UNDER THE HEALTH & DISABILITY SERVICES ACT 1993

IN THE MATTER OF THE MINISTERIAL INQUIRY INTO THE UNDER-REPORTING OF CERVICAL SMEAR ABNORMALITIES

BRIEF OF EVIDENCE OF DR TONY BAIRD

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KENSINGTON SWAN
SOLICITORS
AUCKLAND & WELLINGTON
Person acting:
M F McClelland/J C Elliott

Contact details:
Ph 04 472 7877
Fax 04 472 2291
PO Box 10 246
DX SP26517 WELLINGTON

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Introduction

1 My full name is Michael Anthony Hugh Baird. I am a specialist obstetrician and gynaecologist practising in Auckland.

2 In 1996 I was elected as a member of the first Medical Council established under the Medical Practitioners Act 1995 ("the 1995 Act Council") and was elected as President of the Medical Council each year since.

3 In preparing this brief of evidence I have reviewed the Medical Council file relevant to Dr Bottrill.

4 In this brief of evidence I commence by outlining the role of the Medical Council under the 1995 Act and then the relevant events in which the Medical Council has been involved with Dr Bottrill. I move on to the issue of the maintenance of standards, proposed changes to the 1995 Act, and then to my conclusion.

The Medical Council's role under the 1995 Act

5 The focus of the Medical Council role under the 1995 Act is to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure medical practitioners are competent to practise medicine. The focus is on the public but the powers of the Medical Council are directed towards individual medical practitioners and the legislation is designed to provide support throughout a practitioner's working life to maintain lifelong learning and support through oversight, supervision and involvement in programmes to maintain professional standards.

6 Specifically the Act seeks to attain its principal purpose by amongst other things:

(a) imposing various restrictions on the practice of medicine;

(b) providing for the registration of medical practitioners, and the issue of annual practising certificates;

(c) providing for the review of the competence of medical practitioners to practise medicine;

(d) providing for the notification of any mental or physical condition affecting the fitness of a medical practitioner to practise medicine;

(e) providing for the disciplining of medical practitioners;

(f) providing certain protections for medical practitioners who take part in approved quality assurance activities.

The Council's current role in reviewing doctors' competence

7 The Medical Practitioners Act 1995 authorises the Medical Council to review at any time the competence of any medical practitioner who holds a current practising certificate, whether or not there is reason to believe the doctor's competence may be deficient. In practice, Council will review a doctor's competence in response to concerns raised by, for example, a patient, a colleague, a medical college or Health & Disability Commissioner.

8 This possibility was not available under the 1968 Act.

9 The Medical Practitioners Act 1995 established a new disciplinary system for medical practitioners and the Council's role is now limited to receiving complaints and conviction notices, appointing Complaints Assessment Committees ("CAC") which investigate complaints about doctors (which occurred before 1 July 1996) and all convictions and where appropriate lay charges before the Medical Practitioners Disciplinary Tribunal ("MPDT"). A CAC has other options for action available to it if the matter is not determined to be appropriate for

referral to the Tribunal, and these include referral back to Council for consideration of health or competence.

10 The MPDT is a separate statutory body to the Council (although administered by it, with funds from members of the medical profession through the levy charged with the fee for annual practising certificates) which hears all charges against medical practitioners. The MPDT is chaired by a lawyer and each hearing has a panel of two members of the public. This body hears charges in public and identifies doctors unless name suppression is granted, a radical change from when the case of Dr Bottrill was first considered by the Medical Practitioners Disciplinary Committee ("MPDC") and on appeal to the Medical Council under the 1968 Act.

Medical Council and Dr Bottrill

11 At a Medical Council meeting on 10-11 March 1998 it was noted that the appeals of Dr Bottrill and Patient No. 1 from the MPDC decision had been dismissed ("MAHB/MCNZ/0001").

12 Those present at the Medical Council meeting were: Drs Baird, St George, Adams, Kletchko (who represented the Director General of Health), McKergow, Scott, Mrs Judd, myself and Mr van Roen. At that meeting the full decision from the hearing of the appeal was tabled.

