

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

**AMENDED FINAL SUBMISSION OF THE NEW  
ZEALAND WOMEN'S HEALTH INFORMATION  
AND RESOURCE TRUST**

**SEPTEMBER 2000**

Hon Phillida Bunkle MP  
Wellington

## **PREAMBLE**

### **The New Zealand Women's Health Information and Resource Trust**

1. *The New Zealand Women's Health Information and Resource Trust is a charitable trust that arose, in part, out of the Committee of Inquiry into Treatment of Cervical Cancer at National Women's Hospital (The Cartwright Inquiry). The Trust, together with Women's Health Action, has at their genesis in Fertility Action, the organisation that was pivotal in the Cartwright Inquiry.*
2. *The objectives of the Trust are the provision of health information and the over-sight of public health policy and professional medical practice in New Zealand particularly in relation to the impact these policies and practices have on women's health.*
3. *Trust members have monitored trends in the delivery of health services and the responsiveness of the medical profession to patient rights in New Zealand for the past decade. They have sought to ensure the rights of patients are accorded the highest priority in all health service decision-making and health service delivery.*
4. *In the Fertility Actions' final submission to the Cartwright Inquiry, Phillida Bunkle, Sandra Coney and Dr Forbes Williams analysed the way in which the unaccountable and hierarchical structure of National Women's Hospital (NWH) had allowed the unfortunate experiment to proceed. The institution had become closed to external scrutiny, even to the extent of becoming isolated from international specialist opinion. The medical hierarchy was judge and jury of their own behaviour. The voice of critical conscience had no authority and no process to which it could appeal. A code of patients' rights existed, but there was no mechanism through which it could be enforced or which could afford patients' redress or compensation. No effective sanctions were available.*
5. *Fertility Action maintained that the internal morality of the medical profession was insufficient to ensure patients safety. In its submission, arguments were made that it was essential to establish a system of external scrutiny and sanction including payment of compensation where injury has occurred. Financial sanctions should be available to enforce professional compliance. The recommendations were for ethics committees with a consumer majority, independent patient advocates within medical institutions and an independent lay health commissioner with extensive powers to investigate and enforce patient's rights and ethical conduct.*
6. *Fertility Action also recommended the establishment of a National Cervical Screening Programme, which would exemplify this ethical shift from doctors' interests to a patient-centred approach.*
7. *The Cartwright Report endorsed these recommendations. Had they been established, the tragedy in Gisborne would not have occurred.*

## **Ethical Behaviour of the Medical Profession**

8. *The Cartwright Inquiry Report at chapter 7 deals with medical ethics and patient rights in the context of medical practices at NWH. Judge Cartwright made the observation that patients have an overwhelming trust in the medical, nursing and administrative staff responsible for their care. The article of faith held by patients is that health professionals and those responsible for the public health system have one over-riding goal - **that is the health and welfare of the patient at all times.** This is the 'first principle' of the ancient Hippocratic Oath. [Precised from *The Report of the Cervical Cancer Inquiry 1988, chapter 7, page 127*].*
9. *Judge Cartwright was most concerned that health professionals involved in the 'unfortunate experiment' at NWH and their colleagues had failed in their fundamental duty to put the interests of patients before any other consideration. At page 127 of her report Judge Cartwright had this to say: "It is instructive therefore to review whether medical and health care professionals have seen the patients health and welfare as their prime objective over the past 30 years, and whether practices at National Women's Hospital have reflected that approach."*
10. *Judge Cartwright saw fit to further emphasise the first principle of medical ethics by quoting at page 132 the 1964 Helsinki Declaration of the World Medical Association as follows:*

*"It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission."*

*And from the World Medical Associations Declaration of Geneva binding doctors as follows:*

*"The health of my patient will be my first consideration."*
11. *The Cartwright Report focused not only on informed consent of patients but also on issues of clinical freedom, the professions responsibility to intervene in circumstances of inappropriate practice, and peer review of medical practice.*
12. *These same issues are highly relevant in the Gisborne cervical smear Inquiry and are inevitably central in causal factors of under-reporting in Dr Bottrill's Gisborne laboratory practice. Ethical behaviour issues will also be central to recommendations aimed at protecting the interests of patients in the reporting of cervical smears. The task of the Gisborne Inquiry is to identify changes that will reduce the risk of under-reporting cervical smears. One of the central themes of the New Zealand Women's Health Information and Resource Trust 's submission is that fundamental changes to professional medical practice and the attitudes of the profession are critical in ensuring ethical practice and reducing risks to patients throughout the delivery of health services.*

## **Peer Review, ‘Internal Morality’ of the Medical Profession and Making a Key Ethical Shift**

13. *In her Report at page 132 Judge Cartwright quotes Dr Campbell, visiting professor in Biomedical Ethics at Otago Medical School, as saying:  
  
“An Inquiry into medical practice is one form of peer review, albeit enforced. It is also the most disastrous for the profession, for the patients and for the public purse. I believe that unless the profession can establish adequate peer review and adequate systems to cope with the inevitable mistakes of problems caused by incompetence then there will be a continuing succession of inquiries of this nature.”*
14. *This comment of Dr Campbell 12 years ago has proven tragically prophetic. The medical profession has not established adequate peer review nor has it in place adequate systems to cope with incompetence such as that demonstrated by Dr Bottrill in his laboratory practice. The issues of peer review and ongoing obfuscation by the medical profession when dealing with the behaviour of their own are central to the Gisborne tragedy.*
15. *Judge Cartwright concluded in her report that the medical profession on its own could not be relied upon to change behaviour and bring about a **key ethical shift** that was needed to put the patients interest ahead of those of the doctors. A number of external accountability mechanisms were recommended but not established. Professional self- interest remains. So does the solidarity of the profession in protecting those interests.*
16. *The key ethical shift was nothing more than proper recognition of the first principle of medical ethical behaviour enshrined in the professions Hippocratic Oath. Judge Cartwright was essentially saying that medical professionals have always regarded themselves as the arbiters of what is appropriate for patient safety and welfare. But the complexities in a modern medical practice setting and the conflict with professional self-interest are such that internal interpretation by doctors of patient interests is no longer tenable.*
17. *The concept of ‘internal’ and ‘external’ morality was introduced into evidence through a British Medical Journal publication [KJT/NZMC/019]. This paper by Dr Charlotte Paul explores the state of values, norms and rules that are intrinsic to the practice of medicine within the context of the Cartwright Inquiry. The conclusion of that analysis is that doctors acting in accord with their own obligations brought the problems at National Women’s Hospital to light and therefore external controls are unwarranted.*
18. *Dr. Paul’s revisionism, in the view of the Trust is at odds with the historical facts recorded by the Cartwright Inquiry. At NWH the consequences for doctors speaking out about the practice of their colleagues was extreme. The record shows that the institution closed ranks against its internal critics. Doctors McIndoe and McLean were ostracised, discredited, and marginalised for their efforts. Dr. McIndoe’s daughter Mary Whaley in*

*evidence at the Cartwright Inquiry described the destructive effects on her family and her father for virtually his entire professional career.*

19. *The New Zealand Women's Health Information and Resource Trust will examine evidence from the Gisborne Inquiry that leads to a pessimistic conclusion about the current state of the medical professions 'internal morality'. The Trust recommends more external intervention with a greater level of public input to make patient focus a reality.*

### **Responsiveness of the Medical Profession**

20. *Judge Cartwright made severe criticism of the medical profession (page 131) in regard to the 'Unfortunate Experiment' at NWH over the professions failure to evaluate the work of Dr Green. She had grave concerns that no steps were taken by doctors to ensure that patient's welfare was protected when these medical professionals knew risks existed.*
21. *The responsiveness of the medical profession in the case of Dr Bottrill's practice in Gisborne deserves close scrutiny because it is apparent in evidence that medical professionals and medical professional bodies who had contact with Dr Bottrill's practice ought to have responded but didn't. The medical profession's failure to implement the necessary ethical shift to place patient interest first is demonstrated in this submission. Examination of the actions of Dr Brian Linehan and Dr Clint Teague are relevant in this regard.*
22. *The response of the Royal Australasian College of Pathologists (RCPA) likewise is telling in identifying the willingness of the profession to respond in order to protect patient welfare in circumstances such as those occurring for patients whose smears were misreported by Dr Bottrill. Did the College respond only to defend the profession rather than making patient safety its first priority? The answer to this is likely to have been a resounding yes in the light of RCPA New Zealand Councillor Dr Andrew Tie's literary exposition, "The Tie Line".*
23. *The issues in Gisborne are compounded by the influence of commercial interests creating a particularly insidious conflict of personal profit versus an absolute obligation for medical practitioners to protect the safety of patients at risk.*
24. *The New Zealand Women's Health Information and Resource Trust sees the behaviour and response of medical practitioners in the commercialised health reform environment as relevant. The manner in which the medical profession has responded to the new market driven commercial paradigm introduced in 1993 is examined in this submission particularly for its impact on the health of women in the National Cervical Screening Programme (NCSP).*

## **Ethical Issues of Screening Programmes**

25. *The overriding thrust of recommendations arising out of the Cartwright Inquiry was to signal a fundamental shift in the way in which public health policies were orientated. Patient interests were to be put at the centre of health service provision ahead of the interests of the medical profession.*
26. *Patient welfare and safety is the key ethical issue. Judge Cartwright's responses with regard to patient rights had at its axis empowerment of patients through full information in order for them to defend themselves from harm in the face of the competing interests of the doctor. Patients have a right to be fully informed about their treatment; to give their informed consent to treatment; and to giving informed consent to being a research subject or a teaching subject.*
27. *The 'modern doctrine' of informed consent set out by the World Medical Association includes principles that invoke the need to carefully assess the risks and benefits to the patient participating in research. And the entitlement of the patient to rely on the special skill, knowledge and experience of those conducting the research to first and foremost have regard to their safety. There is a clear and urgent duty for those responsible to take all appropriate steps to protect the life and health of those participating in research. This is their ethical responsibility.*
28. *Although the NCSP is not a research project per se there are elements of research which should be integral to it. For the safety of the women enrolling in the programme research of the data obtained was an essential ethical responsibility to ensure harm was avoided. The behaviour of those with responsibilities for the programme is inevitably bound by all those ethical principles set out to guide medical research.*

*A special duty of care to women participating in the NCSP was acknowledged by all witnesses to whom the question was put during the taking of evidence at the Gisborne Inquiry.*
29. *Offering women, who are essentially well, a service to protect their health invokes a duty of care to ensure informed consent, to ensure appropriate safeguards are in place and implemented and to ensure that at all times the interests of the women is the highest priority. Judge Cartwright acknowledged the particular ethical obligation when medicine seeks out the patient rather than the patient seeking the medicine.*
30. *At page 197 of her report Judge Cartwright quotes McKeown in 'Validation of Screening Procedures' who described obligations on those undertaking screening programmes to ensure a screening procedure is effective. The observations of McKeown are worth repeating here because they invoke the ethical responsibility of a public medical authority in offering a screening programme:*

*“The position is quite different in screening, when a doctor or public medical authority takes the initiative in investigating the possibility of illness or disability in persons who have not complained of signs or symptoms. There is then a presumptive undertaking, not merely that abnormality will be identified if it is present, but that those affected will derive benefit from subsequent treatment or care ... No-one should be expected to submit to the inconvenience of investigation or the anxieties of case finding without the prospect of medical benefit.”*

31. *The New Zealand Women’s Health Information and Resource Trust submit that interpretation of informed consent in the context of the NCSP has become confused and myopic. The position taken by the Department of Health on the programmes register and release of patient information for monitoring, auditing and research reflects a lack of appreciation of the key ethical issues.*
32. *The position taken by ethics committee’s particularly that of the Otago Ethics Committee in interpreting informed consent in a very narrow, legalistic and rigid manner has effectively worked against patient safety. The current interpretations appear contrary to the central thrust of Judge Cartwright’s recommendations. The irony is that the very ethics committee’s set up after the Cartwright Inquiry would have found the study done by Dr’s McIndoe, McLean and Jones in identifying the NWH problems to have been unethical.*
33. *The responses of Professor Don Evans in evidence at the Inquiry give significant cause for concern that ethics committee’s appear to have dislocated patient safety from decision making on patient consent. The Trust submits that patient safety and ethics are inseparable. Women enrolling in the NCSP do give their consent to measures that make the service safe for them. In fact, women have an expectation that this will be the case. There appears a worrying lack of intellectual rigour in the interpretation of the Otago Ethics Committee in relation to the desire of the Gisborne Inquiry to protect women who still may be at risk.*

### **Major Failings in Public Health Administration Prove Disastrous for the NCSP**

34. *This inquiry is asked to consider systemic issues arising out of under-reporting in Gisborne. The New Zealand Women’s Health Information and Resource Trust’s submission is that there was serious and sustained failure in public health administration that had a disastrous effect on the NCSP. The Trust submits that public servants responsible for implementation of the Government’s policy for national cervical screening demonstrably failed in their duty to carry out this policy. Further, uncontested evidence was heard by the Inquiry that a culture was prevalent in the Department of Health that actively resisted and frustrated the lawful implementation of Government policy. This legacy of contemptuous disregard for the policy was passed on to the department’s successor the Ministry of Health.*

