

**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 MICHAEL BERNARD BOTTRILL

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Introduction

1 My full name is MICHAEL BERNARD BOTTRILL. I live at 24 Russell Street, Gisborne.

2 I am a registered medical practitioner and practiced as a pathologist until I retired in 1996.

3. My qualifications are:

- a) MBChB (1953 Birmingham);
- b) Fellow of the Royal College of Pathologists of Australasia (1973);

4. My brief of evidence has been structured taking into account the suggestions made by Counsel Assisting the Inquiry as to the areas which need to be covered under Term of Reference no. 2.

Pathology training

5. I undertook a course of training in pathology lasting four and a half years from March 1957 to September 1961. During that time I had the opportunity to study gynaecological cytology with the specialist at the women's hospital in Leeds, on a part-time basis, for a period of three months. Later on in my training I went to Wakefield (Pinderfields Hospital) in Yorkshire where I worked in a hospital with a large chest surgery unit. At that hospital there were a significant number of cytology examinations on sputum and similar material. I also took charge of the laboratory during the pathologist's absence. Koss' text on Cytology has been mentioned; I recall reading this but I do not recall detail.

6. After September 1961 I emigrated to New Zealand. I worked as the sole pathologist at Whangarei Hospital until 1966 when I was offered the position at Gisborne Hospital.

7. I did not read cytology at Whangarei Hospital. The time needed on my other areas of work precluded this. The gynaecological smears were sent to National Womens. Dr Williams, pathologist at Auckland Hospital, was my visiting pathologist during my time at Whangarei. The Department of Health had a few inspecting pathologists at that time who went around to other laboratories once per year. The pathologist would come for a day and talk about what we were doing and the staff who worked in each Department. I also had regular contact with Dr Williams, Dr Flora Smith and the registrars at National Womens or Auckland Hospital to discuss slides and developments in pathology. These informal meetings with colleagues became a part of a pattern that I kept up for the rest of my practising life.

8. I started reading cytology smears in 1967. After that year Mr Reeve and I

started the private laboratory, and I spent 50% of my time at the private laboratory and 50% in the Hospital until 1974 when I commenced fulltime private practice.

9. Although I was a general pathologist I had a special interest in cytology. This was because of my position in Gisborne and my connection with Dr Stephen Williams. During the thirty years I practiced in Gisborne I examined approximately 90,000 gynaecological smears. I am a founder member of the New Zealand Society of Cytology. I undertook cytology readings from 1967 to 1996 in the Gisborne area. I also worked in the areas of forensic pathology and histopathology.

College membership

10. In 1963 I had applied to take the Royal College of Pathologists entry examinations. There were two reasons why I did not complete those examinations. The first was that I was working in Northland and I was the only pathologist working north of Auckland. The job was extremely busy involving monthly visits to Kaitaia, Dargaville, Kawakawa and a number of other towns. I was also responsible for coroners' autopsies. The other reason was that I contracted tuberculosis. I therefore had to withdraw from the examinations.

11. In the early 1970's the College of Pathologists of Australia was actively recruiting members in New Zealand. At that time we had no professional body of our own, and Australian members of the College came across to address New Zealand pathologists at meetings and encourage us to join them. A number of New Zealand Pathologists had joined the College by that time, and were enthusiastic about it. In about 1972 or 1973 I approached the College again with a view to taking their examination. I was advised by the College that it would not be necessary for me to take the full examination although I was quite prepared to do so. I did however sit two practical examinations and an oral examination. There was no cytology component in the examination. I was made a Fellow of the College on 10 December 1973.

New Zealand Society of Pathologists/Society of Cytology

12. I was a member of the New Zealand Society of Pathologists. I joined this organisation in approximately 1961, and remained a member until my retirement. An interest in pathology was all that was required to belong to this organisation.

13. I regularly attended functions and meetings of that organisation, initially annually and later approximately every two years depending on where the meetings were held. There were also annual meetings of the North Island division of the New Zealand Society of Pathologists in Rotorua, which I attended regularly. I cannot now recall the specifics of the dates relating to these meetings.

14. I had no specialist qualification in cytology. This was in common with many of my colleagues. There was no requirement for any cytopathologist to have any such specialist qualification.

