

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

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

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**SUBMISSIONS OF COUNSEL**

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**ROYAL COLLEGE OF PATHOLOGISTS  
OF AUSTRALASIA**

**DR C A TEAGUE**

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## INTRODUCTION

The Royal College of Pathologists of Australasia (“the College”) wishes to again acknowledge the people of Tairāwhiti, the circumstances that have brought about this Inquiry, and the circumstances that people in this area have been through. It is a matter where it has been the commitment of patients and health professionals, particularly in this area, which has led to the identification, the confrontation, and now, we hope, the resolution of the shortcomings that are the subject of the inquiry. In its opening, the College recognised that it could be said with truth that the people of Tairāwhiti have done more to advance the cause of the screening programme in the course of the initiation and carrying through this inquiry in that period than the senior health professionals have been able to achieve in this country in the preceding ten years.

In these submissions the College, along with Dr C Teague, will traverse in part the history of the programme to identify some of the points where it failed but, more importantly, will look forward. It is by being forward-looking that New Zealand can achieve what is the single most important result from this Inquiry, namely to ensure that avoidable error does not ever recur.

The College is a voluntary professional body, many (though not all) pathologists initially qualify through it and many pathologists in Australasia belong to it. The extent of its role and how it functions was set out in the statement lodged by the College. It does not have powers of discipline or investigation, however it does work cooperatively with those organisations which do have such powers.

When opening, counsel referred to the importance of the public being able to have confidence in the effectiveness of the programme. It was submitted that there is in this country a large, dedicated and often unrecognised team of good professionals, committed to health, not just in cytology and not just in Gisborne. And inquiries which focus on error do have an inherent risk of creating their own damage in health.

It is submitted that there will be challenges to the efficacy of the programme arising from personnel shortages and claimed logistical difficulties. This should not prevent a strong systems skeleton being built into the programme to ensure coordination of each of the components required to create an effective national screening programme. This skeleton will require that the recommendations are implemented and checks and balances by a strong leadership will ensure that what is required to

be done has been done to an accepted, specified standard.

The College and its voluntary members wish to again place on record their support for the National Cervical Screening Programme, its support for it and to affirm that that programme, even now, deserves and should have the continued support and development of the country and its people. While this inquiry will soon be complete, the work that has now started will need to be continued with energy and direction once we leave Gisborne.

It is hoped that the descriptions of the programme that have been made will not ever be able to be applied with any degree of justification to New Zealand's national screening programme in the future.

It is submitted that the hearing has shown that the key determinant of observance of standards and the operation of the scheme lies with government. It is the funder, the legislator, the healthcare provider (directly or indirectly) and therefore the body who must lead. Others, such as pathologists, can only be contributors to such a process.

## CHAPTER 1

### The Expertise of Dr Bottrill and Pathologists Generally in NZ

#### .1 Key Points:

**.1 1 There have been significant improvements in training standards over the past two decades.**

**.1 1 Specialist training in cytology is now available.**

**.1 1 The human resource situation is becoming critical both for pathologists and cytotechnicians.**

**1.1.4 Registrar training has not been properly funded in the past resulting in fewer pathologists being trained.**

**1.1.5 Appropriate levels of funding for pathology generally need to be addressed.**

1.2 Dr Bottrill's file held by the College is contained in Exhibit **EM/CA/008**.

1.3 In his evidence, Dr Bottrill set out the extent of his training. While his training does not equal today's standards it was typical of the time, and met the standards of the day. The evidence reflects that it is recognised that qualifications and training acceptable in the 1970s may be different from those standards required 20 years later.

1.4 When questioned by Mr Grieve QC, Dr McGoogan set out the evolutionary nature of specialisation (see Evidence, page 972) -

*Q: And that is because that, as I understand it, in the 60s and 70s gynaecological cytology was – would it be fair to say – probably beyond its formative stages but still developing ..... yes additionally gynaecological cytology was often carried out in laboratories organised by gynaecologists rather than within laboratories where histopathologists were working. There was a gradual trend over the next 20 years to include cervical cytopathology within histopathology, but at that time many of the cervical cyto laboratories were distinct from histopathology laboratories.*

## Developments

- 1.5 Specialist training in cytology is now available in New Zealand (see the evidence of the College's at 7.4.3) -

*The College, since 1973, has offered examination for fellowship in anatomical pathology slanted towards cytopathology. This examination is considered appropriate for those Fellows with a particular interest in cytopathology or who are contemplating a career specifically in cytopathology.*

- 1.6 See also page B1162, questioning of Dr Tie by Professor Duggan -

*Q: In the training of a pathologist that's the post MD training, five year training programme, are quality control, quality assurance and laboratory management part of the training?*

*A: Yes they certainly are examinable areas of information and they are examined in the College processes.*

*CHAIR INTERJECTS*

*CHAIR: How long has that been the case?*

*A: I can't tell you how long I'm sorry.*

*PROFESSOR DUGGAN CONTINUES XXN*

*PROFESSOR DUGGAN: Did you receive such training?*

*A: We certainly were expected to have some grasp of quality procedures when I trained yes and that was in the early 80's and although cytology at that time was to some extent evolving as a separate entity within anatomical pathology, it had become examinable and I suppose it's probably true to say that the emphasis was more on morphological interpretation and the practice of cytology, the technical aspects of it, rather than the statistical monitoring and analysis of cytology practice. I think as time has gone on, and I would really have to refer to the Board of Censors for a more specific statement on this, but my impression is that a greater degree of understanding of the importance of those aspects would be demanded now than probably in my day.*

- 1.7 The requirements are further clarified by Dr Davies on questioning by Mr Grieve - see Evidence, pages B1185-1187 -

*Q: All right. Am I right in assuming that now, if a pathologist wished to specialise in gynaecological cytology, he/she would have to undergo special training to do so?*

*A: If a pathologist who hitherto had done no training in gynaecological cytology, or cytology or any sort for that matter, and was contemplating a career change which would involve this, then they would certainly be expected to have undergone a period of further training of some sort. This would indeed now be essential for the purposes of appointment as a medical practitioner to satisfy the requirements of credentialling. So they would have had to undergo a period of training and then probably some form of certification, possibly by issue of a letter of attainment from the training authority.*

*Q: And would the College be involved or offer course in specialist training in that field?*

*A: There are courses available. The Victoria gynaecological cytology service offers a 2 week course to which, from time to time some pathologists, certainly in Australia, will go. These may be people who've done some initial training and perhaps have a capability but attend to enhance their competence. There are also weekend courses and of course there are the continuing – the annual course run by the Australian Society of Cytology which is probably used more for the maintenance of proficiency and continuing education. So if somebody wants to go into it completely cold, they probably need to go and work in a dept and get a certificate of attainment.*

*Q: I'm sorry if I could just interrupt. 7.4.2 says that someone first of all needs to be a fellow of the College and in addition shall be skilled in interpreting cytology and histology of gynecological specimens that's the second requirement isn't it.*

*A: Yes.*

*Q: And thirdly demonstrate appropriate training and experience correct?*

*A: Yes.*

*Q: Now then you go on in 4.3 and say that since 1973 the College has offered an examination for fellowship in anatomical pathology slanted towards cytopathology correct?*

*A: Yes.*

*Q: And although it's probably dim in your memory, you may have been familiar with that at the time mightn't you.*

*A: Thank you for drawing this to my attention it's probably helped fix the timing when cytopathology began to emerge as a particularly tested subsequent discipline in the general field of anatomical pathology. Perhaps for the inquiry I might explain that the reason the*

*impact standard of 7.4.2 is complex is that a person might become a fellow of the Royal College of Pathologists or have an equivalent qualification in something like chemical pathology which therefore would not of itself make them suitable for cytopathology so that this would require not only that they had the fellowship in general but the training would have had to have been in anatomical pathology or general training so that both of those requirements are satisfied. In 1973 as this happened here, it was envisaged that there were some persons who would want to make a career in cytopathology, therefore a substream of the general training scheme and examination was offered with a particular greater than average emphasis in cytopathology but it would indicate that the cytopathology was part of the total examinable process about that time, not only in the slanted exam but the broader anatomical pathology exam.*

- 1.8 An on-going challenge for New Zealand will be to have sufficient numbers of cytopathologists and cytoscreeners who meet the standards New Zealanders are entitled to expect, to provide care - see in particular the evidence of Mr Walker at page 548, and Dr Beer at page 1085 -

*Q: Could we quickly go to para 45. What is the human resource situation in NZ in terms of cytoscreeners and pathologists practising cytopathology so as to provide the quality of service described in the policy and quality standards of the National programme and to deal with the further growth of the programme?*

*A: the situation is that most laboratories performing this test are struggling to find suitably qualified staff. They have a reasonable complement at the moment, I believe, but whenever there is a resignation or a retirement, as in fact our own laboratory has experienced in Rotorua recently, we've had difficulty finding a replacement. There is no organised programme of training or education of cytoscreeners, the programmes are all in-house and developed by the laboratories who actually carry out the work, and in fact 95% of this work is carried out by the community laboratories.*

*Q: What about the medical manpower?*

*A: Yes. I think NZ has something like 7 pathologists who have the postgraduate qualification of the Fellowship in the International Association of Cytopathology, and I'm not sure of the number who have the Royal College of Pathologists postgraduate qualification. The remainder of the pathologists working in this area have the Fellowship and the Royal College of Pathologists of Australasia and it is now being recognised by most in this area that they should be looking towards attaining a postgraduate qualification such as that offered by the Diploma offered by the college or by the International Association of Cytology.*

1.9 See also the evidence of Dr Tie at page B1169 -

*PROFESSOR DUGGAN: On paragraph 6.1.2 you mention the College has 218 fellows in New Zealand?*

*A: Yes.*

*Q: Are all of these fellows actively practicing?*

*A: No some would be retired and some may be part-time.*

*Q: In terms of the total numbers, does New Zealand have enough pathologists.*

*A: There is definite perception of a shortage in pathology in New Zealand at present. There are difficulties recruiting to quite a number of different laboratories right throughout the length of the country. We have had the situation where for example just in the College Bulletin we've had 9 advertisements for pathologists for various different positions in New Zealand some of which have been repeated from one edition to another and from my discussions informally with colleagues as well and from discussions at the various College committee meetings that we've had, workforce is acknowledged as a definite problem for us. It's made particularly crucial at the moment by the fact that there is an international shortage of pathologists and New Zealand pathologists are reasonably, what's the word mobile, they don't generally have a great deal of trouble in getting work in other places and particularly in Australia although there is a problem with the provider number legislation there. Pathologists can work relatively easily without a provider number by being part of a large practice so I think we are running a definite risk of loss of manpower here and I think we are near the point where the departure of a few pathologists could put us in a real crisis situation. I know that the hours that pathologists, well I shouldn't say I know, but my perception from discussions with colleagues is that the hours that pathologists work in order to cope with their daily workload is increasing steadily over time and I think it's now surprise that the requirements in reporting of pathologist specimens gradually increase over time and the expectations of the amount of information and the way in which it's presented and various other things creeps up all the time so that for a given number of specimens a greater and greater amount of pathologists time is required to put in to them which is not easy to allow for and I think we are at a point where the work load is a pretty serious issue for pathologists here.*

*Q: I note in Dr Teague's brief of evidence at 17.10 which is page 46, in 1990 Cowick attempted to carry out a manpower survey and the final two sentences in this paragraph said "As a result no analysis was ever done and the original returns were destroyed. Because of this the exercise was not repeated." Do I understand that to mean there has*

*not been a workforce study with regard to medical manpower in pathology.*

*A: No that wouldn't be true the New Zealand Society of Pathologists which has merged nearly 5 years go with the College has kept manpower statistics and data mainly coordinated by one person for I'd say a good decade I would think and the Medical Council also collects data which is required to be returned with the applications for the annual practicing certifications on manpower so there are some databases of information about pathologist manpower.*

*Q: Is this database used to advocate for increased number of training positions in pathologist or recruitment strategies?*

*A: Yes it is and I would have to say that the Clinical Training Agency which is the body within the Funding Authority that was given responsibility for allocating money and allowing positions to be created or adjusted has been pretty positive in the last few years in the way it's dealt with this and has in fact and did increase the number of training posts funded by about 6 in 1997 I think it was. The problem was that we weren't sure how many of those posts were simply posts being refilled that had been vacated but not ... I'm not putting this very clearly. During the time of economic reforms in the health system there were registrar training posts which were dis-established and the funding was directed towards consultant salaries so certainly some positions were lost and quite a significant number. The extent to which the CTA's expansion of the number of training posts in pathologist has redressed that balance is not very clear because of that and we are probably just a little bit ahead of where we were maybe 9 or 10 years ago.*

#### **CHAIR INTERJECTS**

*CHAIR: So are you saying that as a result of restructuring within the health centre, positions within hospitals for registrars which would have ensured more pathologists were trained have been lost because money was diverted elsewhere.*

*A: Yes in some cases money was converted from registrar training salaries into consultant salaries so that the workload could simply be dealt with but I suppose in the eyes of those who did it simply because they didn't think they had any other options and because hospital management in the end determines the stream of funding for pathology laboratories it is also possible and I think likely in some ways that money has been directed to other areas outside pathology from that influence and that's a very difficult thing to quantify. I wouldn't like to be too critical of the CTA because it's in some ways been one of the more bright and more cooperative parts of the system in the last few years.*

*Q: What is the CTA?*

*A: Clinical Training Agency, sorry.*

*Q: And is that with the Ministry of Health.*

*A: No it's in the Health Funding Authority. But I guess they simply don't have quite enough money to give out to satisfy everybody's demands and they've had to balance pathologies demands in case for increased posts against those from other specialties. The other thing was that they had money unbundled which was essentially all medical post graduate training money which was then required to be spread across other occupations which were not medical training post-graduate training posts so they were under quite a lot of financial pressure at times in the early stages of that.*

*Q: So may we therefore be suffering a shortage of pathologists as a result of too few pathologists being trained in recent years gone by.*

*A: Yes I think there is clearly ... in my opinion, I shouldn't say clearly but I think there has been too much of a cutback in training or not sufficient expansion in training posts. The other factor that I would have to mention is that New Zealand has traditionally relied on a fairly high rate of importation specialists and it seems to be in a poor position to do that at the moment because Britain in particular where we traditionally got a lot of our migrating pathologists from has now got a pretty serious workforce in pathology, I gather there are about 190 posts in the UK at the moment advertised vacant so that the reasons to immigrate to New Zealand from that previously useful source for us has been greatly diminished. A similar sort of comment could be made about South Africa I think so there are other international problems which are beyond our solution. We have normally have something like about a third of the medical workforce in New Zealand provided by immigrants. In pathology the figure is perhaps a little less than that but of that order.*

1.10 See also the evidence of Dr Tie at page B1174 -

*Q: Based on what you say, then, it would appear that the ? manpower will be eroded by a decrease in the number of graduates, decreased immigration to NZ and increased emigration from NZ to elsewhere.*

*A: Yes, and if we get into the problem of students with large university debts, beginning to look at options to simply avoid that debt, then I guess pathology will take its share of that problem as well.*

*Q: What impact will this have on the cervical cancer screening in NZ?*

*A: Well, it will certainly make it difficult for standards to be maintained as we would like if the funding stream is not sufficient to enable us to recruit pathologists and to run the service. I don't think it's just pathologists who are at risk here, I think cytotechnologists in NZ are not especially well paid, and there is a fairly free international market in them. So, if pathology funding is squeezed any more, or perhaps not improved from the level it is at the moment, I think there's*

*a real possibility that we will reach a serious crisis in NZ.*

- 1.11 It is submitted that there is a significant risk of New Zealand having insufficient trained pathologists and cytotechnicians. It is respectfully submitted that this issue requires urgent Government attention, both to meet immediate needs and long term patient care requirements.
- 1.12 As a fellowship based on professional as opposed to commercial interests, the College wishes to record its strong commitment to participate, support, and share in such development, both in recruitment, training, and further training in specialities.
- 1.13 The College confirms its commitment to work with government, within valid new structures, to achieve these outcomes to the greatest extent it can as a voluntary body whose objectives are professional standards and voluntary quality assurance objectives.