35. *Public servants with a statutory obligation to carry out the wishes of the democratically elected Government are as responsible for the disastrous health outcome of women participating in the cervical screening programme as the health professional's directly involved. The ethical obligations and responsiveness of public sector administrators in meeting their obligations were explicitly stated at the Inquiry. This is the central issue of the Trust's analysis of systemic factors that led to under-reporting in Gisborne.*
36. *This submission does not provide a detailed chronology of public health sector failings in regard to the NCSP. Highly competent examinations are contained in the submissions of other parties. The submissions of counsel for the women affected and that of the Cancer Society are as thorough a record of events as could be made. The briefs of evidence of Sandra Coney, Betsy Marshall, David Skegg and Brian Cox are likely to have a high degree of reliability given their first hand nature or expert opinion.*
37. *This submission instead will evaluate the environment in which the NCSP was implemented and examines those influences particularly the market styled health reforms that have proved most destructive to the health of women and that have done so much harm to the integrity and reputation of the public health sector.*
38. *The Trust submits that the impact of the influences described have much wider implications for all public sector administration in New Zealand and calls for a new ethic that always looks to the service of the public first before any other consideration.*

**Concluding Remarks to the Preamble**

39. *This submission is made on the assumption that overwhelming evidence has been given to the Inquiry and an admission has been made by Dr Bottrill that the first term of reference of an unacceptable level of under-reporting of abnormal cervical smears did occur for smears read by Dr Bottrill at his Gisborne laboratory.*
40. *The New Zealand Women's Health Information and Resource Trust submission will focus on term of reference two identifying factors that are likely to have led to an unacceptable level of under-reporting by Dr Bottrill. The Trust will also consider in detail terms of reference three and four identifying changes to professional medical practice, to medical professional organisations, and to the public health sector administration of the NCSP to address the future risk of under-reporting of abnormalities in cervical smears.*
41. *In addition to considering the ethical issues raised in the Cartwright Inquiry at NWH the Trust's submission examines the behaviour of the medical profession in terms of the New Zealand Medical Association's Code of Ethics [MBB/001].*

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## Term of Reference One

***“To determine whether there has been an unacceptable level of under-reporting in consequence of mis-reading and/or misreporting of abnormalities in cervical smears in the Gisborne region”.***

- 1.1 There is little danger in concluding that an unacceptable level of under-reporting of cervical smears read by Dr Bottrill occurred for the period 1991 to 1996. The evidence of Dr Farnsworth confirmed that upon rereading the smears of 12,130 Gisborne women 3.5 times more high-grade abnormality was present than was read by Dr Bottrill. Dr Brian Cox demonstrated that this result was statistically significant [BC/CS/0050].
- 1.2 Given that Dr Bottrill read approximately 95% of the cytology for Gisborne women during this period it is safe to conclude that there was an unacceptable level of under-reporting for the Gisborne region as a whole and that this can be attributed to Dr Bottrill’s practice.
- 1.3 The New Zealand Women’s Health Information and Resource Trust seek to consider in detail consequent terms of reference and therefore makes only very limited commentary here.
- 1.4 The first comment that the Trust has to make on this term of reference is that the possibility exists that the smears of some Gisborne women may have been under-reported by pathologists other than Dr Bottrill. The evidence of Tairawhiti Healthcare laboratory manager Mr Brian Morris concerning the reading of smears by Dr Padwell at his home for Dr Bottrill gives rise to the suspicion that this pathologist practiced in a way that was not safe. Further, the smear histories of some of the women who gave evidence suggest abnormal smears may have been read as normal by other laboratories. The extent of this reporting is unknown but nevertheless of concern.
- 1.5 The second comment that the Trust makes is that the term of reference itself was restrictive in seeking to have examined only the issue of under-reporting of cervical smears. Professor McGoogan highlighted the false positive rate as an important element in assessing laboratory practice in cytology. Professor McGoogan also made salient points on the ethical issues around unnecessarily causing concern to women in false positive reporting and the wastefulness of resources when this over-reporting is unacceptably high.
- 1.6 Equally critical aspects of the cervical screening pathway such as follow-up and treatment of women found to have abnormalities and management of the National cervical Screening Programme in the Gisborne region deserved to be specified within the terms of reference. In any event these aspects saw the light of day in the Inquiry.

## **Term of Reference Two**

***“If you determine that there has been an unacceptable level of under-reporting, to identify the factors that are likely to have led to that under-reporting.”***

- 2.1 There are multiple factors at multiple levels throughout the cervical screening pathway that inevitably contributed to under-reporting in Gisborne. However, the New Zealand Women’s Health Information and Resource Trust’s submission on this term of reference focuses mainly on the ethical and professional behaviour of Dr Bottrill and his colleagues in the conduct of laboratory and medical practice in Gisborne.
- 2.2 It is the opinion of trustees that Judge Cartwright’s findings on the behaviour, attitudes and ethical failings of medical practitioners at National Women’s Hospital was the single biggest contributor to that disaster. The ethical jeopardies apparent in the Gisborne Inquiry are strikingly similar and compel a similar level of significant consideration.
- 2.3 The New Zealand Medical Association (NZMA) Code of Ethics [MBB/001] sets out 6 principles of ethical behaviour and a further 49 ethical responsibilities to patients and the profession for medical practitioners. This code reflects universally held ethical guidance for the profession. All medical practitioners swear an oath to uphold such ethical rules whether or not they are members of the professional bodies that may articulate them from time to time.
- 2.4 This submission employs the NZMA code “principles and responsibilities” framework to examine the behaviour of Dr Bottrill in relation to his Gisborne laboratory practice. The commentary made by Judge Cartwright in the Report of the Cervical Cancer Inquiry 1988 is used to examine the responsiveness of the medical profession in relation to what was happening in Dr Bottrill’s laboratory. The issue of clinical freedom where doctors engage in their practices unrestrained by colleague’s or where they feel no obligation to subject their work to peer review is once again explored as a principle cause of professional failure 12 years after the Cartwright Inquiry.

### **The Medical Profession’s First Principle of Ethical Behaviour**

***“Consider the health and well-being of your patient to be your first priority”***  
***(Principle 1.)***

- 2.5 Whatever motivations drove Dr Bottrill to practice pathology in the manner he did there is no room in the evidence before the Gisborne Inquiry to conclude that his highest priority was the health and well being of his patients. This is the first principle of any medical code of

ethics. Dr Bottrill did not demonstrate in his evidence that he took even the most basic of acceptable precautions to protect patients whose slides he read from harm. The consequence of Dr Bottrill's bad practice was the death of at least two women, the pain and suffering of probably a further sixty women who developed invasive cervical cancer and doubtless stress and anxiety to very many more.

?? **Dr Bottrill's Competence and Training**

*"Strive to improve your knowledge and skill so that the best possible advice and treatment can be afforded to your patient" (Principle 2.)*

**And;**

*"Let integrity and professional ability be your chief advertisement" (Principle 6.)*

**And;**

*"Continue self education to improve ones personal standards of medical care" (Responsibility 2.)*

- 2.6 The NZMA ethical guidelines place obligations on medical practitioners to recognise their own level of professional expertise and continue to improve personal skills through ongoing education and to ensure that their practice is 'above reproach'.
- 2.7 Dr Bottrill's training in gynaecological cytology according to his brief of evidence at paragraph 5 comprised some part time study for 3 months with the specialist at Leeds Hospital "*looking at slides that this colleague thought were of interest*" (although Dr Bottrill was unable to name this specialist). He also cites some cytology reading on sputum and similar material at Pindersfield Hospital in Yorkshire during the period March 1957 and September 1961.
- 2.8 Dr Bottrill's post-graduate record held by the Royal Australasian College of Pathologists (RCPA) [EM/CA/008] shows no reference that he had completed any training in cytology. At paragraph 8 of his brief of evidence Dr Bottrill says he commenced reading cytology smears at Gisborne in 1967. He established a private laboratory business with laboratory manager Mr Graham Reeve during 1967 and practiced cytology in his laboratory until 1996. At paragraph 14 of his brief of evidence Dr Bottrill confirmed that he had no formal qualification in cytology.
- 2.9 Dr Bottrill did not sit any sort of examination until late 1973 at which time he sat practical and oral examinations for entry to the RCPA. But these examinations did not include any cytology. Further Dr Bottrill carried out his own primary cyto-screening of cervical smear slides without any training in that aspect of cytology. Dr McGoogan said in her evidence that "*I think for any one to do the task of primary screening without proper training and evidence of competence is bad practice.*" [Page A1021, line 7].
- 2.10 The RCPA has offered since 1973 an examination for fellowship in anatomical pathology slanted towards cytopathology. This examination

is considered appropriate for fellows with a particular interest in cytopathology. Dr Bottrill did not avail himself of this opportunity.

- 2.11 With regard to carrying out primary cyto-screening Dr Bottrill was aware that this task required considerable specialised training [page 3089, line 14-16]. His response to questions about why he did not take steps to train in cyto-screening was that the conditions at the time were different [page 3093, line13-15].
- 2.12 However, Dr Gabrielle Medley, an Australian pathologist of the same era as Dr Bottrill, gave evidence at the Inquiry [page 2687, line 20] that “...one of the most important things in cervical cytology ...is the opportunity to have more than one pair of eyes on a slide and more than one brain to discuss a slide.” Dr Medley agreed that a pathologist working on his own doing primary screening “. is in a risky position that might put women at risk” [page 3095, line20-22].
- 2.13 Dr Bottrill in his evidence at the Gisborne Inquiry could not demonstrate competence in reading cervical smears. When asked to describe his own technique it was found to be at odds with recognised good technique as described by Leopold Koss. Dr Bottrill told the Inquiry he had never read the chapter in Diagnostic Cytology by Leopold Koss on screening slides even though this was the definitive text for cyto-screening technique. Dr Bottrill’s evidence [page 3129, line 17 to page 3133, line 26] leads to the inevitable conclusion that he was not competent to read slides and that his technique was likely to be the cause of significant error in his reporting.
- 2.14 Dr Farnsworth’s commentary on the 23,000 slides sent to her Sydney laboratory for re-reading was that the incidence of high-grade abnormality was readily apparent. The number of abnormal cells was “remarkably high”. The nuclear and cytoplasmic changes in the cells were “remarkably severe”. Dr Farnsworth said in her Report from Douglass Hanly Moir Pathology (DHM), Sydney (Interim Report 6<sup>th</sup> March 2000), that these cellular changes had”..... *large keratinising cells and tumour diathesis more akin to the changes originally described by George Papanicolaou than those normally seen in routine cytological practice.*”
- 2.15 There are two conclusions that can be drawn from the observations arising out of the Sydney re-read. The first is that despite the obvious nature of the cytology that Dr Bottrill had read he was unable to identify high-grade abnormality to an acceptable standard. The other conclusion is that the burden of disease for Gisborne women had not been reduced as would normally be expected in a screened population. This points to sustained incompetence on Dr Bottrill’s behalf throughout the period of his practice since 1967. He had been carrying out opportunistic screening and then screening as part of the National Cervical Screening Programme up to 1996.

- 2.16 Dr Bottrill was not trained nor was he competent to carry out cytopathology. He did not avail himself of opportunities to become appropriately skilled and he did not advance his knowledge to enable him to practice medicine so that no harm was done to his patients. In fact fatal harm was done to his patients.

?? **Dr Bottrill's Approach to Quality Assurance and Peer Review**

***“Recognise both your own limitations and the special skills of others in the prevention and treatment of disease” (Principle 4.)***

- 2.17 Judge Cartwright says at page 130 of her Report that: “... *there has long been an ethical obligation known as peer review that a doctor seek and accept criticism and advice from professional colleagues. There is also a strong obligation to maintain realistic self-scrutiny.*”
- 2.18 Dr Bottrill chose to ignore and disregard the recognised standards of cytopathology practice despite full knowledge that he was a sole practitioner working in isolation. Dr Bottrill's attitude to peer review and external quality control was cavalier and contemptuous. In his evidence [page 3069, line 9] it is apparent that Dr Bottrill regarded accreditation as inflicting “...*draconian measures of quality control on other people*”. In his High Court trial he accepted a description of quality assurance as a “*modern fad*” but sought to revise that view in his Gisborne Inquiry statement of evidence.
- 2.19 At [page 3072, line 7] Dr Bottrill confirmed that it had been his view concerning accreditation that “*quality control, (and) external quality assurance played no part in ensuring accuracy of smear reporting....*”. Dr Bottrill did not carry out peer review by exchanging slides with other laboratories because of the difficulty “...*in finding someone who would take the time and trouble to coordinate...*”.[page 3066, ln22-26]. Dr Bottrill did not pursue TELARC accreditation because: “*It was far more a question of the gigantic amount of work which would be involved in organising the documentation and organisation of the laboratory*”.[page 3059, ln22-26].
- 2.20 Dr McGoogan in her evidence [page 1039, line 12] said that “...*for a pathologist not to participate in well publicised and easily available external quality assurance schemes was regrettably not good practice.*”
- 2.21 The evidence of Graham Walker at paragraph 20 of his brief of evidence describes his preliminary visit for accreditation of Dr Bottrill's laboratory. Mr Walker said: “*It was my clear impression from my visit to Gisborne Laboratories that accreditation was not being actively pursued by the laboratory. And that the process was being pursued begrudgingly for other reasons. . Mr Reeve and Dr Bottrill as much as told me that the laboratory needed to demonstrate for contractual purposes that it was working towards accreditation.*”

- 2.22 It is apparent from the responses given by Dr Bottrill that he made application to have his laboratory accredited only after indications that it would be a mandatory requirement for contracting of cytology. Acknowledgment by Dr Bottrill that his laboratory was worth more in providing “comprehensive” laboratory services including cytology was most likely to be the main motivator for this move given his previous antipathy to accreditation.
- 2.23 Dr Bottrill was wanting to retire. He wanted to maintain a comprehensive laboratory service to preserve the ‘goodwill’ of his laboratory practice and the price he expected to get for it upon sale,[page3073, line1-5]. There was no evidence that patient safety played any part in Dr Bottrill’s decision to seek accreditation up to that point.
- 2.24 Peer review with other laboratories was Dr Bottrill’s last line of professional accountability in the absence of formal accreditation. He chose to ignore this fundamental professional responsibility because of the time and trouble it entailed. The integrity of the medical profession is clearly under threat if this level of response is tolerated within the profession.

