

**UNDER THE HEALTH AND DISABILITY
SERVICES ACT 1993**

AND

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

**CLOSING SUBMISSIONS OF
THE ASSOCIATION OF COMMUNITY LABORATORIES INCORPORATED
SEPTEMBER 2000**

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Introduction

1. The Association of Community Laboratories (“ACL”) had not intended to present closing submissions to the Inquiry. Initially ACL was content to rely on the evidence of its Chairman (Dr I Beer) and its cross examination of Mr C Mules to present its points to the Inquiry.
2. Last week ACL received closing submissions from:
 - 2.1 Women affected;
 - 2.2 Ms Bunkle;
 - 2.3 Counsel assisting;
 - 2.4 Partial submissions from counsel for the HFA/Ministry of Health.

Having taken the opportunity to consider those submissions, ACL now wishes to respond in writing to matters raised in those submissions which relate to ACL.

Ms Bunkle’s Submissions

3. At paragraphs 23 and 24 of her closing submission Ms Bunkle says:

“The issues in Gisborne are compounded by the influence of commercial interests creating a particularly insidious conflict of personal profit versus an absolute obligation for medical practitioners to protect the safety of patients at risk.

... the behaviour and response of medical practitioners in the commercialised health reform environment is relevant ...”

This concern is partially developed in Ms Bunkle’s submission at paragraph 4.61.

4. The Association does not wish to debate the views expressed by Ms Bunkle in the paragraphs referred to above, other than to say Community Laboratories can function as private businesses and simultaneously provide professional services of the highest quality.

It should not be thought ACL failed in its responsibilities when it challenged Midland's attempts to impose economic models for the delivery of community laboratory services. In particular, ACL draws attention to the fact that from the outset of its negotiations with Midland, it was ACL which raised and insisted upon the establishment of quality assurance criteria.

5. The correspondence between ACL and Midland from 31 August 1993 onwards (IDB/ACL/009; tab 1, tab 2, tab 3, tab 4) all clearly record that it was ACL which initiated and consistently raised questions about quality assurance in its negotiations with Midland (refer also cross examination of C Mules p.1173 line 10-27, refer also paragraph 17-23 of the evidence in chief of Dr Beer).
6. The Association wishes to stress to the Inquiry that it responded to the "*...commercial health reform environment ...*" by endeavouring to secure a fair and reasonable fee for services provided by community laboratories, and at the same time consistently stressed the need for quality assurance, and the delivery of services which complied with high ethical standards.

Mr Corkill's Submissions

7. At paragraph 234 of his submissions Mr Corkill refers to the inquiries made by Midland during August to October 1994 when Midland endeavoured to ascertain what laboratories in its region were TELARC accredited.
8. The Association takes no issue with Mr Corkill's chronology or the accuracy of his summary of the facts.
9. The Association acknowledges it did write to Midland on 28 August 1994 and said, inter alia:

"... all laboratories have intimated that they have in place appropriate programmes".

That was correct. At the time all members of ACL had intimated they were TELARC (or equivalent) accredited. The Association's Ethical Rules which required TELARC (or equivalent) accreditation were adopted with the consent of all ACL members. Dr Bottril did not object to this rule, nor did he indicate to ACL

that he would have difficulty in complying with the accreditation requirements of ACL, (refer evidence of Dr Beer paragraphs 14 and 15).

Mr Murray's Submissions

10. Paragraphs 184-194 inclusive of Mr Murray's submissions focus on the protracted negotiations between Midland and RHA and ACL from July 1993 to February/March 1997.
11. The following points are made by ACL in response to paragraphs 184 to 194 of Mr Murray's submissions:
 - 11.1 At paragraph 184 of his submissions Mr Murray reiterates the theme that Midland relied on Dr Bottril's membership of ACL (and therefore compliance with ACL Rules) as a means of being satisfied that Dr Bottril was adhering to appropriate professional standards.
 - 11.2 The cross examination of Mr Mules (page 1166 line 22) emphasised Midland did not have a copy of the ACL Rules produced by Mr Mules until September 1995. The copy of ACL's Rules referred to by Mr Mules could not have been relied upon by Midland prior to September 1995. (Refer paragraph 24 evidence in chief Dr Beer).
 - 11.3 At paragraph 186 of his submissions Mr Murray repeats a veiled criticism of ACL that ACL interposed itself between Midland and Community Laboratories and in doing so impeded Midland in the performance of its task.
 - 11.4 The evidence presented by ACL clearly documents that throughout its negotiations with Midland, ACL was intent on ensuring contracts between Midland and Community Laboratories contained appropriate quality assurance provisions. It would be wrong and most unfortunate for the Inquiry to conclude ACL impeded the imposition of appropriate quality assurance provisions into the contracts developed between Midland and Community Laboratories. ACL initiated and pursued quality assurance

issues with Midland and did so for the sole purpose of trying to ensure patients received laboratory services of an appropriate standard.

- 11.5 ACL's motives are well recorded in IDB/ACL/009 under tab 1, and repeated at paragraph 21 of Dr Beer's evidence in chief where he quotes from a letter written by ACL to Midland dated 31 August 1993:

"We have heard a great deal about the need to improve health services, and this is an objective which we fully endorse. We also agree with the statement made by the Minister of Health, which was reported in the Dominion on 30 August, that 'its important not to loose sight of the fact that the restructuring itself wasn't the goal of reform. The better health of New Zealanders was'.

However, although there have been numerous comments about introducing various systems and procedures which are essential means of advancing goals and objectives, there has been little said about what the goals and objectives actually are. We believe that if we are to work together towards improvements in laboratory services we need to have a very clear intention of what sort of service we are trying to provide. We can then work together to introduce the best systems for providing such services.

As a basis for discussion we believe that the objectives of community laboratories, and presumably the RHA's would be along the following lines:

- (a) To maintain and improve the high quality of laboratory services in New Zealand.*
- (b) To achieve appropriate utilization rates for laboratory services and tests.*
- (c) To provide services at the lowest costs which are commensurate with the long term effectiveness and viability of the industry.*
- (d) To provide a service which operates according to high ethical standards.*
- (e) To provide a service which is accountable to users, timely in terms of geographical coverage and service.*
- (f) To allow competition within the context of 'a level playing field'. We recognize that this is really a means of attaining an objective, rather than objective in its own right. However, it is something which is of great importance and is accepted in*

principle by everyone we have spoken to so we believe it is appropriate to list it here.”

- 11.6 The letter of 31 August 1993 illustrates ACL’s concern to ensure patients received services from Community Laboratories that are of the highest professional and ethical standards.
12. ACL was unaware that Dr Bottril’s laboratory was not accredited with TELARC. As a voluntary body, ACL relied entirely upon its members to advise it if there was any difficulty in a member obtaining TELARC accreditation.

David Collins QC

19 September 2000