9 A: Again it's possible.

10 Q: Now somewhere and I can't remember it but I have read just recently  
11 and I'll ask you about it and it's undocumented, there is something in the  
12 literature which we've had that says that there is an optical reason why it is  
13 preferable to screen a slide vertically rather than horizontally, do you know  
14 anything about that?

15 A: No I'm sorry I don't know anything at all about that.

16 Q: You'll see –

17

18 CHAIR INTERJECTS

19 CHAIR: Mr Grieve it's in Cos, 26 it says although some individuals  
20 prefer to screen cytological slides horizontally this procedure may produce  
21 visual fatigue.

22 MR GRIEVE: I must be having visual fatigue it's right before my eyes.

23 Yes.

24

25 MR GRIEVE CONTINUES XXN OF WITNESS

26 MR GRIEVE: Incidentally doctor when you said you'd read Cos –

1 A: I didn't mean I'd read Cos, I meant that I referred to it as a reference  
2 book.

3 Q: Right. Do you recall seeing this chapter on screening before?

4 A: I don't think I've ever read it.

5 Q: Right. Now it also if you look at the right hand column on the first  
6 page emphasises the importance of marking slides, facilitating examination  
7 of the same cell or groups of cells on numerous occasions or by several  
8 observers you see that, bottom right, right hand column?

9 A: Yes.

10 Q: You didn't mark any abnormalities on your smears did you?

11 A: No.

12 Q: Because you thought that would be a waste of time because no-one  
13 else was going to be looking at them, was that the rationale?

14 A: Not really no because I started doing this job long before Cos had  
15 written this chapter I suspect and seeing I was unaware of what he said I  
16 didn't see any reason to alter what I was doing.

17 Q: Well I mean you were, this 2<sup>nd</sup> edition is 1968 but also have a look at  
18 paragraph 26 on page 7 of your brief would you mind. The very bottom of  
19 the reference 26 IIII, I did not mark abnormal slides as such, there was no-  
20 one who would see such marks?

21 A: Yes.

22 Q: So that is why you didn't take that step isn't it?

23 A: Yeah I guess so.

24 Q: Looking at it now, do you agree with the statement in Cos that "the  
25 importance of proper screening of slides hardly needs to be emphasised".

26 A: Well that self-evident yes.

1 Q: Do you agree also that it is important in screening a smear properly to  
2 look at all available cellular material on the slide?

3 A: Obviously the more you look at the more likely you are to find an  
4 abnormality.

5 Q: If you're going to do the job properly each cell available to be viewed  
6 should be viewed shouldn't it?

7 A: Well that's the theory of it but it never happens.

8 Q: Well it certainly doesn't happen if you don't coverslip all the material  
9 does it?

10 A: No.

11 Q: And we've heard from Dr Farnsworth that it was necessary to  
12 recoverslip approximately 50% of the smears that their laboratories  
13 examined because there was additional material available to be reviewed  
14 that hadn't been covered. Did you appreciate that?

15 A: Yes I've read that.

16 Q: Do you accept that that was a proper course to follow?

17 A: Well if they felt the necessity to examine more of the smear than I  
18 had done it would be yes.

19 Q: Did you not consider that you should have taken that step when you  
20 did the original screening?

21 A: No we just routinely put on coverslips when we had them available  
22 we put on the 50 mms ones, when they weren't I put on the 40 ones, I didn't  
23 try and put two coverslips on one slide no.

24

25 CHAIR ADDRESSES MR GRIEVE

26 CHAIR: Mr Grieve Dr Farnsworth's evidence was that by  
27 recoverslipping it wasn't as if abnormal material which wasn't obvious

1 under the original portion of the slide was suddenly revealed, that there was  
2 abnormality across the whole slide so if it had been the contrary, this point  
3 would be very worthwhile pursuing but as it stands it really doesn't take  
4 matters that far for our purposes.

5

6 MR GRIEVE CONTINUES XXN OF WITNESS

7 MR GRIEVE: Following on from that Dr Bottrill, have you heard Dr  
8 Farnsworth's evidence about the appearances of the abnormalities that she  
9 saw, that her laboratory saw, drawn to your attention?

10 A: Yes.

11 Q: Putting it generally, and leaving aside her description in para 22 of her  
12 brief, but she said that "with a large number, albeit unquantified of the  
13 smears that she saw, the abnormalities were obvious and there to be seen."  
14 Do you now dispute that in any way?

15 A: No, I don't.

16 Q: and I suggest to you that if the abnormalities that she saw were obvious  
17 to be seen by her, they were there and equally obvious to be seen by you.

18

19 CHAIR: Well, Mr Grieve, we don't know that they were the slides that Dr  
20 Bottrill read as normal. One of the problems with para 22 of Dr  
21 Farnsworth's evidence is that she says that she saw slides that were very  
22 blatantly abnormal. She does not go on to say that these slides had been  
23 read as normal by Dr Bottrill; they may very well be the high grade slides  
24 that he read as well – we don't know, so I don't think that's a fair question to  
25 put to him.

26 MR GRIEVE: I will deal with it another way.

27 CHAIR: Very well.

1

2 MR GRIEVE: Do you recall the four smears reviewed and the subject of  
3 the High Court trial of Patient One?

4 A: Yes.

5 Q: And do you recall that at that trial two witnesses for the plaintiff, Dr  
6 Hitchcock and Dr Julian Grace from Australia described the appearances in  
7 3 of those 4 slides as obvious to be seen; do you recall that?

8 A: I don't recall that actual statement, but I'm sure –

9 CHAIR: he doesn't recall the statement so you can't prove a previous  
10 inconsistent statement; it's not as if he's denied it. You are putting hearsay  
11 evidence to him, and in any event, he's accepted there has been unacceptable  
12 under-reporting; he's given us a very fair description of his practices,  
13 including admitting that he didn't go back over past history. Getting into a  
14 debate now about what the slides actually looked like for Patient One is not  
15 going to take the Inquiry anywhere further than it already can go with the  
16 evidence we have about this witness.

17

18 MR GRIEVE: Dr Bottrill are you aware of the Royal College statement of  
19 a pathologist's ethical obligations to his/her patients?

20 A: I think I've seen that, yes.

21 Q: It's at para 7.5.1 of the College statement, and we will get you to look  
22 at that please. Do you see there at 7.5.1.1: "the fundamental objective of  
23 the practice of pathology is to promote the welfare of patients in terms of  
24 maintenance and restoration of health." See that?

25 A: I see it, yes.

1 Q: So that you would accept that according to that ethical obligation you  
2 would be, as a pathologist, required to put personal considerations and  
3 financial considerations behind the interests of your patients, wouldn't you?

4 A: further than that, I would say that that is exactly what I've been doing  
5 for the last however many years it is I have been in practice.

6 Q: Do you accept that the ethical obligation to which I've referred you to  
7 and you've accepted involves also an obligation to, at an appropriate time,  
8 recognise your own limitations?

9

10 MR HODSON: We can go on with these generalities for quite a long time.  
11 If my friend wishes to say that in some respect some specific action or  
12 inaction of the Dr breached an ethical obligation, surely he should say so.

13

14 CHAIR: Can you cut matters a bit short Mr Grieve?

15 MR GRIEVE: Well, I'm just dealing with it generally, I've been dealing  
16 with specific matters for most of the cross-examination. Do you accept that  
17 proposition Dr Bottrill?

18 A: I accept the proposition, yes.

19 Q: You see, what I'm suggesting to you is that, certainly in 1995 when Dr  
20 Teague suggested that you send your cytology to him, and that being a time  
21 when you knew that your memory was failing and you had lost confidence,  
22 you then had an ethical obligation to put the interests of your patients before  
23 your own considerations – whether they be desire to continue reading  
24 cytology or desire to do better on goodwill, and at that point you should have  
25 stopped reading cytology; what do you say to that?

26 A: I would say that I thought we'd already dealt with this matter before.

1 Q: Well, I'm asking you again in the context of this specific Royal College  
2 ethical obligation. So what's your answer?

3 A: Well my answer is that the fact the I felt at the time that I was not as  
4 confident as I had been of my diagnostic ability meant that I'd probably look  
5 rather harder at the slides I saw in the future. And having asked to check  
6 that my figures were similar to other people's, I believe I was to some extent  
7 – or to a large extent – fulfilling my ethical obligations.

8

9 CHAIR: How did you know that your reports were the same as others,  
10 because my understanding of your evidence is that the reporting figures in  
11 relation to cervical smears – this is para 67 of your evidence – did not  
12 become available until after you retired. You saw those figures in 1997?

13 A: How did I? I've got the answer to that one.

14 MR HODSON: It is not that he is able to – he asked to. In other words, he  
15 wrote to Dr Teague trying to find out. I don't think he said he actually did  
16 find out.

17 CHAIR: Right.

18 MR GRIEVE: So, irrespective of whether or not you should have been  
19 replied to, you didn't know how your results compared with anybody else,  
20 did you?