## CHAPTER 2

### Continuing Medical Education

#### 2.1 Key Points:

**2.1.1 Continuing medical education is essential.**

**2.1.2 The College cannot force its voluntary members to participate.**

**2.1.3 The Medical Council have powers to require proof of completion of approved courses, workshops, conferences and training as a condition of issuance of a practising certificate.**

**2.1.4 Funding issues and the particular difficulties of practitioners who practice in isolated areas require priority attention from the Government.**

2.2 It is trite to say that qualifications in themselves are not sufficient. Continuous upskilling and maintenance of standards, in addition to on-going learning that results from daily practice is now recognised as being essential. The evidence shows that Dr Bottrill's practice in this regard and others was suboptimal. The importance and relevance of accreditation to pathologists such as Dr Bottrill are set out in paragraph 32 of the evidence of Dr Robertson where he stated -

*Competence in cytology is essentially related to correct calibration of the pathologist's eye rather than in specific equipment. It is therefore extremely important, particularly for a sole pathologist in a geographically isolated area, to regularly test his or her competence internally against known reference slides in the laboratory and textbooks, and externally through proficiency testing programmes. In addition, attendance at professional development meetings and seminars and contact with other pathologists is crucial.*

2.3 The importance of continuing medical education was highlighted in the evidence of Dr Tie at page B1177 -

*Q: To what extent does the lack of training of the pathologist and participation in continuing medical education on these issues contribute to this lack of appreciation of the significance of the data?*

*A: Well, I think it's a very important factor. If you don't have sufficient time or freedom to remain current in practice and to update yourself and to discuss with colleagues what are reasonably minimum requirements, then I think it is quite possible to slip behind the norm or the accepted standard.*

- 2.4 It is submitted that Dr Boyd's contention that the Ministry relied on individual practitioners' competency standards was an unacceptable position for the Ministry to take, given there were no powers of enforcement of continuing medical education or participation in quality assurance programmes at the time concerned. In particular, it was contrary to the advice of the advisory committees, who universally recognised the importance of external and internal quality assurance.
- 2.5 Whether the College should impose conditions on competency was discussed with Dr Tie, see his evidence at page B1165 -

*CHAIR: Is the College in a position at present to impose on pathologists a requirement that they maintain their competency?*

*A: this has certainly been discussed and there have been serious discussions about the need to make it compulsory.*

*Q: Is it at the moment?*

*A: It is not compulsory at the moment, no, but the requirements for re-certification in NZ will determine that within a fairly short time and the College has been taking part in the development of strategies which we hope will satisfy that requirement.*

*Q: and when those strategies are ultimately finalised will it then become compulsory in some way or other for pathologists to take steps to maintain their competency?*

*A: That's a little difficult to answer neatly because there is such variation between different pathologist's practice, that to describe in advance exactly what you need to do and keep up-to-date with is administratively difficult and conceptually a bit difficult. And the College's thrust is really one of encouragement and I suppose providing information to pathologists of the need to maintain currency in practice and to keep up-to-date with developments. I am not sure that the College, in the foreseeable future, is likely to be able to be very prescriptive with the individual's particular programme. Partly, or I suppose mainly because of the range of sub-specialties in pathology and the variation in the mix of individual pathologist's work.*

*Q: So in the field of cytopathology really it's the requirement that*

*laboratories be TELARC accredited, which is now being imposed through the Health Funding Authority's contracts with laboratories, which is more likely to be the means by which compulsory external quality assurance and internal quality assurance is put in force?*

*A: Yes, I think a little further than that. There will be, as proposed as present and accepted by the Medical Council, a requirement that pathologists take part on a regular basis in external quality assurance programmes through their practices, and the accrediting body will have the job of ensuring that the external quality assurance programme is being taken part in by all pathologists and that the performance in those programmes is acceptable and if deficiencies in performance are highlighted that some steps have been taken to address those.*

*Q: And if a pathologist doesn't participate in the programmes will a pathologist therefore lose accreditation?*

*A: Yes. The pathologist, as I understand the situation, will he to be in a practice situation where they participate in the external quality assurance in order to get their revalidation.*

*Q: And if they do not do that and they do not get a revalidation, does that prevent them from practising as pathologists?*

*A: Yes, I think it would, they would no longer be able to get an annual practising certificate.*

*Q: And these are changes that are about to happen but they haven't happened yet?*

*A: Yes.*

## 2.6 The significant quality controls introduced as a result of the Medical Practitioners Act 1995 were set in the evidence of Dr Baird at page 1002 -

*A: Indeed. The Medical Council's been working with the medical colleges as our competence provisions are developed. In recent years its become apparent that performance of any clinician can be improved if some self-audit is undertaken and peer review, and these are developments within the programmes for maintenance of professional standards. We now have the evidence, I think, that strengthens the hand of the Medical Council to require all clinicians to participate in such a programme. We have to link with the colleges because they organise the programmes. We have to encourage them, as a professional duty, to identify and notify a poor performer, whereas the college programmes have been designed in the past to improve the performance of everybody. And there's an informal link between the Medical Council and the Health and Disability Commissioner. We are strengthening that link particularly if the complaint concerns standards of care specifically or as a main complaint rather than some of the other issues in the code of rights.*

- 2.7 Practical difficulties that arise from lack of funds or internal work pressures were identified in the evidence of a number of persons who gave evidence. In particular, this Committee is referred to the evidence of Mr Walker at page 549 where noted the effect of funding restraints on laboratories -

*A: Four of five typical ones, very often when there is a senior laboratory person, whether they be a pathologist or a medical technologist who resigns for whatever reason with 20 or 30 years experience and on an \$X salary, they are very often replaced with a much much more junior person with much less experience on \$X minus \$Y salary and they are often replaced with more junior people as a cost cutting measure in my opinion so many of our laboratories now while they have similar numbers of people, their accumulated resource in terms of experience is a fraction of what it has been in the past. We see many laboratories who have difficulty finding budget to send specialists to national or international conferences and you will note that in attending those conferences as we do around the country that they are now attended by many fewer people than they have been in the past. There are many laboratories who have little or no budget for textbooks and journals and many laboratories who express considerable concern to our organisation about the relatively modest cost of accreditation. Those are just a small number of quite a large number of ramifications that we see of cash strapped laboratories and I apologise if I use that terminology.*

- 2.8 The on-going difficulties for specialists practising in isolated areas such as Gisborne, where there was a high workload, were apparent from the evidence of Dr Van der Mark, see page B649 when being questioned by Mr Grieve -

*A: Yes. Well, I went to one this year. I didn't last year. I don't know if there was one – there must have been some kind of meeting, I didn't last year I did this year.*

*Q: so at meetings prior to this year did you take that opportunity to discuss your observations of the Tairāwhiti area and cervical cancer?*

*A: I had lamentably little contact with colleagues in NZ, really through to this year when I did go to the annual meeting. There were the opportunities there. Tairāwhiti offered to send me to meetings out of town and I was anxious to go to them, but my first year here I didn't really have the opportunity. The person I worked with was more senior, he went to the meetings. I stayed at home and worked basically. Last year, as I said, I was a solo practitioner here and getting off to meetings was difficult. I went to a big one in the US in*

*98 I think, but not here. So no, I'm not answering your question either. No, my contact with other NZ gynaecologists was pretty much limited to the calls I made to principally the clinicians at Waikato when I had questions about patients with cancer which I did a lot. And with the radiation oncologists from Palmerston, but not general obstetrics and gynaecology specialists very much at all.*

*CHAIR: What opportunities do you have for peer review, discussing problems with colleagues who are also a member of your profession?*

*A: Well it's very difficult when you have small numbers. Last year I was it. so my opportunities for peer review were my telephone conversations with people at Auckland, Waikato and Palmerston. Now we do have at Tairāwhiti we have instituted a system where surgical cases are periodically discussed and reviewed. We are following the Otago model there.*

- 2.9 The practical difficulties faced by Dr Van der Mark were clarified in the evidence of Dr Jones, see page B1567, looking at the restraints on her ability to carry out a peer review of her work -

*Q: Would you be concerned about the risk to women if the colposcopist was not following that process or a process of regular monitoring and peer review?*

*A: I think what we say here is the ideal. In Tairāwhiti there has been one obstetrician and gynaecologist for a lengthy period of time. That individual has to be responsible for every high risk obstetric case over a very large area. The individual needs to be responsible for all women with gynaecological problems. There are only so many hours in the day and while this recommendation, I would certainly approve, one also has to ask whether that individual is able to perform the same audit on all other aspects of his/her work, which includes all other aspects of obstetrics and gynaecology, and in an understaffed community such as Tairāwhiti, I think it would be a difficult task for that person to audit all of the work he or she did.*

*Q: However, is that an acceptable risk to be taking with Tairāwhiti women?*

*A: I don't think it's got anything to do with Tairāwhiti women it's all women.*

*Q: We're dealing specifically with a location which is isolated, you have a clinician who is working in isolation. Do you agree ...*

*A: As Dr Teague said there are only so many hours in the day and if there is only one clinician, there is only a certain amount of work that that person can do.*

*Q: Should resources be put into ensuring ...*

*A: Exactly. We're not arguing about that.*

*Q: Thank you. That's all I have.*

### **Future Developments**

- 2.10 It is submitted that for future improvements the Government should look urgently at providing funding resources to enable clinicians to maintain on-going and continuing medical education.
- 2.11 It is further submitted that in cases of incompetence the Medical Practitioners Act 1995 gives the Medical Council wide powers to undertake competence reviews which have been used effectively, see the evidence of Ms Jones at page 1015 -

*There have been matters arising from competence reviews and also from hearings before the MPDT that have alerted those bodies to wider issues of public safety that are outside the jurisdiction of the council, but which the council has knowledge of. And in both those cases an informal process had to be used to advise the Chief Medical Adviser at the Ministry of Health so that in one case look back programmes could be put in place. In the other case, a strategy adopted to persuade the Dr to retire forthwith.*

## CHAPTER 3

### Quality Assurance Programme and Monitoring of Performance

#### 3.1 Key Points

**3.1.1 The Quality Assurance Programme was available to Dr Bottrill from 1989 onwards.**

**3.1.2 The College actively encouraged (which is all it could do) the participation in quality control activities.**

**3.1.3 The Medical Council of NZ and IANZ now have the powers to sanction non participation or poor performance.**

3.2 If he had chosen to, Dr Bottrill could have regularly participated in the College's Quality Assurance Programme - see evidence of Dr Teague B1126 -

*Q: Would it be your opinion then that at the time of the introduction of the National Cervical Screening Programme there was sufficient knowledge on the benefits of quality control? There were sufficient vehicles for bringing such knowledge to the attention of the New Zealand pathologists and the information was disseminated such that pathologists would acknowledge that this is the correct thing to do?*

*A: Many of us who promoted this did the best we could to promote it in all the vehicles that we had to do so. How sufficient or effective I can't answer but certainly there were strenuous efforts made to do so.*

3.3 The unchallenged evidence of the College at paragraph 7.1.6 set out the initiatives taken by the College over the last 20 years -

*The College has been active in developing external Quality Programmes in Pathology. As far back as 1970 the College undertook Laboratory Proficiency Surveys. These gradually evolved into Quality Assurance Programmes in the major disciplines of Pathology. In 1988 the College handed the management of these external Quality Programmes to RCPA Quality Assurance Program Pty Ltd. There has been a formal Quality Assurance Programme in Cytopathology since*

*1989 with preliminary surveys introduced in 1987. New programmes are developed in association with the College's Quality Assurance Scientific and Education Committee.*

And at further on the College's evidence is -

*7.1.8 Many laboratories in New Zealand participate in the RCPA Quality Assurance Programme Pty Ltd, Quality Assurance Programmes. Many also participate in the College based Surgical Pathology New Zealand (SPANZ) slide circulation programme for anatomical pathologists.*

*7.1.9 The NPAAC Requirements for Gynaecological Cytology also detail requirements for internal quality control programmes. These state that laboratories be able to demonstrate:*

*7.1.9.1 A system of follow-up for correlating the results of gynaecological cytology with relevant histopathology;*

*7.1.9.2 A system for evaluating screening performance;*

*7.1.9.3 A review of past negative cytology smears from patients with current abnormal cytology/histology.*

*7.1.10 In addition to the formalised external quality assurance programmes, and such internal quality control programmes as above some practices do undertake further activities to monitor and improve quality. The format of these measures will vary depending on the nature of the practice. Examples of other quality activities that practices may undertake include:*

*7.1.10.1 A formal review session with multiple practitioners involved at a combined meeting;*

*7.1.10.2 The circulation of case material or a selection of cases to be re-read by other practitioners;*

7.1.10.3 *The double sign out of malignancy reports;*

7.1.10.4 *Review of cases by international experts.*

## 7.2 ***College involvement with Accreditation within New Zealand***

7.2.1 *Accreditation is also now compulsory in New Zealand if a laboratory is funded by the Health Funding Authority on a fee for service basis, a requirement that only came into effect in the mid nineties with the changes to New Zealand health funding.*

7.2.2 *Part of the IANZ (International Accreditation New Zealand) requirements is for laboratories to participate in external quality assurance programmes such as the RCPA QAP Pty Ltd or equivalent.*

7.2.3 *Unlike Australia, IANZ sets the standards for accreditation as well as undertaking the inspections. IANZ has a Medical Testing Professional Advisory Committee which provides advice on professional issues in relation to standards and accreditation. The College has one representative on this Committee.*

3.4 For a useful summary of how the programme works, see the evidence of the President of the College, Dr Davies, when being questioned by Mr Hindle at page B1194 -

*In the 70s Dr Michael Gribble was particularly active in promoting quality assurance and indeed it was to a large extent through his energies that the National Pathology Accreditation Advisory Committee was established. But he developed a committee, which has had a couple of names which we don't need to go into, that for a number of years in the College itself ran a number of quality assurance programmes. But as this became a much bigger and much more complex activity, a decision was made to move this from within the College to a separate organisation which is now constituted as a separate incorporated entity which is at arm's length from the College. The College council itself is the Board of Directors of one incorporated coy, and Royal College of Pathologists of Australasia, QAP Pty Limited is another separate company with its own Board of Directors, Chairman and Company Secretary, and it offers a number of different*

*programmes which it produces in some disciplines in conjunction with various specialist societies such as the Australian Association of Clinical Biochemists in chemical pathology and with other specialised societies in some of the other disciplines. So they operate now separately. There is obviously good communication between the two bodies but they are separate corporate entities.*

- 3.5 It is Dr Teague's evidence that this was advocated in the President's Annual Report. See also page B1226 where he stated that for many years he championed the cause that New Zealand pathologists should be involved with the College Quality Assurance Programme.