?? **Dr Bottrill’s Gisborne Laboratory Practice**

***“Practise the science and art of medicine to the best of ones ability in full technical and moral independence and with compassion and respect for human dignity”  
(Responsibility 1.)***

- 2.25 Dr Bottrill practiced cytopathology in his Gisborne laboratory in circumstances of extreme risk to the patients whose cervical smears he read. Dr Bottrill was a sole practitioner reading less than 5000 cervical smears per year. His laboratory was geographically isolated and he did not participate in any external quality assurance programmes with other laboratories or engage in any formal peer review with other pathologists. There was minimal internal quality control practiced by Dr Bottrill. His laboratory was not compliant with any accreditation process. The most significant and concerning part of Dr Bottrill’s practice was the fact that he performed the entire primary screening of smears in his laboratory.
- 2.26 Expert cytopathologist Dr Euphemia McGoogan said in her evidence that in the circumstances applying to Dr Bottrill’s laboratory in Gisborne “....it would be extremely difficult and would require exceptional measures to be put in place by the individual (pathologist) to ensure competence and a quality service” [page 939, line14-16]. Dr McGoogan’s further comment was that this would be a way of setting up a “bad service”.

- 2.27 Dr McGoogan explained several measures that would be needed to lower the risk to women in the circumstances described above including frequent interaction with pathologists from other laboratories, exchange of work, well-documented processes and data collected for internal quality control. Biopsy smear correlation would be imperative, along with frequent participation in external quality assurance, frequently attend meetings with cytologists and ensuring the laboratory met all external accreditation procedures. Dr McGoogan said that even then there would be “major risks involved”. [Page 939, line 20 to page 940, line 4]
- 2.28 Dr Bottrill did not apply any of these essential processes to his laboratory practice to ensure a competent, safe and quality service for Gisborne women.
- 2.29 Dr Farnsworth in her evidence highlighted the issue of professionalism in gynaecological cytology that obliges practitioners to follow “normal” and “basic” laboratory processes that are well known in the international literature. These quality assurance processes and the method for screening slides were contained in the work of Leopold Koss published in the 1960’s. Dr Farnsworth said that it is up to the pathologist to ensure the smear reading is carried out at a standard accepted by peers around the world. [Page 1789, line 8 to page 1790, line 2].
- 2.30 Dr Farnsworth went on to say that if the circumstances of the Gisborne laboratory practice that it would be extremely concerning that a laboratory was not accredited, that the task of primary screening was extremely difficult and a great skill. Dr Farnsworth knew of only one pathologist in Australia who did primary screening and then went to great trouble to develop that skill. In addition working in isolation required a “huge effort” and go beyond normal quality assurance to achieve the required standard of practice.
- 2.31 When asked to consider a response in the circumstances of a pathology colleague practicing in isolation and not following any quality assurance processes, Dr Farnsworth said that this would be very concerning and she would be obliged to take action. [Page 1791, line 25].
- 2.32 As well as the commentary of overseas expert witnesses the Inquiry heard from New Zealand pathologists of the concerns over pathology practice in isolation. Dr Brian Linehan said in his statement of evidence at paragraph 68 that “...it is extremely difficult, if not impossible to run a small laboratory in complete isolation and still achieve acceptable levels of quality and professional service.”
- 2.33 Dr Linehan also said in his brief at paragraph 69 that: “...it is dangerous for a pathologist to work in professional isolation”. He then referred to the Gisborne and Whanganui laboratory experiences where

“geographical” and “personal” isolation had tragic consequences surrounding them.

?? **The State of Dr Bottrill’s Laboratory**

***“Ensure that all conduct in the practise of the profession is above reproach and that neither physical, emotional nor financial advantage is taken of any patient”***  
**(Responsibility 5.)**

- 2.34 The evidence given by TELARC accreditor Graham Walker in the technical category of his pre-audit consultation visit to Dr Bottrill’s laboratory was that: *“... I had not either then or since visited a laboratory that has been as deficient in the major areas as Gisborne Laboratories...”* (Paragraph 22).
- 2.35 Tairawhiti Healthcare Limited laboratory manager Mr Brian Morris said in evidence at page 2900, having visited Dr Bottrill’s laboratory that: *“... the laboratory was quite a small, cramped environment; the lighting was poor; the histology area where the tissue processor was I would consider it unsafe because of the absence of any decent ventilation with all the solvents there; the media was made using domestic pressure cookers, there wasn’t a proper autoclave; the windows were very small windows and high up on the walls so there was no natural outlook.”*
- 2.36 Mr Morris also said in his observations of Dr Bottrill’s laboratory: *“One of the main things about an accreditation process is that everything has to be documented, you have to have full working manuals and there was an absence of manuals, and the textbooks that were available were ancient.”* [Page 2899, line 4-6].
- 2.37 In a supplementary exhibit produced by Dr Brian Linehan at page 0085 is a document titled Gisborne Visit Report on 19 April 1996. Medlab Hamilton quality manager Greg Warren wrote this a month after the purchase of Dr Bottrill’s laboratory. He commended local staff for moving Dr Bottrill’s laboratory *“...from the sixties into the nineties in just seven weeks”*.
- 2.38 Dr Brian Linehan, the director of Medlab Hamilton, which purchased Dr Bottrill’s laboratory in March 1996, said at paragraph 22 of his brief of evidence that when the laboratory was taken over a considerable amount of work had to be done to achieve accreditation. Also at paragraph 22 Dr Linehan said: *“Documentation of method procedures was virtually non-existent so we had to introduce all the documentation required for a modern quality manual.”*
- 2.39 From the evidence there is little room to conclude other than that Dr Bottrill’s laboratory was a wholly unsatisfactory and a dangerous environment in which to carry out the highly precise skills demanded by cytopathology screening. The laboratory practice posed a clear threat to

the safety of all patients relying on that cytopathology for their good health. Yet Dr Bottrill appeared not to demonstrate any desire to even take basic steps to improve the quality of his service.

- 2.40 The manner in which Dr Bottrill cared for his patients slide histories epitomises the poor state of his practice and reflects a singular lack of respect towards his patients. Slides were stored in an outside shed. Many of these slides dating prior to 1988 were stated by Dr Bottrill in his brief of evidence to be badly damaged in the “Cyclone Bola” storm and were thrown out (paragraph 63). However this explanation does not explain the whereabouts of the smear records from around 1987 to 1990, which would have been stored inside the laboratory building itself but these, were not made available for the Sydney reread. Dr Bottrill’s competence prior to 1990 was unable to be assessed as a result. The record only begins with the advent of the NCSP but there is no evidence that Dr Bottrill’s problems only began at that time.
- 2.41 Dr Bottrill’s medical practice as evidenced by the state of his laboratory was negligent and his behaviour flew in the face of his profession’s ethical principle that obliges all practitioners to provide the best possible treatment for their patients.

?? **Personal Conduct**

***“Accept responsibility for ones personal heath both mental and physical”  
(Responsibility 29.)***

- 2.42 Dr Bottrill suffered a major heart attack in 1990 and underwent a coronary bypass operation. He was 61 years of age at the time. This caused him to be off work for three months. He reported that his short-term memory was of concern requiring him to make large numbers of notes to cope with the memory loss.
- 2.43 In evidence Dr Bottrill offered only one reason why his cervical smear reporting was unacceptable. That was his health. He described his problem as “a form of attention deficit” or a “lack of concentration” [page 3082, lines 7-12]. In these circumstances Dr Bottrill had a duty of care to stand aside and give up his practice given the absolute need for mental acuity in the practice of cytopathology. It is entirely reasonable to conjecture that the desire to preserve a highly lucrative income for himself and his business associate played a key role in the choice Dr Bottrill made to continue in practice.
- 2.44 There is little evidence but a good deal of suspicion that Dr Bottrill’s health played a role in making an already parlous position of competence in his laboratory practice worse. The medical profession as a whole should be most concerned to ensure much greater rigour of competency assessment in circumstances such as those that applied in Dr Bottrill’s case. The clinician attending Dr Bottrill ought to have been much more vigilant in recommending a return to such precise work in

these circumstances. It is not hard to conjecture that a 'blind eye' may have been turned by his fellow clinician in giving Dr Bottrill a clean bill of health especially when the memory problem was so apparent.

?? **Financial Arrangements**

*“ Motives of profit shall never be permitted to influence the free and independent exercise of professional judgement on behalf of a patient”*  
(Responsibility 41.)

and;

*“ Standards of care should not be compromised in order to meet financial or commercial targets whether these are set by a doctor personally or by an organisation”*  
(Responsibility 49.)

- 2.45 Reading cervical smears has become a very significant part of medical laboratory practice over the past ten to fifteen years in New Zealand. The fee for service arrangements under section 51 Notices with the Department of Health and then the Regional Health Authorities has seen millions of dollars flow into laboratory coffers particularly since the introduction of the national cervical screening programme.
- 2.46 At page 0034 of a Tairawhiti Healthcare exhibit [BMD/THL/001] a record is provided of Dr Bottrill's Gisborne Laboratory test volumes and their respective percentage profit on revenue for the 1994/95 financial year. Cytology and histology tests are shown to generate the highest percentage profit of any laboratory tests at 86.43%. [ *Financial information subject to suppression order*].
- 2.47 Dr Bottrill and his business partner Mr Graham Reeves made a lot of money out of their Gisborne laboratory. The net profit before director's fees of the laboratory for the years to 31 March 1993, 1994 and 1995 was \$511,948, \$522,530 and \$541,448 respectively. This is recorded at page 0028 of [BMD/THL/001]. [ *Financial information subject to suppression order*].
- 2.48 The Gisborne Laboratories Limited financial statements for the year ended 31 March 1995 show that Dr Bottrill earned \$272,226 in salary and interest for the year. Mr Reeve is shown as earning \$255,165 [BMD/THL/001], page 0055. [ *Financial information subject to suppression order*].
- 2.49 Tairawhiti Healthcare Limited was considering the purchase of Gisborne Laboratories Limited for \$780,000 in 1995 (page 0063). A valuation of the business at the time put the value of its goodwill at between \$653,870 and \$1,089,784 (page 0077). [ *Financial information subject to suppression order*].
- 2.50 Dr Bottrill said in his brief of evidence that negotiations were going on for the sale of his laboratory to Tairawhiti Healthcare limited from

about the end of 1992 (paragraph 53). In a Tairawhiti Limited memorandum 13 march 1995 page 007 [BMD/THL/001] the comment was made that Dr Bottrill and Mr Reeve were wanting to “.... *extract their retirement money from the sale of the business*”.

- 2.51 Given Dr Bottrill’s health concerns affecting his performance, his age and the external pressure to bring his laboratory up to an appropriate level of accreditation, his desire to sell his laboratory and retire were understandable. However ‘a woman on the train to Petone’ might muse that a half million dollar annual payout from the business would be a hard habit to break. The prospect of stopping business or diminishing the potential of a large sale price by withdrawing from cytology would be equally unpalatable to Dr Bottrill and his partner Mr Reeve.
- 2.52 Dr Bottrill acknowledged the need to maintain the cytology part of the business for commercial reasons. At [page 3068, line18] he told the Inquiry in relation to sending cytology to another laboratory that “.... *it would detract from the goodwill certainly....*”. At [page 3075 line 21-24] in response to a question about sending his cervical smears to Dr Teague’s laboratory Dr Bottrill agreed when asked: “...*you didn’t want to detract from the potential goodwill that you might receive on sale, correct?*”
- 2.53 It is readily apparent that Dr Bottrill chose not to invest in essential quality control and quality assurance measures for his laboratory. Dr Linehan acknowledged and sympathised with Dr Bottrill about the cost of becoming accredited. And yet the actual cost of accreditation was insignificant in terms of the profit being reaped from the business. Dr Bottrill’s claims of a large burden of effort to provide the paperwork to achieve accreditation were truly lamentable.
- 2.54 Dr Bottrill chose to do his own cyto-screening. He likewise chose not to invest in the upkeep of his laboratory so that it was most unsuitable to be used to carry out cytology. The state of the laboratory in the circumstances would, to a reasonable person amount to bad practice. That view would no doubt be compounded by the knowledge that as a result of this bad practice, women died or were maimed for life.
- 2.55 Dr Bottrill clearly had the means to carry out all of the steps needed to provide his patients with at least a satisfactory quality of service given the profit levels derived from the business. A reduction of net profit of only 10% for example would have resulted in taking on board a person to do primary cyto-screening.
- 2.56 The circumstances of Dr Bottrill’s medical practice lead to an inevitable conclusion that financial motives were most likely to have influenced his behaviour. Dr Bottrill admits to this in regard to maintaining cytology services in his laboratory. Standards of care (e.g. sending slides out) were compromised to meet financial objectives.