21 A: No.

22 Q: In 1995?

23 A: I didn't. However, I was seeing about 30 high grade lesions a year and  
24 without knowing any statistics it seemed a reasonable sort of number for the  
25 population we were dealing with. I can't go any further/closer than that  
26 because the figures just weren't available.

1 Q: You were still hopeful of achieving a good sale price for the business,  
2 weren't you?

3

4 MR HODSON: Ma'am, are we really going to go through this ground  
5 again?

6 CHAIR: Ask the question and then I think bring matters to an end on this  
7 topic.

8

9 MR GRIEVE CONTINUES XXN OF WITNESS

10 A: Money was not the primary consideration then, money was not the  
11 primary consideration later. It was something which obviously would come  
12 into consideration when the sale was made but certainly there was no  
13 attempt to maintain the volume of work simply to keep up the value of the  
14 goodwill.

15 Q: Dr Bottrill I note that in paragraph 43 of your evidence you've said  
16 there that around about July 1995 you had a conversation with Dr Teague  
17 about patient 1, he suggested you send your smears to his laboratory, I note  
18 that you did not retire until March 1996. Why after July 1995 when it had  
19 been brought to your attention that you had read a number of slides in  
20 respect of patient 1 wrong and Dr Teague was suggesting you send your  
21 cytology cervical smears to his laboratory to have them read, did you  
22 continue to work until March 1996?

23 A: He offered to do the smears for me if I didn't feel able to continue to  
24 do so. I didn't regard it as more than an offer.

25 Q: I see.

26

27 MR GRIEVE CONTINUES XXN OF WITNESS

1 MR GRIEVE: You in fact ended up achieving a significantly greater  
2 price from Dr Linehan didn't you than from that which had been offered by  
3 Tairawhiti.

4 A: Yes.

5 Q: How much greater?

6 A: Is that really important.

7

8 CHAIR INTERJECTS

9 CHAIR: No we don't really need to go into how much greater it is.

10 A: I can say that their estimate was wrong.

11

12 MR GRIEVE CONTINUES XXN OF WITNESS

13 MR GRIEVE: Now I'll get you to produce this extract from Cox as –

14

15 [Bottrill 002 produced]

16

17 CHAIR ADDRESSES INQUIRY

18 CHAIR: We're just about near afternoon tea and I realise that Dr  
19 Bottrill has been going for some time. Perhaps if we take a break now until  
20 3:40 and Mr Kirton I know that you are going to go next. Just to remind you  
21 cross-examination is with leave. I am not going to refuse leave but I would  
22 ask you to direct your questions to issues that have not been covered by Mr  
23 Grieve. I don't want to go over old ground.

24 MR KIRTON: Certainly ma'am.

25 CHAIR: We'll adjourn now.

26

27 INQUIRY RESUMES UNTIL 3:40 P.M.

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INQUIRY RESUMES AT 3:48 P.M.

MR HODSON ADDRESSES CHAIR

MR HODSON: Mr Kirton has indicated he will not cross-examine and I appreciate very much his indicating that. On the basis that there will be now produced by consent the New Zealand Medical Association Code of Ethics which I'm very happy to do, it was mentioned some time ago.

CHAIR: I think that's already come in.

MR HODSON: No I said I would in the course of today Dr Bottrill's evidence. All counsel agree, I have a couple of copies here and it can be entered I think as MBB/003.

MR KIRTON ADDRESSES CHAIR

MR KIRTON: Madam Chair with regard to the message from Mr Hodson about cross examination I have agreed with him after his approach to me that it would be unsafe to continue. However that does leave the issue of the document we've just referred, the code of ethics, which I did want to pursue. I had indicated on Saturday that Dr Linehan would be the appropriate person to deal with that and it appears at this point those issues will not be canvassed with this witness but it does leave those issues uncanvassed.

CHAIR: Yes.

MR HINDLE ADDRESSES CHAIR

1 MR HINDLE: Ma'am I've followed my friends line of questioning  
2 this morning very carefully and have come to the conclusion I can't add  
3 anything by asking anything further so I won't ask any questions thank you.

4

5 CHAIR CONTINUES XXN OF WITNESS

6 CHAIR: Dr Bottrill in paragraph 7 of your brief of evidence you refer  
7 to a visiting pathologist from the Department of Health inspecting your  
8 laboratory. Can you tell me if you can recall when this practice of a visiting  
9 pathologist from the Department of Health ceased?

10 A: No I'm sorry I can't. It would be I suspect mid 70's.

11 Q: And was it this visiting pathologist's responsibility to check on the  
12 laboratory?

13 A: Yes this was something which I was sort of faced with when I arrived  
14 in New Zealand. I'm not really sure exactly when it started. I think the idea  
15 was that the Health Dept as it was then appointed a senior person to go  
16 around and make sure that the younger people were not having any great  
17 problems and help them out if necessary. How successful it was I'm not  
18 sure but I understand that the inspecting pathologists put in a report to the  
19 Health Dept.

20 Q: Just so I can be sure I understand paragraph 27 of your brief of  
21 evidence, as I read it you seem to be saying there that if there were  
22 borderline cases the type of report that you made as to whether it was a low  
23 grade abnormality or a high grade abnormality depending on your calling the  
24 patient's doctor and finding out whether the patient was someone who  
25 would come back regularly for check ups?

26 A: Yes we're dealing particularly here with pregnant women and as I  
27 think I explained one of the gynecologists didn't really like interfering if

1 they could possibility help it and it was really just a question of whether the  
2 women should be left with a fear that she might have cancer for the rest of  
3 her pregnancy or whether to be told yes there's something there and we'll  
4 deal with it afterwards and that I'm afraid is reading between the lines but  
5 that's what it was about.

6 Q: I see so I should read paragraph 27 as relating to those patients who  
7 were pregnant and who were borderline.

8

9 PROFESSOR DUGGAN INTERJECTS AND XXN WITNESS

10 PROFESSOR DUGGAN: Dr Bottrill in those situations did you  
11 downgrade the smear if it was a high grade?

12 A: Well no a high grade smear was a high grade smear.

13 Q: So based on the clinical information that you received and the clinical  
14 scenario.

15 A: If I had doubts as to whether to call it high or low grade I would then  
16 discuss with the doctor as to previous factors including whether he thought  
17 she would come back again in the post natal period and make decisions on  
18 that basis. As I've also said later it was impossible to do it that way. You  
19 had to go entirely on the cytological appearances.

20 Q: Perhaps maybe I can ask you the question slightly differently. If the  
21 smear showed a high grade or a cancer and the woman was pregnant and you  
22 had discussed –

23 A: I would recommend referral for assessment.

24 Q: And how would you report it, what diagnoses would you give it? If  
25 you thought it was high grade you would have called it?

26 A: Whatever it was, high grade or cancer. I'm only dealing with the  
27 minor abnormalities here.

1

2 CHAIR INTERJECTS AND XXN WITNESS

3 CHAIR: Dr Bottrill I'd like you to look please at Mules volume 2  
4 exhibit 19.

5 A: Yes ma'am.

6 Q: That is a letter from the Health Funding Authority which was  
7 prompted by the problems with the laboratory at Good Health Whanganui  
8 and Dr Birkenshaw. Did you know Dr Birkenshaw.

9 A: Yes.

10 Q: Did you know that he was a pathologist who was at times working on  
11 his own as the sole pathologist at the hospital laboratory in Whanganui?

12 A: Yes.

13 Q: And did you know that at the time he was working the hospital  
14 laboratory at Whanganui was not TELARC accredited?

15 A: No I'm sorry I'd no idea which were and which were not accredited.

16 Q: Given that you knew that he was a pathologist working on his own  
17 and that there had been problems at Whanganui, did you not see the letter  
18 from Midland Health of August 1994 as being a red flag to you that perhaps  
19 you ought to reassess the way in which your practice was being run?

20 A: No ma'am.

21 Q: You've said in your brief of evidence that if someone had an  
22 abnormal slide there are times when you would go back over the past history  
23 to see if there were earlier abnormal slides. How often did that happen?  
24 Paragraph 41 of your evidence.25 A: Certainly several times a year but I'm not really sure. We're dealing  
26 with such small numbers and because they weren't spread throughout the  
27 year they weren't done in groups.

1 Q: We heard evidence on Saturday from a patient Wendy Joy Ure who  
2 had a smear read by you as CIN II or CIN III in February 1996 that was read  
3 as high grade by Dr Hitchcock. You had read previous smears of hers on 11  
4 May 93 as normal and Australia read that as CIN III and Dr Hitchcock as  
5 high grade and you had also read a smear of hers on 2 March 1990 as normal  
6 and that too was read as high grade by Dr Hitchcock. At the time when you  
7 read her smears in 96 as being CIN II or CIN III did you go back and look at  
8 the two previous smears to check what your reading had been of those  
9 smears?