*Q: You were championing the cause that New Zealand cytopathologists should be involved with the College quality assurance programme?*

*A: Yes I had been championing that cause for some years.*

*Q: And just while we're on that, I think in 1994 you became the College representative on the body that oversaw the processes of the quality assurance scheme weren't you?*

*A: The management committee of that group.*

- 3.6 In response to a suggestion that there was some resistance to participation in the programme, Mr Walker, of TELARC, responded that those reservations were procedural not substantial - see page 564 -

*... reservations ...we had more reservations in relation to the manner in which information was reported to the College either electronically or in writing rather than reservations about the integrity or completeness of the programme and some of those reservations in relation to manner of reporting to the College in Pathology anyway exist until today.*

- 3.7 See also the evidence of Dr Teague at page B1243 -

*CHAIR: Are you aware of any ideological concern about using regulations, are laboratories particularly resistant to having Telarc accreditation imposed by regulations?*

*A: I think the bulk of laboratories actively supported Telarc registration. I can't answer for all laboratories but I believe the vast bulk of them are very supportive.*

*Q: Do you know then why there wasn't a regulation passed to require Telarc accreditation?*

A: *I've got no idea.*

Q: *At that time what was preventing laboratory physicians themselves introduced such quality control standards in their own laboratories?*

A: *I believe that in a voluntary way most of the laboratories in New Zealand did do this. In fact I think more than half the community laboratories were already Telarc registered on a voluntary basis. Most of them had quality control programmes in place and I believe that they encompass most of the larger laboratories.*

Q: *Did the New Zealand Society of Cytology endorse the benefits of quality control in the practice?*

A: *Absolutely.*

- 3.8 In addition, Dr Bottrill could have participated in education workshops to a greater extent. The availability of the workshops was referred to in the cross-examination of Dr Teague, page B1126 -

Q: *And did the Society have educational sessions and workshops?*

A: *Yes it did, every year the New Zealand Society of Cytology has a workshop and it has case presentations and it has had a number of presentations relating to quality control and it's been widely discussed and debated, particularly issues like rapid re-screening vs. 10% reviews and issues like that had been actively debated and indeed the Society has had at times guest statisticians to talk about these sort of issues.*

- 3.9 While available throughout the period relevant to this inquiry, awareness of the importance of quality assurance programmes has increased over recent years. The evolving nature of quality controls is highlighted in the evidence of Dr Farnsworth at page 1724 -

A: *Well as I said the process of accreditation, pathology accreditation in Australia has been a stepwise process. The initial NATA inspection and registration process was introduced in 1987 but at that time there were no specific standards for laboratories reporting gynecological cytology. They were general laboratory standards that looked at a whole range of things and I won't – but in fact it was part of the organised approach to cervical screening introduced in November of 1991 that the very first set of guidelines for laboratories reporting gynecological cytology were introduced and that was the first time that there had been any attempt to put in any kind of standards and they are special standards because it was understood that pap smears were part of a public screening programme. If I wear my Government hat for one minute, the Government had every right*

*to make sure for their women that the laboratories were performing at a reasonable standard and that's why those standards were introduced.*

- 3.10 Sadly, in some cases, improvements in some cases have occurred because of adverse incidents rather than foresight - see the evidence of Dr McGoogan highlighted that often improvements come about as a result of adverse incidents. She said at page 941 -

*You seem to have an exemplary civil service ..... no, quite a number of public incidence requird us to put in place accountabilities and clear lines of responsibility and we have explicit standards against which to measure the delivery of all components of our programme, these are in the public domain and have to be accounted for.*

### **Developments**

- 3.11 The accreditation system set up under the 1995 Medical Practitioners Act is an important safeguard to ensure participation.
- 3.12 Compulsory IANZ (formerly TELARC) accreditation has similarly ensured that in order to receive payment laboratories must participate in Quality Assurance Programmes).
- 3.13 It is submitted that the evidence of Dr Peters shows that there is now a significant recognition of the importance of quality controls and measures put in place to monitor standards in the future within the HFA.
- 3.14 It is submitted that the close association between the College and NATA would be a useful model to consider adopting in New Zealand - see the evidence of Dr Tie at page B1160 -

*PROFESSOR DUGGAN: What role does the Royal College have in the monitoring of laboratory performance with regard to cytopathology practice?*

*A: The College itself, it has a recently formed disciplinary advisory committee in cytopathology so broadly that committee is able to look at data although it more often looks at specific questions raised in relation to the practice of cytopathology. On an individual basis most of the information that comes to College fellows I think would come through the screening programme and the College obviously has a part in that through it's advisors to the programme but I think that's*

*probably the extent of it at present.*

*Q: So there is no committee within the College that actually looks at individual laboratory data?*

*A: No not a separate committee in the College, not that's correct.*

*Q: Do you think that the College should do something like this?*

*A: I think it would certainly be desirable if we have the resourcing for it. I suppose once it's set up the time commitment is not so great but it would take certain amount to establish it and I guess the College would also have to rely on sources of data outside itself so it would obviously have to have the right relationships with whoever is collecting that data.*

*Q: In this brief of evidence I note that in Australia the Royal College and NATA jointly are involved in the accreditation process whereas in New Zealand the Royal College has no role in the accreditation process, is that a correct summary?*

*A: If I could perhaps modify that slightly, the College does have one representative on the medical testing professional advisory committee of IANZ the accrediting body and obviously a number of the other people are College fellows although not there in an official capacity for the College. Does that answer your question?*

*Q: Yes. Do you think that position should be strengthened?*

*A: It would be desirable certainly yes.*

*Q: And how do you see that happening or what format do you see that in?*

## CHAPTER 4

### TELARC

#### 4.1 Key Points

**4.1.1 TELARC accreditation was available and known about since at least 1988.**

**4.1.2 The College actively supported and promoted TELARC (now IANZ) accreditation to its members and stated its official support to the Ministry.**

**4.1.3 The College, as a voluntary fellowship, could not force accreditation nor did it have the mechanism to know what individual Fellows did or did not do.**

**4.1.4 On a voluntary basis, the College and its members provide time and expertise to review the performance of laboratories and the individuals who work at the laboratories.**

4.2 Dr Teague's unchallenged evidence was that the advice of the Committees he was a member of (namely, CALC, CSLAC, the Expert Group, and the Ministerial Review Committee) was not followed, in a number of respects including compulsory accreditation.

4.3 The evidence shows that the Porirua workshop in 1988, the Straton Report in 1990 (see **JMG/MOH/4**), the Expert Group in 1991 (see **JMG/MOH/005**), and the 1991 Policy Committee of the Ministry (see **GRB/MOH/16**) all recommended compulsory TELARC registration. At page 100 of his evidence, Dr Boyd acknowledged -

*It is quite clear I was part of a Department which was pushing for compulsory TELARC accreditation of laboratories and for internal quality assurance activities within laboratories, and it didn't come to pass in the time up to 1996. So there was a failing there from the programme.*

4.4 The evidence also shows that the College and the Association of Community Laboratories supported compulsory accreditation. There is no evidence of any individual or group opposing imposition of this requirement. Given the clear support of all potentially affected parties to this requirement, it is submitted that the failure to achieve its implementation could reasonably be described as inexplicable.

4.5 Before looking at why this compulsory accreditation was not achieved until 1996, it is of relevance to consider whether it would have made any difference.

4.6 The unchallenged evidence of Mr Robertson from TELARC (see paragraph 5 of his brief of evidence) was -

*The standards for accreditation required by TELARC are comparable with the highest standards in the developed world, and TELARC is highly regarded internationally. This is in part due to the fact that individuals employed by TELARC are involved in training and assessing colleagues from accreditation agencies overseas.*

Dr Robertson's evidence was also that at one time New Zealand had a leadership role in being only the second country in the world to introduce accreditation (see paragraph 10 of his brief of evidence). It is submitted that this evidence is important in showing that at one time New Zealand actively led the way in setting standards and implementing them.

4.7 The evidence of Dr Boyd, Ms Glackin, Mr Walker, Dr Robertson, Dr Teague, Dr Wain, Dr Farnsworth and Dr McGoogan was consistent with the proposition that had TELARC accreditation been made compulsory it could potentially have averted the tragedy that occurred in Gisborne - see in particular the evidence of Mr Walker at paragraph 41 of his brief of evidence where he said -

*My professional opinion, I am very confident that accreditation would have ensured that checks were in place that were very likely to have prevented the under-reporting of cervical smear readings by Dr Bottrill at Gisborne laboratories, as the competence and validity of test results would have been audited yearly with a full audit being carried out every four years.*

See also paragraph 50 of Mr Walker's brief of evidence where he said -

*Although the reading of cytology is ultimately the decision of one individual, it is my honest believe that the requirements for accreditation would have gone a long way to ensuring confidence in the individual's performance. Accreditation would not be able to ensure that a cytopathologist did not have an "off day", but it would pick up cumulative variations in performance or non-performance issues.*

Finally, in his evidence, Dr Boyd agreed -

*It was quite clear. I was part of the department which was pushing for compulsory TELARC accreditation of laboratories and for internal quality assurance activities within laboratories, and that didn't come to pass in the time up until 1996. So there was a failing there from the programme.*

4.8 In examining the evidence showing that TELARC accreditation was not only important but could have averted the tragedy, it is important to look at why it was that the system failed to introduce this important safeguard.

4.8.1 The first was the failure to have a coordinated approach that allowed the monitoring, funding and implementation to be carried out in one unit. This is reflected in the questioning of Ms Glackin by the Chair when she asked -

*Q. But the programme had no control over funding so if someone was not performing well it couldn't refuse to pay. Is that correct?*

1. *That is correct.*

And further on -

*Q. Do you not consider that to be a problem ...*

*A. Certainly, later on, it was difficult for the programme in the sense of raising TELARC registration and relying on the Regional Health Authorities to implement that through its contracts, but that was in accord with the accountability arrangements as they existed at the time.*

And -

*Q. If you couldn't withhold funding to a laboratory that wasn't performing properly, what other effective means did you have of holding the laboratory accountable ...*

*A. This programme relied on the expectation that health professionals would be competent, the registration, the work on developing standards was intended to define what appropriate practice was. The processes available, apart from contracting, are related to professional discipline. In addition the Ministry sponsored best practice which is what the development standards were.*

4.8.2 The second factor highlighted caused a failure to implement this accreditation standard or the reliance on a legal opinion (see **GRB/MOH/0041**).

4.9 At page A539 of the transcript Dr Boyd was asked by Mr Corkill - *Now, you say in 146 that the department received legal advice that it would be doubtful if it had the authority to demand that laboratories already claiming benefits under the Act could be compelled to seek TELARC accreditation ... That is correct.*

Dr Boyd was then taken to Regulation 6 of the Social Security Laboratory Diagnostic Services Regulations, and agreed that in fact the Minister had the power to impose conditions under the Regulation in relation to TELARC accreditation.

4.10 It is submitted that this error in the legal opinion highlights the lack of in-house expertise in the Ministry at that time.

### **Future Improvements**

4.11 Since 1996 TELARC registration has been compulsory. The evidence of Dr Peters shows that there is now someone within the Ministry who is coordinating the implementation of laboratory standards. A question of relevance is whether in a country the size of New Zealand there should be two agencies carrying out this role.



## CHAPTER 5

### Practice Standards

#### 5.1 Key Points

**On a largely voluntary basis, CALC consulted on and produced two sets of laboratory standards for TELARC.**

- 5.2 The evidence of Dr Teague was that on a largely voluntary basis CALC provided laboratory standards/TELARC.
- 5.3 There is no evidence of any assistance or concern being offered or expressed by the Ministry to achieve quicker or more extensive standards.
- 5.4 CALC's advice has been characterised by a consistent practice of not being implemented. Criticisms by the Ministry of this group of experts when they were ignored and neither adequately paid nor resourced are utterly unjustified.

#### Future Improvements

- 5.5 The evidence of Dr Peters sets out tighter, more extensive standards (in line with the Australian standards brought to the Ministry's attention by CSLAC in 1995).
- 5.6 Dr Poutasi has confirmed that these standards will be implemented - see her evidence -

*Q: We have heard from Dr Peters that one of the advantages for a programme would be sustainability in terms of planning and the ability to consolidate and have seen some excellent documents in terms of standards and performance indicators and I assume that in the reformed structure that they are going to have the chance to be implemented and followed up.*

*A: Absolutely, one of the approaches that we are using in the sector change process is the concept of building forward and I believe that applies more appropriately than in this particular position or in this particular circumstance in the sense that the work done to date will be*

*consolidated and built on.*

## CHAPTER 6

### Monitoring and Evaluation

- 6.1 The consequences of not enforcing TELARC accreditation were compounded by the programme's failure to implement comprehensive monitoring and evaluation. This in turn delayed the development of performance standards based on the New Zealand experience and a failure to be able to monitor and to achieve actual monitoring of quality controls and performance standards.
- 6.2 The World Health Organisation requirements underscore the importance of monitoring and evaluation.
- 6.3 Dr Poutasi gave assurances that these controls will be secured despite future changes to the health system -

*Q: And in particular you can commit to the first of those, the WHO requirement underscoring the importance of monitoring and evaluation for the programme?*

*A: Absolutely, and I think in evidence today the Ministry has shown its commitment to that and I think in evidence before the inquiry you have been briefed on the work that the Health Funding Authority has done to secure all the features of the programme within a particular unit and it's that unit that we envisage transferring lock stock and barrel into the Ministry of Health with no disruption whatsoever.*

## CHAPTER 7

### Measurement of Performance

#### 7.1 Key Points

**7.1.1 Key consistent advice from advisory committees that would have allowed measurement of performance was not implemented by the Ministry.**

**7.1.2 The failure to implement was a consequence of a lack of good operational leadership.**

**7.1.3 A lack of internal expertise resulted in the significance of advice not being appreciated. When data became available clerical and computer staff were not able to process it or make it available in any meaningful way.**

7.2 A significant failing of the programme was the failure to provide correlation of histology and cytology - see the evidence of Dr Teague, paragraph 20.

7.3 The benefits of such information were not disputed by any witness who appeared before the Inquiry - see evidence of Dr Teague (page B1393) -

*Q: Well then, in terms of the benefits of the histology/cytology correlation, it's of benefit in recognising over-reporting, is it of any assistance in recognising under-reporting?*

*A: In an indirect way, yes, because when you then go back, as a laboratory should, and retrospectively analyse - if you get a positive cytology then you should retrospectively analyse your previous smears on that person. The histology is confirmation that that was a true positive rather than a false positive. So it has an indirect help in that regard.*

*Q: So indirectly the histology/cytology correlation does help in identifying whether or not there are false negatives?*

*A: It's an aid to that because it confirms the true positive diagnosis.*

*Q: And therefore, in terms of being an indication of accuracy of reporting generally, one would extrapolate from someone who keeps reporting too many false positives in terms of querying whether or not they were likely to be reporting false negatives as well?*

*A: That's not necessarily so, to be honest. You may in fact have a laboratory which has set its own internal, what, limits slightly high. So it doesn't necessarily follow that they would equally be under-reporting.*

*Q: Well then, in terms of the benefits of the histology/cytology correlation, it's of benefit in recognising over-reporting, is it of any assistance in recognising under-reporting?*

- 7.4 It is submitted that the need for good operational leadership should be a given in any organisation. The importance of such leadership for the National Cervical Screening Programme was stressed in a report from CSAC - see **GLA/MOH/35** at page 13. See also the evidence of Ms Marshall at paragraphs 68, 92, 93 and 94. The evidence shows that fundamentals such as the importance of this information were not appreciated by staff responsible due to a lack of operational leadership - see cross-examination of Dr Teague by Ms Scholtens -

*Q: In terms of the discussions with the National co-ordinator at the time, was the National co-ordinator someone who had sufficient knowledge and background in medical matters to appreciate the benefits of the histology/cytology correlation and the need to implement it?*

*A: they probably either were not themselves experienced or didn't have the resource base within the programme to do what you're suggesting, I believe. They had a number of committees advising them what to do, but I don't believe within the group itself it had the necessary resources.*

*Q: And although there might have been the expert advice coming in, if there wasn't a background knowledge it might have been difficult, would it not, for the persons concerned to be able to appreciate the importance of the advice received?*

*A: I don't know that the advice was rejected. I think that they were doing what they could with the resources that they had.*

*Q: At the moment I understand that the programme is now managed by Dr Peters who has expert qualifications in public health.*

*A: Yes.*

*Q: Would it have been better that if at the outset the programme had been managed by someone with that background?*

*A: I'm sure it would have.*

*Thank you.*

- 7.5 The late achieving of a mechanism to make this information available was clear from the evidence - see evidence of Dr Teague at page B1229 -

*Q: And then a little further down you make the further comment that next year there will be improved information.*

*A: Yes I was hopeful that that might happen.*

*Q: Hopeful at that stage. And was that because in process at that stage was the legislative change whereby histology correlation was going to be incorporated into the programme?*