Correspondence from Mr Grieve QC, Ministry of Health and the Health & Disability Commissioner

13 On 29 March 1999 Stuart Grieve QC, as counsel for Patient No. 1 in the High Court case, wrote to me as President of the Medical Council of New Zealand ("MAHB/MCNZ/0002"). Mr Grieve advised that whilst Dr Bottrill had been found to be negligent by the trial Judge it had not been established that his conduct was so outrageous as to warrant an award of exemplary damages. He referred to evidence

given at the High Court trial that since Dr Bottrill had become a Fellow of the Royal College of Pathologists of Australasia in 1973 he had undertaken no continuing education nor had he participated in any quality assurance programmes; and the evidence had indicated that his laboratory standards with regard to his cytology slides were well short of the norm. Mr Grieve expressed his view that there was a real danger that other women had had their slides similarly underreported and maybe were developing invasive cancer. He stated that the purpose in writing to the Medical Council was in the hope that appropriate steps would be taken to review the slides read by Dr Bottrill. A similar letter had been sent by Mr Grieve to a number of other organisations.

14 In a letter dated 3 May 1999 from Dr Julia Peters of the Health Funding Authority to Mr Grieve, and copied to the Medical Council, the HFA advised that it was at that time finalising a proposal to review pathology specimens read by Dr Bottrill ("MAHB/MCNZ/0003").

15 On 10 May 1999 Sue Ineson (Chief Executive Officer of the Medical Council) and I met Dr Bob Boyd and Mr Michael Chapman from the Ministry of Health. The purpose of the meeting was to look for ways to prevent in the future a repeat of the concerns and issues arising out of the Dr Bottrill case. Both the Ministry of Health and Sue Ineson made a file note ("MAHB/MCNZ/0004") of the meeting. One of the factors identified at the meeting was that the disciplinary process had been heard in private. A comparison was made with the more recent case (under the 1995 Act) where a doctor had reused needles and in that case the disciplinary hearing had been held in public so that the public and the authorities were alerted to the problems. It was noted that this case also highlighted the fact that even then there were no systems or procedures in place identifying who should be alerted and by whom. It was agreed that a system should be put in place that ensures that where there is a possibility that systemic issues contribute to a problem they are identified and acted on.

16 In a letter dated 12 May 1999 to Mr Grieve QC ("MAHB/MCNZ/0005") (in response to his letter of 29 March 1999) I indicated that I would discuss the issues he had raised, with the Ministry of Health. I also recorded that the current Medical Council has no influence over the hearings of the MPDC and appeals heard by the Medical Council established under the 1968 Act.

17 I did note that in my view there was an issue of public health and safety arising from the recent case in the High Court and it was for this reason that I was meeting with officials from the Ministry of Health.

18 By letter dated 17 May 1999 ("MAHB/MCNZ/0006") the Health & Disability Commissioner wrote to the Medical Council and enclosed a copy of her letter dated 4 May 1999 to Mr Grieve. She requested that when the Medical Council implements its requirements for vocational registration it should note that membership of a College should not automatically entitle a person to vocational registration unless that College has relevant continuing medical education and quality assurance programmes in place for its members.

19 In a letter dated 1 June 1999 ("MAHB/MCNZ/0007") I wrote to the Health & Disability Commissioner and, amongst other things, pointed out that vocational registration by the Medical Council is quite separate from membership of a professional College, it being necessary to ensure the Medical Council is independent of the Colleges; but that the Medical Council does take advice regarding the equivalence of training and experience prior to considering applications for vocational registration in New Zealand. I also noted that there remained a problem of practitioners working in isolation.

20 In addition I pointed out that from July 2001 all practitioners in New Zealand will have to provide evidence that they are partaking in programmes for the maintenance of professional standards when they are vocationally registered deeming them re-certification programmes

as required by s63 of the 1995 Act. The Medical Council is intending linking this requirement to the granting of an annual practising certificate. Reference was also made to the fact that existing College members who gained vocational registration automatically after the change of the 1995 Act will partake in these programmes and therefore maintain clinical competence. The letter also acknowledged that it will be the responsibility of the Medical Council to ensure that vocational registrants who are not members or Fellows of a College undertake an approved programme. (In fact most of the members of the Council of Medical Colleges have now agreed that their collegial programmes to maintain standards, will also be made available to non-Fellows).