2.57 Financial advantage was taken of patients to enable Dr Bottrill and his business partner to enjoy the profits of the laboratory and look forward to a prosperous retirement. It is submitted that in contemplating his actions, Dr Bottrill is unlikely to escape from a conclusion in the minds of the many women harmed that the health of his patients was not always his first priority.

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## **Term of Reference Three**

**“If you determine that there has been an unacceptable level of under-reporting, to satisfy yourselves whether or not this was an isolated case rather than evidence of a systemic issue for the National Cervical Screening Programme”.**

- 3.1 The Du Rose Study set out to examine other laboratories throughout the country in order to answer term of reference three. However under scrutiny at the Inquiry the study was found to be unable to provide conclusive evidence about the quality of cervical smear reading for the rest of New Zealand. Evidence that some concerns may be present for some laboratories was raised but at the time of writing this submission no useful comment can be made until the further study ordered by the Inquiry is reported.
- 3.2 However the Inquiry heard very substantial evidence of systemic failure from the outset of the NCSP at critical points throughout the cervical screening pathway but particularly at the most senior levels of public administration of the Department of Health and later the Ministry of Health. The New Zealand Women’s Health Information and Resource Trust will focus in this part of its submission on public health administration as the central cause of systemic failure leading to under-reporting in Gisborne.
- 3.3 This submission does not attempt to repeat the chronology established in the briefs of evidence of Sandra Coney, The Cancer Society, Brian Cox and David Skegg. As the evidence in the main was unchallenged, strong grounds exist to accept the opinions of these reliable witnesses as an accurate account of events relating to public administration of the NCSP.

### **?? Implementation of Cartwright Recommendations for a NCSP**

- 3.4 External evaluation and strong leadership of a nationally coordinated cervical screening programme was to exemplify an open, accountable patient centred national cervical screening programme. Quality control and surveillance, greater emphasis on training and monitoring of information derived from a centralised register were recommended as central elements of the NCSP.
- 3.5 These were the mechanisms needed to bring about, for the first time in New Zealand a ‘women centred’ and accountable health service that shifted the balance of power to the patient. The Cartwright Inquiry recommendations were a direct challenge to the hitherto sacrosanct autonomy of the medical profession and the policy-making bureaucracy that had always had the power to determine the direction of health services in New Zealand.
- 3.6 New Zealand’s public health administration at the most senior level of the Department of Health was not disposed to give away its autonomy at the

behest of Judge Cartwright or the clamour of the women's movement. There were other agenda's afoot at this time. One emanated from within the department itself focused on GP based primary healthcare. A much more pervasive movement however, was sweeping through the public sector in the shape of market styled economic theology.

### ?? **The Primary Healthcare Movement and Devolution**

- 3.7 In 1988 Dr George Salmond was the Director General of Health. This was a time of massive downsizing of the public sector. The centralised powers of government departments were being devolved or dissipated altogether. Area Health Boards were under way at this time taking on many of the former Health Department roles. New models of health service delivery were in vogue.
- 3.8 The push to make primary healthcare the driving force for health service delivery was particularly current at this time. The thinking was to integrate hospital services into primary healthcare. This would put GP's in command to make decisions on what services their patients needed rather than those decisions made by hospital administrators.
- 3.9 GP driven services were uncapped and on a fee for service basis. Cost containment through GP's managing the budget was seen as the salvation of rampant health sector costs. The model coincided with the Department of Health's thinking that devolution of health service management to primary practice and community care was the key to improving health status.
- 3.10 A centralised, nationally orientated cervical screening programme just did not fit the devolution model. There was an inevitable clash of philosophies in the desire by the Government of the day to deal politically with the fallout from the Cartwright Inquiry. Government ministers wanted urgent action in implementing the Cartwright recommendations for the NCSP. But the bureaucrats were by now wedded to a primary GP led model and devolution to area health boards. They actively resisted the Ministers' desire to have the Cartwright recommendations implemented in the desired manner.
- 3.11 The medical profession's hostility to a national cervical screening programme was well known. Such a programme cut right across the autonomy of clinical practice. Further, the prospect of externally held information about patients on a national register challenged the long held "ownership" GP's held for their patients. The challenge also from non-medical smear takers may have been threatening to the primacy of the medical profession at the time. Women are central to the financial viability of general practice because, with their children, they make up the vast bulk of a GP's daily work.
- 3.12 Dr Salmond may have taken a partisan stance in this in favour of the GP centred primary care model and in devolution of health service

management away from his department. The influence of lay people in driving health policy initiatives was an alien concept to bureaucrats long used to calling the shots. So too was the prospect of the Minister of the day actively pursuing this agenda initiated from outside the department. These factors may explain the clearly observed resistance to implementing the Cartwright Report recommendations given in evidence at this Inquiry.

- 3.13 The consequences for the establishment of the NCSP was that the Cartwright recommendations encountered “foot dragging and a lack of commitment” according to Sandra Coney in her evidence [page B2744]. Sandra Coney said that the programme had been ‘hijacked’ by the Department of Health and Judge Cartwright’s recommendations had been reworked to suit the bureaucrats.
- 3.14 Advice given to the department was ignored. Those persons driving the programme encountered tension and outright resistance. This was a disastrous start to the programme. Most concerning for the health of women was the atmosphere of indifference and neglect in leadership of the NCSP. Such programmes rely on strong leadership and a commitment to quality of service right throughout the screening pathway.
- 3.15 The Health Minister at the time, Helen Clark demonstrated a clear understanding of the need to focus on quality assurance. Sandra Coney produced in evidence Helen Clark’s speech to the Cytology National Conference in October 1989 [SC/1/001]. The Minister recognised that quality control could only be achieved through a mixture of internal and external audit and peer review. Helen Clark saw an accreditation scheme for cytology laboratories as critical to measuring the performance of laboratories. *“Formalised programmes of quality assurance would help restore public confidence in a health service by allowing the public to see that a quality service is being provided”*. (Coney brief, paragraph 45).
- 3.16 New Zealand laboratories in the 1980’s were reported by Dr Charles Cameron in his evidence (paragraph 15) to face many problems in compliance in quality assurance. Minimum protocols of quality control, data management, reporting formats, terminology, staff supervision, performance criteria were all mandatory overseas. In New Zealand these were voluntary. The Department of Health’s approach to compliance did not meet international standards.
- 3.17 The Department of Health chose to undermine Cartwright recommendations for urgent training of skilled staff by withdrawing funding of the cytology school for laboratory staff at the Central Institute of Technology (CIT). The tutor in charge of cytology at CIT, Harold Neal in his evidence said that consistency and quality in the assessment and reporting of cervical smears were critical to the NCSP (paragraph 37).
- 3.18 Dr Cameron and Harold Neal stated that one reason contributing to the closure of the CIT training course was that private laboratories were

unwilling to meet the costs for training their personnel in cyto-screening. The private laboratories placed increased profit margins above their obligation to use properly trained screeners. Safety standards were compromised in the name of material self-interest. In some laboratories a majority of screeners had no formal training, even while the CIT course was running. Untrained labour was cheaper. The safety of patients was not the first priority.

- 3.19 CALC and the Ministry of Health agreed that formal training was the best way to achieve safety in cervical screening. Harold Neal described the closure of the CIT cytology training course as contradictory of all the reasons relating to quality and minimum standards in education. He described the actions of the Ministry of Health as a disgrace in putting cost savings ahead of the safety of the programme (paragraph 38).
- 3.20 The Health Minister also recognised the need of the NCSP to have strong leadership in order to secure appropriate resources. The national coordinator also needed to provide on-going advocacy for the programme at the highest level within the Department of Health. Helen Clark instructed the Department to appoint the NCSP national coordinator at a senior management level. This instruction was not complied with.
- 3.21 This defiant behaviour was again apparent seven years later in 1997 when programme manager Judy Glackin was directed by the then Associate Minister of Health with delegation for the NCSP to undertake appropriate consultation in advance of re-locating the programme. Ms Glackin circumvented that instruction with the result that the NCSP was finally devolved away from the Ministry of Health [JMG/MOH/0046].
- 3.22 This behaviour is reflective of the arrogant and defiant attitude of public servants that was to plague lawful Government direction concerning the NCSP for many years to come including the crucial non-compliance with Government policy stated as early as 1991 that laboratory accreditation was to be compulsory. Those ministerial instructions were well founded and the Trust submits that had they been carried out the disaster at Gisborne would not have occurred.
- 3.23 Helen Clark wanted explicit standards which health services were expected to meet. Her vision for the programme was for a “*world class cytology service in New Zealand*” Her department manifestly failed to embrace this vision and the evidence remains unchallenged that they actively subverted it. (Coney brief, paragraph 46).
- 3.24 The sad reality appears to be that this institutionalised contempt for the NCSP became part of the Department of Health’s internal culture. It was a heritage that was passed on to the reformed Ministry of Health perpetuating the consequent risk to women. The bureaucratic neglect of quality assurance, monitoring and evaluation were the programmes most pressing safety obligations. The current leadership in the Ministry of

Health must accept full responsibility for the tragic neglect that they were both direct and indirect participants in.

### ?? **Background to the New Health Reform Environment**

- 3.25 The theory of rational, competing markets allocating resources in the most efficient manner with minimalist state involvement had by 1988 colonised much of New Zealand's public service. This was an infallible organising concept to its advocates who now dominated the state sector. Major reform of the health sector was already well in the sights of the 'new right' reformers. Allan Gibbs was chair of the Government taskforce that produced the report "Unshackling the Hospitals". This report spelt out the vision for privatisation of the health system with an array of competing providers creating a new health care market.
- 3.26 The competitive health care market was complimented by massive change in state sector administration under the auspices of the State Sector Act 1988. This major public sector change saw the establishment of the corporate business model for running the residual organs of State.
- 3.27 Health services were not exempt from the competitive corporate model. The genesis of the purchaser/provider split was the result and this mechanism was seen as an essential step in creating a competitive health care market place through contestable contracting processes. Crown Health Enterprises were soon to boldly go where no other public hospitals had been before. Making profits for their shareholders was the grotesque outcome for public health service rather than assuring the health of New Zealanders.
- 3.28 Dr David Lambie had a key responsibility for the Ministry of Health's performance monitoring and review of health service provision for most of the period under consideration by this Inquiry. In exhibit (DGL/MOH/001) the Ministry of Health's review of the new funding/purchasing contract arrangements is set out. At page 8 of the review the expectations of the health reforms new market styled environment are expressed. Public health provision was to be "*... characterised by increased competition and the introduction of different patterns of service provision.*" The purchaser provider split was "*... to provide better value for money through the increased efficiency expected as a result of competition being introduced to the sector.*" (Page 15).
- 3.29 The RHA review document illustrates the faith bureaucrats put in the contracting process. The leverage afforded by contracts was expected to increase accountability and the ability to increase quality of service provided at the right price. The great hope, according to the contracting review was "*... greater accountability, translating into increased public assurance through greater transparency.*"

- 3.30 An influential comment within the Ministry of Health’s review document at page 15 is the expressed desire for “*different patterns of service provision to emerge*”. The examples given were extended general practice, and secondary care budget holding. This push would arise for the NCSP a year later with the move to devolve the programme to the RHA’s for further devolution to the awaiting GP’s.
- 3.31 In the evidence of Judy Glackin at paragraph 118.3 reference is made to the RHA’s need for “*more flexible purchase arrangements*” as a reason to devolve the NCSP out of the Ministry of Health. The programme and its register were a hurdle in its centrally managed form. As a patient data base it represented a potentially valuable marketing tool in the hands of corporate medicine.
- 3.32 The reality in the new purchaser/provider environment was the creation of a “cascade of contractual relationships” that in the case of the NCSP, diluted accountabilities so that no one it seems was actually accountable for anything in the contract. This was a cumbersome and naïve way of administering public health services. The approach to ensuring quality was “so laid back it was falling over”.
- 3.33 The New Zealand Women’s Health Information and Resource Trust submits that the introduction of the market model into the management of public health, in particular the advent of commercial contracting of service delivery, confused accountabilities and fragmented services. The effect of this approach was so pervasive that there was effectively no monitoring of quality assurance actually taking place. Assuring public safety appears little more than rhetoric appended to contract documents that no one responsible for their administration took any notice of or sought to ensure they were being complied with.
- 3.34 The commercial market model was about cost containment. Lip service only was paid to patient safety and quality of service delivery. The bureaucracy put blind faith in a contracting approach that was supposed to deliver “the best services at the best price”. The public sector administrators essentially abrogated accountability for the proper oversight of the health of women enrolling in the NCSP to the nebulous “fools paradise” of a theoretically rational health care market place.
- 3.35 The two most critical failings of the contracting process for NCSP services were firstly the omission by the Ministry of Health to ensure systematic monitoring and auditing of the NCSR data and the associated neglect to establish a cytology/histology correlation. The second critical failing was the failure to ensure laboratories complied with TELARC accreditation.