*A: Yes it was something that we had advocated from the start but we hoped it was going to be incorporated.*

*Q: And the reasons for needing that are obvious aren't they?*

*A: Yes.*

*Q: Just on this question of the histology cytology correlation, we've heard and you've no doubt read it because I think you mentioned her evidence yesterday, Professor McGoogan talked about positive predictive value. That's a mathematical of statistical means of importing histology correlation into the results.*

*A: It's one of the uses of that information.*

*Q: Without that information, that is the histology correlation, the value of the statistics is somewhat limited isn't it?*

*A: Well obviously the value is enhanced by having that information.*

7.6 The inability of the Department to process the information is also set out in the brief of Dr Teague, paragraph 20. This was further expanded on at page B1246 -

*Q: In retrospect would there have been any advantage to phasing this in?*

*A: Absolutely because I believe we would have been able to utilise the statistics more rapidly because the data entry problems would have been less and I believe we could have kept up with it and being able to produce useful data much earlier.*

*CHAIR: My understanding is that at the time you were at odds with the Dept over this, you had a legal opinion which supported phasing in of the histology results but the Dept had a legal opinion which took the converse view, is that correct?*

*A: Well, it was quite clear that the Dept's legal opinion was correct in terms of the Act, it said you had to send all of it in. the legal opinion that I obtained, and it was informal but it could perhaps be challenged by having histology that had no particular relevance to the programme being put into it.*

## **Recommendations for Change**

- 7.7 At page B3208 of the evidence Ms Marshall identified the need for securing the future of the programme and recommended -

*But our concern is that, and I think it's reflected in this letter, that we must ensure that those achievements are maintained and enhanced and we indicate that that office must be secured over time. We have seen in the evidence I think that has been put before this inquiry by number of witnesses that the programme has been moved from one section to another section and we're very concerned that the expertise needed to planning, coordinating, monitoring and evaluating, that that is secured over time and on the second page in item 2 we are very concerned that that office be positioned in the health system at a sufficient high enough level, in fact in this letter we had recommended that the office report directly to the Director-General of Health, we feel that that reflects the responsibilities and obligations of the programme. The third item there again identifies the fact that it needs to operate in a stable environment and that the fourth it requires adequate resources in terms of the range of expertise, the sufficient number of staff and continuity of staff and I think that there have been a number of witnesses who have been asked what expertise that should include and I would concur with previous witnesses, Dr Cox in particular, who was referring to the report of the CSAC committee of 1994 which was produced as Glackin 35 that this sort of expertise there. I think one of our concerns is not just to identify in these reports and in our evidence what is needed but the need really to have an independent review, external review of what is needed. I think that the staff over the years have worked very hard to identify what is needed and advisory committees have identified, but I feel it's really important, in looking to the future, that some sort of external review be undertaken to identify what expertise is needed.*

*Q: This is a review of staffing needs within the central registry, if you like?*

*A: A review of staffing needs within the national co-ordination unit. And I feel, in my experience, that such a review should be undertaken by an independent person - possibly, for example, someone who is experienced in screening programmes overseas - maybe someone, for example, someone like from the Scottish programme. In 1990 ...*

- 7.8 The legislation necessary to achieve correlation has been enacted. The challenge is now to input the data and make it readily available to those who can use it to benefit the women of New Zealand.

## CHAPTER 8

### Failure to Follow Advice

#### 8.1 Key Points:

**The Ministry failed -**

- 8.1.1 to adequately resource the committees, both in recompense to members and in provision of services;**
  - 8.1.2 to properly constitute the groups;**
  - 8.1.3 to listen to and routinely action recommendations without intervention;**
  - 8.1.4 to provide a structure to an appropriately senior level, i.e. Director-General or Minister;**
  - 8.1.5 to have parallel internal expertise that could action recommendations;**
  - 8.1.6 to set up committees with effective powers;**
  - 8.1.7 to appreciate that committees without power or authority could not and did not have any role in operational management;**
  - 8.1.8 to vest in the committees the authority or mechanism to break through obstacles such as legal impediments that affected operation and research.**
- 8.2 It is submitted that the failure of the Ministry to follow and implement the advice of experts played a pivotal role in the failure of the Cervical Screening Programme and, in particular, has failed the women of Gisborne.
- 8.3 Constant failures to follow advice from 1988 through to 1996 are set out in

Dr Teague's evidence. In addition, the difficulty of a management structure where those with the knowledge did not have the power to achieve their recommendations should not be permitted to occur again - see Dr Teague's evidence paragraph 20.13, 20.14, 20.15, 20.17 -

20.13 *In 1993 the Health Amendment Act was passed which required histology results to be sent to the Register. At the CSAC meeting on 5 November 1993 (see JMG/MOH/11) the National Coordinator advised us that "The legislation is difficult to implement and an enormous amount of work has to be done in this area." She advised us of a legal opinion. I had taken my own legal advice and questioned the opinion obtained by the Ministry of Health. By now, this issue was becoming rather tetchy and the meeting records a suggestion that "CALC and the Ministry of Health productively work together to seek a solution to the problem ... It was commented [that there] has been a measure of intolerance and non-constructive comment about this issue which has hindered progress."*

20.14 *When steps were finally taken to start loading the histology information onto the computer I expressed strong concern - not against the information but about the relevance. The programme was already under-resourced. I did not think it wise to overload it with results from hysterectomies for prolapsed fibroids or menorrhagia which are unrelated to cervical cancer.*

20.15 *This concern was summarised in a letter to the Minister of Health dated 8 December 1993 (see JMG/MOH/11). This letter was sent from CSAC where we stated: "It was considered that the NCSP could be compromised if the current interpretation of the Act is followed. The intent of the legislation was to include the histology of women already enrolled on the register as a quality assurance measure. As currently interpreted, however, the Act requires all histology results to be entered on to the register. This includes results of women whose cytology results are not on the register or who have gynaecological surgery unrelated to cancer. As a result, time and resources are required to collect unnecessary information."*

20.17 *As it transpired, the programme was overloaded and considerable delays occurred as a consequence. This was noted by the Minister of Health in her letter to CSAC dated 26 January 1994 (JMG/MOH/11), where she stated "I acknowledge there have been some problems in the*

*implementation phase of including histology results on the Register which has produced extra workloads.”*

See also Dr Teague when being questioned by the Chair at page B1526 -

*Q: And was one of the problems in terms of being able to do something about it the fact that CSLAC was a group of voluntary persons?*

*A: Absolutely.*

- 8.4 Another difficulty highlighted in the evidence was that these advisory committees were advisory only with no effective powers. This is highlighted in the evidence of Dr Cox at page B2579.

*Q: when it comes to the question of doing something such as imposing standards such as the need to read a minimum number of smears, in your experience is that something that can be done in a consensus way or ultimately should that be something done by way of regulation if consensus is not working?*

*A: I believe if consensus is not working then you may need to resort to regulation, and it depends on the circumstances of the laboratory structures, and in NZ we have historical development of many laboratories serving relatively small populations, with some large ones.*

*Q: Just to continue with this document, from your experience of screening programmes I would like your opinion on a policy document, which this is, which in one clause says that cytology laboratories should be TELARC accredited; in the next clause it says that the Department of Health will be responsible for confirming that the cytology screening is going to be carried out to meet the requirements in the following clause, and that following clause says that criteria for registration by TELARC will include – and it sets out a number of things. What is your opinion of a policy document that sets this up in circumstances where the development of the criteria, or the establishment of the criteria – to use the word in the document – is to be done by an advisory committee which has no terms of reference?*

*A: It's bizarre.*

*Q: And the impact would be that if the advisory committee failed to establish the criteria set out in 4.1.4 then there wouldn't be any TELARC accreditation because until that criteria is established there is nothing for the Ministry of Health to be responsible for confirming that the requirements in 4.1.4 are met; do you see what I mean?*

*A: Yes, I think I see what you mean, and also it asks the CALC to specify to TELARC what they should and shouldn't do. And it has no formal relationship with TELARC either; I'd call it a floating*

*committee.*

*Q: Yes. So in terms then of the Cervical Screening Programme and the structure this policy was attempting to set up for the role of laboratories in the implementation of the screening programme, how effective do you think this policy is?*

*A: Not very effective. It doesn't appear that the process has been thought through.*

*Q: Does it appear to you, given your role on CSAC, your obligation was there to monitor and evaluate the programme, when it came to looking at this aspect of the programme what could you have made of this policy document and whether or not it was being followed?*

*A: It was of limited use to CSAC, but also in the climate of the day it did indicate to us that there was some government commitment to a National Cervical Screening Programme.*

*Q: Just for completeness if you would look please at volume 6 of Glackin, the 93 policy starts at page 26 and the particular part I've been referring to to do with laboratories starts at page 34 in the top right hand corner and goes on to 35.*

*A: Starts when enrolling.*

*Q: Yes top of page 24 see that headed laboratories.*

*A: Number 4 laboratories.*

*Q: And you will see 4.1.2 starts on the bottom of the page.*

*A: Yes got it.*

8.5 The lengths the Committees went to in order to achieve implementation of their advice were set out in Dr Teague's evidence at paragraph 13, in particular 13.2 and 13.5 -

*13.2 My view was that despite frustrations with progress, it was better to work inside with people than outside with animosity. However, my frustration about the abolition of a cytologist training programme was so great that I made a statement to the media in August of 1993. This created difficulties for me in achieving change which is in part evidenced in Exhibit JMG/MOH/087. In July of 1994 the Ministry carried out reforms on the Committee.*

*13.5 At the meeting of CSAC on 11 March 1994 I am recorded as expressing concern "about resource constraints nationally while local evaluations of varying quality are occurring on an ad hoc basis. Sue Dahl confirmed that funding at the local sites is devolved and that it is impossible to transfer or retrieve it. The meeting noted that it was a useful exercise to evaluate the evaluations that have been done by local programmes." It was agreed that a letter would be written to the Associate Minister*

*of Health expressing “concern that the Report’s recommendations have not been implemented, ... at the loss of 0.5 support/word processor person ... about national coordinator’s access to expertise and that there should be a person with permanent responsibility for evaluation of the NCSP ... The meeting noted that matters regarding routine monitoring are yet to be sorted out.” (See JMG/MOH/11)*

See also the evidence of Dr Cox, see page B2536 -

*Q: Thank you. Can we just on another historic topic refer again to the CSLAC report on monitoring and evaluation of 94 which is Glackin volume 9 tab 35, page 28 onwards, top right hand corner. Now I think you were a member of the CSLAC which produced this report.*

*A: Yes.*

*Q: The highly unusual I suggest step was taken when this report was prepared of including as an appendix at appendix 3 page 19 of the report, a chronology of all the committees documents and recommendations regarding programme monitoring and evaluation and again at page 23 of the report, a tabulation of all the committees submissions regarding the screening programme, page 24 selected outgoing correspondence from CSLAC and there were other schedules there also setting out relevant chronologies. Why was that step taken?*

*A: We were driven spare.*

*Q: Because.*

*A: By frustration within the Ministry in terms of our recommendations being taken up.*

- 8.6 The “black hole” response (i.e. recommendation went into a black hole and not coming out as implemented requirements) to advice was apparent in the evidence of Dr Cox - see further on at page B2538 -

*To the best of your knowledge at any time did the Minister or any official of the Ministry of Health communicate with CSAC in any way which appeared to you to contradict the descriptions you had given in the 1994 report in terms of how you described the programme working and your recommendations for what was needed; in other words, did anyone tell you you’d got it wrong, you were over-reacting, that in fact the programme was in better shape than what is described in your report of 1994?*

*A: the manner of reply tends to be in the nature of excuses rather than contradiction, particularly from the national co-ordinators who I actually think at a personal level wanted this thing to be successful and*

*proceed. I think they were – and the staff of the screening unit, were frustrated by decisions further up the chain. We didn't have, well we didn't request it, but also I don't believe – I'm not sure – I don't believe we would have been given the correspondence and memos that they sent between themselves within the organisation, or memos to the Minister or whatever else. So that is all an unknown. So as an advisory committee we had excuses and often, "oh well we can't do this because of that", and, "when this is done we will be able to do this", and issues of resources and I think the task was way beyond – and it's not the individual's fault, it's just the requirements of running the programme and the lack of expertise that we mentioned earlier. The difference between what was required and what they were able to provide was so wide that excuses tended to be used. So there was programme, it was made at a snails pace when it was made, and a lot of things – I think there was an issue, "well, we'll do this for this period of time, we can't do all these other things, then we'll do a bit more". I think the organisation as a body felt very obstructive,*

*Q: So there was never any communication back to CSAC from the Ministry of Health in which the Ministry of Health stated that CSAC had over-stated the case in its report of 1994?*

*A: there may have been but I can't actually recall it, and I think that would have been like putting a red rag to a bull just quietly.*

*Q: So you would be more likely to recall it if it did happen?*

*A: That's one way of putting it, but I can't vouch for that.*

*Thank you.*

- 8.7 The evidence identified that part of the problem in implementation was the lack of in-house expertise, resulting in advice not being appreciated and therefore implemented.

### **Future Recommendations**

- 8.8 It is suggested that an appropriate change for the future would be to give advisory committees the sort of powers that those in the UK have - see the evidence of Dr McGoogan at page 948.

*There is a National Co-ordinating team based in Sheffield, led by Mrs J Patnick as the national co-ordinator with responsibility for the day to day direction and management of the programme . in addition there is national Advisory Committee on cervical screening with a terms of reference to advise ministers in the Department of Health and the NHS executive on the development of the cervical smear service to monitor the effectiveness of the screening programme and to advise on research concerned with the provision of the cervical smear service*

*(screening - led by Professor Martin Vessey).*

*The Advisory Committee, what sort of power does it have to procure change or to monitor or procure correction if it sees a problem in the programme ..... it has a lot of power. It would be very difficult for the NHS executive to ignore the advice of a nationally set up advisory committee such as the one for cervical screening. We have similar committees for our breast screening programme.*

*Would it be similarly difficult for the Minister to ignore advice ..... yes it would be similarly difficulty, I do not believe it would happen.*

*There seems to be some suggestion in evidence before the inquiry that advice given to the Minister by our various advisory committees has not always been followed. Is that a situation that you would expect to find in the UK system ..... no, the national advisory committees are permanent committees and I would be most surprised if their advice was not followed and implemented. I cannot think of a situation where that has actually happened.*

See also page 940 -

*In the UK with an expert group to what degree is there an expectn that their advice would be followed ..... If they were working as a working group they would come up with recommendations which may/may not be followed because they would be given the task of looking at a specific problem in isolation and it would up to others to take those recommendations in the context of the whole health service its funding and what is practical in this particular point of time. The difference with the NHS is their remit is to actually do that, to take the whole programme in the context of the whole health service, its funding, orgnstr, what is practcl what is not practice.*

*Do the advisory groups do cross analysis..... sometimes they are asked to do just that.*

- 8.9 It is submitted that the move to properly pay members of committees will assist in putting the relationship on a more professional footing. It is submitted that this problem has now been recognised by the Ministry as evidenced by Ms Mellor - see page 2044 -

*Q: Well we've heard for example from Dr Teague that a lot of the work that he did on CALC and the experts group was unpaid work so he was there in that sense on a voluntary basis.*

*A: It's not something I've specifically checked. It certainly is to be a formally established group and it's normal practice with most of these groups in the Health Funding Authority at this stage is to pay the members but I cannot say that –*

*MR MURRAY INTERJECTS AND XXN REFERS*

*MR MURRAY:* Clause 8 of the draft terms of reference does deal with remuneration for members so it is envisaged they be paid.

*CHAIR:* Thank you Mr Murray.

## 8.10 The importance of in-house expertise has now been recognised -

*CHAIR CONTINUES XXN OF PETERS*

*CHAIR:* Are you able to comment, if you can't please say, on why there is this notion of using an advisory group made up of outside experts rather than having the expertise in house within the Ministry Health Funding Authority – I'm sort of combining the two words there because they are going to be working together.