21 On 4 June 1999 the Medical Council received a letter from the Ministry of Health summarising the discussions at the meeting held on 10 May 1999 ("MAHB/MCNZ/0008"). In that letter issues were identified and discussed relating to the definition of a complaint and its co-relation with competence and competence reviews under the 1995 Act; the competence review procedures under the Act were also discussed; as was the issue as to whether there should be power to suspend a practitioner while under investigation rather than simply at the end of the investigation when charges had been laid; there was also discussion about putting in place an effective mechanism whereby in the course of an investigation by the HDC or a CAC there is the power to notify the Minister of Health if a risk to the public was identified and where a possible follow up of patients was necessary; it being noted that an amendment to the Medical Practitioners Act and the Health & Disability Commissioner Act would need to be made.

Working Party report

22 In July 1999 a working party was established to look at registration matters and to ensure that risks to the public are minimised through adequate provisions within the Medical Practitioners Act 1995. A

copy of the Working Party's Terms of Reference are attached ("MAHB/MCNZ/0009") The members of the Working Party included representatives from both the Medical Council and Ministry of Health.

23 At the end of July 1999 the Working Party completed its report ("MAHB/MCNZ/0010") which included a number of recommendations in respect of registration and competence. This was considered by the Medical Council at its August 1999 meeting.

24 On 26 August 1999 the Ministry of Health distributed a discussion paper ("the Competence Paper") on proposed amendments to the Medical Practitioners Act 1995 to give better protection of the public from incompetent doctors. The Council sent a summary of progress to the Ministry of Health on 10 October 1999 ("MAHB/MCNZ/0011") and a paper was tabled at the Medical Council's meeting in October 1999, regarding the report of the Working Party ("MAHB/MCNZ/0012").

25 At its meeting on 12-13 October 1999 the Council reviewed the paper and I attach an extract of the Council minutes for 13 October 1999 ("MAHB/MCNZ/0013").

26 By letter dated 5 October 1999 the Medical Council and other organisations were invited to respond to the Ministry of Health discussion document in respect of proposed changes to the 1995 Act ("MAHB/MCNZ/0014").

27 On 24 November 1999 the Medical Council responded in detail to the Ministry of Health's discussion paper ("MAHB/MCNZ/0015"). While the Working Party has now completed its tasks, Council has been continuing to work on the outstanding issues. This includes working on changes to the 1995 Act, including changes relating to maintaining competence, further work on registration policies and scopes of practice and delegation to the registrar.

Complaints received by the Medical Council in respect of Dr Bottrill

28 On 18 October 1999 the Medical Council received a report from ACC with respect to claims for medical error which it had accepted on behalf of Patient No. 3, Patient No. 8 and Patient No. U. On 8 November 1999 the Council received notification from the HDC about complaints in respect of Dr Bottrill from these same women. These complaints were referred to the Council because they related to events occurring between 1990 and early-1996.

29 On 10 November 1999 Council received notification from the Health & Disability Commissioner about several complaints for events 1990-1996 relating to Dr Bottrill. The Commissioner referred these to the Council for action as they were pre-1996 complaints. They had originally been sent on by ACC as there had been claims of medical error.

30 I discussed setting up a CAC to deal with these complaints but we were informed by ACC that they expected to forward more cases to the Council. For this reason setting up a CAC was postponed so that one CAC could be appointed to deal with all cases and because it was known Dr Bottrill was not practising, so there was no public safety consideration.

31 Council understands that most of the additional cases have been referred to the Commissioner as they are post-1996 complaints.

32 The Council is now in the process of appointing a CAC to investigate the further complaints ACC had forwarded in respect of Dr Bottrill. The CAC sets its own procedure but at this stage it is likely it will wait until the Ministerial Inquiry has been concluded before it embarks on a detailed investigation of the complaints.

Maintenance of Standards

33 The medical colleges have now developed programmes to maintain professional standards; these have been evolving over the past two decades and, as evidence has accumulated, the components of the programmes have been assessed. The Medical Council has had discussions with representatives of the colleges on many occasions and, since a meeting in November 1998, there is agreement that programmes should include self audit and peer review.

34 Starting 1 July 2001, the Medical Council will commence a cycle which will require evidence of involvement by vocational registrants in an approved programme to maintain professional standards before granting Annual Practising Certificates. Doctors will have three years to comply with the requirements (Section 63). In the early 1990s maintenance of standards was the responsibility of each individual practitioner, although the Royal New Zealand College of Obstetrics and Gynaecology has had a formal programme of continuing medical education for twenty years. In previous years, most hospitals and laboratories have made arrangements for the maintenance of quality, with members of the senior medical staff travelling to overseas centres to gain new skills or improve existing ones, and dealing with poor performance when it was recognised. For the most part this worked well.