#### **?? Monitoring of the NCSP and Laboratory Accreditation**

- 3.36 Dr Lambie in his brief of evidence outlines the Ministry’s approach to monitoring for accountability at paragraphs 50 to 61. The funding

agreements between the Ministry of Health and the RHA's contain service obligations for which the Performance Monitoring Unit of the Ministry had established monitoring indicators. However the indicators for the NCSP comprised only data on colposcopy waiting times. There was nothing in the funding agreement to monitor NCSP outcomes to protect women enrolled in the programme [DGL/MOH/008].

- 3.37 Dr Lambie attempted to justify the dropping of the Governments stated policy for compulsory laboratory accreditation from funding agreements. He said that Policy Guidelines appeared "at their face" to be an absolute requirement of the Ministry of Health. The funding agreements had relegated the explicit compulsory obligation stated in the policy to one of "reasonable endeavours". [Paragraph 44].
- 3.38 Dr Lambie stated that the policy guidelines had no legal status and were provided just to give a broad understanding of Government policy. At paragraph 46 he said that: "*The funding agreement represented an agreement about the range of the services to be purchased. This involved debate and negotiation between the parties about trade-offs and priorities.*" [Paragraph 46].
- 3.39 The direct implication of Dr Lambie's statement is that laboratory accreditation was actively debated. Compulsion was then negotiated out of the agreement and replaced with "reasonable endeavours" on the basis that this essential element of quality control did not have priority. Dr Lambie's admission encapsulates the Ministry of Health's indifference to the NCSP and to the safety of women enrolled. No cost benefit analysis to justify this decision was presented in evidence. It is likely that this was an arbitrary decision with no foundation in fact.
- 3.40 The Ministry of Health's document "Review of RHA Contracting 1994/95" concluded that in relation to the NCSP there was "*no systematic monitoring of quality by the RHA*". The changes under way were expected to lead to "*considerable improvements in quality*". No appropriate systematic monitoring has ever been put in place by the Ministry of Health despite this alarming conclusion.

### **?? Ethical Breaches by Public Health Administrators**

- 3.41 The Inquiry is charged with determining if evidence exists of systemic issues arising out of under-reporting in Gisborne. The New Zealand Women's Health Information and Resource Trust's submission is that there was a serious ethical failure at the highest level of public health administration. This had a devastating effect on the health of many Gisborne women. At least two women have died as a result.
- 3.42 Under reporting would most likely have been detected in time to have avoided the suffering of the women if public servants from the Director General of Health down had fulfilled their ethical obligations to the NCSP.

- 3.43 Statements made by a number of witnesses were consistent in highlighting the ethical obligations evoked in providing a screening service to well women. This was recognised as a different situation to a patient seeking treatment. There was in operation a special duty of care on behalf of public health administrators to protect the health of women enrolled in the NCSP.
- 3.44 The Ministry of Health had the responsibility to ensure the data gathered on behalf of New Zealand women was appropriately monitored and that laboratory standards were adhered to. The organisation failed to meet its obligations.
- 3.45 This failure by Ministry of Health staff was a neglect of duty. The ethical responsiveness and behaviour of senior public servants was every bit as responsible in terms of patient safety as the health professional directly involved in under-reporting patient smears. Those responsible should be held accountable. The New Zealand Women's Health Information and Resource Trust submit that the situation has precedence in the 'Cave Creek' disaster and that the consequences for public sector administrators should be the same.

### **Recommendations**

- 3.46 The following recommendations are made in relation to term of reference three:
- (a) The Ministry of Health is not a safe environment in which to locate the NCSP given the litany of failure in administration observed over the past decade. The most appropriate location for the NCSP is as part of a collaborative, multi agency arrangement called the **Cancer Control Agency**.
  - (b) This agency should have structural independence similar to the former Public Health Commission.
  - (c) The Cancer Control Agency should include the key parties in cancer control in New Zealand and it should have participation by leading cancer research organisations. It should be governed by a board of appropriately skilled persons involved in cancer control and report directly to the Minister of Health.
  - (d) The Cancer Control Agency should bring together epidemiology, prevention strategies, screening, diagnostic services and treatment in a coordinated way.
  - (e) All NCSP laboratory tests should be provided by publicly owned and operated laboratories that are part of a **National Laboratory Service**. Publicly owned and operated specialist laboratory services will ensure that profit margins do not compromise patient safety again.

- (f) Greater quality of service should be provided by small number (one or two) of strategically located public laboratories of sufficient capacity to meet all the NCSP laboratory needs. The Cancer Control Agency should be responsible for the new National Laboratory Service.
- (g) The Cancer Control Agency should control laboratories and radiology services involved in other cancer screening programmes to ensure similar problems do not occur in the Breast Screening Programmes or other programmes. The lessons of Cartwright and Gisborne must not be lost.
- (h) The new National Laboratory Service should organise training for screeners and organise process of career progression through recognised steps rewarding skill and retaining expertise. Cameron and Neal identified high turnover of relatively inexperienced screeners who were cheaper to employ as a source of compromised quality.
- (i) The Ministry of Health should urgently undertake an audit of all programmes of public health service delivery to determine key issues of ethical responsibility for the programmes. Statements of specific ethical obligations should be incorporated into all health programme documents.
- (j) The Ministry of Health should ensure that the code of patients' rights and code of ethical standards become a central component of professional behaviour for all Ministry staff. The Director General of Health should take personal responsibility for the improvement of ethical standards in the organisation.
- (k) The Ministry of Health should directly support the establishment of ethical research as a part of all health professional training and education. The Ministry should also actively support the teaching of ethical issues in health administration education.

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## TERM OF REFERENCE FOUR

**“To identify changes already made to legislation, to laboratory or other processes or to professional practices to address the risks of under-reporting of abnormalities in cervical smears.”**

- 4.1 The central thesis of the New Zealand Women’s Health Information and Resource Trust’s submission in relation to term of reference four is that the attitudes and behaviour of the medical profession towards their patients requires major change in order to achieve a safer environment for those patients.
- 4.2 The Trust contends that it is the responsiveness and accountability of the pathology profession that, at the end of the day, is the most critical element in assuring the welfare of patients in cervical screening. Looking down the microscope is probably the weakest link in the screening pathway. It is essential therefore to examine this responsiveness to address the risks of cervical smear under-reporting.
- 4.3 The medical profession, in the view of the Trust, has not accepted the essential Cartwright Inquiry recommendations that are necessary to really put the patient’s interests ahead of those of doctors. The outcome for Gisborne women has proven disastrous as a result of the patient’s interests once again being subsumed by those of the medical profession, which has failed once again to uphold the article of faith it has with the public.

### **The Situation at National Women’s Hospital**

- 4.4 The issue of accountability of doctors for their patients vexed Judge Cartwright in regard to behaviour at National Women’s Hospital. The first ethical principle of the profession demands that the health of the patient is always the first consideration. She concluded at page 176 of her report with: *The focus of attention must shift from the doctor to the patient.*”
- 4.5 The failure of doctors and hospital administrators to act appropriately after concerns had been raised about the safety of patients at National Women’s Hospital was described by Charlotte Paul in her British Medical Journal (BMJ) letter as: *“...a failure to put the safety of patients before the reputation of colleagues...the notion of clinical freedom was used to defend the actions of colleagues.... Possibly the situation at National Women’s Hospital is no exception to the way that doctors usually behave” [KJT/NZMC/020].*
- 4.6 Judge Cartwright made the following commentary on doctor attitudes at page 171 of her report: *“I had fully expected that most doctors, and other health workers or administrators who have been the focus of attention during this Inquiry would have demonstrated changed*

*attitudes and updated their knowledge of the scientific and ethical issues that have been discussed. Some obviously have done this. But there is a pervading atmosphere of defensiveness and even arrogance which, while understandable at a human level, does not bode well for the future care of patients at NWH.”*

- 4.7 At page 172 she said: “Gynaecologists, administrators and health professionals need to listen to their patients, communicate with them, protect them, offer them the best health care within their resources, and bravely confront colleagues if standards slip. If this does not happen, then the kind of event disclosed during this Inquiry may well occur again.

**With some regret I have concluded that I cannot leave the encouragement of new habits and practices to the medical profession alone.** [ **Emphasis** added].

- 4.8 After the Cartwright Inquiry the public of New Zealand were entitled to expect a major shift in the responsiveness, attitudes and ethical behaviour of the medical profession towards patient care. It is the public through their taxes that train doctors and it is through the public purse that doctors receive the vast bulk of their lifetime income.
- 4.9 Clinical freedom, that is the autonomy of decision making about how doctors manage their practices, could no longer be considered the sole prerogative of the clinician. Judge Cartwright said of clinical freedom at page 129 of her report: “Now the patient must be involved in decisions concerning her management and medical colleagues must intervene if there is a risk to the patient for any reason. The doctor is no longer wholly autonomous. As a concept clinical freedom has been proved worthless at National Women’s Hospital when patients’ safety or the rigorous testing of a new treatment protocol were at stake.”
- 4.10 Judge Cartwright said that Dr Greens’ peers failed him. The publication of scientific papers did not arouse a ‘ripple’ of concern. No steps were taken to locate and treat Dr Green’s patients when his colleagues knew the danger they were in. A magazine article written by lay people produced an ‘instant’ and ‘spectacular’ response compared to the years of neglect by those in the medical profession who ought to have known better.
- 4.11 The medical hierarchy at NWH could and did close down scrutiny by enforcing professional solidarity often in a most vindictive manner. They did so even at the price of isolating their hospital from mainstream international opinion. Those who raise concerns had nowhere to turn within their profession. The protracted struggle required after 1988 to ensure compliance with the Cartwright Report recommendations for structures and sanctions ensuring accountability is further evidence of the force of the medical profession’s resistance to external sanction well beyond NWH.

## **Responsiveness of the Medical Profession in Protecting the Interests of Gisborne Women**

- 4.12 This submission now considers in two parts the responsiveness of the medical profession when knowledge of Dr Bottrill's practice became known or ought to have been known to individual clinicians and to the pathology professions representative bodies.
- 4.13 In part A specific analysis is made of the actions of Dr Linehan from the point of his purchase of Dr Bottrill's laboratory. In Part B the responsiveness of the professional bodies representing the interests of pathology practice in New Zealand include the Royal Australasian College of Pathologists (RCPA), the NZ Society of Cytology, NZ Society of Pathologists and the Association of Community Laboratories (ACL) are considered.
- 4.14 At the profession's representative level, the actions of Dr Clint Teague are considered given his direct knowledge of Dr Bottrill's clinical practice. Dr Andrew Tie's responses are evaluated in his role as the RCPA New Zealand Councillor. They are made in relation to ethical matters raised in the Cartwright Inquiry and in the light of the Code of Ethics as described by the NZMA.

### **PART A: DR LINEHAN BUYS DR BOTTRILL'S GISBORNE LABORATORY**

- 4.15 Dr Linehan, as managing director of Medlab Hamilton purchased Gisborne Laboratories Limited in March 1996. In his statement of evidence Dr Linehan said he travelled to Gisborne and spent a day with Mr Reeve and Dr Bottrill in January 1996 (paragraph 16). Dr Linehan said he was aware at about that time that a patient had made a claim to ACC regarding a misdiagnosis by Dr Bottrill (paragraph 28).
- 4.16 Dr Linehan is a trained pathologist. His training included histology but not cytology. Dr Linehan has held an extensive array of professional positions from the 1970's including chairman of NZMA and chairman of the NZMA ethics committee. He has been president of the Society of Pathologists and consultant adviser to the Minister of Health. He was chairman of International Accreditation NZ (TELARC/IANZ) from 1987 to 1998. He is currently chairman of the medical professional advisory committee of TELARC/IANZ and has held this position since 1979 (paragraph 12).
- 4.17 Dr Linehan has been the chairman of the medical registration advisory committee of TELARC/IANZ from around 1980. This organisation has carried out accreditation for nearly all laboratories in New Zealand since its formation (paragraph 13). Dr Linehan's own laboratory Medlab Hamilton was the first community laboratory to achieve accreditation and did so in 1981.