10 A: I couldn't have done.

11 Q: OK thank you.

12

13 PROFESSOR DUGGAN INTERJECTS AND XXN WITNESS

14 PROFESSOR DUGGAN: Dr Bottrill I have a question. When I use  
15 the term supplementary report do you understand to mean that's an additional  
16 report you send out?

17 A: Yes.

18 Q: Did your laboratory ever issue supplementary report on the cytology  
19 reporting?

20 A: I don't remember issuing supplementary reports on cytology no.  
21 Histology from time to time.

22 Q: Under what circumstances did you issue such supplementary reports?

23 A: Mainly when I was sufficiently satisfied as to the nature of a disease  
24 but sent the specimen away for another or some other opinions. I would  
25 report and say supplementary report will follow.

26 Q: No I noticed in your brief that you said you sent cytology away  
27 sometimes?

1 A: Rarely.

2 Q: On those occasions would you then submit a supplementary report?

3 A: No I think I would hold it until I got the answer back. It would only  
4 be a matter of 2 or 3 days perhaps.

5 Q: If I understand you correctly then you didn't issue a report at all until  
6 you got the external consultation.

7 A: That's what I would do yes.

8 Q: So it was just one report.

9 A: Yes.

10 Q: Did you ever have any mix up of specimens in your laboratory?

11 A: I'm unaware of such at the moment. We thought we took sufficient  
12 care to prevent such a thing. However, I've worked in these laboratories for  
13 such a long time now that I know that these things can and do happen – I  
14 can't remember any incidences.

15 Q: What procedure did you have in place to prevent specimen mix-up?

16 A: Well, mainly retaining the request forms and the specimens until we  
17 were absolutely certain that the specimens had the right name and right  
18 number on them. Perhaps I misunderstand you.

19 Q: Could you just describe for me the procedure you went through when  
20 you started your cytology reporting – i.e. when you received the slides and  
21 you received the requisition form?

22 A: A requisition form comes in with the slide. Sometimes in a slide  
23 container, sometimes with the requisition form wrapped around it.

24 Q: Actually, the procedure I'm interested in is when you got the slides  
25 after they were stained and they came into your office.

1 A: Yes. The slides were numbered, with the histology number on them –  
2 cytology number; the forms also had the same cytology number on – that  
3 was all.

4 Q: So which did you do first, did you pick up the requisition form first or  
5 the slide first?

6 A: No, I would get the requisition form first because I'd have to bring up  
7 the number on the computer.

8 Q: And how did you do that?

9 A: the first one each day I would put in the cytology number that I wanted,  
10 the computer would bring it up. From then on it would present me with  
11 consecutive numbers, which I could override if I wanted to have a different  
12 one.

13 Q: When you say you "brought it up", how did you actually do that?

14 A: Typing in the cytology number.

15 Q: You typed in the number?

16 A: Hmm.

17 Q: What's the next step?

18 A: The next step would be take the slide, look at its number, place it under  
19 the microscope, the label to the right -I don't know why, but that's just  
20 routine – and examine it strip by strip. I usually used 10 eye pieces and 20  
21 objectives. I know it's no usual but I found the times 10 objective gave you  
22 rather small cells, and although your field is rather smaller with 20, I was  
23 happier using it. The slide would then be examined end to end and then up  
24 one field and backwards and forwards until I came to the end. Having done  
25 that I would mentally be assessing the slide as I went along of course.  
26 Having come to the end I would issue my report.

27

1 CHAIR: Could you just describe for me so I've got a good appreciation  
2 because I'm not familiar with laboratory practice, the manner in which you  
3 read the slide?

4 A: Yes. You start at one corner –

5 Q: Would that be the left or the right?

6 A: I would routinely start at the bottom right, go along to bottom left, up  
7 one field, back again in strips.

8 Thank you.

9

10 PROFESSOR DUGGAN: Before you put the slide on the microscope stage  
11 did you check that the number on the slide matched the number on the  
12 requisition form?

13 A: Yes.

14 Q: Did you check that the number on the slide matched the number on the  
15 requisition form as well as the number on the computer screen?

16 A: I believe so. Yes, that was the routine, yes.

17 Q: You don't think there was ever a time where you might have mixed  
18 them up?

19 A: I have got no evidence to suggest that there was.

20 Q: How would you know if you had mixed them up?

21 A: I don't know. If the numbers tallied I would assume that all was well.  
22 I can't see where the fault would come in, in the identification process.

23 Q: Did you have any system in place to ensure that this didn't happen?

24 A: Well, only that when the specimens were numbered the request form  
25 and the slide were numbered at the same time.

26 Q: Would you agree with me that it is important to check that the number  
27 on the slide matches the number on the requisition form?

1 A: It's essential ma'am.

2 Q: As well as the number on the computer screen?

3 A: I say it's essential.

4 Q: And if you don't have such a check system in place it could happen,  
5 that you could mix them up?

6 A: Yes.

7 Thank you very much Dr Bottrill.

8

9 CHAIR: Dr Bottrill, in respect of another patient whose evidence we heard  
10 on Saturday, Jane Vertongen, on 23 August 1994 you found atypical  
11 squamous cells and your report suggested a smear in 6 months. That was  
12 done. You found abnormal squamous cells, you've put in brackets (CIN 1  
13 or HPV). We now know both smears were high grade. You made a  
14 recommendation "referral for assessment as recommended". What was  
15 your expectation in terms of that recommendation being carried out?

16 A: You mean what I thought would be found?

17 Q: Well, because you wrote that your recommendation was "referral for  
18 assessment", did you expect that to happen?

19 A: Yes.

20 Q: Because we know it didn't happen.

21 A: Oh.

22 Q: the last question I want to have is these were issues that Mr Kirton may  
23 wanted to have covered in respect of the Code of Ethics. Under the code of  
24 Ethics there are principles of ethical behaviour applicable to physicians  
25 which include "consider the health and wellbeing of your patient to be your  
26 first priority, strive to improve your knowledge and skill so that the best  
27 possible advice and treatment can be afforded to your patient, recognise both

1 your own limitations and the special skill of others in the prevention and  
2 treatment of disease. Do you consider that at the time that you were  
3 practising your conduct was consistent with the Code of Ethics?

4 A: I do, yes.

5 Q: Looking back in retrospect, do you still adhere to that opinion, looking  
6 back now, knowing what you know?

7 A: I think if I were doing it again I wouldn't make any major changes. I  
8 was completely unaware at the time that I retired that there was a problem.  
9 Thank you very much.

10

11 MR KIRTON: Madam Chair, I wonder if you could continue just with para  
12 25, 29 and 33

13 CHAIR: 25 – “transplantation”?

14 MR KIRTON: No, under standards of care, 1 and 2, 5, 29 and 33.

15

16 CHAIR CONTINUES XXN OF WITNESS

17 Q: In terms Dr Bottrill under the code of ethics under the heading  
18 responsibilities to the patient standard of care, one of them is to practice the  
19 science and art of medicine to the best of one's ability and full technical and  
20 moral independence and with compassion and respect for human dignity.  
21 Two is to continue self education to improve one's personal standards of  
22 medical care. Did you think at the time that your conduct was in compliance  
23 with the standard of care as set out in the Code of Ethics.

24 A: I believe so yes.

25 Q: And looking back now do you still adhere to that opinion or do you  
26 have a different opinion.

27 A: Oh no I still hold to it.

1 Q: Under the heading respect for patients, that's number 5, it says ensure  
2 that all conduct in the practice of the professional is above reproach and that  
3 neither physical, emotional nor financial advantage is taken of any patient.  
4 Did you consider at the time that your conduct was in compliance with that  
5 obligation to the patient?

6 A: Indeed I do.

7 Q: And looking back now do you still adhere to that opinion or do you  
8 have a different opinion?

9 A: No I still hold to it. I fail to see how anything that I was doing was in  
10 any way unethical.

11 Q: Right, just go through the last two. 29 responsibilities to the  
12 professional, this deals with personal conduct, accept a responsibility for  
13 one's personal health both mental and physical. To this end have the right,  
14 except in an emergency, to refuse to accept a patient or in any other situation  
15 not an emergency, to withdraw from the responsibility for the care of any  
16 patient provided that the patient is given adequate notice of this intention  
17 and alternative care is reasonably available. Did you consider at the time  
18 that your conduct was in compliance with that rule?

19 A: I believe so yes.

20 Q: And do you still adhere to that opinion now or have you changed that  
21 opinion?

22 A: I've not changed my opinion but as I have indicated, I don't know  
23 what went wrong but something did, however I was not conscious of it.

24 Q: The last one, 33 is to build a professional reputation based upon  
25 ability and integrity, only advertise professional services or make  
26 professional announcement where the chief purpose of the notice is the  
27 factual presentation of information reasonably needed by any person to make

1 an informed decision about the appropriateness and the availability of  
2 services that may meet his or her medical needs, any advertisement must be  
3 demonstrably true in all respects, may not contain any testimonial or  
4 endorsements of clinical skills and shall not be likely to bring the profession  
5 into disrepute. Do you consider that at the time your conduct was in  
6 compliance with that rule?