15. In the late 50's and early 60's the importance of cytology as a subject was highlighted by Professor Carey, together with Dr Stephen Williams and Dr John Sullivan who were interested in cervical cytology as pathologists. In the late 1960's it was suggested that a Society should be formed composed of both pathologists and technologists. This Society was formed so that all of those who were interested in cytology would be able to learn and confer and talk to each other because they held this common interest. Up until that time there had been something of a wall between the medical and non-medical cytologist. The leading light in the formation of the Society of Cytology was Dr Stephen Williams of Auckland. He invited me to join. I thought it was an excellent idea. I joined when the scheme was mooted. The Society did not involve anything mandatory, but annual meetings of a scientific nature were held and in addition there were sporadic meetings when overseas visitors were in New Zealand. For the first ten years in the 70s and 80s I attended all of the Society's meetings. After about 10 years I started going on alternate years.

16. I was aware that formation of the International Academy of Cytology was being propounded. Dr Williams put my name forward to the organisers as a potential member, but because I felt this should be an academic society and I did not regard myself as a specialist in cytopathology, I declined the offer. Not being a member I have not studied for election as a Fellow of that Society. I did already have available to me the periodical *Acta Cytologica* which was one of the benefits of membership.

Gisborne Laboratory

17. As I have stated, I began practice at the Gisborne Laboratory in 1967 following one year as the pathologist at Gisborne Hospital. At the laboratory I examined nearly all the cervical smears from the Gisborne and East Cape regions.

18. I was the only person at my laboratory to read cytology smears except when I was on leave when a locum pathologist would read those slides. Occasionally, if there was a time period when I needed assistance during the year, I would ask the hospital pathologist, if they were available, to assist me by reading some smears for a period of one or two weeks. This generally happened when the work load increased, and I utilized the services of the hospital pathologist so that I did not get behind in my reporting. Between 1990 and 1996 the locum pathologist would generally be the pathologist who was at that time at Gisborne Hospital. I cannot now remember who performed the locums from 1990 to 1996. The pathologists who were at Gisborne Hospital during this time were Drs Singh, Chan and Padwell.

19. When I asked a locum pathologist to look over the slides, I would go over their reports and slides for the first week, and then would perform the usual 10% random re-screen that I did myself. When I was away I did not go back and check on smears read by locums.

20. I will describe the procedure for the time period relevant to this inquiry on receipt of cytology specimens. There was generally a 24 – 48 hour time lapse between the slides being received at the laboratory and the reports being issued. Every slide that was

received at the laboratory was labelled immediately with a number using a diamond pencil. The slide was already labelled with the patient's name as given by the referring doctor or smear-taker. This label was a paper label and was removed once the diamond pencil label was applied. If the specimen had not been labelled when taken, or mislabelled, then administration telephoned the taker to check the missing data.

20. All specimens were given consecutive numbers, manually at first, and then later on the computer. Cytology slides had their own numbering system. Cytology slides were numbered from 1 at the beginning of each year, and had the year of referral as part of the numbering system. The slides were then stained and coverslipped and referred to me with the ink markings on in a slide tray. The laboratory used as a standard coverslip size 50 x 22 mm. Sometimes however, these coverslips were not available, and 40 x 22 mm coverslips were used. I do not recall any detail of this.

22. I then looked at all the cytology slides in my office. I put the patients' names up on my screen. Bethesda codes were entered into the computer for the various reports. If a cytology slide was normal I pressed "N" and a normal cytology report ensued.

23. It was my practice to enter the results as I looked at the slide and to print out the reports at the end of the session. When the reports were printed they were divided into the reports to be sent out and the reports for filing. The reports were then placed with the request form together in a pile. It was my usual practice to look at them to make sure that the reports were suitable for the slides to which they referred; that I had not missed any obvious clinical particulars which would have led me to re-examine the slide for example. I stopped signing each report shortly after I started using the computer to print the reports.

24. The reports were filed numerically and alphabetically, the original having been printed and sent. The cytology slides themselves were then stored in filing cabinets in my office and moved to a separate storage facility outside the laboratory later.