*A:* It's an approach that's used a lot within the Health Funding Authority and Ministry. There are medical experts within both organisations but there are also a number of us who are if you like expert in coordinating and developing policy, implementing policy and it's a different role so the job of the Ministry and the Health Funding Authority is and will be to pull together expert advice and do something with it so it's considered more effective to bring in expert advice on a part time basis which means that we are getting advice from people who are still actively participating, that's if you are participating in the disciplines which they're representing and they're therefore close to their colleagues in current practice rather than just bringing those experts in and removing them from that environment. So there are advantages. We also – I think it has to be remembered – deal with a very large variety of different services and different specialisms (sic), and to try to have staff within the Health Funding Authority and the Ministry who covered all of those disciplines would not be possible.

*CHAIR:* We've heard, for example, from Dr Wain in respect of the NSW programme where they have an in-house epidemiologist and biostatistician and that the persons employed by the NSW programme are listed at the front of one of his exhibits. In terms of your role in auditing and quality assurance do you not think at some point it's actually more valuable to have the skills in-house so that you have persons who not only are dealing with the issues coming up before the advisory group but they are persons who have some authority in terms of implementing them?

*A:* I'm not sure that I quite meet –

*Q:* Well, one of the concerns that I think is shown by the minutes from groups such as CALC, CSLAC and the expert group is advice is given to Ministry officials but then it never seems to percolate through.

*A: I understand that question, I'm not that that question directly links to a question about why we don't directly employ the experts. I think they are two different questions. There's a question about whether the person or people receiving the advice from the advisory group have the authority to implement their advice. There's a different question about whether the expert advice that's been gained from the advisory group should be within the organisation, so I do think those two are quite distinct.*

*Q: Except that if you are receiving advice given from an expert group, in order for the full ramifications of not following that advice to be fully appreciated, the person within the Ministry/Health Funding Authority receiving the advice would need to have sufficient qualifications and knowledge to be able to see whether or not the advice being given at any particular time was advice where you might say "this would be a good idea but we can put this to the side for now, or this is an absolutely must".*

*A: I agree, but I think that there are many circumstances which the Health Funding Authority deals with where there are staff within those organisations who can reach those conclusions. Most of these advisory groups are multi-disciplinary advisory groups, so the chances of you finding one person who has all of those different skills – so an epidemiologist and a pathologist and a gynaecologist all rolled in to one person is not going to happen. So even if you had somebody within the Ministry that was, for example an epidemiologist, they are no more expert in any of the other fields than somebody who hasn't got any of those. So I am making a distinction. I do think people can learn this sufficient about the sector and about the way things have to happen and can get expert advice from a range of people, combine that, understand the implications and act on it without having to have a specific medical or other qualification. The advisory groups are there to input the specific advice. There are clinical advisers within the organisation who can assist if there are additional questions.*

- 8.11 It is further submitted that there appears to be a strong likelihood there will be better liaison between the Ministry and the College in the future. This is identified in the evidence of Dr Tie at page B1154 -

*Q: So you can see that in fact the list is quite extensive isn't it, it goes back to the early 1990's and probably preceding that and comes right up to date so the College has had a pretty intensive involvement in pretty much every aspect of it.*

*A: No I'm sorry I couldn't agree with that. It may have had intensive involvement in certain areas but in general terms it has not been engaged in any sort of overarching advisory body and I think that that has been a deficiency which now appears to about to be rectified.*

*Q: And I think your main complaint about that was in relation to such a brief consultation about the Gisborne investigation, you highlight that point.*

*A: That highlights that point but it's not the only occasion on which we have raised it, I wrote in 1995 and I think 1996 to divisional Regional Health Authorities and later to the Transitional Health Authority recommending that a broadly based pathology advisory group be established.*

8.12 The evidence of Dr Poutasi was reassuring in this regard -

*Q: Mr Corkill: ... you will see there the advice given by this committee [referring to CSAC] as long ago as '94 was that skills in the fields of medicine, epidemiology, public health, statistics, computing and cytology will be required. In light of that advice are you able to set that there is a good deal of - there is a wide skill mix which requires a strong leadership of a national programme of this nature. Are you able to accept that proposition?*

*A: Absolutely.*

*Q: And that to the extent that is needed the Ministry will be in a position of making available those disciplines for the future leadership of the programme?*

*Q: Yes.*

## CHAPTER 9

### The Rescreen Exercise

#### 9.1 Key Points:

**9.1.1 The reasons for the holding of the rescreen were ruled inadmissible to the Terms of Reference of the Inquiry.**

**9.1.2 Allegations made by Mr Grieve concerning the College's initial reservations about the rescreen exercise should be quashed with a clear statement that there is no basis for a finding of a lack of professionalism by the College or its members.**

9.2 **As stated in its opening**, the College respects the Inquiry's ruling that the reasons for the rescreen are not relevant to the terms of reference - see the evidence of Dr McGoogan at page 1003.

*CHAIR: certainly the inquiry may have to assess the quality of the Sydney reporting at some point but the reasons for the Health Funding Authority rescreening persons and how it went about that seems to be beyond the scope of this inquiry.*

*MR HINDLE: there are two issues, one is the question of whether the Sydney data is of any use in terms of reference one.*

*CHAIR: and to what extent it is taken into account certainly is very relevant.*

*MR HINDLE: I appreciate this is not at the centre of the terms of reference but we have here Dr McGoogan who has particular expertise in these rescreening exercises, and I don't know what lies ahead in terms of the work I now understand the Health Funding Authority is doing and much of it was put to Professor Skegg yesterday in terms of the study they are planning. It would be a pity if Dr McGoogan had some useful input and left the country without assisting the committee.*

*CHAIR: any advice Dr McGoogan could give on that point - the Health Funding Authority could speak to her before she leaves the country. How the Health funding Authority chooses to deal with the matter and*

*who they consult seems to me a matter for them.*

- 9.3 Accordingly, the College has not called specific evidence on whether the rescreen was the most appropriate means for achieving a review of Dr Bottrill's work and identifying at risk patients.
- 9.4 Compliance with this direction has, however, led to difficulties in that challenges most injurious to the reputations of individuals and the College itself have been made alleging that a failure to support the re-reading was in some way indicative of a lack of internal morality.
- 9.5 It is submitted that the evidence of Dr Tie shows that the concern of the College was that other means might be preferable. See page B1140.

*QUESTION: You see what concerns me about the future doctor is that I suggest to you that in fact you personally were very dismissive of the whole notion of a re-read, that you didn't give it serious consideration at all.*

*ANSWER: I think that's a very unfair comment. We took the matter seriously. My view at the time was that the information would not necessarily make a reliable judgment of the performance of Dr Bottrill, and the other main purpose of the re-read, which would have been to improve the outcome for patients in the area, could have been achieved by other means.*

- 9.6 It is submitted that the evidence of Dr McGoogan is also of relevance to the extent that she was able to comment prior to the ruling being made. In particular you are referred to her evidence of a different approach that would have been taken in the United Kingdom at page 954 where she was asked by Mr Hindle -

*MR HINDLE: I want to move to a third possibility altogether. EM/CA/006 - last document. Would it be possible in your view to do some kind of sample of slides ... yes.*

*In comparison with another group of slides ... yes, this is the way that we would begin to approach in the United Kingdom an investigation to see whether or not we had a real problem when questions were raised about the particular laboratory or an individual within a laboratory. How would it work in general principle...I would suggest that a number of consecutive smears from perhaps two periods of time say 500 slides*

*from two years apart during the period in question were collected from the laboratory in question say from 1 April in one year and 1 April next year and a similar number of slides collected from two or three other laboratories from exactly the same period one would expect those slides to contain negative smears true negatives, abnormal smears, perhaps some false negatives and some false positives. If these were collected together by an independent third party renumbered so that the laboratory of origin was not recognisable and allocated randomised numbers so that the slides from each laboratories were randomly dispersed in the batch and these slides were screened again one could calculate whether the performance of the re-screening laboratory or laboratories preferably for one of the original laboratories work was different from the other bundle I would caution that the primary screening of this batch of slides the individuals chosen should be chosen randomly by lottery rather than select the best person in the laboratory. Otherwise the slides should be screened according to the protocol in place in the restructuring laboratory in the period in question. Consecutive slides from 1 April, can you explain why you see it necessary to use a consecutive batch ... it is very important not to use any selection of the slides from the laboratory in question. In paretic you do not want to select slides which you knew were false negatives or true positives, it's better to have a continuous number of slides, it removes a lot of the bias.*

- 9.7 The evidence of Ms Mellor was that at the time she met with the College her knowledge was very much in an evolutionary phase. See questioning of Phipps -

*QUESTION: At the time of that meeting I think you have described yourself as needing more information on this subject because your knowledge was evolving at this time. Is that correct?*

*MS MELLOR: Yes.*

- 9.8 It is submitted that the limited knowledge held by the Health Funding Authority at that time is apparent from Ms Mellor's jotting for the meetings of **TMA/HFA/091** the inexperience of HFA staff and the newness the information to them, it is submitted, was unlikely to instil confidence that they had the immediate ability to be able to make the decisions required at that time.

- 9.9 The limitations, advantages and disadvantages of the way the re-read was carried out are contained in the cross examination of Dr Farnsworth and will

not be set out in full.

- 9.10 What has not been the subject of evidence is whether other methods such as that proposed by Dr McGoogan should have been considered as was advocated by the College when it met with the HFA.
- 9.11 It is submitted that the College's view that other methods should be considered and the College's concerns about the lack of expert advice as set out casually in the "Tie Line" are indications of appropriate professional concern. A further indication of the concerns and appropriate action taken by the College is set out in the evidence at page B1139.

*QUESTION: I understand that is a complaint, but the fact is that the College was consulted, albeit to a limited degree, and presumably you thought that your views would be accorded some weight, didn't you?*

*ANSWER: Yes, certainly. And I might say that the College viewed the whole matter with considerable concern. We established a cytology focus group which was originally intended to examine what data was or became available on the subject and to assist with any further actions which may be required. And that group was engaged with the funding authority in the review of the community laboratories subsequently.*

*QUESTION: But coming back to the time when you were giving this advice to Ms Mellor, do I take it that you certainly didn't seek to obtain further useful information upon which you could base your decision beyond the statistics already referred to?*

*ANSWER: I don't believe we were in a position to ask for - well, we could have asked for further information obviously, but I wasn't aware that there was other information that would have a significant bearing on the situation that we didn't know about at the time.*

- 9.12 The impropriety of the attacks against the College was referred to by counsel - see page B1280 -

*What my friend has set out to do over the last couple of weeks, it began on 3 July, is to lay tags on Doctors Teague and Tie. Now he is entitled to ask questions, elicit facts and later make comments and suggestions, but to try and lay these tags in the route that he is doing as indicated with respect yesterday, is quite inappropriate ...*

- 9.12 Mr Grieve has not produced any evidence that shows that the advice of the College in respect of the re-read reflected an internal immorality. This should be shown in a finding by this inquiry that there is no basis for such general attacks on the professionalism of the College and its members.

## CHAPTER 10

### Statistical Reports

#### 10.1 Key Points:

**10.1.1 Reliable, timely statistical reports are a cornerstone of an effective cervical screening programme.**

**10.1.2 There was a failure to accumulate data and produce meaningful reports that became increasingly valuable the greater the time period the programme existed for.**

**10.1.3 Reports that were prepared were inadequate.**

**10.1.4 There was a failure to ensure key statistical information was conveyed to those who needed to be aware of it and act on it.**

10.2 The universal view of those qualified to give evidence on statistical reports was that timely, reliable statistical reports are an essential part of an effective screening programme. The importance of not only accumulating the data and producing the reports, but also disseminating that information, then acting upon it was highlighted throughout the evidence - see evidence of Dr Teague -

*A great part of my life in the last 12 years has been trying to get that sort of information made available, gathered and made available.*

10.3 An obvious example of this was that although there was information in existence throughout the period of time relevant to this inquiry that showed that the incidence of death from Tairawhiti was the highest in the country (see **JMG/MOH/62/39**), that evidence was not known or acted upon. See the evidence of Dr Duncan at B695 -

*Q: Are you aware, at any time from 1991, of any statistical information that could have led to an identification of incidence of cervical cancer in the Tairawhiti region? Was there any statistical information that was collected and that you reported on that would have shown the incidence of cervical cancer or cervical abnormality in*

*the Tairāwhiti region?*

*A: No I don't think there is, without comparable data no. Our reports alone would be useless to identify that.*

*Q: So if somebody had wished to access data on the incidence of cervical disease in this area, that information would not have been able to be accessed through the programme here in Tairāwhiti, is that correct?*

- 10.4 The unchallenged evidence of Dr Teague, at paragraphs 22.1 and 22.2 of his brief, is set out below.

*It was expected that an annual report would be provided by the programme. There were considerable delays in publishing the first report arising from factors which have been outlined earlier but having at their heart a lack of qualified senior staff. Ideally the report would have been compiled by the programme using the expertise of an epidemiologist of significant standing, together with the assistance of statisticians, cytologists and other specialists. Employment of such people had been suggested from time to time. It is one of the unfortunate parts of the programme that despite the endeavours of those on the Advisory Committee, the statistics reports when produced were insufficient.*

- 10.5 The inadequacy of what was delivered is apparent in the evidence of Dr McGoogan at page 939 -

*You've seen the 3 statistical reports, firstly can you tell me as a pathologist are those r- would those reports be helpful to you in deciding whether or not you were happy with the performance of smear-reading in your laboratory ..... it wouldn't help me at all. Secondly, the first report is dated 18 August 92, it was released in August 93 ..... yes*

*As a pathologist seeking feedback on the performance of your laboratory and smear-reading, what sort of statistical data would you expect and how regularly would you expect to get it ..... of course I would be expecting to deliver the information that would be returned to me and I would be expecting all laboratories to do the same. That would allow me to compare the performance of my laboratory with other laboratories*

*How regularly would you expect to receive that information ..... I'm not sure that the actual defined period needs to be exact, annual is an appropriate length of time. It has to be delivered back to you closely enough to the period of time for which the analysis is made to allow you to make adjustments if your performance you think may need to be*

*adjusted or improved.*

*Taking that, looking at these reports, the first one rlsd August 93, the second one its analysis of data to 30 June 94, rlsd in October 95, and the third one is analysis of data to 31 December 95, it was rlsd in 98. how helpful to you would receiving statistical information of the nature contained in these reports at the time at which it was received be to you as a pathologist running a laboratory wanting to gauge what the performance of your laboratory was ..... I think my reaction to each of the these statistical reports might be slightly different. The first one is understandably the best that they can deliver at that particulr point in time. And I think most people would have understood the limitations in dlvrng data at that time. It was delivered a year after the period for which the analysis was made, that's not unrsble. The second report was delivered in October 95*

*Just over 2 years later ..... yes, but dealing with data to June 1994. so there's a 15 month delay in delivering the information. Again not too bad, but drifintg out from what is being helpful if one thinks that a practice needs to be ijmpd or adjusted. Also if one thinks the statiscl information being collected should be different, it's already too late to influence things – you can only start from where you are, so if this statistical report is delivered in October 95 you can only start collecting new or better statistics thereafter. That's why it is extremely disappointing that the third report, which dealt with analysis of data up to the end of December 95 took until June 98 to be delivered. Its further dispntg that the quality of the statiscl information leaves a lot to be desired and the authors of the report have done their best to identify the limitations of the quality of the information in the report. While producing the statistics, its simply telling you what the data is on the register but saying it is not perfect so how do you interpret it As a pathologist wanting to measure the performance of your laboratory how helpful are each of these reports ..... not very helpful, particularly the last one is very unhelpful.*

- 10.6 There is no evidence that the information was brought to the attention of the national coordinator and, indeed, the regional coordinator stated at page B693 -