7 A: Not only that ma'am but I can't quite see in what way it could be  
8 suggested that my conduct did not apply. I didn't advertise.

9 Q: Do you consider that you may have held yourself out as being able to  
10 offer a quality cytology service when in fact you could not?

11 A: Well I thought I could.

12 Q: Thank you very much. Any reexamination Mr Hodson.

13 MR HODSON: No ma'am.

14 CHAIR: Thank you very much Dr Bottrill.

15

16 MR HODSON ADDRESSES CHAIR

17 MR HODSON: Ma'am may I thank all concerned for their  
18 consideration today.

19 CHAIR: Thank you Mr Hodson.

20

21 CHAIR ADDRESSES INQUIRY

22 CHAIR: The committee of inquiry would like to very much thank those  
23 persons in the gallery for the way in which they have conducted themselves  
24 through the conduct of Dr Bottrill's examination.

25

26 MR HINDLE ADDRESSES CHAIR

1 MR HINDLE: Perhaps if we could just have a minute to organise the  
2 next witness.

3 CHAIR: Before we do that, Mr Murray is Mrs Sholtens available.

4 MR MURRAY: Going to inquire about line up of witnesses.

5 CHAIR: This is something that I wanted to raise with you both I can do  
6 it at the end of the day, there's no rush so we can move on to another  
7 witness.

8 MR HINDLE: The next witness proposed is one of the Cancer Society  
9 witnesses, Janice Hobbs but I see Mrs Marshall's who is leading the Cancer  
10 Society's evidence has just gone to liaise with her and hopefully ..

11 CHAIR: So we're not going to have Mrs Marshall first, we're going to  
12 have Janice Hobbs first.

13 MS JANES: Ma'am Mrs Marshall has indicated that because Mr  
14 Rennie would like to cross examine Janice Hobbs it would be better that she  
15 goes.

16 CHAIR: Certainly. Mrs Marshall I understand there are some  
17 alternations to the brief and it might be best if at the beginning of the  
18 evidence Ms Hobbs actually crosses out the erroneous part of the brief as it  
19 now stands and with her handwriting inserts the alternations and then initials  
20 the alterations.

1

2 MRS MARSHALL calls –

3

JANICE HOBBS (sworn)

4

5 MRS MARSHALL: I'd now like to call Janice Hobbs as the Cancer  
6 Society's second witness.

7

8 MR GRIEVE ADDRESSES CHAIR

9 MR GRIEVE: There is in my submission the matter of admissibility in  
10 relation to some of these exhibits.

11 CHAIR: You want to raise that, that's fine, well lets get the witness  
12 sworn in, the alterations done, and then we'll deal with the admissibility  
13 issues.

14

15 MRS MARSHALL XXN WITNESS

16 MRS MARSHALL: Could you please confirm that your full name is  
17 Janice Anne Hobbs.

18 A: Yes.

19 Q: And have you prepared a brief of evidence?

20 A: I have.

21 Q: And do you have it before you?

22 A: I do.

23 Q: As Madam Chair has indicated there are some minor changes to the  
24 brief of evidence and to the exhibits, do you have the brief of evidence  
25 before you.

26 A: I do.

1 Q: In terms of the brief of evidence there are minor changes with regard  
2 to patient numbers and the first is on page 10, para 50, line 2, and I  
3 understand that needs to be changed from number 9 to number 10.

4 A: It does.

5 Q: Then on p13, para 68, lines 7 and 8, that number 10 needs to be  
6 changed to number 9 in three instances; that's in the three cases on lines 7  
7 and 8.

8 A: Yes.

9 Q: And finally there is an amendment, by consent with Mr Murray and Ms  
10 Sholtens, which relates to p5, para 19, the second sentence beginning "My  
11 recollection" – do you have that before you?

12 A: Yes, I'd like to change that too.

13 Q: Could I perhaps read that out and perhaps if you could note that as I  
14 read it out. This sentence should be deleted altogether and replaced with the  
15 following sentence: "She subsequently sent me a Fax recording advice  
16 from Di Best, the national programme co-ordinator, and Dr Brian Cox, an  
17 adviser to the Cancer Society, which is produced as BC/CS/0042. Madam  
18 Chair, those are the only amendments to the brief of evidence; there are  
19 some amendments needed in the exhibits which all relate to the matter of  
20 suppression, and I don't know whether you would like to hear those first.

21 CHAIR: Yes, we should deal with that first. But before we do, Ms Hobbs  
22 if you would, please, where you've put in the hand-written alterations in  
23 your brief and crossed out material, just initial those if you haven't already  
24 done so.

25

26 MRS MARSHALL: Do you have before you now your exhibits?

27 A: I do.

1 Q: And the first suppression issue relates to exhibit 4, tab 4, p3.

2 A: Madam Registrar, do I have to do this on an official copy?

3 CHAIR: Yes.

4 MRS MARSHALL: Just starting at exhibit 4, tab 4, p3, you will see  
5 Tuesday 4 May entered on line 3. And if you could suppress the name  
6 before the words "very tired".

7 CHAIR: Very well. I will make an order suppressing the name – I will  
8 have to say it so we know what the order is about.

9 MR HINDLE: I wonder, ma'am, since I'm not absolutely sure whether one  
10 simply make an order suppressing the names on that page of the exhibit –  
11 it's not going to make any difference to anyone, and the only names that  
12 appear there are patient names as I understand it.

13 CHAIR: Well, I don't know whether other patients want their names to be  
14 made known or not. What's the position Mrs Marshall?

15 MRS MARSHALL: I'm not sure. Perhaps I could ask Mr Grieve or Mr  
16 Corkill.

17 MR GRIEVE: I can't deal with patient names, I will ask Mr Corkill to deal  
18 with that, but if my objection is upheld, then these issues will solve  
19 themselves.

20 CHAIR: I see. For the meantime we will deal with it one at a time. I will  
21 just make a suppression order saying that the name [suppressed] as  
22 appearing on p3, exhibit 4, Hobbs, must not be published, and any material  
23 which may refer to the name [suppressed] is not to be published in any way.

24 MRS MARSHALL: Thank you. The next relates to exhibit 5, tab 5, p1,  
25 in the upper right hand corner is a 7 digit telephone number that needs to be  
26 suppressed. Do I need to read out that number?

1 CHAIR: No, I think we can describe that all right. It's just a matter of  
2 being able to describe these things. On Hobbs' exhibit 5, p1, top right hand  
3 corner is a 7 digit number beginning with the number [suppressed], ending  
4 with the number [suppressed]: publication of the entirety of that number and  
5 any reference to that number, including the first and last digit, is suppressed.

6 MRS MARSHALL: The third item relates to p2 of that same exhibit, and  
7 in the middle of the page and 2/3 down, just above Friday 23/? is the name  
8 of ? and that will need to be deleted.

9 CHAIR: Very well.

10 MR HINDLE: Now that name does appear more than once on that page. It  
11 appears about 4 lines up from that as well.

12 CHAIR: What I will do is make an order in respect of Hobbs exhibit 5, p2,  
13 that the name [name suppressed] wherever it appears is not to be published  
14 nor is any material which might in some way lead to the name [name  
15 suppressed] being made known to be published.

16 MRS MARSHALL: Thank you. And just one final one, for exhibit 7, tab  
17 7, p3, the 5<sup>th</sup> para down, with the sentence "There certainly has been" – at  
18 the end of the second line in that para in brackets is the name [name  
19 suppressed].

20 CHAIR: In respect of Hobbs, exhibit 7, p3, any reference to the name  
21 [name suppressed] in that exhibit, and particularly on p3, is suppressed,  
22 there is to be no publication of the name [suppressed] or any material which  
23 might lead to the name [suppressed] becoming known.

24 MRS MARSHALL: Thank you. With those alterations, is your brief now  
25 and exhibits to the best of your knowledge a true and accurate record?