25. My work station in the early 1990's was a largish desk, the microscope was kept on a shelf and was placed in the middle of the desk for me to work with. The computer keyboard was just to the left of the microscope when I was working. The microscope was an Olympus BH2 with x 10 eyepieces, x 4, x 10, x 20, x 40 flat field objectives. Prior to that time, I had microscopes of similar capacity. Most of the time I used a x 20 magnification for screening. Any cell of importance would be examined under x 40 objective. It would be usual for me, when screening slides, to go to a x 40 objective.

26. When I read cytology slides, my procedure was as set out below:

i) It was first necessary to look to see if the slide was satisfactory for reporting. If the slide was deemed satisfactory for reporting, ie the specimen was visually clear and contained cells recognised as originating inside the cervix, then I could continue with the procedure to report the slide. If the slide was not satisfactory for reporting, I would ask the smear taker to perform a repeat smear.

ii) Some slides fell between the categories of satisfactory and unsatisfactory.

These were classified as less than optimal. In these cases, if I was able to accurately report the slide I would advise the smear taker that the slide was adequate for examination but I also set out the difficulties with the slide that made it less than satisfactory. This alerted the smear taker to the need to repeat the slide.

iii) Provided that the slides were satisfactory or adequate for reporting, I would then scan the slides looking for cells that did not correspond with normal cells. If such cells were found then it would be necessary to determine why they did not correspond with normal cells.

iv) The reading of cytology slides would have taken 20-25% of my daily practice time. During the last few years of practise I read approximately twenty cytology slides per day; or approximately 100 per week. I would take 5 – 7 minutes on screening each slide. Those with abnormalities would take longer. I did not mark abnormal slides as such; there was no-one who would see such marks.

Principally I divided my cytology reports into four groups; normal, low grade, high grade or cancerous. I defined high grade as CIN 2 onwards and low grade as HPV alone or CIN 1 with or without HPV.

My attitude to an ascus classification was that it was a category to be avoided whenever possible. There were times when there were cells present were of doubtful significance. A repeat smear would be requested by me. On the whole however, it was not a category that I would have often used.

27. I knew the doctors in the area very well. Sometimes that meant that I could use some latitude when reporting smears. For example if a woman presented in the early stage of pregnancy with a routine smear and the smear was normal or showed minor abnormalities, there was no problem. If the smear showed severe abnormalities, again there was no difficulty in reporting that. Very occasionally however one would come across slides where the abnormality was on the borderline of mild and severe, in other words between CIN 1 and CIN 2. Under those circumstances I would telephone the patient's doctor and ask if there was additional clinical data that would help me and in particular whether this was a person who was likely to come back regularly for check ups when required. If the answer was in the affirmative I would probably report the abnormality as a low grade. If on the other hand it was not advisable because of doubts as to whether repeats would be done I would report it as high grade.

28. After about 1990 and following litigation in Australia and potential litigation in New Zealand I made all my reports entirely on cytological grounds. In my opinion that was not necessarily to the advantage of the patient. I can recall this litigation being discussed at an Association of Community Laboratory meeting but no longer recall the details. The compelling cause was that if you reported a high grade squamous intraepithelial neoplasia the recommendations were (and still are) that the person should be referred for colposcopy biopsy and cone biopsy. If a woman was pregnant, one of the two gynaecologists in Gisborne was very averse to doing anything with women during pregnancy.

29. The population that I catered to was small; the total Gisborne community not surpassing more than 45,000 people. I estimate that I read 90 - 95% of all the cytology in the area. However, I have subsequently been told that approximately 2,000 of the 23,000 slides that were read over the 1990 to 1996 time period were read by locums. I would therefore reduce my estimate of the amounts of cytology I read in the area to approximately 90%.

30. In my practice I concentrated on haematology, histology and cytology. The laboratory manager and chief technologist was in charge of the administration work in the laboratory from 1967. I had a total staff of sixteen. That included the administrator, two clerical staff members and myself. The other members of staff were technologists and laboratory assistants who primarily took blood, assisted in the microbiology, haematology areas and in the biochemistry area. The laboratory had a total number of referrals covering about 750 patients and 2,200 tests a week. Of these, 1,800 a year were histology with 4,500 to 5,000 being cytology annually. My workload between 1990 and 1993 was approximately 16 - 18 smears per working day. By 1995 it had risen to approximately 20 per day or approximately 5000 per annum. While histology and cytology was approximately 6% of the total workload, these referrals occupied my time fully.