- 4.18 Dr Linehan stated in paragraph 40 of his evidence that he had a long commitment to accreditation and quality. He also said:  
*“ accreditation... does ensure that a laboratory has appropriately trained staff, well maintained equipment and recognised methods and procedures...” (Paragraph 39).*
- 4.19 At paragraph 68 and 69 of his statement of evidence, Dr Linehan comments extensively on the problems of operating a laboratory in the circumstances of Dr Bottrill’s Gisborne laboratory. He said: *“ ...it is extremely difficult, if not impossible, to run a small laboratory in isolation and still achieve acceptable levels of quality and professional service”.*
- 4.20 He went on to say: *“...I believe it is dangerous for a pathologist to work in professional isolation. The two major public concerns relating to pathology – Gisborne and Whanganui – both involved pathologists whom either for geographical or personal reasons worked in professional isolation.*
- 4.21 Also at paragraph 68, Dr Linehan expressed his belief that small laboratories need to have a close association with a larger laboratory so that they can share in the quality assurance programmes, continuing education, peer review, support and supervision by senior specialised technologists, scientists and pathologists. Further, he said that unless a laboratory was examining a minimum number of slides they should send work elsewhere. He suggested that level should be about 20,000 slides per year.
- 4.22 Upon buying Dr Bottrill’s laboratory a number of changes were immediately instituted by Medlab Hamilton staff. All cytology and histology was sent to Medlab Hamilton for reading and Dr Linehan said that this was to achieve *“better quality”* (paragraph 20). Dr Bottrill was reading less than 5000 slides per year.
- 4.23 At paragraph 22 Dr Linehan said that after taking over the Gisborne Laboratory a *“ ...there was a considerable amount of work to be done in order to achieve accreditation.”* The state of Dr Bottrill’s laboratory at the time was confirmed by Medlab Hamilton quality manager Greg Warren with his comment that the laboratory needed to be moved *“from the sixties to the nineties.”*
- 4.24 Dr Bottrill’s documentation of method procedures was stated by Dr Linehan to be *“virtually non-existent”* (paragraph 22). A pathologist of the standing of Dr Linehan, with such an impressive history, a working lifetime in fact of dedication to the advancement of quality in pathology practice, would be expected to have been very concerned by what he had seen at Dr Bottrill’s laboratory. It is submitted that the danger to the women whose cervical smear slides Dr Bottrill had read was readily

apparent and he ought to have taken urgent steps to investigate the problem.

- 4.25 Yet at paragraph 28 of his evidence Dr Linehan acknowledged the problem Dr Bottrill was having in regard to patient one's misdiagnosis under investigation by ACC and made the following statement: **"...but this did not raise any concerns regarding his (Dr Bottrill's) professional reputation or the overall quality of his work."** [ **Emphasis** added].
- 4.26 The state of Dr Bottrill's laboratory, it is submitted was a shambles and known to be so by Dr Linehan. It is almost unfathomable why Dr Linehan would believe there was no reason to be concerned about Dr Bottrill's quality of work having knowledge of the "*extremely difficult, if not impossible*" task of "*achieving acceptable levels of quality and professional service*" in a small isolated laboratory and knowing that it was "*dangerous*" for a pathologist to work in isolation.
- 4.27 In his Gisborne laboratory, Dr Bottrill was practicing in a way that broke those rules of pathology practice that Dr Linehan indicated in his evidence to be critical to the safety and well being of the patients. These patients relied upon those laboratory results for their health and even their lives. It is submitted that Dr Linehan's obligation was urgent and immediate. As someone who has held so many important posts in the medical profession dedicated to upholding its standards and rules for good practice, Dr Linehan's position is very difficult to reconcile.
- 4.28 There is no evidence provided to the Inquiry that Dr Linehan responded in any way to protect the women who were at risk from the incompetence and bad practice of Dr Bottrill. The knowledge of that bad practice, it is submitted was evident to Dr Linehan when he observed first hand the state of the practice in January 1996. Even when he had knowledge that Dr Bottrill was the subject of a claim of misdiagnosis, Dr Linehan dismissed this as somehow not unusual and not of any significance. He said at paragraph 28 "*...there was no reason for the new owners to become involved in a matter that dated from a period prior to purchase (of Dr Bottrill's laboratory)*".

#### ?? **Fundamental Ethical Responsibilities**

- 4.29 It is submitted by the New Zealand Women's Health Information and Resource Trust that Dr Linehan had a responsibility to uphold the first and fundamental principle of his own committees' (NZMA) code of medical ethics. He did not respond to the threat to the safety of Gisborne women whose cervical slides Dr Bottrill had read.

In submission at paragraph 5, Dr Linehan claims that the NZMA code of ethics is primarily directed towards the patient doctor relationship. The code however has at its foundation various international expressions of what a doctors obligations to the health of people and the

community in the wider sense. The most obvious reference in the NZMA code is to the Declaration of Geneva 1964, which says: *“It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission.”* The Trust is concerned that medical professionals of the standing Dr Linehan have such trouble in recognising the importance of this concept in the conduct of the profession and within the profession’s stated ethical code.

- 4.30 Dr Linehan was in a better position to know the threat posed to the health of Dr Bottrill’s patients than any other medical professional in New Zealand at the time. But he did nothing. Dr Linehan attempted to justify his position in his evidence saying at paragraph 17 that Medlab Hamilton *“...purchased the assets (but not the liabilities) of the old laboratory.”* This in no way relieved him of his duty to the patients whose cervical slide histories he had inherited from Dr Bottrill nor of his duty to take action when confronted with the bad practice he observed when seeing first hand the laboratory and having such extensive knowledge of the risk factors present in that practice.

In his submission to the Inquiry Dr Linehan says at paragraph 3(c) that it is unfair to criticise him on the basis that he is not a cytologist and has never practised as such. But this is fundamentally at odds with his own brief of evidence that demonstrates extensive understanding of quality assurance processes and his recognition of how dangerous Dr Bottrill’s practice was.

- 4.31 Dr Linehan became the custodian of those patient records, which in the context of the NCSP where much more ‘live’ and vital records than would be the case for other types of historical patient information. These records were needed for look back purposes and review. Dr Linehan’s laboratory practice had an ongoing duty of care to those patients whose health depended on the ability to access these previous slides.

Essentially Dr Linehan’s laboratory practice became a party to the ongoing management of those patients the slides represented. That reality cannot somehow be extinguished in a sale and purchase transaction. These slides are a precious record and not some inconvenient chattel that can be disposed of or disregarded without a second thought.

It is submitted here, that the need to preserve the slide record and treat those slides with respect is not a difficult proposition to absorb. To the patient it is easily understood and adamantly expected to be the case. The very fact of having to raise it in argument is a distressing prospect for women. Many ask the following question: is this really the way doctors regard this piece of my own tissue.... a part of me that I have offered up to them for safekeeping and for the protection of my health?

## ?? Financial Influences on Medical Practice

- 4.32 The thesis of Charlotte Paul in her BMJ letter [KJT/NZMC/0020] was that at National Women's Hospital, doctors failed to put patient safety ahead of the reputation of colleagues. Her contention in that letter was that the motivation not to respond in the face of danger to patient safety by those medical practitioners was their wish to preserve clinical freedom in the care of their patients. The same motivation for a failure to act in the situation Dr Linehan found himself is hard to find in the evidence at the Gisborne Inquiry.
- 4.33 However a potential conflict of interest was evident for Dr Linehan's laboratory practice in the ongoing operation of Medlab Gisborne. Dr Linehan's laboratory practice had a strong incentive to preserve the near million-dollar investment made in Dr Bottrill's Gisborne laboratory.
- 4.34 As has already highlighted in this submission the goodwill of Dr Bottrill's practice was put at between \$653,870 and \$1,089,784 (page 0077) [BMD/THL/001]. Essentially this goodwill was represented by Dr Bottrill's reputation because the fixed assets of the business were only valued at \$123,131 as recorded in Gisborne Laboratories Limited 1995 financial statement [BMD/THL/001]. It is submitted that Dr Bottrill's reputation would be damaged by public exposure of any bad practice at his laboratory, particularly in the eyes of medical practitioners of Gisborne on whom the newly acquired Gisborne Laboratories relied upon for referral of laboratory tests. *[The financial information in this paragraph is subject to a suppression order]*.
- 4.35 At paragraph 27 of his brief Dr Linehan explains why Dr Bottrill's name was retained on the Medlab Gisborne stationery as an associated pathologist even though he was not actually involved in any way with it. He stated: "*Dr Bottrill was considered a very respected, senior pathologist and we thought that his association with the new Medlab Gisborne would be an (financial) advantage*".
- 4.36 Exhibit TM/HFA/0031 refers to a media release made by Phillida Bunkle MP about the use of Dr Bottrill's name on Medlab Gisborne stationery. Dr Linehan is recorded as calling the retention of the name as a "marketing exercise" because the Gisborne GP's might not refer laboratory tests if a pathologist was not on site at Gisborne Medlab. The RCPA said of this behaviour that it was totally inappropriate for Dr Bottrill's name to be used because he did not have a licence to practice.
- 4.37 It is submitted that essentially the continued use of Dr Bottrill's name was designed to leverage his reputation among local doctors in the face of a 'very concerning' drop in test referrals to Medlab Gisborne. Dr Linehan said in his paragraph 27 that: "*No fees were paid to Dr Bottrill and he was not actually required to do anything other than promote our interests among the local doctors*".

- 4.38 Dr Linehan explained the commercial problem he had in paragraph 24 of his brief saying that Tairawhiti Healthcare had launched an “*aggressive marketing campaign*” and had “*captured almost half the market*”. He said they were portrayed as “*out-of-towners*”. In these circumstances Dr Bottrill’s reputation was needed to shore up a large investment under serious threat.
- 4.39 Dr Bottrill’s name was again used when he was listed as a Supervising Pathologist in the contract for laboratory services with the Midland Regional Health Authority signed in February 1997. [Linehan exhibit tab 2, page 0044].
- 4.40 On both occasions that Dr Bottrill’s name and reputation were used by Dr Linehan’s practice when the reality was he played no part in that practice.
- 4.41 It was unfortunate that no opportunity was afforded to Dr Linehan at the Gisborne Inquiry to reconcile his behaviour with the principles set out in the NZMA committee’s Code of Ethics of which he was the chairman. Under Principles of Ethical Behaviour for example the code says:

***“Let integrity and professional ability be your chief advertisement.”***  
**(Principle 6.)**

Under the heading Responsibilities to the Profession the code says:

***“Ensure that ones professional conduct is beyond reproach and report to the appropriate body of peers any conduct of a colleague which may be considered unethical or unbecoming to the profession”*** (Responsibility 28.)

**And;**

***“Build a professional reputation based upon ability and integrity. Only advertise professional services or make professional announcements where the chief purpose of the notice is the factual presentation of information reasonably needed by any person to make an informed decision about the appropriateness and the availability of services that may meet his or her needs. Any advertisement must be demonstrably true in all respects, may not contain any testimonial or endorsement of clinical skills, and shall not be likely to bring the profession into disrepute.”***  
**(Responsibility 33.)**

- 4.42 Dr Linehan ought to have been asked about the level of integrity and the chief purpose of putting up Dr Bottrill as some sort of ‘straw man’ to Gisborne GP’s. Were the GP’s given the opportunity to make an informed decision on behalf of their patients?
- 4.43 The NZMA Code of Ethics is very precise in stating the obligations of doctors in regard to the conflict of interest between the health of the patient and the wealth of the doctor. This recognises that financial

interests are probably the most erosive frailty confronting the profession when it comes to upholding the undertaking to society to always ensure the patient is the first priority.

- 4.44 In relation to financial interests, the NZMA Code of Ethics has already been recited in this submission when examining the behaviour of Dr Bottrill. But it is well worth repeating for Dr Linehan's sake:

*“Ensure that all conduct in the practice of the profession is above reproach and neither physical, emotional nor financial advantage is taken of any patient”*(Responsibility 5.)

And;

*“Motives of profit shall never be permitted to influence the free and independent exercise of professional judgement on behalf of a patient”* (Responsibility 41.)

And;

*“Standards of care should not be compromised in order to meet financial or commercial targets whether these are set by a doctor personally or by an organisation”*(Responsibility 49.)

- 4.45 Dr Linehan has held some of the most senior positions in New Zealand's medical profession including the highest post with regard to ethical behaviour. The ethical issues outlined are the more concerning in this light.
- 4.46 The sad reality arising from a leading medical professional apparently not recognising that there are ethical issues at stake give weight to a conclusion that Judge Cartwright's fears about the responsiveness of the profession appear to have been confirmed. The medical profession appears incapable on its own account of changing habits and practices and coming to terms with what is meant on a practical level about putting the health of patients above all other considerations. Dr Linehan's actions add fuel to the suspicion raised by Charlotte Paul in her BMJ letter that: “...*this is the way doctors usually behave.*”
- 4.47 In his brief of evidence at paragraph 87 Dr Linehan advanced the view that the advent of the Commerce Commission has meant the medical profession is unable to address breaches of medical ethics. However the Commerce Commission is most unlikely to regard the actions of a medical professional intervening to protect patients at risk as anti-competitive behaviour. The reality is that the profession has not been sufficiently motivated to see to its own **internal morality** both before and after the advent of the Commerce Commission.
- 4.48 If for example Dr Linehan had sought to allay the concern that Dr Bottrill's dangerous practice may have put Gisborne women at risk, he could have decided to have his own laboratory cyto-pathologists review some of the slides held by Medlab Gisborne. He could have raised the matter with the funding authority to initiate a more formal investigation. The irony in Dr Linehan's position is that the Fair Trading Act would certainly apply in the circumstances where promotion of a 'phantom'

service such as that of advertising Dr Bottrill's association with Medlab Gisborne when no association actually existed.