26 A: It is.

27

1 CHAIR: Mr Grieve, you've got an objection?

2 MR GRIEVE: Yes, Madam Chair. It doesn't relate to the text of the  
3 evidence, rather to the material we've just been dealing with. By and large,  
4 although there are some exceptions, and an example of the exception is  
5 behind tab 1 where there are notes that go back to April and October 1996,  
6 and we've I think seen one or two notes going back that far; there was  
7 another one behind tab 7, but with those exceptions, nevertheless, most of  
8 the notes are 1999 or later. And I'm talking here about the handwritten  
9 notes. The status of these notes, from an evidential point of view, and I of  
10 course bear in mind that strict rules of evidence don't apply

11 CHAIR: No. The Erebus principle which you referred me to?

12 MR GRIEVE: Yes. Nevertheless, these notes are only that. They would  
13 be if the evidence of the witness was to be questioned as to reliability,  
14 previous notes presumably made at the time which she could use to refresh  
15 her memory. They would not even if she was given leave to refresh her  
16 memory, they would not be produced as exhibits, the practice would be that  
17 she could use them to refresh her memory and give her evidence with that  
18 assistance so that in my submission irrespective of date, they are not  
19 admissible as proof of anything, the proof of what was done is in her brief  
20 and as I've said I certainly don't question that in any way so that there is no  
21 challenge as far as I am concerned, I don't know whether there is any other  
22 counsel intending to challenge anything that Ms Hobbs has said so in that  
23 event it's my submission that the handwritten notes ought not to be admitted  
24 as exhibits and that's the substance of the objection. I accept that –

25 CHAIR: Can you tell me as a matter of curiosity why you take such  
26 objection to these notes. Your objection is very technical. If you're going to  
27 be prejudiced in some particular way, I'll deal with it on a technical basis but

1 I've read through these notes. All they seem to do to me is just set out a  
2 chronological record of the various steps this witness had taken since the  
3 problem in Gisborne has been brought to her attention. They seem to me,  
4 although I can't at the moment put my hand on the terms of reference, to be  
5 relevant to the later ones 5, 6 in terms of, you've already raised with me this  
6 whole issue of internal morality of pathologists and people's willingness or  
7 lack of willingness to recognise there is a problem and it seems to me that  
8 it's helpful to hear this witnesses evidence and look at her notes made at the  
9 time which provide a perspective from her view of the steps she was taking  
10 to bring the concerns in Gisborne to the attention of the appropriate persons.  
11 I'm really quite curious as to why you are objecting to this material.

12 MR GRIEVE: Well I'm simply objecting because in my view Madam  
13 Chair the evidence should stand on what's in the brief. I'm not raising the  
14 issue of prejudice in any way.

15 CHAIR: It's just a technical objection. I agree that the material is  
16 technically inadmissible. I don't interpret your Aribus principal in the way  
17 you do. My interpretation of the Aribus principal is that the rules of natural  
18 justice require a decision to be based on some probative material whether  
19 that be strictly speaking admissible or not.

20 MR GRIEVE: I don't think we differ on that Madam Chair.

21 CHAIR: No, and 4b of the Commissions of Inquiry Act allows the  
22 commission to receive his evidence, any statement, document, information  
23 or matter that in it's opinion may assist it to deal effectively with the subject  
24 of the inquiry whether or not it would be admissible in a Court of law. My  
25 inclination is to admit the material because I can't see anything that is  
26 terribly objectionable about it.

1 MR GRIEVE: Well as I say I don't claim any prejudice Madam Chair.  
2 If that's your ruling then I accept it

3 CHAIR: Does anyone else want to be heard. Yes Mr Rennie?

4 MR RENNIE: Well ma'am very briefly, and I think the fact that I'd  
5 indicated I had two or three questions to ask Mrs Hobson, they do derive  
6 from issues arising out of these notes and I would not have minded if my  
7 friend has said that. The problem simply with these notes is that they report  
8 was this person was told by other people about some of the narrative  
9 sequences. No I don't have a problem at all with the brief in fact I'd like to  
10 say something highly favorable about that at the moment but if the notes  
11 come in then one does as Counsel face the problem that there are remarks  
12 attributed in my case quite specifically to the parties that I represent, that is  
13 to say third party remarks which were made to this person and that is really  
14 the main heart of the difficulty. I wonder if I might just mention –

15 CHAIR: Can you take me to the various passages because there's a lot  
16 of notes here and if there is a particular note I'll look at that.

17 MR RENNIE: Just as a sample ma'am at tab 1 page 3, this will do to  
18 cover all three of the points that I'm after. There's an issue there about what  
19 certain people did or didn't do and did or didn't send and so forth. I'm not  
20 going to seek to go into the triviality of that but if that is there I think I'd  
21 have to ask the witness about whether there was an understanding in the  
22 community in Gisborne that certain things had happened or not and whether  
23 that effected their willingness to make approaches to medical people for  
24 consultations and things. If that is not there, then that really could be left to  
25 one side. The issue is not the triviality, the issue is the impact on a  
26 community interface with medical services. Much the same thing ma'am  
27 applies to page 4 at tab 3 and there's a discussion there about a GP and

1 certain aspects of the GP's position and then at tab 6 page 3 there's a  
2 reference to certain things that Mr Duncan may or may not have said. Now  
3 those are the kind of things, if they're not in front of you, if the notes are not  
4 in front of you you can rely on the brief and the brief is excellent. It's just if  
5 you start going in to the detail of the notes, and I think probably my friend  
6 Mr Grieve may have some concerns about things that are said about aspects  
7 of a legal case or legal advice or things like that, he might not want to make  
8 that explicit but it's when all this material comes in, that's where it starts to  
9 get difficult. The only other thing which is not a matter which directly  
10 concerns me but I did understand Mr Corkill to say the other day that as  
11 patient 10 was not coming forward, there was a question about the deletion  
12 from this material of patient 10's notes.

13 CHAIR: Yes I raised that. I've got a concern about that and I think

14 MR RENNIE: Tab 4 I think ma'am.

15 MR CORKILL: I can deal with that when you're ready Madam Chair.

16 CHAIR: And there's a reference to patient 10 in the brief of evidence as  
17 well.

18 MR RENNIE: Yes well I don't think with respect ma'am a lot of time  
19 should be taken up on all of this. If the notes are simply taken as being  
20 material which the witness has available to her to refresh her mind and not  
21 otherwise probative of anything, then I don't need to ask any questions at all.  
22 But if the notes were seen as being probative of more than that, that's the  
23 point at which I have certain duties that I have to face up to.

24 CHAIR: Right. Mrs Marshall do you have any comment.

25 MRS MARSHALL: Madam Chair as you know I'm not really in a  
26 position to argue one way or the other so I really am in your hands.

1 CHAIR: Well perhaps you could just help me here because at the  
2 moment I've got all these notes but it would help me in terms of deciding  
3 whether or not I do let them in but in circumstances where Mr Rennie can  
4 explore with this witness just how great her knowledge is of events because  
5 obviously if what she is getting is a second hand account then it may be I'm  
6 asked to discount the reliability particular if, for example, Mr Rennie takes  
7 issue with some of the facts. But why are the notes here, in other words, to  
8 what degree are you going to suffer a disadvantage if these notes are  
9 excluded?

10 MRS MARSHALL: I don't believe we'll suffer any great  
11 disadvantage if they are excluded.

12 CHAIR: You won't. I see. Because they are technically hearsay and  
13 the other thing is the evidence from this witness which as Mr Grieve has  
14 said, actually I don't think they are hearsay at all, I'll take that back, they  
15 are the witnesses own notes but they contain hearsay statements and also the  
16 witness could use her notes to refresh her memory but it is not acceptable to  
17 produce evidence of prior consistent statements so where she says something  
18 in her brief of evidence, that should stand and it doesn't need the support of  
19 anything which she has said in the past which is consistent with what she has  
20 said. So if you're not disadvantaged by the notes being excluded, given the  
21 technical objection has been made, I'll uphold it. Do you want to be heard  
22 Mr Hindle?

23 MR HINDLE: Well, ma'am, it just occurred to me as the debate was going  
24 on that these notes are really in no different category from a good deal of  
25 material that's come in many ways, and in some respects they contain  
26 information which is relevant and which this witness can produce, and in  
27 other respects different passages in the same page are records of

1 conversations which are obviously hearsay and to which no great weight –  
2 probably no weight can be attached. My sense of it is that on the basis  
3 which Mr Rennie suggested there isn't a lot of harm in having the notes  
4 come in, but if Mrs Marshall doesn't object –

5 CHAIR: Well I didn't actually understand Mr Rennie's submission to be  
6 that. What his submission was is that if the notes don't come in he will not  
7 cross-examine the witness, he doesn't need to; if the notes come in he does.

8 MR HINDLE: I had heard him, and he will correct me if I am wrong.

9 CHAIR: I think he's going to say –

10 MR RENNIE: I think, with respect, ma'am, was that if they were simply  
11 treated as being material which the witness relied on for her evidence and  
12 were not in themselves probative of anything, then I do not need to cross-  
13 examine.

14 CHAIR: well, if I treat them as not being probative of anything, there is  
15 simply no point in having them before the committee. There's no point in  
16 having material before the committee that has no probative value. My view  
17 is in the circumstances I'm aware that other documents have come in which  
18 are of the same nature as these documents, but no-one has raised an  
19 objection about them, and in the fact of no objection being raised they've  
20 been accepted. In this instance an objection has been raised, Mr Grieve is  
21 entirely correct – technically the notes are inadmissible. In terms of  
22 deciding whether or not to exercise the discretion the committee has under  
23 s4b of the Commissions of Inquiry Act, I have enquired of Mrs Marshall  
24 whether or not she will be prejudiced if the notes are excluded and to what  
25 degree she relies upon them; she says she will not be prejudiced, is that  
26 correct?