31. Because there was a shortage of cytotechnologists between 1990 and 1995, I essentially acted as my own screener. There was not enough work for a full-time screener. I did not want to act as my own screener, but there were not sufficient screeners to fill city vacancies, let alone vacancies for part-time screeners in rural areas. I did not wish, however, to give up cytology altogether, as I wished to offer a full service to the Gisborne locality. I had placed an advertisement for a screener in the mid to late 80's, locally, to see if anyone was interested in part-time work. I had no response. There was a member of the hospital staff who had trained in cytotechnological diagnosis in about 1989, I think, but she was the only cytotechnician in Gisborne during my time of practice.

32. A question has been raised by the report into the Sydney re-reading, regarding a number of smears that have supposedly had cover slips on the wrong side of the smear. My view would be that it would be quite impossible to have examined such slides under a high power. It would be immediately apparent under x40 magnification if the cover slip was on the wrong side of the slide. I could not have reported slides with the cover slips on the wrong side of the slide. I do recollect that rarely slides would be presented with coverslips on the back. It was my practice to return these for the coverslip to be removed and replaced on the correct side. I am told that 5-10 slides have been found with coverslips still on the wrong side. I cannot definitively explain how this could happen. However, it is consistent with my practice that if despite the coverslip being on the wrong side I could determine that the smear was not adequate for examination I would not have it recoverslipped but simply request a repeat. With reference to Dr Farnsworth's comments on keratinised slides, I do recall seeing some; I was not surprised because many women had had no previous smears.

Laboratory records – computer use

33. The laboratory files were kept on a card index system for cytology.
34. A computer was used to store laboratory data from 1982. Cytology files were entered on to the computer system in 1986. The system did not allow for the automatic retrieval of all information on a patient. Many women changed their names and there was no certainty under which name they would be referred (for example Patient One's name changed; she married before her last smear). Also in Gisborne there is a high Maori population and many women use more than one surname.
35. I still kept the manual system so that both systems were running side by side. The systems always ran side by side mainly because I found it easier to go through the report forms and request forms than to look it up on computer. The numbers were relatively small and I did my own computer programming. It is very hard on the computer to make the machine allow for differences of spelling and minor differences of that sort which I found extremely easy when done by eye.
36. By 1992 I could bring up patient reports for that year by name. I could not access the other reports while doing a particular report; searching the data base would have to be done separately from reporting the slide. My computer held the current Bethesda codes which I changed when notified to do so by the Ministry.
37. In 1989 I was visited by Mr Miller, and Ms Francis-Saunders, of the Implementation Unit for the Cervical Screening Programme. I cannot now recall very much about that visit, however I do recall that the majority of the discussion was technical, about the information that could be presented to the screening programme by our laboratory. I have read their note of the meeting. I make no comment on their view of me. I can recall however that I was given options, by Mr Miller and Ms Francis-Saunders, which included an option called the "minimum data entry option" which meant that data could be produced on floppy disk and given to the screening programme. This was an option given by AZIMUTH, a computer software firm which had the job of integrating the National system for cytology and histology. It was my recollection that minimum data entry option was one discussed with Ms Francis-Saunders and Mr Miller.
38. I have had the opportunity of reading Dr Boyd's evidence in relation to a complaint made by Dr Sam Coster who was at that time the special area doctor at Te Araroa, regarding his concern that he had had no abnormal smears reported by me in a three year period. I was not ever notified by anyone of those concerns, nor am I able now to comment on them.
39. At the end of the 1980s I was averaging approximately 4,000 to 4,500 smears per annum. By the mid 1990's I was averaging approximately 5,000 plus smears per year. I felt that that number was a maximum for me. I could not have realistically increased that number in my working day.

Quality Control

40. During my time as a practicing pathologist I did a number of quality control checks in relation to cytology readings. I would select every smear with a zero on the end of the number, and re-look at that smear and my report. This meant that I was reviewing randomly 10% of the slides that I reported. I cannot now recall exactly when I commenced this practice, but believe that it was in the mid 1980's. I reviewed the slides by looking at the slide first, and then looked at the report. I did not keep a note of the results of the random re-screening. I am sure that if I had suddenly come across a serious abnormality I would have remembered it. Because of the number of slides I was reading I would have conducted a random review approximately once a week.