**PART B: THE RESPONSIVENESS OF THE PATHOLOGY PROFESSION'S REPRESENTATIVES**

- 4.49 Pathologist members who took leading and influential roles in the NCSP actively represented the interests of the pathology profession. The Royal College of Pathologists (RCPA), New Zealand Society of Cytology, New Zealand Society of Pathologists and Association of Community Laboratories (ACL) were similarly influential in shaping the environment in which cervical cytology was being delivered throughout the period of relevance to the Gisborne Inquiry.
- 4.50 Given the opportunities of the pathologist's professional bodies to effect change to standards of laboratory practice their responses to the Gisborne situation are directly relevant to addressing the issue of future patient safety, particularly in regard to under-reporting of cervical smears.
- 4.51 New Zealand pathologists knew they had a major problem with the accuracy of reading cytology smears from the 1980's onward. In 1986 the Society of Cytology established standards required for optimal practice in diagnostic cytopathology in order to improve quality in New Zealand laboratories. The so-called "Fitzgerald Standards" were explicit in detailing management practices, qualifications of staff and laboratory reporting. All Society members were on notice about what quality standards were expected from that time on [GRB/MOH/019].
- 4.52 In his evidence Dr Clint Teague acknowledged that in the period 1988 onwards there was a great deal of knowledge with regard to quality control in cytopathology laboratories and a great deal of media exposure on the negative impact of a lack of quality control in the context of litigation involving American pathologists, (page 1243, line 23-27).
- 4.53 In November 1988 Michael Churchouse conducted a survey on the qualifications of cytology technicians employed in New Zealand laboratories. In accompanying notes he reported on a visit by professor George Wied, a world-renowned cytopathologist who had come to New Zealand in 1988 to address the NZ Society of Cytology on the importance of quality control. Professor Wied had spoken about media exposure of the cervical smear business in the United States and had referred to a Wall Street Journal article entitled "US Women Risk Misdiagnosis". The picture was of a poorly qualified, overworked, under supervised and poorly paid technicians. The article claimed: "*...that with weak laws and scant professional oversight there is little to protect women from misdiagnosis.*" [CAT/RCPA/015].

- 4.54 Michael Churchouse said of cytology screening in 1988 that it required continual long-term training with two years full time experience under the supervision of a qualified cytotechnologist. But the reality was that some screeners had a “crash course” of only a few weeks before commencing screening in a laboratory often in isolation. His survey showed that only 43.2% of New Zealand laboratories employed someone with a qualification that assessed practical screening skills. Cyto-screeners were poorly paid some getting only a few cents more per hour than cleaners.
- 4.55 Dr Teague was asked in his examination about Michael Churchouses’ view that New Zealand pathologists were not required to undergo specialist training in cytology but were nevertheless making critical diagnoses and performing primary screening in an area requiring a very highly level of skill. Dr Teague said he did not totally concur with that view, (page 1250, line 21-25).
- 4.56 Dr Bottrill in his examination was similarly most reluctant to concede that a pathologist trained in histology was not skilled to do primary screening, (page 3089, line 19-20). The prospect of non-medically trained persons being better at screening than pathologists was a ‘great surprise’ to the profession according to Dr Bottrill.
- 4.57 In his brief of evidence at paragraph 16, Dr Charles Cameron a qualified cytologist as well as a pathologist, made the point that no statutory body has the authority to challenge the right of a specialist medical practitioner to practice if they have qualifications recognised by the NZ medical Council. Regulations are exceedingly liberal about who may perform laboratory tests. Pathologists are not required to have any specialist post-graduate qualifications in cytodiagnosis. Dr Cameron’s expressions of concern about unqualified colleagues and his support for statutory controls were not well received in his profession.
- 4.58 Michael Churchouse observed that a similar investigation into the cervical smear industry in New Zealand to that undertaken by the Wall Street Journal “..*may well find some parallels.*” That prospect and the potential for litigation appear not to have been lost to many in the pathology profession given their subsequent actions.
- 4.59 It was apparent that throughout the next 12 years pathologists were abundantly aware of the need for stringent quality control in the conduct of cervical cytology. Many would have known of their own vulnerability in not being qualified or trained in cytopathology. At least from 1988 onwards the need to have highly skilled laboratory staff would have been well known throughout the profession. Contact with overseas colleagues at international conferences and the “scandals” highlighted in the media would have heightened awareness of the high risk of misdiagnosis for New Zealand women.

#### **?? Laboratory Profits and Cervical Cytology**

- 4.60 The importance of cervical cytology to bottom line profits of laboratories grew exponentially in the 1980's spurred on by the development of the national screening programme. Laboratories could not afford to miss out on this area of high growth in their businesses. Dr Teague refers to the dramatic increase in smear reading in paragraph 17.12 of his evidence. Cervical cytology proved a most lucrative earner generating more than 86% in net profits. At \$16-50 for reading a cytological smear and \$67-31 for an histology smear the accumulator appears most compelling. [CM/HFA/009].
- 4.61 Spending the money on improving the quality of their practices, particularly in ensuring staff was well trained, or taking the time to become qualified and trained themselves appears to have been a vexatious issue to pathologists. The evidence of Chris Mules expresses the difficulties the Midland Regional Health Authority had over price expectations and contestability of laboratory service contracts. The differences of viewpoint on quality are underscored in Dr Linehan's evidence; paragraph's 97 – 100. Pathologists appear to have been entrenched in a position that effectively sought to have increased quality assurance aspects of their businesses under-written by taxpayer-funded fees. The funding authorities were most interested in contestable processes to drive efficiency gains.
- 4.62 Finding the principle 'movers and shaker's' at the centre of a lack of action in achieving compulsory TELARC accreditation for laboratories has been one of the great mysteries of the Gisborne Inquiry. The Ministry of Health was most reluctant to 'step up to the plate'. The Regional Health Authorities absolved themselves of having to insist on TELARC accreditation in their contract negotiations with the "reasonable endeavours" clause in their funding agreements. In 1993 Dr David Lambie's performance monitoring group in the Department of Health was prevailed upon to drop the performance indicator on the numbers of TELARC accredited laboratories from the RHA's funding agreements. The loneliest exhibit of the Inquiry appears at [DGL/MOH/007].
- 4.63 The reasons for this shyness to commit to accreditation making it compulsory in laboratory contracts and the whereabouts of the documentation around it are unknown but had to exist. However it is not unreasonable to conjecture that at the centre of the lack of agreement with pathologists was the price to be paid for this essential step in protecting the health of women. Again it is not unreasonable to ask if the health of patients was the first priority or if the wealth of pathologists loomed larger given the actions of all concerned in contract negotiations.

?? **The Tie Line**

- 4.64 Dr Andrew Tie was Chairman of the RCPA when he offered a most revealing illustration of his profession's intense sensitivity to public exposure over laboratory practice. In a commentary called "The Tie Line" recorded in the RCPA (NZ) News (winter 1999) edition [AT/RCPA/001], Dr Tie lamented the 'scare mongering' and 'desperate hunt' of the media over Dr Bottrill's misread smears. He rounded on the Health Funding Authority saying they were in "*damage control mode*" and he described their response in pursuing a review of Dr Bottrill's work as "*over-kill*". Dr Tie sideswiped the lawyer who "*flouted a High Court suppression order in writing to The College ostensibly to express concern about the welfare of Gisborne women*". An Alliance politician was said by Dr Tie to have "*stumbled on another National Women's Inquiry*" in forcing an inquiry into Dr Bottrill's practice.
- 4.65 Dr Tie resorted to the "known limitations" of screening programmes embodied in the inherent false-negative rate to effectively throw a blanket over issues of competence in cervical smear reading. Dr Tie vigorously set out to defend his colleague Dr Bottrill and the pathology profession from charges of incompetence and the 'increased willingness' of patients to litigate. The pathology profession's near apoplectic reaction to the prospect of a 'tide of litigation' is not in the least suppressed in Dr Tie's extraordinary literary revelations.
- 4.66 Dr Tie justified his "Tie Line" comments saying ". Pathologists in New Zealand have felt pretty much under siege for quite some time, with workforce shortages and reported difficulties in pathology and difficulty in recruiting and retaining pathologists, and they needed something to keep their morale up." [Page 1141, line5-9].
- 4.67 At page 1142, line14-17, Dr Tie said: "At times there were some wildly inaccurate allegations or statements made about the situation and my comments in this column were an attempt to somewhat redress the balance for pathologists who were feeling very threatened under the circumstances." Dr Tie agreed in his evidence that the comments about Dr Bottrill's under-reporting in Gisborne turned out to be true.

#### ?? **The RCPA Reject a Re-Read of Dr Bottrill's Patients Smears**

- 4.68 Judge Cartwright's observations about a "*pervading atmosphere of defensiveness*" among doctors at NWH are also apparent in the attitude of pathologists responding to the patient safety issues arising at Gisborne, (Report of the Cervical Cancer Inquiry 1988, page 99). Equally the "*wall of resistance*" experienced by those wanting to find the truth at NWH was also evident in the responses of Dr Tie and Dr Teague and their RCPA colleagues when responding to concerns about Dr Bottrill's misreading of smears.
- 4.69 A letter to the RCPA, 29 March 1999 from Mr Stuart Grieve QC, counsel for patient one who had 4 misread smears, expressed a view that other slides of Dr Bottrill's patients should be re-read. The College replied on 21 April 1999 rejecting a re-read on the basis that from the

NCSP data, Dr Bottrill's performance was not significantly different from that of other New Zealand practices. Also that on RCPA QAP Pty Ltd performance standards Dr Bottrill's practice fell within the acceptable range.

- 4.70 Dr Tie, the RCPA New Zealand Councillor, Dr Peter Bethwaite the Colleges' secretary and Dr Clint Teague the Colleges' professional performance review coordinator, considered the Colleges' response. These three pathologists are business partners in Medlab Wellington. Drs Bethwaite and Teague gave evidence for Dr Bottrill in his Auckland High Court trial regarding negligence in relation to misreading of Patient one's smears.
- 4.71 There was however very considerable evidence presented in the Inquiry that the NCSP statistics on which the College based a decision not to instigate a re-read of other patient's slides were misleading and unreliable. The statistics did not include a cytology/histology correlation. They did not take into account the incidence of cervical cancer in the Gisborne region, (page 1131).
- 4.72 Dr Tie was questioned in his examination about the expectation of a high abnormality rate for the Gisborne region given the known high incidence of cervical cancer but he said he was not aware of this. However a NCSP newsletter had reported this high rate for Gisborne in 1991.
- 4.73 To a cytopathologist these statistics should have been "bread and butter". Dr Teague, who holds a PhD, had special expertise in cytopathology and in fact acknowledged at page 1386 line 20 that the NCSP data was "*..a weak statistical base.*" **It is beyond belief that these three prominent, highly qualified specialists were incapable of critically evaluating the statistical evidence and the consequent danger to women in accepting the figures at face value.**
- 4.74 There were other factors that ought to have been taken into account by this trio of RCPA representatives when deliberating over what actions to take in protecting the health of Gisborne women. They all knew of Dr Bottrill's misconduct finding by the Medical Practitioners Disciplinary Committee. Drs Teague and Bethwaite knew of the negligence trial in which they had given evidence. Dr Teague at least was aware of another case of smear misreading by Dr Bottrill that had been brought to his attention. Dr Teague was well aware that all the risks were present in Dr Bottrill's practice including not being TELARC accredited, working in isolation with no formal peer review and the fact that Dr Bottrill did his own primary cyto-screening and was reading less than 5000 smears annually.
- 4.75 Breach or non-compliance with any of these basic quality assurance processes for laboratory practice ought to have caused grave concern for

the safety of patients. But Dr Bottrill had the lot! The three pathologists chose to smother the safety interests of patients in a web of fiction around inherent false-negative outcomes of cervical smear programmes rather than confront the obvious issues of incompetence in Dr Bottrill's practice.

- 4.76 The same advice not to undertake a re-read was tendered to the Health Funding Authority by Dr Tie and Dr Teague. Such advice was inevitably coloured by an entrenched desire to protect and defend the pathology profession from such embarrassing public exposure. The risk of litigation clearly pervaded the atmosphere in which this advice was made.
- 4.77 The significance of this blatant intransigence of the pathologist's representative bodies is that it is demonstrative of a very strong bond of collegiality that had the effect of over-riding the medical professions fundamental obligation to put the patient before all other considerations. The Gisborne Inquiry is seeking answers to the means of protecting the safety of patients in the future. The medical profession's responsiveness to patient safety is one of the key issues to achieving this.

#### **?? The Pathology Professions Self Protection In Cervical Screening**

- 4.78 It has been previously noted in this submission that from the outset of the NCSP pathologists and their professional bodies played a very active part in shaping the development of the programme. Foremost in that representation was Dr Clint Teague. Dr Teague records in his brief of evidence at paragraph 6.2 the formation of a committee in 1989, comprising representatives of the NZ Society of Pathologists, NZ Society of Cytology, RCPA, and the NZ Institute of Medical Laboratory Technologists.
- 4.79 The committee called the Cytology Advisory and Liaison Committee (CALC) was voluntarily instigated with no terms of reference and saw itself as an advisory committee to facilitate the implementation of the NCSP and the urgent needs arising out of the recommendations of the Cartwright Inquiry.
- 4.80 CALC evolved to providing advice to the Department of Health with Dr Teague becoming the chairman. Given the eagerness of pathologists to facilitate implementation of the Cartwright Inquiry recommendations, the absence of any external or consumer representation on CALC was a glaring omission on behalf of these medical professionals. Central to the Cartwright Inquiry recommendations was the inclusion of patient's advocates and particularly for independent audit of treatment and management processes.