27 MRS MARSHALL: Yes.

1 CHAIR: She confirms she will not be prejudiced, and on that basis, given  
2 the objection has been made, I'm going to uphold it and I will therefore  
3 exclude the notes. Now that means exhibit 1 goes out, exhibit 2 – in fact, I  
4 think these exhibits –

5 MR HINDLE: Everything except 8.

6 CHAIR: Everything except 8 will be excluded. Hold on, I think we will  
7 go through this one by one, it is just the witness's notes that have been  
8 objected to. So that is all of exhibit 1. Madam Registrar, could you just  
9 put a line diagonally through exhibit 1. The same with exhibit 2. Now the  
10 first 6 pages of exhibit 3 are notes which will be excluded for the same  
11 reason.

12 MR GRIEVE: The next 3 pages Madam Chair are already in patient 9's  
13 records.

14 CHAIR: Yes, and we will leave them here, the next 3 pages. Page 10, this  
15 is the witness's note again, so that should go out. Medlab Hamilton, I have  
16 got a mind to leave it, that's a document that speaks for itself, and 12. And  
17 then we get to exhibit 4, which is all notes, which will go out. Exhibit 5,  
18 which is all notes, and will go out. Exhibit 6, which is all notes, and will go  
19 out. Exhibit 7, the first page is a note. What is the second page Mrs  
20 Marshall, is this a letter that the witness has written?

21 MRS MARSHALL: Yes.

22 CHAIR: what is the attitude to this letter?

23 MR RENNIE: I wouldn't have thought there could be any objection to that  
24 ma'am.

25 CHAIR: Right, so exhibit 7 from p2 onwards will remain in. And I don't  
26 see any reason to exclude the remainder of the exhibit. Very well.

1 MRS MARSHALL: Thank you Madam Chair, and I think Janice would  
2 now be pleased to –

3 MR CORKILL: Madam Chair, just before we get to that point, could we  
4 tidy up the issue you raised with me on Saturday.

5 CHAIR: Yes, please.

6 MR CORKILL: That's the question about paras 43 through to 51. My  
7 learned junior has taken instructions and indeed taken an affidavit from  
8 Patient 10, and I'm just going to read it: she confirms that she's read paras  
9 43 to 51 inclusive. The information contained within those paras is within  
10 her first hand knowledge, she believes it to be true and correct. On the basis  
11 of that, I am regarding that as an instruction and an affidavit that I hold and I  
12 have no objection to that material.

13 CHAIR: Very well. Are you going to be able to provide us with a copy of  
14 Patient 10s medical records?

15 MR CORKILL: ma'am, I wasn't proposing to treat this particular patient in  
16 the same way as we have the other patients. I can put this affidavit in for  
17 what it's worth. We are, of course, not leading evidence from all of those  
18 for whom we act.

19 CHAIR: No.

20 MR CORKILL: and she was one from whom we weren't proposing to lead  
21 evidence.

22 CHAIR: right. The thing is it is actually – I appreciate the effort that  
23 you've gone to with the briefs, but really, in order to get – if we're going to  
24 have material before us about a patient it is good to have a full appreciation,  
25 and I think, therefore, we should have –

26 MR CORKILL: we can put in the medical notes.

27 CHAIR: That would be good if we could.

1 MR CORKILL: Ma'am, if that would be of assistance, yes.

2 CHAIR: Yes. So far we've found the medical notes very helpful.

3 MR CORKILL: Thank you.

4 MR RENNIE: Perhaps I should then say formally ma'am that I have no  
5 questions for the witness, and with your leave I am asked to state on behalf  
6 of the medical interests that I represent their admiration for the extraordinary  
7 work of Mrs Hobbs throughout this period.

8 CHAIR: Thank you Mr Rennie. Now Mrs Marshall do you wish to lead  
9 any extra evidence, or is it a matter of questions?

10 MRS MARSHALL: No, I don't. Just for questions, thank you.

11 CHAIR: Does anyone have any questions of this witness?

12

13 [No cross-examination by counsel]

14

15 XXN BY PROFESSOR DUGGAN:

16 Q: Ms Hobbs I just have one question. With regard to the provider group,  
17 how long do you think this group will need to continue?

18 A: I believe we have one more meeting coming up and I don't know the  
19 exact date, and I'm sure a decision will be made at that point. Probably not  
20 too much longer.

21 Q: You believe you've fulfilled your goals or met your goals in the time  
22 allowed?

23 A: The group has mostly been a networking group of people involved.  
24 It's been very helpful to meet with the others within the group and discuss  
25 concerns and see points of view from their discipline.

26 Q: You may have been present when I asked Ms Coney this question.  
27 Perhaps I can ask you as well. With regard to the responsibility women have

1 to the screening programme, when you present when I asked her that  
2 question?

3 A: I'm not sure, possibility not.

4 Q: Maybe you have a fresh perspective then. What responsibility do you  
5 think women have to the national screening programme.

6 A: I have found in my experience women have been very responsible for  
7 their personal health and have taken the advice that has been put out there  
8 for them and have presented for smears. They appear to be appreciative that  
9 it is the best tool we have to detect cervical cancer and this point I think was  
10 proven in the fact that when this first came to light in March/April of this  
11 year the community in their numbers turned out for smears so I believe there  
12 is still faith very much so in the programme and the majority of women I am  
13 aware of have taken responsibility for themselves and presented for smears.

14 Q: A National Cervical Screening Programme is quite a complex  
15 programme to deliver and there appears to be a tremendous reliance on  
16 accurate information in terms of patient's names and recording of name  
17 changes and recording of address changes etc. In your opinion are the  
18 women that you know in the community aware of the importance of  
19 communicating this change of information to their health care provider or  
20 the programme?

21 A: I believe that trust is delivered to their smear-taker . Women in my  
22 experience present for the smear but then rely on the smear-taker who is  
23 usually their GP who usually does have that information anyway to carry  
24 that information forward and name changes and address changes usually – in  
25 Gisborne we have the option of also going to the Well Woman Clinic for  
26 smears and in my experience I noted a number of women did go between  
27 GP and smear-taker and Well Woman Clinic and for whatever reason

1 women did appear to have that choice and take that choice option up and I  
2 guess at that time the smear-taker if that was a new patient, did request that  
3 kind of information but on the whole I can speak for myself, I would have  
4 expected the smear-taker if I had been there to have already had that  
5 information and I may not have again told them the same information I  
6 expected them to have.

7 Q: OK thank you.

8

9 CHAIR INTERJECTS AND XXN WITNESS

10 CHAIR: Mrs Hobbs paragraph 25 of your brief of evidence you refer to  
11 the period between 97 and 98 when you were kept informed of events  
12 involving a woman effected but you felt no further steps could be taken and  
13 you've given reasons why that was. One was you felt you had alerted those  
14 with responsibility to inquire further and thirdly you were aware of the  
15 Medical Council being aware of the circumstances and the patient was  
16 legally represented and you've said although you were deeply concerned you  
17 weren't sure what you could do, given all the experience that you have  
18 gained now looking back with the benefit of hindsight, can you give the  
19 committee of inquiry some idea as to whether or not you think there ought to  
20 be some process set up so that an alarm can be signaled earlier on.

21 A: Yes ma'am there was – my understanding as of 1997 as to what it is  
22 now you can appreciate I had a very very steep learning curve in March and  
23 April of 1999 and back in 1997 I naively believed that those who could have  
24 been alerted to a problem were aware of that problem. I in my lay persons  
25 knowledge believed that the medical disciplinary committee would have the  
26 knowledge and the ability to follow on with a concern such as what was  
27 presented to them. I followed it through by giving my concerns through to

1 my national office who passed those on through to the national co-ordinator  
2 of the Cervical Screening Programme at that time and I also took it through  
3 to our local co-ordinator. Yes had there been one very – to answer your  
4 question had there been on visual approachable person to go to I would have  
5 very obviously gone to that person but at that time I certainly wasn't aware  
6 of one if there was one in place.

7 Q: Do you consider that the programme needs to make provision for  
8 occasions such as what happened in Gisborne happening by having a process  
9 in place and a identifiable person so that someone like yourself would know  
10 to whom to go when you had serious concerns?

11 A: The answer is very definitely yes, absolutely.

12 Q: The other questions I'd like to ask you is I believe you've been sitting  
13 in the inquiry for most of the time when people like Professor Skegg and Dr  
14 Cox were giving their evidence and we've heard about the importance of  
15 being able to correlation the Cancer Register with the Screening Register for  
16 the purposes of reviewing a woman's smear history and therefore getting an  
17 accurate picture of the accuracy of the smear reporting. Given that you have  
18 had a lot to do with the women effected in Gisborne, are you able to give me  
19 a general impression as to whether or not in your view women would have  
20 any objection to this information matching occurring if they knew how  
21 beneficial it would be to ensuring the programme was working properly?