41. As I have previously stated, I archived slides according to the computer number allocated to them with the intention of keeping them indefinitely. Every month I had a system whereby I obtained a printout of all abnormal smears that had been reported by me within that month. I would then check by name for previous abnormal smears. Whether or not I reviewed the patient's slides would depend upon the nature of the abnormality found. I did not routinely review patients with inflammatory slides, but I did routinely review more serious findings.

42. In 1994 I was contacted by letter from Midland Regional Health Authority (from Dr Malpass dated 17 August) seeking information about quality assurance programmes. I responded to this letter on 23 August 1994, advising that there was no formal programme for either histology (which was the Midland Regional Health Authority's concern) or cytology. I did however advise the Midland RHA that I regularly went to Gisborne Hospital Laboratory and liaised with the pathologist there. I did see that as a form of quality assurance, although on an informal basis. I heard nothing further from Dr Malpass or the RHA.

43. Following notification of patient one's development of invasive carcinoma, I sought a report from Dr Clint Teague as to how Gisborne Laboratory was performing in relation to other laboratories in New Zealand. I asked Dr Teague for this information by telephone, and he asked me to put the request in writing because he was unable to access the information without consent in writing. He also advised me that without a written request, he was not advised of the identity of laboratories. I put my request into writing and this is set out in a letter dated 10 July 1995. I do not recall ever receiving a response. I did however forward to Dr Teague Patient One's cervical smears, so that a number of laboratories could review the same. At the time of forwarding those smears I can recall talking with Dr Teague about new internal quality control techniques. He said that his laboratory had introduced rapid rescreening. I explained to him that that would be difficult to do in my laboratory. Dr Teague said that I could always send the smears to his laboratory and that they could read them. At that time I thought that the laboratory would be sold in a few months. I do not now remember discussing Telarc registration with Dr Teague.

Quality Assurance

44. The introduction of a quality assurance programme into cytology began being

discussed by the RCPA in the mid 1980's. I had, whenever I was able, participated in informal meetings with other pathologists regarding interesting or difficult slides. I viewed this as a form of quality assurance. I viewed the quality assurance programme as useful but I was unclear about its practical benefits in a laboratory the size of mine. One of the main values of the programme was that in larger laboratories the quality control material could be examined by all relevant members of staff and their answers compared and discussed. As I was working as a sole pathologist I believed that I would not have obtained the same immediate practical benefit. Inquiries of colleagues revealed that the only programme available was one from the Royal College of Pathologists of Australia. At that time, and subsequently, the Australians used a different system of reporting than that used in New Zealand. In the late 80s, early 90s the opinions of various colleagues who had taken part in the programme were less than flattering. It was suggested that it was not really suited to New Zealand pathology and that the results took too long to get back. Cost was not an issue for me in not joining that programme. In the High Court I accepted a description of it as a modern fad. I wish to withdraw that; I did not regard it in that light.

45. I have perused records that show that I attended a meeting in 1992 as a representative of my laboratory. All the laboratories in New Zealand appear to have been represented. My recollection of that meeting is that the principal concern was the question of reorganising the Bethesda coding, and the action to be taken in that regard. I can recall that that was the major discussion topic of the meeting. I do not recall how much attention was given to the discussion surrounding Telarc accreditation being compulsory by 1993. I cannot recall at that date whether or not I thought that any preparation would be needed by my laboratory.

46. I have perused records that suggest that on 6 October 1994 I attended a meeting in Hamilton between representatives of Mid Health and the Association of Community Laboratories. I have no recollection of that meeting, and I am unable to comment on the particular detail of it. I do recollect being aware that in about 1992 the ACL, of which I was a member, adopted a rules requiring accreditation by Telarc. In common with other laboratories, mine was not accredited.