*Q: Do you recall whether at the time that you began working for this programme whether you were ever given any information about the rates of cervical cancer in Tairawhiti or the position in respect of maori women in Tairawhiti.*

*A: I recall lots of different reports and statistics in fact that was part of .. I was required to read a lot of that sort of stuff by Leanne to learn as quickly as I could an overview of the programme. I do recall not so much specific to maori for Tairawhiti but certainly specific to maori as compared with other ethnicity's in the world.*

*Q: Are you able to tell us what reports you were asked to read or to look at at that time.*

*A: I'm not able to tell you exactly what reports they are no.*

*Q: Were you aware in 1991 that Tairāwhiti had the highest incidence of cervical cancer for women in New Zealand.*

*A: I don't recall having that sort of awareness at that particular time no.*

*Q: Did anybody from Tairāwhiti Healthcare ever highlight the fact that there was a high incidence in this area?*

*A: To myself, in 1991, no.*

*Q: In determining the issues relating to consenting to funding, to direction for the programme, was this information ever discussed as the basis for planning for the programme in any year from 1991?*

- 10.7 The uses for that information was set out in various parts of the evidence. For example, see the evidence of Dr Tie when asked by the Chair (page B1131) -

*CHAIR: Dr Tie, does this emphasise the importance of ensuring that what statistical information is available is robust and sufficiently adequate to inform the persons relying upon that information in such a way that they will get a clear picture of what is happening in respect of a pathologist's practice in a laboratory?*

*A: Very much so, I would agree with that.*

*Q: and if the statistical information you receive fails to do that, can that create within you a false sense of security about the competency of the pathologist whose work you've been asked to consider?*

*A: Yes, I think that's a fair comment, certainly.*

Further on he says -

*Q: Para 16 you have again stated there, you've said now that you expect "no accurate statistics were available and if they were I had not been able to access them, I needed data to back up my clinical impressions." How strong were the attempts that you made to access information? It is very important to us, not because we're looking to criticise you at all, but we are trying to get an understanding of to what lengths does a clinician, who is busy in day to day practice, have to go to be able to get the type of statistical information that the clinician needs?*

*A: Well, I'd thrown out the question to people within the organization to people at Midland Health, to the Cancer Society, to the Cancer Registry. I was finding it a very frustrating experience and not getting very far, and honestly didn't know if the statistics were out there or, if*

*they were, how reliable they were for our particular regions.*

10.8 A number of witnesses gave evidence on the use the statistical data could be put to.

10.9 See for example the evidence of Dr Tie at page B1143 -

*CHAIR: Is it the case Dr Tie that if the College receives adequate data it can form a conclusion on a pathologist's work and if it doesn't receive adequate data it is not really in a position to perform a conclusion on a pathologist's work?*

*A: Yes I think that's a fair statement of the situation.*

*Q: And therefore if in the future there is no change in respect of the availability of data the College is not likely to be in any better position to form an assessment on a pathologists work as it was in the case of Dr Bottrill is it?*

*A: Yes I'd agree with you.*

*Q: And if you do get more meaningful data then would the College be in a better position to form an assessment of a pathologists work?*

*A: Yes I think that's correct and the College has certainly been involved in assessment of pathologists work in the last 6 or 7 years in New Zealand on several occasions. It has taken spontaneous actions in respect of concerns of pathologists practice and their work situations, it is not a body which is primarily about defending pathologists, it is a body which is about setting and maintaining standards of practice in pathology in the interest of patients predominantly.*

10.10 The importance of disseminating the information is apparent from the evidence of Dr Van der Mark - see her evidence at paragraph 13 of her brief of evidence. This issue is further clarified on questioning - see her evidence, page B685 -

*Q: Para 13, you've said that when addressing public meetings of women you voiced your concern saying you didn't know why there appeared to be so much cervical disease in the area but you felt it needed investigating, how do you think such investigating could have been done?*

*A: Well through statistics first of all. I know I keep coming back to this but really you need to know the extent of the problem before you decide how much resource to throw into it or where to take that investigation. But if I had known back then the numbers that I know now, there are I think things that would have suggested themselves.*

10.11 See also further on in the evidence of Dr Van der Mark at page B689 -

*Q: Para 16 you have again stated there, you've said now that you expect "no accurate statistics were available and if they were I had not been able to access them, I needed data to back up my clinical impressions." How strong were the attempts that you made to access information? It is very important to us, not because we're looking to criticise you at all, but we are trying to get an understanding of to what lengths does a clinician, who is busy in day to day practice, have to go to be able to get the type of statistical information that the clinician needs?*

*A: Well, I'd thrown out the question to people within the organization to people at Midland Health, to the Cancer Society, to the Cancer Registry. I was finding it a very frustrating experience and not getting very far, and honestly didn't know if the statistics were out there or, if they were, how reliable they were for our particular regions.*

10.12 At page B625 -

*A: You've just said that's a recent document, that came out about 3 weeks ago. If that information had been available to me and had it been freely available throughout Tairāwhiti I cannot believe that people would have even commented there's not a problem. Why would they have done that? The information wasn't available. That kind of information should have been freely disseminated to me as a clinician right from the beginning. I really don't think it was my job, or even the job of the people at Tairāwhiti to be searching around in research manuals, or wherever they would have had to go to get this kind of data, I have a big problem with that.*

10.13 And further at page B700 -

*Q: Was there information that was kept on the Register that would have been able to indicate, for example, if you wanted to look at women with a high grade history the number of women who had normal smears or high grade smears or low grade smears, did you have that information available on the Register?*

*A: Yes.*

*Q: Would you consider that in attempting to determine the effectiveness of the programme, having that information available would have been helpful for planning for the programme?*

*A: Absolutely yes. In reality we didn't really have the time to determine all those things with statistics, we just got on with the work*

*of the day and that was very operational. We would have loved to have done all those – you know, analysed some of the data. We just didn't have time to do that.*

*Q: And when you say you didn't have time to do it, is it fair to say because there was a lack of resources that were available to the programme here in Tairawhiti.*

*A: Yes I think so.*

*Q: Would it be fair to say that the effectiveness of the programme here was reduced by the resources made available by Tairawhiti Healthcare to implement the programme?*

*A: I'm not sure.*

10.14 The use to which information is put in Australia is summarised by Dr Wain at page 1993 of his evidence -

*A: It depends on which bit your talking about. The bits about participation rates for example, we tailor our recruitment programmes specifically to those areas which have low participation rates directing specific activities into that. The report breaks down into both area health services and local Government authorities which are small geographical zones and report the varying rates so that we will concentrate our recruitment activities for example on those areas with low participation rates. A second aspect for example relates to something that is a problem in Australia in term of over-screening women who have more screening than is necessary, there's information in that about how the incidence of over-screening, so we'll use some of that information to try and reassure women that they don't need such frequent smears in particular areas. Some of it relates to laboratory information and that's an area where we have very little information about specific laboratories but we can get general overviews about the conduct of cytology in NSW so we can have a general sense of what's happening. Some of it in relation to cancer incidence I think we look at that really as an end stage monitoring of what's going on.*

### **Future Developments**

10.15 It is submitted that there should be a system in place for the public good that enables clinicians to access statistics without charge and in a convenient way - see the evidence of Dr Farnsworth at page B1715 -

*CHAIR: In terms of the question I asked you though about access to information such as incidence of cancer and cancer mortality, how long is it, can you put a time frame on it since you have*

*been able to receive that information in New South Wales?*

*A: The first was basically 1994 and then it was purely Australia wide. The ability to look at data from all over Australia per state, the first one is the one that I've showed you and that of course doesn't include Queensland because –*

*Q: When did that come into being?*

*A: That was published in December of 1998 and that didn't include Queensland because the Queensland Register was only started two years ago, well actually it's 18 months ago, February of 1999.*

*Q: And when was the Register in NSW started?*

*A: It started in the end of July 1996.*

*Q: Right, so that information that you have which is state wide except from Queensland relates to all the state registers?*

*A: That's right.*

*Q: And the Victorian state register started in November 1991?*

*A: No the Victorian cytology register had commenced in 1987 or 1988 but the organised screening programme which was a federal as a commonwealth Government initiative commenced in November of 1991 and part of that initiative was for all States to have their own Register.*

*Q: And that was an opt off register?*

*A: Well that's quite interesting because it was actually left to the states to negotiate what kind of Register they would have.*

*Q: So just so I can be precise, NSW started in July 1996, is that an opt off register?*

*A: It is.*

*Q: And Victoria started you think in 1988.*

*A: Yes and it was an opt off register. They are all, in Australia they are all opt off registers.*

*Q: In South Australia?*

*A: I don't know the actual timing of it all.*

*Q: Do you know Western Australia?*

*A: No I don't. They all began after 1991 but Western Australia, Northern Territory, South Australia, Tasmania all occurred in the period between November 1991 and 1996 because NSW and Queensland were the two last ones so they occurred during that period at staggered times.*

*Q: And would that have an impact on the publication of information state wide?*

*A: Absolutely because before there was a register and of course the other thing too was that they had to wait for a two year cycle to have any kind of data available so that one of the reasons why the data wasn't available until December 1998 was because the states hadn't collected that data.*

A: *It certainly would and Dr Van der Mark outlined some issues to do, from her perspective, with data access and it would be fair to say that it's an area of frustration. I would qualify that by saying that it was an area of frustration because my ability to access timely data in my previous role in Scotland was considerably more straightforward and easy, lets face it, but also I performed a different role as a purchaser. It may be that as a purchaser one has a greater access to information but finding data, I can use one example if you like and it might described some of it. I would be used to in Scotland having for example routine hospital utilisation data across specialty by including things like cancer, screening and a variety of things as a routine publication every year which is available to anyone in the health service. A routine publication. If a result of looking through that I felt there was an issue in my area of responsibility, either geographically or a specialty area, I would then be able to either by phone or electronically contact the information services centrally and say could I get a further breakdown. That was usually fairly timely but it also allowed what I suppose I would describe as tinkering with data and exploring it for the data's sake and saying well I wonder if, what if. I find that much harder to do here because the routine data sets are not available routinely and to get data, while it's a good practice to be very clear about what one wants from data, the process here is such that yes one can get access from NZHIS NZ Health Information Service, and very swiftly, but it's a user pays environment, one has to pay for the information, one has to be pretty clear about the definition of that data – it's a good process to go through, but I would certainly say it inhibits the kind of "I wonder if" process of saying "I just wonder if", which while it may not sound like extremely rigorous epidemiology I think is one of the ways that public health can either discover issues or explore issues by being able to manipulate data. So I do find, while NZHIS are very swift when they do return data, the process of access to data – particularly in an environment when through the Internet data acquisition can be very swift, it is disappointing that it took I suppose the issues around the investigation and this inquiry to derive some of the data sets that we see particularly in the rates of high grades. And I'm sure that they will create discussions in other parts of NZ, not just Tairāwhiti.*

*CHAIR: The Health Information Service, that's part of the Ministry of Health, isn't it?*

10.17 The ideal information that should be available in statistical reports was set out in the evidence of several witnesses including Dr Cox - see page B2519

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*Q: So although table 11 might not be so helpful in identifying a regional issue, do you still think it's vital information to have?*

*A: It's vital for the programme as a whole.*

*Q: And we don't have it at the moment?*

*A: No we don't.*

*Q: Table 12, interval cancers re-evaluation of previous smears.*

*A: Now we're starting to get into some of the, if you like, audit side of things and that's vital.*

*Q: Do we have it?*

*A: No we don't. I must say that interval cancers are actually – there are – because you are identifying issues associated with the practice in some cases there are a whole lot of medico-legal perimeters that people feel can be an obstacle to such audit.*

*Q: Is it necessary?*

*A: It's necessary.*

*Q: And what does it allow you to do if you have this information?*

*A: It allows you to make some assessment of the component of a drop in sensitivity if you like that might be associated with the diagnostic process rather than the fact that there were no smears on the cells or cells on the slide that were abnormal so it allows you to start distinguishing between those sorts of issues I think.*

*Q: Table 13, consumption of smears. What does that mean and do we do it and should we do it?*

*A: This is the number of smears taken, down the second column if you like, and you can then calculate the number of smears for women, there's a special guidance I think within the guidelines as to how you should produce this table and it's helpful as a measure, helps you assess the amount of short interval re-screening that's occurring because you can screen too frequently too in the sense that you create a lot of referral for colposcopy without necessary reduction in incidence and mortality to any significance.*

*Q: So do you do this?*

*A: No not routinely and not in the way described.*

*Q: In table 14 distribution of smears, % of women with more than 1 smear, do we do that and should we do it?*

*A: I don't believe we do, there have been special reports from time to time but it's not done on a regular basis either quarterly or annually.*

*Q: Table 15 distribution of smears, % of women with an abnormal smear, do we do that?*

*A: No not by age, I don't believe we do.*

*Q: Should we do it?*

*A: Yes. I'm going to probably say yes to just about all these tables. No I don't believe we do that in a routine manner.*

*Q: And why should we do it?*

*A: Now I'm having a bit of stumbling block here. I just think it's important to know the proportion of women who have abnormal*

*smears, it gives you an idea of how much further either follow up in terms of repeat smear or colposcopy is required.*

*Q: Table 16 use of smears in a screening round, do we do that and should we do it if we don't?*

*A: We don't actually do anything by screening rounds for individual women at the moment. We look to some issues by calendar year but that's it.*

*Q: Is there a benefit of doing it by screening round?*

*A: Definitely.*

*Q: Why is that?*

*A: It's partly because the inference you can make from the data that's produced in that manner is stronger and therefore it has more relevance if you like to the screening programme and process and clinical issues associated with it.*

*Q: Incidence of invasive cervical cancer before and after start of organised screening programme do we do that and if not should we?*

*A: We should do it, the screening programme itself doesn't actually produce this data, it should be relatively easy to produce.*

*Q: So it could be done?*

*A: Absolutely.*

*Q: Table 18 mortality from cervical cancer before and after start of organised screening programme do we do this, could we do it?*

*A: It's not routinely done but again it's easy to do. I think it has been done from time to time.*

*Q: Tables 17 and 18 would that be worth while having information as contemplated by those tables for the programme manager?*

*A: Yes, it's the sort of thing you might actually not necessarily do every year. Yes, I think it would be really useful for people, it would help them understand the natural history and the incidence of the disease which they should understand.*

*Q: Having gone through all of these 18 tables then, it seems that a large majority of the tables we do not collect this information in this form or any similar form at the present time; is that your view?*

*A: There are parts of that we have done from time to time but it's not a routine ongoing thing, and most of them we do not collect.*

*Q: For the information that we do collect, as you have said we don't do it routinely. Do you think we should do it routinely or is it acceptable to do it on an ad hoc basis?*

*A: I think it should be done routinely, someone should have responsibility for doing it and it should be fed back to the participants and clinicians and other health professionals of the programme and it helps them – I think it reinforces the reason they do their work. And that's vital because a lot of screening processes are actually relatively – boring's not the right word, but not intellectually challenging. Some of it is, a lot of it is not and it requires a lot of team work between a lot of different players and you need to give them that feedback that what*

*they're doing is actually useful and helpful.*

*Q: Well apart from being a moral booster for those working on Cervical Screening Programmes, what other use can be made of this information?*

*A: Oh well it tells you how you're going and whether you're actually making an impact and identifies areas where you could do better.*

*Q: This information contemplated in tables one to 18 talks about women generally. Given in NZ we have been collecting data on Maori women because of the higher incidence of cervical cancer, should ethnicity be taken into account and should there be separate collection of information for Maori women as well as including them in the general statistics or not?*

*A: I think there should be separate tabulations available for a variety of reasons. I'm aware there's a whole lot of issues about the definition of ethnicity and different data sets which need quite a lot of qualification, and I'm also aware that there's some sensitivity about how that data's presented. I also notice in Dr Peters evidence that it would appear that if you like the gap between Maori and non-Maori in terms of cervical cancer incidence and mortality seems to be closing and I think some of that is attributable, is likely to be attributable to the cervical screening programme in extending the coverage of screening in the population at large to Maori groups over and above the level of screening that was there previous.*