35 The other processes that are relevant to the maintenance of standards are the Health & Disability Services Code of Consumers Rights (Right 4 in particular) the requirements of “purchasers and funders and providers” within the new health structure, the formal requirements for measures of quality, changes to processes for accreditation of units and individual practitioners including the current project on credentialling of medical practitioners (an initiative of the HFA to which the Medical Council is contributing).

Changes proposed to the Medical Practitioners Act 1995 to try to prevent a recurrence of the problems that have been brought to this Inquiry

36 Currently the focus is on the medical practitioner and not on systemic or wider issues though in the last few months the Council has used s123(g) of the Act to advise the Minister on a case concerning the competence of a medical practitioner where it had reason to believe wider public health issues may exist.

37 However under existing legislation a post-1996 complaint may be being investigated by the Health & Disability Commissioner without the Council being aware of the case. In addition, ACC and other workplace insurers are not required to report cases of medical error to the Council. The Council has argued against this and has unsuccessfully asked work place insurers to voluntarily inform us of any cases of medical error.

38 Direct involvement of the Director-General of Health on the Medical Council ended with the passage of the Health Occupation Regulation Amendment Act last year and that is seen as a loss for the Medical Council because the potential for the flow of information between the two bodies ceased. Some alternative arrangements are being made to provide contact between the Ministry of Health and Medical Council. These include the setting up of six monthly meetings between the President and CEO of the Council and the Director-General for exchange of information, six monthly meetings between the Council President and the Minister of Health on current issues, formal links between the CEO of Council and the Ministry Desk Office, Council and Ministry Policy Adviser meetings and liaisons, and liaisons as required with the Ministry staff member responsible for ministerial appointments to Council and the CEO.

39 Co-ordination of these bodies and strengthening the ability of the Council and its committees to consider wider issues are currently being proposed as consequential amendments to the Act which are

supported by the Council (as shown in the Council's response to the Ministry on the proposed changes). These will:

(a) encourage reporting by other health professionals of a medical colleague whom he or she has reason to believe is not competent to practise;

(b) put in place systems and Act changes ensuring CACs and Competence Review Committees have an obligation to report to the Minister where they have reason to believe other members of the public may be at risk;

(c) ensure the Health & Disability Commissioner and Colleges, employers, ACC and other health and safety insurers refer cases of incompetence to the Council.

Other aspects of the current Act that help to maintain professional standards

40 The current Act in s52 requires the Council to be informed by the Registrar, when APCs are to be issued, if:

(a) the applicant has at any time failed to maintain a reasonable standard of professional competence; or

(b) the applicant has failed to satisfactorily complete the requirements of any competence programme that applies to him or her or that he or she has been ordered by the Council to complete; or

(c) the applicant is a medical practitioner to whom a re-certification programme applies; or

(d) the applicant has not held an APC within the three years immediately preceding the date of application; or

(e) the applicant has not engaged in the practice of medicine within the three years immediately preceding the date of application.

41 Medical Practitioners:

(a) with temporary registration must have supervision that the Council has approved;

(b) with probationary registration must work under the supervision of a doctor approved by Council;

(c) with general registration need to be subject to the general oversight of a person who holds vocational registration in the branch or sub-branch concerned (s20(1));

(d) with vocational registration must be in a re-certification programme to ensure the maintenance of professional standards.

42 These processes, once completely implemented, will ensure no medical practitioner is operating alone and practitioners will need to undergo self audit and peer review to ensure maintenance of standards.

Conclusion

43 I wish to pay tribute to three groups of people: first, the women who brought their stories to this inquiry, reminding us of the purpose of the health service. Secondly, to the people in the Ministry of Health who have continued to work despite repeated upheavals with changes to the structure of the health service and the Ministry. Thirdly, to the members of the medical profession who have endured a difficult decade of unprecedented change and whose representatives in Colleges and Societies have worked hard to show accountability and to improve professional standards.

44 The challenge is to continue to work together constructively, supporting each other to improve the service and reduce error through education and at the same time striving to improve the environment in which practitioners work. The Medical Council is committed to working towards this end.

M A H Baird
President, Medical Council of New Zealand
16 June 2000