47. I can however recall Dr Brian Linehan discussing Telarc accreditation with pathologists throughout New Zealand. I can remember saying to him on that occasion that I felt that the accreditation system, although obviously a good thing, was of very limited use to a very small laboratory like mine, mainly because Telarc concentrates so very much on documentation. The degree of documentation in my opinion is not so necessary in a small laboratory where there is personal contact at all times. However in 1994 we applied for Telarc registration in keeping with other New Zealand laboratories. There had been discussions between the laboratory manager and a representative from Telarc in 1993. I can recall meeting Mr Walker briefly on both visits, and exchanging pleasantries. I cannot recall any discussion with Mr Walker regarding accreditation. The laboratory manager handled those discussions. It is fair to say that in 1993 I had no significant understanding of what would be required to complete Telarc registration. After talking to Mr Walker, that year, the laboratory manager and I discussed what we

thought we could manage, given the man power available to us. On what I understood to be Mr Walker's recommendation, we applied for accreditation in histology and cytology, because we were of the view that we may be able to manage the documentation required in those areas. There was also talk in 1994 that the National Registry of the Cervical Screening Programme would in future probably require laboratories to be accredited. We applied for accreditation but shortly after that there was a distinct possibility that I would be able to retire and hand the laboratory over to someone else. At the end of 1994, I understood that it was likely that Tairawhiti Healthcare, the prospective purchaser, would use our laboratory as a collection agency only and that all of the work would be done at the hospital. Clearly full Telarc registration would be a waste of time in this situation.

48. Despite this, I did commence some work towards the documentation that I understood would be necessary for Telarc accreditation in the areas of cytology and histology. I did this work on my computer, and do not recall it ever being printed out into hard copies. The documents that I started preparing were descriptions of methodology used.

49. I have looked at the documents labelled Midland Health Data Base Questionnaire No. 650 (exhibit CM/HFA/43). I have no recollection now of that document. The majority of the document has been completed by the laboratory manager, Mr Reeve. My handwriting appears on the final page under the heading "Declaration".

50. I have no recollection of signing that document, although it would have been my usual practice at that time to have read through a document before signing it. At the time that this document was dated, I understood that the laboratory manager had had discussions with Telarc, and requested information from them regarding accreditation processes. I did not have a complete understanding of the requirements of a Telarc application, at that time; the specific requirements were only clear to me after Mr Reeve had met with Mr Walker in 1993. I do not now recall whether or not I saw Mr Walker's letter of October 1994. I was certainly advised about its content by the laboratory manager.

51. Mr Walker has described a number of areas of deficiency, in his evidence, that were never brought to my attention. I do not understand them to have been brought to the laboratory manager's attention either.

52. In particular Mr Walker has criticized the haematology analyser and the biochemistry analyser. In the exhibits produced (BMD/THL/001) at page 56, there is a schedule of Gisborne Laboratories Limited fixed assets and depreciation as at 31 March 1995. This confirms that the haematology analyser (Cell Dyne 3000) was purchased in April 1994, and the Roche Biochemistry analyser (Cobas Mira), had been purchased in June 1990. Both pieces of equipment were relatively new, and in particular the Cell Dyne 3000 was less than a year old as at the date of Mr Walker's second visit. The equipment used at the laboratory was serviced by representatives of the engineers who sold us the equipment. I cannot now recall on what basis the equipment was serviced or calibrated. It was likely that this was done routinely, or when required. I understand that

this equipment was used by Medlab Gisborne when they took over the laboratory.

53. The initial approaches about selling the laboratory came from Tairāwhiti Health Care at the end of 1992 and negotiations continued slowly with that organization throughout 1994 and 1995. By the end of 1995 it became clear that Tairāwhiti Health Care was not going to purchase the laboratory, although they did not confirm that until December 1995. We had some concerns about their willingness to purchase the laboratory, after they advertised in the local media, advising local general practitioners that they were Telarc accredited.

54. Given that the negotiations had been going on for approximately three years I was very upset when Tairāwhiti Health Care advised that they would not be purchasing the laboratory. Within three months of that advice however we had sold the laboratory to Med Lab in Hamilton.

55. I took no active role in the laboratory following the handover date of March 1996. My name remained on the letterhead, as an arrangement of convenience. It was seen as essential to have someone on the spot who could advise on administrative matters if necessary, or to give advice or for doctors to consult. In fact, I had no further role in Medlab Gisborne, and in any event in 1996 I was very unwell. I was not involved in any negotiations with the Health Funding Authority relating to a Section 51 Notice for Medlab Gisborne. I applied for an annual practising certificate (APC) in March 1997 to honour my arrangement with Medlab Hamilton, although I had had no involvement at all in the running of Medlab Gisborne. I did not apply for an APC in March 1998, although I advised the Medical Council that I wished to remain on the register. I notified Medlab later in that year that I wished to have my name removed from the letterhead .