*Q: So therefore should the current programme manager be looking at ensuring that the ways and means are put in place to enable the programme to collate the information contemplated in tables 1 to 18?*

*A: Yes and I believe the Health Funding Authority are trying to do that sort of work at the moment.*

*Q: From the perspective, I know that you and Dr Richardson have already run into with your study, are you able now just to list the obstacles that you could see to the gathering of the information contemplated within tables 1 to 18?*

*A: Major and important tables, particularly associated with cancers, the audit of cancers and interval cases of cancer would be dependent on Ethics Committee decision regarding the release of data from the Cancer Registry, which is an obstacle we've come across.*

*Q: What Ethics Committee would you go to because I understand they're regional ?*

*A: I would prefer a national one.*

*Q: For a national programme would a national Ethics Committee not be better to deal with these issues?*

*A: Well I think it's preferable, but I think also that Professor Skegg did warn that it could end up being a national committee of the chairs of the individual committees which would essentially be the same or may be very similar to actually going through roughly 156 members of the Ethics Committees around the country.*

*Q: But at the moment I know that Professor Skegg had to get permission from Tairāwhiti Ethics Committee for his proposed study, but you have had to go to the Otago committee for the evaluation you and Dr Richardson are doing. I know that for the preparation of the first I think the second statistical reports there was a need to go to the Wellington Ethics Committee*

- 10.18 It is submitted that the evidence of Dr Fraser, Dr Peters and others shows that significant steps are being taken in New Zealand now to remedy the situation. However, it would be appropriate for a recommendation to be made that -
- 10.18.1 annual statistical reports should be produced;
- 10.18.2 the reports should be prepared on the advice of an epidemiologist, statistician, cytologist, gynaecologist and other specialties where appropriate;
- 10.18.3 that the reports should be made available without charge to the national and regional coordinators of the programme, laboratories (both private and hospital), IANZ, Kaitiaki, and on request to other bodies with an identifiable interest.
- 10.19 Where a potential problem is identified, there should be a clear and timely process for investigating, addressing that problem and giving priority to remedying it if confirmed.
- 10.22 It is submitted that any process for addressing concerns about an individual pathologist or other health professional should be devised in conjunction with existing processes under the Health and Disability Commissioners Act and the Medical Practitioners Act in order to avoid duplication and added expense, and ensure a coordinated approach is taken to avoid slippage between cracks.

## CHAPTER 11

### Correlation of Programme Information With the Cancer Registry and Achievement of a Cancer-Control Strategy

#### 11.1 Key Points:

**11.1.1 A coordinated cancer control strategy requires urgent implementation.**

**11.1.2 Failures to implement a coordinated strategy have arisen from inertia, lack of expertise within the Ministry, failure to follow advice and lack of operational leadership.**

11.2 Dr Teague's evidence at paragraph 18.6 was -

*The minutes of 29.9.90 record our concern [of the Ministerial Review Committee] that it "was impossible for [our committee] to adequately perform its task as the Cancer Registry was not adequately functional ...*

Dr Teague also commented at paragraph 18.3 -

*There was some concern that it was inappropriate to establish guidelines such as these without first establishing a clear national policy for the cervical screening record.*

And at 18.5 -

*In 1989 the Ministerial Review Committee noted resource issues and made recommendations including the appointment of a single national coordinator. The evidence shows this recommendation was made to ensure that "adequate monitoring and evaluation systems [were] established for all aspects of the programme.*

11.3 The linkage of Cancer Registry information was described as the gold standard by Dr Teague. When asked about it under cross examination he stated:

*PROFESSOR DUGGAN: Dr Teague I just have one question about the*

*Registry. The expert group's recommendations with reference to the Registry were made in order to establish the policy of the screening programme, is that correct?*

*ANSWER: The expert group referred to was an expert group put together to form the policy of the programme, yes.*

*QUESTION: And the policy of the programme was to reduce the incidence and mortality of cancer?*

*ANSWER: That was the goal of the programme.*

*QUESTION: But you were impeded because you did not know what those figures were, is that correct?*

*ANSWER: Absolutely.*

*QUESTION: And this was the reason why you made all of these recommendations with regard to the Cancer Registry?*

*ANSWER: Not only that, but people such as myself and others went on to various other committees, that were attached to the Cancer Registry - or at least examining the Cancer Registry - to try and get this to happen as well.*

*QUESTION: Was it appreciated at that time that a fully functional and robust Registry would be necessary in order to evaluate the success of the screening programme?*

*ANSWER: Well, it was appreciated at the level that I worked at. I can't say for other levels. But it was, as you can see, a recurrent and repeated theme. More than that I can't say really.*

*QUESTION: I see Dr Teague that at page 192 this is in a document which begins on page 154 it's the National statement of the National Cervical Screening Programme expert group in August 1990 and at 192 at paragraph 10.1.7 you say another difficulty limits the effectiveness of the register plan for the programme to monitor the proper treatment of women with abnormal smears, histology results need to be linked to the cytology registers, this is not part of the current plan, achieving this link could be done either by including histology results on the cytology registers or by linking in with an updated New Zealand cancer register which has been extended to include dysplasias. Until there is such a histology cytology link up the quality of smear reading in laboratories cannot be evaluated by the Register and more importantly the monitoring of women with*

*abnormal smears would not be as complete as it could be. You then go on to talk about legislation and refer to the fact that as currently designed the Register does not meet the requirements of Registers used in successful overseas programmes. So you knew all of this in August 1990?*

*ANSWER: Yes.*

*QUESTION: And no-one was doing anything in response to what you were advocating at that time?*

*ANSWER: Well I suppose one of the frustrations is that nobody rejected it, nobody said we're not going to do this. It was really a matter of yes this is something that needs to be done and I guess there were assurances that it would be done it's taken a long long time to happen.*

*QUESTION: If it had been put in place shortly after you recommended it in August 1990, do you think we would be here today?*

*ANSWER: No I don't think so and I don't think so particularly the one thing that I think was crucial to the particular situation that we may be facing here is the correlation or the assessment of all cases of cervical cancer which I think as I've said in my brief is the gold standard for such a programme.*

The evidence suggests that had this action occurred when first recommended deaths of women may have been avoided. What could be achieved by national correlation was summarised in the Azimuth report.

#### 11.4 The sentiments of Dr Teague were echoed in the evidence of the following:

##### 11.4.1 Professor Skegg (at page 860)

*And in terms of assessing how well the cervical screening programme is working how helpful is it to have an effective Cancer Registry ... its's absolutely essential and if the Registry is not functioning adequately quite misleading impression could be obtained about the performance of the system, the cervical screening programme.*

*Why is that ... the most fundamental evaluation of the system is the incidence of invasive cervical cancer and we've looked at those data yesterday. We rely on them as being complete. But*

*also the registration of women with invasive cancer should be the starting point for an ongoing audit of the programme to ensure that attention is drawn to problems such as an unacceptable level of under-reporting. Or indeed other problems such as inadequate follow-up and treatment for women who have abnormalities reported.*

#### 11.4.2 Dr Wain (page 1992) -

*PROFESSOR DUGGAN: In terms of your practice as a gynecological oncologist, do you find this statistical report useful?*

*ANSWER: It's hard to separate my roles as a gynecological oncologist as the Director of the screening programme as to how useful I find it. As someone who treats cervical cancer I find the tables about the incidence of cervical cancer the age ranges, the difference between microscope-invasive disease, adenocarcinoma the trends over that time, I find that absolutely fascinating, I wonder if that's because also I'm the Director of the screening programme that I'm interested in that but -*

See also page 1993, Chair/Wain

*CHAIR: What do you mean by that, an end stage monitoring of what's going on.*

*ANSWER: Well the whole purpose of a screening programme is to reduce cervical cancer so we like to look for example at the continuing decline of cervical cancer. We like to see each year a progressively smaller number of cancers, we would like to see this programme being successful in preventing cancer. That's really the end of the story.*

#### 11.4.3 Dr McGoogan (page 942) -

*CHAIR: I see in your programme that there is a linkage to the CA Registry ... yes. How important is that ... that's very important. You will note we don't have on this diagram a national register because the register as such is simply issued as a call and recall and failsafe database - we do not derive statistics from our register, they are collected by other means. CA information and ensuring the quality of the information on the Cancer Registry is very important. Each year I'm given a*

*printout from the Cancer Registry in Scotland of the women with invasive cancer that have been registered during the last year to verify the data. Verify the diagnosis of invasive cervical cancer is correct from my laboratory information. Because coding errors can occur and every year I adjust one or two codes which have been inappropriately applied to that particular individual.*

#### 11.4.4 Dr Farnsworth (page B1662)

*CHAIR: We are going to get them produced. So you got some information in June 2000, that was when you got final figures?*

*ANSWER: Yep, of incidence of cervical cancer, that's right.*

*QUESTION: As a medical practitioner what did you make of that, having to wait that long? Did it surprise you, given that we have an organised screening programme in New Zealand?*

*ANSWER: It didn't surprise me. I've been working in this area for a long time. We in NSW have had enormous problems, both with our own Pap test register and also even with our own Cancer Register. The Cancer Register is of all cancers. The Pap test Register of course is an opt-off register, similar to what you have. We had enormous trouble just establishing in NSW our Pap test register because of privacy concerns. I think it would be simplistic to say that these areas are very difficult and I work extensively with government and it's a very circuitous route. It is not unique to New Zealand, I can promise you, that these are areas of difficulty. Even in NSW there have been periods of time when our Cancer Register as opposed to our Pap test Register has been many years behind in the actual collation of the data. I've been a cytopathologist for a long time and it's quite an interesting shift in mentality whereby concepts of public health and publication of this data and actual usage of this data is something that is really happening - it's quite a recent thing, so no, it didn't surprise me; in fact, it's sad, given it's an area of medicine that I'm particularly interested in, but I think things are changing quite rapidly. The other thing of course was I needed to know it very much in terms of the eternal question I had as to why we were seeing what we were seeing.*

- 11.5 Professor Skegg suggested that one of the reasons this gold standard was not achieved was due to the Ministry who treated it as a low priority - see

page 859.

*I don't think our Cancer Registry is up to the standard of other registries in Australasia. The second question is why I thought the Ministry had wanted to get rid of the Cancer Registry, I'm not saying this in an attempt to blame people - but why I think it is a priority in that organisation. Certainly it was the perception of staff in the Registry in the early 90's that the Ministry accorded it a very low priority.*

*CHAIR: How do you know that ... from discussions with the staff and their superiors and I was given the impression that the Cancer Registry was something that was of dubious importance. And then when a bill was introduced which I think has been discussed to make cancer registration compulsory, and this became the Cancer Registry Act 1993 that legislation was not prepared by the Ministry of Health it was introduced by Christine Fletcher the member for Epsom as a private members bill.*

- 11.6 In his evidence at paragraphs 18.2 and 18.5, Dr Teague referred to difficulties arising from there being no clear national policy. At paragraph 18.16 he stated that the programme did not have a place -

*18.16 CSLAC noted that the National Coordinator "does not easily fit in this reformed environment" but agreed that NCSP needs to "be a centrally coordinated unit. CSLAC is concerned that the programme should not be devolved to individual RHAs given the size of New Zealand's population. There would still be a need for central co-ordination. There is still work to be done and it would be foolish to jeopardise its success so far especially in light of international evidence about the importance of a nationally coordinated programme. The NCSR is a unique reporting system, and is potentially one of the best research and monitoring facilities in the world. New Zealand's population size is too small for some key data to be meaningful at a CHE or RHA level."*

- 11.7 The difficulties in linking histology and cytology information was summarised in the evidence of Dr Teague at paragraph 30 onwards. It is submitted that this difficulty in part reflected a lack of expertise and understanding within the Ministry about the importance of the information and what it could achieve.

- 11.8 The evidence of Ms Matcham and Mr Fraser sets out some of the logistical difficulties - see in particular B3597 where Ms Matcham states

*ANSWER: The Cancer Register forms part of what we call the National Minimum Dataset of Health Information. It is part of that database. It is different and unique in the sense that it's major source of information is copies of pathology reports from laboratories. It is essentially the only paper-based system that we still have, or wholly paper-based system in terms of our inputs. But the computer system that it is entered into is a computer system that contains information from all of our systems.*

*QUESTION: So there's not stand alone computer system as such dealing with cancer registrations?*

*ANSWER: Not at the present time, there are plans to create a stand alone system. And those plans have been in place for a year, we just haven't rebuilt it yet.*

*QUESTION: Is that a matter of resources?*

*ANSWER: Yes.*

*QUESTION: And can you just explain to the panel why it would be desirable to have a stand alone computer system?*

*ANSWER: Mainly because, for example, at the present time we cannot store names and addresses on the system alongside the record of the cancer. Names and addresses sit in the National Health Index, for example. And if we want to do an extraction as has been described to identify the women, the 61 women, we need to go to two computer systems to actually do it. In terms of correcting and updating, because the information from pathology reports is entered in to enlarge a record that may have come from a public hospital, if the hospital corrects that record through the system the worm that we have done may possibly be wiped and have to be re-input. Cumbersome.*

*QUESTION: So a stand alone computer system will make it less clumsy and cleaner?*

*ANSWER: Yes, it will be more efficient.*

See also page B3622 where Mr Fraser states -

*ANSWER: When the Cancer Registry Act was passed there was already an even longer delay in publication. It's a two part thing: one is the*

*backlog that existed when the legislation was passed; secondly, the decision made some years ago that certain cancers should be treated as priority for publication, so in other words we haven't concentrated on completing one year before starting the next. We have, in fact, done priority processing for approximately 40% of total cancers on an ongoing basis, which diverts resources from completing all cancers from previous years. It's simply a matter of resource and logistics I guess.*

### **Future Recommendations**

11.9 It is submitted that finalising a link of data between the programme and cancer registry should be given high priority.

11.10 In her evidence, Dr Poutasi confirmed awareness of this issue -

*Q: And I want you just to now note ... the need for a national cancer control strategy which draws on the available expertise of the community management, oncologists, surgeons, GPs, nurses, public health physicians, allied health professionals, non-Government organisations and the Ministry and that that is essential to ensure a strategic cost-effective approach to address the projected incidence of cancer in and mortality in New Zealand ... first of all what is your view regarding the need for a national control strategy of the nature outlined ...?*

*A: I would be fully in agreement and indeed the Government health strategy signals a significant health commitment in that regard. It is a draft strategy, consultation is in finished, we will be reviewing the consultation but there is every evidence that that commitment is there and this is something that we require.*

*Q: We have heard, just looking at the audit that the register is a key management tool as well as being a very good quality assurance measure. Are you able to comment on whether it will be located with the national cervical screening programme or the information technology ...*

*A: ... as a result of consulting on that proposal we have determined that it should be with the cervical screening programme in public health.*

11.11 The unit should have a proper place within the Ministry, safe from external changes.

11.12 The programme itself should be subject to internal and external quality

control and audit.