22 A: First ma'am if I could take this opportunity to express my admiration  
23 for all those women effected. It's just amazing how they have coped under  
24 such circumstances. In my opinion I have not spoken with any woman who  
25 has objected to their particulars going forward to such a survey. Under such  
26 circumstances and such publicity and the way perhaps, I'm loathe to say,  
27 they are victims in any ways, it would be nice if they were asked for their

1 opinion or approval for that to happen. In saying that, I'm not aware of any  
2 who would refuse that.

3 Q: No I'm not asking about these women in particular. What I am  
4 asking is whether or not you have gained an impression where there is a  
5 matter of general practice if women thought it would be beneficial to the  
6 screening programme to have the information on the Cancer Register and the  
7 Screening Register matched, do you think they would object?

8 A: No I believe they would not object in my opinion, all these women  
9 would not wish this experience on any other woman.

10 Q: Any questions?

11

12 MS JANES ADDRESSES CHAIR

13 MS JANES: Madam Chair I should have stood up earlier I'm  
14 conscious Mr Ross is not here and there may just be a couple of areas they  
15 may wish clarification on and if I may quickly seek those with this witness.

16 CHAIR: Certainly.

17

18 MS JANES XXN WITNESS

19 MS JANES: Mrs Hobbs just at paragraph 20 of your brief of  
20 evidence you indicate that to the best of your recollection in a conversation  
21 with Sharon Reid that you were both aware of the cases and the names. I'm  
22 not sure whether you were in the audience when Sharon Reid gave her  
23 evidence and indicated that she believed to the best of her recollection that  
24 no names were spoken and she's not sure that you were both speaking about  
25 Patient On.

26 A: Sharon and I had an informal conversation, I became very aware early  
27 in the piece that she was aware of Patient One and Patient One's

1 circumstances, although I most certainly wasn't in a position to give Sharon  
2 the name, and I did not at that time, and have not since because – I repeat – I  
3 wasn't in a position to do so. There was certainly the assumption on both of  
4 our parts that, well, my assumption on my part, that we were aware of who  
5 we were talking about.

6 Q: Is it possible that you may have been speaking at cross purposes and  
7 she may have been aware of somebody else?

8 A: I think my reply to that would be if she was aware of somebody else on  
9 top of the patient that I was discussing who had 4 slides misread in 4 years, I  
10 expect that would have rung even greater alarm bells with her.

11 Q: So to the best of your knowledge you felt that you were both talking  
12 about the same individual?

13 A: Yes, although I do endorse what Sharon said. We didn't discuss names  
14 and I wasn't in a position to give her a name, but I certainly assumed that  
15 she knew who we were talking about.

16 Q: And just quickly at para 23, you've indicated it was your very clear  
17 impression that the national co-ordinator and shortly after the Manager of  
18 Tairawhiti Screening Programme were aware of the Medical Council or  
19 disciplinary outcome. Are you able to just clarify what constituted your  
20 clear impression of those facts?

21 A: My diary notes recorded at that time.

22 Q: Finally, was any follow-up taken with Sharon Reid later on –  
23 particularly in relation to para 25, as to whether she had taken any action?

24 A: I'm not aware of what action Ms Reid took at that time.

25 Q: And there were no further conversations with her in relation to what  
26 action she may be taking as the regional manager?

27 A: No.

1 Thank you.

2 [No re-examination]

3 CHAIR: Thank you very much Mrs Hobbs. You are excused.

4 Mrs Sholtens, are you going to be hear tomorrow?

5 MRS SHOLTENS: I am, ma'am.

6 CHAIR: Well there is a matter I wanted to raise with both the Health  
7 Funding Authority and Health, but it's been a long day, and if you're both  
8 going to be here tomorrow I can deal with it first thing tomorrow. So I will  
9 leave you in suspense and do that.

10 MRS SHOLTENS: We will await with interest.

11 CHAIR: Very well, we will adjourn until 9.30 tomorrow morning.

12 MR GRIEVE: Madam Chair, there is just one matter of programming, it  
13 relates to issues that arose because of timing difficulties on Saturday.

14 CHAIR: Yes.

15 MR GRIEVE: And that is the evidence that remains of Dr Linehan, Janet  
16 Wilson and a cytopathologist from Hamilton Medlab. Now I understand, of  
17 course, that there are time constraints which may impact on all this. In the  
18 event that there is time, then if possible, not necessarily now but perhaps  
19 tomorrow morning, it would be helpful to have an indication of when it's  
20 likely that either of those three people might be called. With regard to Dr  
21 Linehan, counsel assisting advised me at the afternoon adjournment of three  
22 things: one, that he wasn't available any longer; two, she raised the time  
23 problem; and three, indicated that it may be that the committee doesn't want  
24 to hear from him further. Now, yes, time is a problem, I accept that. But if  
25 he is available – if there is time then I, as I indicated on Saturday, did not  
26 complete my cross-examination, nor did Mr Kirton. If availability is a  
27 question, then I would be asking for leave to issue a sub-poena. If the

1 committee has formed a view that it does not want to hear from him, then I  
2 will simply have no other recourse but to record the fact that I still wish to  
3 complete cross-examination and so on.

4 CHAIR: I understand everything you are saying. As a result of what you  
5 say, perhaps I had better deal with Health and Health Funding Authority  
6 because that impinges on what you say and we'll deal with it now in  
7 circumstances where I will foreshadow my concerns and we can then  
8 perhaps tidy it up tomorrow after everyone has had an opportunity to think  
9 about it. Mr Murray and Mrs Sholtens, it has struck me that we have heard  
10 evidence from Professor Skegg and more particularly Dr Cox, Sandra Coney  
11 and we have evidence to come from Mrs Marshall which is critical of the  
12 Ministry of Health. And this is no fault of the Cancer Society or Ms Coney,  
13 but they are not legally represented and so the persons leading that evidence  
14 did not specifically put the thrust of that evidence to the health witnesses and  
15 the Health Funding Authority witnesses. Now, I'm aware that there was  
16 nevertheless a lot of challenge to what those witnesses had to say, and it may  
17 be that that was sufficient, but as I am aware that the content of those briefs  
18 of evidence was not expressly put to the Health and Health Funding  
19 Authority witnesses, nor the questions and answers that Dr Teague gave to  
20 the Committee of Inquiry. In order to ensure that the Ministry of Health and  
21 Health Funding Authority have ever opportunity to answer evidence, which  
22 on the face of it appears to be critical of those bodies, I am giving you the  
23 opportunity to call any witnesses you may wish to do that this week.  
24 Equally, I want to say, issues that had concerned me – and this is by no  
25 means exhaustive, but this is what I had taken from those witnesses evidence  
26 – it seems they were saying that there was to great a reliance on advisory  
27 committees; that there had been a failure to implement advice in a timely

1 way, and if it wasn't going to be accepted, a failure to communicate that,  
2 why advice wasn't being accepted in an attempt to modify the advice. The  
3 impression given from the Cancer Society witnesses is that advice was  
4 given, nothing happened. There is also, on a separate point, it seemed to me,  
5 I've asked for Dr Teague to come back but I understand that he's not  
6 available this week. This is because while he was here giving evidence,  
7 under the rushed circumstances at the end, I omitted to specifically ask him  
8 to comment on para 4.1.4 in the screening policy document. It seems to me,  
9 on my reading of that para, that 4.1.2 and 4.1.3 are, in a sense, dependent on  
10 the matters set out in 4.1.4 being completed. And the question I wanted to  
11 ask Dr Teague, and it may be this has to be asked in writing and we obtain  
12 an affidavit from him, is whether or not CALC delayed in establishing  
13 standards as contemplated by 4.1.4 and, if it didn't delay but simply couldn't  
14 get standards in place given the way it was set up, did it communicate that to  
15 the Ministry of Health, and in turn, what was the Ministry of Health's  
16 response and should the Ministry, by 1993, have realised that a new  
17 approach to achieving the matters set out in 4.1.4 (which has consistent para  
18 number in both the 91 and 93 policy) needed to be achieved in some other  
19 way, or there be a decision not to achieve them, or there be a definite  
20 decision to delay accreditation rather than a concern that matters have drifted  
21 which is the way Ms Coney presented it. The other concern was that  
22 perhaps there had been too great a reliance on consensus and no  
23 consideration ultimately of using regulatory powers available. The other  
24 concern I have on another point is the question regarding the variation to the  
25 laboratory contracts in terms of the draft minimum standards both as to 1)  
26 whether they are legally enforced and 2) if they are legally in the contract,  
27 are they being performed at the moment, is there an expectation on the