Continuing Medical Education

56. My continuing medical education during the relevant years was threefold:

- a) attendance at local postgraduate meetings. About six to eight per year.
- b) attendance at conferences and workshops relating to cytology and histology. I attended the cytology sessions (of the College Meetings) about every two years from 1968 to 1993. In 1993 I attended the conference in Mexico of the World Association of Societies of Pathology (W.A.S.P.) and in 1995 I attended the next W.A.S.P. conference in Auckland. I attended New Zealand Society of Cytology meetings on numerous occasions, the last being in 1992 in Rotorua.
- c) I spent some time each week in the library at the Gisborne Hospital, which was kept up-to-date.

Liaison with Gisborne Hospital Pathologists

57. Since I arriving in New Zealand, I have always maintained a level of liaison with

the nearest pathologists. Whilst in Whangarei, that had meant travelling to visit Dr Williams and his team at Auckland Hospital. In Gisborne, following my changing to full time private practice in 1974, Gisborne Hospital employed a series of pathologists through to the time period that we are concerned with. When there was a pathologist at Gisborne Hospital, I met regularly with him or her. I used to go up four or five times a week around lunchtime, to have a general discussion, and to show any slides of interest or difficulty. This was generally reciprocated by the Hospital pathologist. I maintained good collegial relationships by doing this, and also was able to obtain second opinions on difficult or interesting slides. During the early 90's, there were three consecutive pathologists that I liaised with at Gisborne Hospital; Dr Singh, (1989-1990) Dr Chan (April 1991-April 1992) and also Dr Padwell (1993-mid 1996) to some extent. We reviewed each other's slides on an informal basis. At our regular meetings, it was usual to share a multi-piece microscope with the pathologist at the Hospital. This would be particularly when we were reviewing difficult slides. I maintained professional contact with Dr Padwell during his employment, although we had differences of opinion on various matters.

58. There was not always a pathologist at Gisborne Hospital. There were periods of up to one year when nobody was there. At those times I was the only pathologist in Gisborne. If I had difficult slides during those times I would have to send the slides away. This would be rare because the usual course would be to ask for a repeat. These slides would be returned to me with a report. I would review them and issue my own report.

Health

59. In 1990 I underwent a coronary artery bypass. I was conscious of only one important after effect and that was that my memory, which had been extremely good up to that point, deteriorated. My memory of past events was good (with the exception of the two years preceding the bypass operation) but my short term memory became a concern in that I needed to write notes of all sorts of things I had previously not had difficulty remembering. For that reason my system changed after 1990. The main difference was that I made large numbers of small notes for myself and I tried to be more careful in annotating anything I was involved in. Until then, in my practice, I had been required on numerous occasions to give evidence in Court particularly in relation to forensic pathology reports. I was very interested in the forensic pathology side of the practice but because I found that my memory was bad I felt it necessary to give up doing Coroner's reports, autopsies and any other forensic pathology. The reason was that I could never know when I was going to be involved in a homicide or something more complex and it did not seem fair to anyone to go into Court some nine to twelve months later with nothing but my notes to remind me of the events earlier.

60. In 1996 I had three episodes of sudden cardiac arrhythmia. I nearly died during the first of these episodes, but was resuscitated. My health since then has been reasonably good and I believe that my condition is now stable. However my short-and medium-term memory has very definitely deteriorated since these admissions.

61. I find now that I do not have full recollection of all the detail of this evidence, but I feel confident in relying on documentation produced earlier, particularly during the litigation instigated by Patient One.

Retention of slides

62. Over the years the slides were kept in a filing cabinet in my office until the filing cabinet got full and then they were transferred to slide trays, which were slide boxes containing about 100 slides each. These were stored in an outside shed. They were to be kept there, in theory, indefinitely.

63. In 1988 we had a flood caused by Cyclone Bola which caused a lot of damage to the outside sheds where the slides were kept. After the flood we were left with a soggy mass of matted glass slides and cardboard. The cytology slides had been stored on the ground level of the outside shed. I looked at the mess with the Gisborne Laboratory manager and we thought that the chances of ever needing to refer to those slides again was very small. Consequently we threw them all out. From then all slides were stored on higher shelves. I was not actually involved in the storage of these slides but they were quite heavy and I can understand why the staff concerned put them on the floor.