- 4.81 Dr Teague was appointed to the Minister of Health's advisory group the Cervical Screening Advisory Committee (CSAC) in 1991, either as a nominee of the RCPA or NZ Society of Pathologists.
- 4.82 CALC undertook the establishment of a uniform reporting system in New Zealand called the Bethesda system. The committee also advocated compulsory TELARC accreditation and other recommendations on quality standards including re-screening of negative smears, checking of abnormal smears and external quality control. CALC advocated for cytology and histology to be recorded on the cervical screening register. Dr Teague agreed in his evidence that he had been a "champion" of improving quality standards especially for TELARC accreditation.
- 4.83 However in practice CALC demonstrated quite inconsistent behaviour when it came to enforcing compulsion for TELARC accreditation. CALC had advocated strongly for accreditation to be made compulsory "within two years" and this was incorporated into the Government's NCSP policy document in 1991. In November 1993 CALC advised that "a reasonable period of grace" should be allowed for laboratories to become accredited because "some laboratories will go out of business". Foot dragging continued on accreditation right up until contracts were signed in 1997. Patient safety issues were certainly not at the forefront in the giving of this advice. [Boyd Vol 4, tab 16, page 63].
- 4.84 Dr Teague said in his evidence that from time to time CALC was asked to comment on the performance of individual laboratories (paragraph 25.1). He commented at 25.3, "*Issues of quality control were clearly of concern to the committee*". Dr Teague shepherded complaints about laboratories made to CSAC but little evidence is contained in the minutes about what he actually did about them.
- 4.85 Dr Teague investigated a complaint concerning a Rotorua laboratory mis-reporting a slide in 1991. CSAC minutes 12 December 1991 record Dr Teague's report. The report explained the mis-read result as the inherent false-negative rate occurring in cervical screening. Dr Teague advised CSAC that: "...15% high grade lesions are missed" overseas. The remedy for the Rotorua laboratory was for it to become TELARC accredited.
- 4.86 Dr Cox records CSAC minutes of 31 January 1992 (Cox, paragraph 85), where the committee discussed the power of CALC to enforce accreditation of laboratories and whether a consumer representative on CALC was required. No records were in evidence to show that CALC ever got around to introducing anyone other than those in the pathology profession onto the committee. Having the issue raised would have most likely led to some consideration of consumer representation for CALC but the profession apparently chose to remain silent on the prospect of "outsiders" being embraced within the fold.

- 4.87 At its 17 August 1992 meeting CSAC discussed the first statistical report of the NCSP (Cox, paragraph 87). For the first time laboratory results were compared nationally. The report recorded quantitatively laboratory variation. In Dr Brian Cox's evidence at paragraph 92 he reports that concerns were raised about the potential for the report to be "misinterpreted" or "misused". The release of the report was delayed for six months to allow CALC to "consider the results".
- 4.88 At paragraph 6.11 Dr Teague explains CALC's position on delaying the release of laboratory comparative data by saying that there was no independent person with the expertise to assess inadequate performance of laboratories. CALC then put up its own essentially "in-house" process to deal with potential problems with laboratory quality assurance data. The recommendation was that: "*The issue should be presented to CALC and the laboratory concerned*" and "*CALC will monitor the situation and review the issue after six months..*" and "*If no improvement then CALC would present the issue to TELARC.NZ Society of Cytology...NZ Society of Pathologists.*"
- 4.89 In 1993 CALC was asked to comment again on an issue involving under-reporting of abnormalities in a Rotorua laboratory. Dr Teague states that the committee felt that: "*the statistics supplied did not support the concerns raised...*"
- 4.90 In the CSAC minutes 15 June 1994 Dr Teague explained concerns about events in Australia involving litigation over false positive and false negative rates, which had become a major issue there. He told the meeting that some New Zealand laboratories would be putting riders on their reports stating that there are false negative rates of 20%. Dr Teague is recorded as saying: "*Some of the Australian problems may have been avoided if publicity had not been misleading.*"
- 4.91 Pathologists were by now clinging limpet like to the false negative story as a means of deflecting any criticism about the quality of cytology practice in New Zealand laboratories. Bad press, according to the professions' leaders was a matter of misunderstanding the issues.
- 4.92 In 1994 a cytology review panel was set up under the auspices of the ACL. This process was an "in-house" and anonymous system of rereading slides that were the subject of a dispute. The review process was confined to a small group of laboratories. The notion of incorporating independent persons to protect the interests of patients was nowhere in sight.
- 4.93 By keeping such review processes "in-house" the doctors succeeded in resisting the requirements for external accountability recommended in the Cartwright Inquiry report. They took a huge responsibility to themselves but did not act on it remaining impervious to the need for action. It was a re-assertion of the sort of professional self-regulation

that Judge Cartwright recognised as so erosive of patient rights at NWH.

### ?? **Dr Teague's Response to Dr Bottrill's Problems**

- 4.94 On 10 July 1995 Dr Bottrill sent 10 smears to Dr Teague for review. Four of these slides were those of patient A. Dr Teague coordinated the review according to the protocol and collated the result sending it to Dr Bottrill in August 1995. Dr Teague acknowledged in examination that Dr Bottrill had mis-read to varying degrees all four of patient one's smears (page 1292, line8).
- 4.95 Dr Teague took no further action in the face of Dr Bottrill's mis-reporting of patient one's smears (page 1300, line1).
- 4.96 There was a mountain of information known to Dr Teague about Dr Bottrill's practice at the time of deciding not to take any steps to protect patients at risk of incompetence and of highly suspect laboratory practice. Dr Teague was aware that Dr Bottrill's laboratory was not accredited; that he was a sole pathologist working in isolation; that he read less than 5000 smears annually; that he carried out his own cyto-screening; and that he did not participate in any formal peer review process.
- 4.97 At page 1307, line 13 Dr Teague said: "*I did not believe there was evidence of a problem.*" [Emphasis added].
- 4.98 On 20 February 1997 Dr Bottrill was found guilty of conduct unbecoming a medical practitioner by the Medical Practitioners Disciplinary Council in relation to misreading patient one's smears. He was fined \$400. Dr Teague gave evidence for the complainant at that hearing.
- 4.99 In October 1998 a Gisborne GP, Dr Smale, contacted Dr Teague about another smear that had been misread by Dr Bottrill. Rather than have this smear reviewed by the pathologist's review process, Dr Teague referred the GP to the NZ Medical Council or the Health and Disability Commissioner. Dr Teague also advised Dr Bottrill's legal counsel and spoke to the laboratory concerned. Dr Teague said in his evidence that he saw no need to take the matter further than this, (paragraph 26.8).
- 4.100 Dr Teague's responses in dealing with this second smear mis-read complaint involving Dr Bottrill raises issues about whether sufficient weight was given to such a concerning accumulation of factors pointing to a problem in Dr Bottrill's laboratory.
- 4.101 Dr Teague gave evidence for the defence in the High Court trial of Dr Bottrill in March 1999. He told the Court that: *...there was no evidence of systematic under-reporting by Dr Bottrill*".

- 4.102 Along with his colleague Dr Tie, Dr Teague gave advice to the HFA that Dr Bottrill's slides should not be reread. Dr Tie's views about conducting a reread were expressed in "The Tie Line". He stated in evidence the need to defend the profession, which was "under siege" and "feeling threatened".
- 4.103 Dr Teague however, is now profoundly distressed by the finding of under-reporting by Dr Bottrill and feels desperately sorry for the women adversely affected. Dr Teague by his efforts made a very significant contribution to the NCSP however he was not apparently able to overcome the "*pervading atmosphere of defensiveness*" evident among his RCPA colleague's.

### **Summary of the Responsiveness of Pathologists to Incompetence in Their Ranks**

- 4.104 Individual pathologists demonstrated by their actions or inaction's that there is a chasm between the expression of their ethical duties and the reality of their behaviour in practice. The fact that the leaders of the pathology profession who ought to have appreciated the circumstances are found to be so compromised is a sad indictment on the profession as a whole. These men held so many important posts in the medical profession dedicated to upholding its standards and rules for good practice. They had an additional duty of care to ensure their behaviour was beyond reproach. It was not.
- 4.105 Pathologists eagerly sort and achieved a position of significant power and influence over the NCSP. It is likely that goodwill and a desire to prevent cancer was intended by those seeking this power. But the evidence strongly supports a conclusion that pathologists used their position to protect the interests of fellow pathologists rather than the interests of patients. The outcome for Gisborne women was as disastrous as the outcome for women at the NWH Inquiry.
- 4.106 The pathology professions' representatives were well aware of the danger to Dr Bottrill's patients as early as 1995. It was their fundamental ethical duty to take decisive action to discover the extent of the risk to patients and then to moderate that risk. They took no action and put up obdurate resistance to the attempts of others to find the truth of Dr Bottrill's mistakes.
- 4.107 We submit that there was both individual and collective abdication of ethical and professional responsibilities concerning Dr Bottrill's practice in Gisborne. The profession's internal morality was found to be moribund. The situation demands that fundamental corrective action of ethical and professional responsibilities of the medical profession are taken immediately.

### **Recommendations**

- 4.108 Judge Cartwright in her report at page 171 said: “...*the following factors have led me to believe that fundamental corrective work is needed*”. She went on to include the following factors: “*failure of peer review and the consequential dominance of clinical freedom*” and “...*collective abdication by NWH medical staff [and members of the profession outside NWH who knew what was going on...] of their ethical and professional responsibilities in respect of CIS patients.*”
- 4.109 Judge Cartwright’s lamented that: “**I cannot not leave the encouragement of new habits and practices to the medical profession alone**”. This was a sad but insightful reflection on the profession in 1988. Things cannot be said to be any better in the year 2000. The New Zealand Women’s Health Information and Resource Trust contends that the public has such a large stake in the behaviour of the medical profession that it must have a say in its “internal morality”. Our recommendations are aimed at providing a morality framework that restores the gravely eroded trust the public has in the profession.

#### ?? **The Programme**

- 4.110 In addition to the recommendations for the Cancer Control Agency, and the National Laboratory Service, contained in 3.45 (a) – (m), we also recommend the following concerning the structure and external surveillance of the programme, internal ethical behaviour and mandatory reporting of impaired doctors as follows:
- (a) In addition to placing the programme under the control of the Cancer Control Agency and forming a new National Laboratory Service, the Trust recommends that the programme accesses information on cervical cancer available on the cancer registry and correlates this with information on the programme registry. Cytology and histology should be routinely correlated for patients who develop abnormalities.
  - (b) Consent to this procedure should be sought at the point where a woman is diagnosed with an abnormality by the programme. Such quality audit is essential to quality practice.
  - (c) A protocol should be developed for the safe storage and maintenance patient’s cytology slides and personal records. Audit of the transfer of patient cytology slides and records between laboratory practices should become a part of the TELARC accreditation process.

#### ?? **Impaired doctors**

- 4.111 All medical practitioners should follow a protocol of always obtaining a second medical opinion in regard to the return to practice of a colleague after a serious illness. Another practitioner should give that opinion as independently as possible. The NZ Medical Council should make reporting of the impaired doctor mandatory.

## ?? **Ethics internal to the medical profession**

4.112 The following recommendations are made in relation to internal ethical oversight of the medical profession:

- (a) All medical professional bodies including societies, colleges and associations should convene their ethics committees or establish such committees to urgently consider breaches of the NZMA Code of Ethics and their own respective ethical codes in relation to the findings of the Gisborne cervical screening inquiry.
- (b) An ethics forum should be convened that includes representation from all medical professional bodies in order to establish a definitive common code of ethical standards and professional responsibilities for all medical practitioners. Such a code should be incorporated into the foundation documents of every such medical society, college or association.
- (c) All medical professional bodies should establish and maintain a permanent common ethics committee – the Medical Practitioners Ethics Committee - that is responsible for monitoring the improvement of ethical standards and professional responsibilities and to consider breaches of these standards by any medical practitioner.
- (d) As recommended by Judge Cartwright, teaching of ethical principles and professional responsibilities should be a compulsory component of all medical degree courses in New Zealand.
- (e) The medical profession should ensure the integrity of any formal audit or review processes involving patient safety or concerns such as the ACL cytology slide review panel by always including a majority of independent persons to report on the issues.

## ?? **Patient Rights**

4.113 To ensure ethical practice based on patient safety a system of external scrutiny must be made effective. The Cartwright Inquiry recommendations set out a blueprint for external oversight through the office of a health commissioner, however those recommendations have been diluted to the extent that patient safety is still at issue. The following steps are recommended to ensure the effectiveness of the office of the Health and Disability Commissioner:

- (a) Medical misadventure resulting in harm to patients should be dealt with through the Health and Disability Commissioner's office and not through ACC. Injury should include pain, suffering reproductive and sexual impairment and loss of enjoyment of life.

- (b) The Health and Disability Commissioner, prosecuting through the Complaints Review Tribunal, should deal with professional discipline issues involving harm to patients. Professional self-regulation must end.
- (c) Patients should be able to take cases directly to the Complaints Review Tribunal. The Complaints Review Tribunal should develop a specialist tribunal to hear health-related cases.
- (d) The Complaints Review Tribunal should, as was intended, consider violations of the code of ethics and patients rights and determine appropriate compensation to the harmed patient and suitable deterrent fines for offending medical practitioners.
- (e) The Health and Disability Commissioner should retain the capacity to take cases to the Complaints Review Tribunal, but should not monopolise that access.
- (f) The advocacy service should be enhanced and the Health and Disability Commissioner should be the employer of all advocates, actively identify breaches of safe ethical conduct.

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