## CHAPTER 12

### Privacy Issues

- 12.1 It is submitted that the environment in New Zealand is one where it is safer not to disclose than to disclose. The two most significant reasons being:
- 12.1.1 The penalties that can be invoked for breach of privacy (up to \$200,000.00 under the Privacy Act).
- 12.1.2 The absence of any good faith defence such as exists in the Children Young Persons and Their Families Act, which provides at section 16.
- “Protection of persons, reporting ill treatment or neglect of child or young person - no civil, criminal, or disciplinary proceedings shall lie against any person in respect of the disclosure or supply, or the manner of the disclosure or supply, by that person pursuant to section 15 of this Act or information concerning a child or young person (whether or not that information also concerns any other person, unless the information was disclosed or supplied).”*
- 12.2 The discussion between Janice Hobbs and Sharon Reed may be an example of the difficulty created by this culture where due to the protection of patient confidentiality an opportunity for Ms Reed to be put on greater inquiry was potentially missed due to communication constraints.
- 12.3 The difficulty of conducting the Skegg report has been the subject of submissions. On behalf of the College it is submitted that this study should be “enabled” to proceed. As was succinctly stated by Professor Skegg (see page 911 of the evidence) -
- “I find it extraordinary in the year 2000 we are still having these problems in using a register established many years ago for this purpose. But I think there are a number of ways this could be addressed,....”*

## CHAPTER 13

### Professional Standards

#### 13.1 Key points:

**There should be a finding that makes it clear that there is no evidence of a breach in proven professional standards by Dr Teague.**

13.2 On behalf of Dr Teague it is submitted that there is no evidence of a breach in proven professional standards by Dr Teague. There have been significant and reputation-damaging allegations made against Dr Teague which, in fairness to him, it is submitted should be resolved with finality.

13.3 The evidence shows:

13.3.1 Dr Teague was asked by Dr Bottrill to coordinate a slide review as the independent co-ordinator of the panel under rules established by ACL. It was of the essence of this independence that he was involved as facilitator only and not in a professional role in respect of the slides.

13.3.2 The panel was established by ACL to undertake expert reviews where (a) there was a slide or slides in dispute within an existing claim, litigation, or disciplinary structure and (b) the alleged error or failure was not accepted by the reporting laboratory.

13.3.3 The slide review was carried out and the results provided to ACC which was undertaking a medical error investigation - see page 0027 of Exhibits, Dr Thomson.

13.3.4 During the phone call between Dr Bottrill and Dr Teague, Dr Teague learned that Dr Bottrill was not TELARC registered. Dr Teague's response was that he should get his smears read elsewhere. The evidence of both Drs Teague and Bottrill is largely consistent in this respect. Indeed Dr Bottrill stated that Dr Teague

offered him assistance with the slide readings and he declined this.

- 13.3.5 On obtaining the review results, Dr Teague did not take action, beyond reporting the panel results, for the reasons set out in his evidence. When questioned by the Chair -

*CHAIR: Dr Teague can you recall now the reasons why you decided at the time when you were aware of the results of the ACL review of Dr Bottrill's work, that it did not require you to report any concerns to any other body that might have an interest in his competency?*

*A: There were two things. I did believe that that was evidence of a problem. Secondly I knew that the whole case was going to be the subject of a proper review by the disciplinary body.*

*Q: At that point in time when the ACL review was being carried out?*

*A: Well that's why it was carried out I believe.*

*Q: In other words you anticipated that that review was the early stage of a process which would lead to some formal inquiry about Dr Bottrill?*

*A: Yes I understood that there had been some formal complaint.*

*Q: I see.*

- 13.4 As stated by the Chair, to establish any professional error by Dr Teague, it was necessary to have evidence about -

*What does the reasonable, moral pathologist do, when it is appropriate for the reasonable for the reasonable, moral pathologist to act, and I've heard nothing on that, and theirs is no indication we are going to get any evidence on that. So apart from the jurisdictional point of the terms of reference which Mr Rennie has taken, this is another issue which I see could be a hurdle for you ...*

- 13.5 Evidence about this point was adduced from Dr Farnsworth. Putting to one side that the evidence of one pathologist is insufficient to establish an applicable standard, Dr Farnsworth's evidence is an indication of what one other pathologist might have done and therefore has some limited relevance. She was asked what she would do if she learned of a pathologist practising in isolation and not participating in a quality assurance programme. Her response was -

*A: Well I must admit, if it was me, even if I didn't know the*

*pathologist I would probably write to them. It's interesting, isn't it, that I would, typical me, get all righteously indignant and write to the person and suggest perhaps we could chat or perhaps we should try and help them some way. I think my first thing would be to try and persuade them to get a cytologist. I have a very high opinion of cytologists, so I mean I think that would be – so I probably, especially in a small community like this, I would probably – maybe if I had an association with the College people, there is a local College chapter so to speak, one would probably speak to them and try and do it that way. It would therefore have to be on a very – what I'm really saying on a personal basis, that one would try and work that through.*

And further on (at page 1805) -

*A: Additionally one would follow it up. One would wait to see the response of that particular laboratory. I think it would be very difficult and we're talking about someone in not my position, but someone who is say particularly interested in quality and cervical screening. If I knew of that and nothing then happened, I would be very concerned for the women. Again that's the bottom line is that the women who chose to have a pap smear need to be – I would be very concerned for them and therefore would have to probably do something more but as I say I don't know what was done but yes I've already said that I would not be able to rest personally in this situation if I knew about something like that in Australia.*

- 13.6 It is submitted that Dr Teague's response, namely to express concern to Dr Bottrill, suggest a remedy that the smears be read elsewhere and to be reassured by the fact that a formal complaint process was under way, is essentially the same as the response Dr Farnsworth indicated she would undertake. It is notable that Dr Teague subsequently appeared as an expert witness for the prosecution in the disciplinary proceedings against Dr Bottrill. He therefore had positive knowledge of both an ACC medical error action, and disciplinary action. He also knew of Dr Bottrill's retirement, which meant there could be no ongoing issue. Neither he, nor the various doctors involved in those two hearings, and in advising Patient No.1, and in giving evidence at the two hearings, saw cause to do more. There cannot be one standard on which to test Dr Teague and another for all the other medical professionals involved.
- 13.7 In short, it is submitted that there is no evidence for any adverse finding against Dr Teague and indeed, evidence to the contrary.

- 13.8 Furthermore, there is a lack of evidence that meets the threshold required by the Chair for the admissibility of this issue of lack of internal morality. On this point emphasis is placed on the following excerpt from the evidence (page B1276) -

*CHAIR: Before you sit down, there's one practical concern I have about this, and that is that you say "when information relating to Dr Bottrill's competence became known, failed to act appropriately", one of the difficulties I've had so far with the line of questioning is that it hasn't become clear to me just what the information was relating to Dr Bottrill's practice which was known in these earlier years, because in order to be able to assess whether or not there's been a failure of internal morality, and whether that was a factor contributing or leading to under-reporting, the committee would first of all have to decide whether or not the group of pathologists concerned – be it the College, be it CALC, whatever the professional persons – had failed to act appropriately. We therefore need to know just what did they know at the time in order to assess what should they have done in terms of what was the moral thing to do. And I haven't really had that set out clearly enough to be able to decide that threshold fact first. I raise this now because I don't know whether you're in a position to lay the foundations or not, because if you aren't, then we're really wasting our time. ...*

*CHAIR: Well all I can say at the moment is that I haven't yet heard from Mr Rennie, but if this line does proceed, be aware that the threshold you must pass over is a question of what was the information so that the inquiry can make its own assessment of what was it appropriate to do. And in order to do that, we'd really have to have some idea of what the view of the specialist body was generally. By that I mean to draw a comparison with lawyers. It could be said from time to time lawyers are aware that a particular practitioner is not practising in the most competent way, but we don't all race off to the Law Society to complain about it; there is obviously a point of time at which there could be a consensus within most members of the legal profession that, yes, it's time to blow the whistle on someone. Now when that stage arises, in respect of pathologists, I don't know. We haven't heard any evidence on that either.*

*MR GRIEVE: the analogy with the legal profession is a difficult one, because generally people don't start blowing whistles until a particular client has perhaps lost money or suffered directly in some way or other, whereas with the medical profession, and in particular the circumstances we're dealing with here, there are different considerations, and in particular, the over-arching concern of the health of the women concerned. Maybe because of that over-riding*

*concern, or issue, the threshold is lower.*

- 13.9 Allegations were also put to Dr Teague that he should have acted differently over the circumstances of a phone call with Dr Smale. Details of this call were freely volunteered by Dr Teague in his brief of evidence at paragraph 26.7 although not relevant to the Terms of Reference. In response to questions about his conduct at this time, Dr Teague stated (at page B1315)

*A: No, that's not correct, sir. She asked me if I co-ordinated reviews of slides, which I said yes I did, and she said there was a case that she had heard from Hamilton laboratory who had re-examined a slide and said it was malignant and was I in a position to arrange or coordinate a review. I said that normally reviews are instituted by laboratories and are usually following a complaint. The review process that I coordinated or had coordinated was specifically set up for cases where there was a complaint and, more than that, if there was a complaint and the reviewing laboratory looked back on its slides and found that it had obviously made a mistake, then the review process was not activated because it was immaterial. It was used – this review process was set up only where there was a contention about the original diagnosis so that if the reporting laboratory looked back on its own slide and said “Oh, gosh, we've made a mistake here” and freely admits it, then it was not set up to do a review in that circumstance. It was set up, however, to do a review if there was any doubt about the original diagnosis. I explained that and I asked the practitioner to bring a complaint. I believe she – and this is from memory, I believe that she indicated that the patient concerned did not wish to bring a complaint but I said if she had concerns she should do so and then I believe we talked about other cytology matters and that I believe was the basis of that conversation.*

- 13.10 That call occurred after the ACC investigation into Patient No 1 and after the disciplinary hearing had occurred. By that time, the following persons of relevance knew about or had the opportunity to make inquiries about Patient No 1's misread slide. This evidence is from the Exhibits produced by Dr Thomson, the page reference is referred to below.

13.10.1 Dr Bierre, expert adviser to ACC, see page 60.

13.10.2 The Medical Misadventure Committee of ACC whose

members are doctors.

- 13.10.3 Dr McFarlane, Patient No 1's general practitioner.
- 13.10.4 Dr Wijeratne, Patient No 1's gynaecologist (page 76).
- 13.10.5 Dr Mark Insull, Patient No 1's gynaecologist.
- 13.10.6 Dr Mackintosh, Patient No 1's gynaecologist.
- 13.10.7 Dr Williams, Chair of the MPDC.
- 13.10.8 Dr Clayton, member of the MPDC.
- 13.10.9 Dr McCoy, member of the MPDC.
- 13.19.10 Dr Gudex, member of the Medical Council (see page 278).
- 13.10.11 Dr Herbert, member of the Medical Council.
- 13.10.12 Dr MacLaurin, member of the Medical Council.
- 13.10.13 Professor Morton, member of the Medical Council.
- 13.10.14 Dr Eastwood, member of the Medical Council and representative of the Minister of Health.

13.11 In addition, from the questioning of Dr Teague by Mr Grieve -

*MR GRIEVE: I understand in October of 1998 you were in the course of, along with others, preparing for the trial in relation to Patient 1 that was to proceed at the end of the year, weren't you?*

*A: Yes.*

*Q: And on 10 October I suggest to you, you were telephoned from a GP from Gisborne, weren't you?*

*A: Yes.*

*Q: 12 October, sorry.*

*A: I don't recall the exact date.*

*Q: And that practitioner was a Dr Smale?*

*A: That's correct.*

13.12 A copy of the judgment of the Court in the case of A v B will be annexed to the hard copy of these submissions. The Commission is entitled to take judicial notice of that decision and, in particular, page 13 of that judgment which shows that for the hearing two doctors, Drs Grace and Hitchcock, gave evidence for Patient No 1, and two doctors, Drs Bethwaite and Teague, gave evidence on behalf of Dr Bottrill.

13.13 It is submitted that the above shows that by this time no less than 18 doctors had considered the matter in addition to Dr Teague.

13.14 In addition to medical practitioners who were aware of this matter and had potential to take some action, the evidence shows that others also had knowledge and potential for action. In the evidence of Janice Hobbs at paragraph 15 she states -

*In June 1997 I had a call from R [Patient No 1's mother] to say the medical tribunal had found Dr Bottrill guilty of conduct unbecoming.*

\_\_\_\_\_ Paragraph 16 -

*R said that patient No 1 was now asking to have all Dr Bottrill's work reviewed. She was also due to meet with lawyers to draft a press release.*

There was no mention of the lawyers contemplating a referral for competence which there was the power to do at the time under the Medical Practitioners Act 1995. The suggestion of the Chair is adopted in this respect, namely is that it is useful to consider appropriateness of conduct of medical professionals in the context of what is considered appropriate conduct by other professional groups such as lawyers.

13.15 There is also the evidence of Janice Hobbs at paragraph 23 that -

*It was my very clear impression as at 10 June 1997 that the national coordinator of the cervical screen programme and shortly after, the manager of Tairawhiti Cervical Screening Programme were both aware that Dr Bottrill had been found guilty of conduct unbecoming in respect of four misread cervical smears taken from a patient in Tairawhiti district.*

At paragraph 24 -

*Commonsense told me if there was one patient in this situation there may well have been others. I recall absolutely clearly that I raised these concerns in my discussions with Sharon Reid and with Betsy Marshall.*

- 13.16 Mr Grieve has sought to impugn Dr Teague's character by drawing the unreported, unsubstantiated concerns expressed by phone to him by Dr Smale into his evidence of unjustified allegations. To put this another way, he has attempted to suggest that this subsequent information can be used to "supplement earlier evidence".
- 13.17 With respect, Mr Grieve has attempted to stretch credibility with assertions that are not properly based from the evidence.
- 13.18 As was appropriately noted by the Chair, to criticise Dr Teague for failing to act on information another doctor had communicated to him which he in turn chose not to act upon has the potential to be "wasting time". You are referred to the questions at page B1324 of the transcript -

*CHAIR: And did Dr Smale go to the authorities in October 1998?*

*MR GRIEVE: No, she didn't. the patient was at that stage dying, ma'am, and died the following year. The patient was too sick.*

*CHAIR: well how does that affect Dr Smale if she has a health risk on her hands, she has a dying patient, if this is a matter of morality why isn't she going to the Medical Council?*

*MR GRIEVE: well, she's got a patient on her hands who's had 2 misread smears to her knowledge. And with respect Madam Chair, whether or not she went is a separate issue. The issue I'm addressing is whether Dr Teague should have done something about it.*

*CHAIR: Well I point this out to you because unless you can show me that other medical practitioners would have acted differently, you are not going anywhere with this line of questioning. Technically I've ruled its relevant to the terms of reference and I accept that. I still think that it is. But you are not going anywhere with it.*

### **Future Recommendations**

- 13.19 On behalf of Dr Teague it is submitted that a clear finding should be made that publicly restores Dr Teague's reputation which has been damaged by the unfounded allegations put in cross examination.

## CHAPTER 14

### Governance and Coordination

- 14.1 Witnesses during the evidence referred to the adverse impact of incessant changes that occurred in New Zealand from governmental level down.
- 14.2 In particular this is expanded upon in the evidence of Ms Marshall.
- 14.3 Dr Poutasi was particularly asked about proposed changes and reassurance sought that history would not be repeated -

*Q: One of the problems that we have heard quite a bit about as well is the fact that with health reforms in the last decade there have been a tremendous amount of changes in personnel and resources that in some ways have hindered the programme because it takes people time to get up to speed and the loss of institutional knowledge. Now obviously you can't assure me that all the people will stay in their current jobs but would it be correct that there is a recognition of the requirement for that institutional knowledge to be retained if at all possible?*

*A: Absolutely and we are doing everything in our power and in particular I am doing everything in my power to secure institutional memory and the people who are currently involved so we can move forward from a position of strength.*

## CONCLUSION

This inquiry has been timely in two particular respects. The first, because a full inquiry has been conducted into the under-reporting of smears in Gisborne, the second because it coincides with a time when significant changes are proposed to our health system.

The challenge for this inquiry, our Government and Ministry is to ensure as far as possible that history does not repeat itself and that we do not find ourselves back in yet another ten years finding that the recommendations of this Inquiry, as with the Cartwright Inquiry, have not been implemented.

The College confirms its availability and commitment to work with the Government and Ministry to achieve an effective National Cervical Screening Programme. The College has the mandate to represent the views of its members collectively, thus enabling the Government benefit of the considered views of the Fellowship as a whole.

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G.E. Phipps  
Counsel for RCPA and Dr Teague

Date: 1 September 2000