Screening Programme and Statistics

64. Following the Commission of Inquiry into Cervical Cancer, the National Cervical Screening Register was set up. All laboratories, both community and public were analysed for this Register. Our laboratory provided copies of reports for patients on the register to the local coordinator regularly. The local manager of the register would issue summaries of our reading rates on an irregular basis. The rates were analysed in

terms of your laboratory, and then your area. No other comparative figures were available. This occurred after 1991. I cannot recall now how many of these reports I saw, but it was infrequent. The laboratory figures were analysed against those for the region, and the reports sent to me were for the Tairāwhiti region. This meant in practice that my own figures were sent back to me, along with information on the quality of smears.

65. In August 1996 the Minister of Health forwarded to Gisborne Laboratory a report of the analysis of the Gisborne Laboratory smear results which are now stored on the National Cervical Screening Register. I produce a copy of this report (**MBB 1**). The committee analysed 7,355 of the smears which I had analysed up to 30 June 1994, which was the relevant time period from the committee's perspective.

66. The analysis shows that the smears reported by my laboratory have been compared with both community laboratories, public laboratories and all laboratories. The important category for the diagnosis of abnormalities is the comparison of readings of high-grade intra-epithelial lesions codes. My results were 0.6% which is well within the community laboratories range of 0.4-2%. The community laboratories' mean was 0.8%.

67. The analysis showed that my reporting figures in relation to the cervical smears were well within the mean figures of the community laboratories, and all laboratories, when taken as a whole. That report was not available however until after my retirement. I saw it in 1997.

Medical Practitioners Disciplinary Committee/Medical Council

68. A complaint was referred to the Medical Practitioners Disciplinary Committee in 1996 by the Accident Compensation Corporation following a finding that I had negligently failed to diagnose two slides correctly. Charges were laid by the Medical Practitioners Disciplinary Committee alleging professional misconduct in relation to the reading of the three smears from 1990 to 1992.

69. Unfortunately, due to serious ill health, I was unable to participate in the Medical Practitioners Disciplinary Committee hearing in February 1997. The Medical Practitioners Disciplinary Committee found me guilty of conduct unbecoming a medical practitioner in relation to the reporting of two slides.

70. This finding was taken on appeal to the Medical Council by both parties. The Medical Council in its decision of 10 December 1997 upheld the finding at the level of conduct unbecoming a medical practitioner. As a result of this, I was fined and ordered to pay a percentage of costs. The Committee had also imposed a condition on my medical practice which was that I could not read or report cytopathology slides for three years (from 23/7/97) except under supervision of a senior cytopathologist. I had already retired at this time, as the Committee was aware.

Complaints

71. At the time of the initial trial and the exemplary damages claim I had no reason to believe that there were any difficulties in connection with my standard of reporting of cytology slides, or that there was any other aspect of my practice that gave reason for concern. I had not had any previous complaints at that time. Dr Teague has mentioned another patient of whom he heard in October 1998, but no claim was made in respect of this case until mid-1999.

Significant time periods of my absence from the laboratory

72. As I have already stated, in 1990 I had a bypass operation. I was off work for approximately three months. I cannot now recall who read the cytology slides over that time, although it was usual for me to ask the Hospital pathologist, if there were small time periods for which I was away, to read the smears. If the time periods were longer, I generally asked Med Lab in Tauranga to read the slides.

73. I was away for approximately six weeks in Winter 1991 and again in Winter 1993. In 1994 I did not travel extensively, but went to Sydney for one week or less in December of that year. I did not send the slides away for that week. In 1995 I believed that I was going to be selling the lab that year so did not take a break.

Conclusion

74. The statistics provided by the Sydney re-read came as a complete bomb-shell to me. I have read the evidence of Dr Farnsworth and it is now clear to me that I under-reported many slides. There were many more in this category than there should have been. I can only say that I had no knowledge of this in my practising career. I was and I remain greatly distressed to find that my misreading of slides has caused so much pain and suffering to so many people.

Michael Bernard Bottrill

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