1 Health Funding Authority's part that they are being performed. If not is  
2 there any definite date as to when they will be performed and the other issue  
3 being the question of if contracts are relied on rather than regulatory powers,  
4 can that not lead to the possibility that the funder could if sufficiently  
5 moved, excuse non-performance because it's seen that a regulatory power, if  
6 it wasn't being complied with, at the very worst if nothing was happening  
7 consumers could take action through the Courts. Now that's the best that I  
8 was able to do on Sunday and as you'll realise I haven't had much time but I  
9 would appreciate hearing from the Ministry, Health Funding Authority on  
10 those points and if you have concerns, I want to let you know that we will  
11 make time available this week to enable you to have every opportunity to  
12 answer those concerns and if there is any other issues throughout the course  
13 of inquiry that has caused concern, you are free to lead evidence to deal with  
14 that. It had also struck me that at the moment under our schedule we have  
15 for example Teena Handiside down for Thursday and my concern there was  
16 well if she, and I don't know what she will say, if very critical of the  
17 Ministry and the Health Funding Authority then of course you have no  
18 opportunity to respond and therefore we will not be able to rely on her  
19 evidence so my intention is to see if she can be moved back so that you do  
20 have an opportunity. Now I don't have firm views on this because I raise  
21 this because it does have an impact on what Mr Grieve has said because if  
22 we are going to contemplate bringing back Dr Linehan or Ms Wilson it has  
23 to be realised that given that this is the last week in the hearing, I want to  
24 ensure that witnesses or parties who need to have an opportunity to respond  
25 to material have every opportunity to do so and that is for everyone's benefit  
26 because I remind you of the rules of natural justice that if anyone wishes to  
27 make submissions that we should accept certain evidence, if that evidence is

1 critical of anyone and that person has not had an opportunity to deal with it,  
2 we will not be able to accept the submission so therefore all of you if you  
3 have ideas at the moment of what evidence you prefer, what type of  
4 approach you would wish to advance in submissions think hard about  
5 whether or not that evidence has been lead in a way that anyone who would  
6 be criticised by it has had an opportunity to respond because this week is the  
7 only time that we've really got to bring someone back to deal with that and I  
8 would make that a priority rather than hearing from Dr Linehan or Ms  
9 Wilson but if we can fit them in we will. I should also say, Mr Grieve, if  
10 you want to sub-poena one or both of them, my recall – and I don't have any  
11 authority with me – is I think you need three clear days for a sub-poena, so  
12 you would have to move promptly. Not that I'm inviting you to, but that is  
13 something that you could check out.

14 MR KIRTON: Madam Chair, just in terms of the issues you raised with the  
15 Ministry of Health, you may overlooked the issue of monitoring and  
16 evaluation which you'd asked for, if I remember correctly, a response from  
17 the Director General in terms of her commentary with the Select Committee.  
18 I bring that to your attention.

19 CHAIR: Yes, well, we've certainly thrashed monitoring and evaluation to  
20 death, but you are right, Mr Kirton. I had, as a result of a newspaper report,  
21 and then cross-examination of Dr Peters, queried whether or not there was a  
22 tension there between the evidence the Inquiry has heard and what was  
23 reported in the newspaper and I left it, Mr Murray, on the basis that you  
24 would get back to me and let me know what the position was.

25 MR MURRAY: We haven't forgotten.

26 CHAIR: No. All I can say is, I, to a degree, am in your hands, but bear in  
27 mind I will give you the opportunity to lead more evidence, but obviously

1 the closer we get towards the end of the week the more difficult it becomes.  
2 The other point I'm aware of is that there was one woman affected who  
3 wanted to give evidence on Saturday by reading her evidence out – she did  
4 not have that opportunity; there are three others who want their evidence to  
5 be accepted just in the usual way and taken as read. I will, if I can, fit that in  
6 as well. From my own perspective, the priorities really are to hear the  
7 witnesses that are set out here in the schedule, to hear anyone who is giving  
8 evidence to respond to any adverse criticism, to hear the women affected  
9 who want to be heard, and I would put Dr Linehan and Ms Wilson at the  
10 bottom of the list. That's my preliminary indication. I was not going to  
11 deal with this because I wanted to think about it more tonight, and I also  
12 thought it was late in the day, but having given you my preliminary views  
13 you could all think about it and we could firm up on things tomorrow.

14 MR HODSON: If I can make one observation, ma'am.

15 CHAIR: Yes, Mr Hodson.

16 MR HODSON: In case there be concern that the additional evidence which  
17 my friend wishes to adduce from Dr Linehan and Ms Wilson might be  
18 critical of Dr Bottrill and thereby lead, in turn, to the further difficulties, I  
19 understand from my friend that he is not leading evidence of that nature and  
20 I'm perfectly happy to stay out of this particular debate on that basis.

21 CHAIR: Yes, I understood, too, on Saturday that he dealt with all that  
22 evidence first, yes. Very well, we will come back to it tomorrow, but you  
23 know what the committee is thinking for the moment.

24 MR GRIEVE: When the time arises tomorrow Madam Chair, will you, I  
25 take it, accept an oral application for the issue of a sub-poena?

26 CHAIR: Well, I have to be persuaded. You can make an oral application,  
27 you don't have to make one in writing, but I will need to be persuaded that it

1 is necessary. In other words, I will need to know what the evidence is that  
2 you want to extract from this witness, and to what degree it will assist us in  
3 answering the terms of reference, and my other concern is if we do sub-  
4 poena Dr Linehan I don't want a situation arising where he's sitting in the  
5 back of the hearing room and we still don't get to hear from him because  
6 he's been pulled back and forwards a number of times.

7 MR GRIEVE: I entirely accept that Madam Chair. My concern is that if  
8 there is time, then I don't want to be met with, "Oh, well, he's gone to  
9 Sydney for a holiday."

10 CHAIR: Right. We will come back to it first thing in the morning. As I  
11 said, bear in mind, too, the other matters that I have raised, because these  
12 other witnesses named here – for example, Mr Lambie is being called  
13 because during Ms Glackin's evidence there were questions which we  
14 wanted answered which she could not answer and she said Mr Lambie  
15 could, we still want those questions answered. We are certainly interested to  
16 hear from Ms Matcham on the Register. We want to hear from Mr Cohen  
17 and, if we can, from Ms Handiside. There are new issues I want to raise  
18 with Dr Peters. So, they are important. I understand, Mr Murray, that Ms  
19 Wynn – I haven't read her brief, but I'm told by counsel assisting that she's  
20 very new to the Kaitiaki Group and really doesn't have much to add to it.

21 MRS SHOLTENS: Ma'am, she basically has managed the administrative  
22 support for the group for a two year period, so as far as I am aware she  
23 hasn't attended any meetings or anything like that.

24 CHAIR: It doesn't seem she's helped. The reason why there was this  
25 opportunity to call someone from the Kaitiaki Group is because throughout  
26 the Inquiry we have heard from various witnesses who have described  
27 scenarios whereby information which they say is important has not been

1 made available, or if so, not in a timely fashion as a result of the Kaitiaki  
2 Group or the regulations. It also seems that there has been an improvement  
3 in that process as of late. But it may be, in the report – or firstly it may be in  
4 submissions that we are faced with submissions about the Kaitiaki  
5 Regulations having a detrimental impact and we may wish to deal with that  
6 in the report, and, therefore, we wanted to ensure that the Kaitiaki Group had  
7 every opportunity to provide their views to the committee. Now I can't see  
8 how Ms Wynn could do that.

9 MRS SHOLTENS: No, she couldn't ma'am, she simply provides the terms  
10 of reference and copies of minutes that I understood the panel were after.

11 CHAIR: It would be helpful to have the terms of reference and the minutes  
12 so that we could get a – at the moment we've heard a very one-sided picture;  
13 we've heard from people who are complaining about the impact, we haven't  
14 really heard the opposite side and it's very difficult, therefore, to get any  
15 view on this group and the regulations when we haven't had a balanced  
16 picture of what is going on.

17 MRS SHOLTENS: At this stage what Ms Wynn's affidavit does is simply  
18 produce those documents, and to the extent that if the panel would wish to  
19 hear from another member of the Kaitiaki Group, I could make enquiries or  
20 otherwise perhaps let them know that these are the concerns which you have  
21 and offer them an opportunity.

22 CHAIR: Yes. It's perhaps the latter course. Let them know what our  
23 concerns are – you will be aware of the evidence, and a number of concerns  
24 certainly were raised with Ms Earp when she was giving her evidence – and  
25 see whether or not anyone from that group wants to take the opportunity of  
26 coming forward and giving us a picture of the work they do and why they do  
27 it in the way that they do.

1 MRS SHOLTENS: All right, thank you ma'am, we will make enquiries.

2 MR HINDLE: Just so that I'm clear, does that mean that the affidavit of  
3 Ms Wynn will be received into evidence?

4 CHAIR: Yes.

5 MR HINDLE: But no further hearing of it is expected or required?

6 CHAIR: No. We will adjourn now until 9.30 am.

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10 THE HEARING ADJOURNED AT 5.22PM, TO RESUME AT 9.30AM

11

TUESDAY 1 AUGUST 2000

12