Auckland Women's Health Council

Reporting on and Analysis of the Gisborne Cervical Screening Inquiry - 2001

In lieu of attending the Inquiry hearings in Gisborne the AWHC made good use of the official website that was set up, and used it to read the evidence carefully and reflect on the transcripts of the cross-examinations of the witnesses in a thoughtful and considered way. The Inquiry was regularly reported on in the AWHC Newsletters and the following text comes from those Newsletter updates, written by Lynda Williams.

The picture that is emerging from the Inquiry is a very disturbing one which has implications for the whole health system, and not just the National Cervical Screening Programme (NCSP). Following testimony from eight of the women at the centre of the Gisborne Inquiry, the Inquiry team turned their attention to the evidence presented by the Ministry of Health.

Under cross-examination that has been painstakingly slow and frustrating at times all three Ministry of Health officials have revealed evidence of:

- the reluctance of the Ministry to take any responsibility at all for what happened in Gisborne and anywhere else;
- a tendency to try and rewrite the early history of the establishment of the cervical screening programme in the wake of the Cartwright Report;
- the damaging impact that the constant changes to the health system has had on the NCSP (and probably on many other health services);
- the loss of institutional memory that constant restructuring has had on health authorities like the Department of Health/Ministry of Health;
- the lack of monitoring and prompt follow up of problems and difficulties that emerged as the NCSP was set up;
- the desire to point the finger at the Regional Health Authorities/Transitional Health Authority/Health Funding Authority when being questioned about responsibility for ongoing monitoring;
- the lip service paid to Māori health issues in spite of knowing that cervical cancer was an important health issue for Māori in the Gisborne area.

In evidence from Ria Earp (Deputy-Director General for Māori Health in the MoH) there was no reference at all to any of the problems experienced by the cervical screening programme in Gisborne. Instead, she chose to accentuate the positive by listing the achievements of the Ministry of Health in relation to Māori women, by pointing out that in 1995 Tairawhiti Healthcare had all Māori staff in their cervical screening programme, and assuring the Inquiry that the region has been seen as a model because of the high rates of participation in the programme by Māori women.

What happened to those Māori women in Gisborne who had participated in the NCSP and whose smears were then misread was simply not mentioned?

Testimony from Professor David Skegg

David Skegg has been the Professor of Preventative and Social Medicine at the University of Otago Medical School since 1980. During the 1980s he chaired a number of national working groups on cervical screening as well as on screening for breast cancer. Professor Skegg is considered a world authority on screening programmes and in 1990 he was awarded an OBE for services to medicine.

Professor Skegg began his testimony by outlining the development, benefits and characteristics of screening programmes and then described the setting up of the National Cervical Screening Programme (NCSP) in New Zealand. While acknowledging that the NCSP had achieved a great deal, he expressed his concerns about the length of time it has taken to ensure laboratories met appropriate standards and his disappointment in the NCSP's inadequate investment in research and evaluation.

He stated "At the time of the discussions of our working group in 1984 and 1985, the point was often made that several New Zealand laboratories were examining far smaller numbers of smears than would be regarded as adequate according to some overseas standards… After the passage of 15 years, I am surprised that those responsible for the NCSP have not grasped the nettle and dealt with this problem."

With reference to the lack of evaluation he had this to say: “When one urges apparently healthy people to undergo a medical procedure, there is surely an obligation to monitor the quality of the process and the outcomes achieved. There have been repeated calls for better evaluation of the NCSP, but too little action… Better procedures for evaluation could have drawn attention to any major problem in Gisborne many years ago, when remedial action could have been taken.”

Under cross-examination Professor Skegg was refreshingly forthcoming. He was asked to discuss the reasons behind the establishment of 14 separate regions and computer systems at the inception of the programme which was in direct contravention of the recommendations in the Cartwright Report.

He described the attempts to make cervical screening fit “the model of the day for the health system” by devolving as much as possible to 14 Area Health Boards, and the tendency for central government to devolve responsibility for the NCSP “for obvious reasons – because of inquiries like this one.” This decision was made despite “very consistent strongly presented advice from both experts in screening and consumer groups.” The result was “14 separate registers [which] was a major problem and delayed the implementation of an effective system and no doubt wasted a large amount of money.”

He was also critical of the way the national screening co-ordinator was placed at a much lower level in the Ministry of Health than that recommended and with little power to do more than try and influence those further up the MOH hierarchy.

Professor Skegg was very clear that he believed that health reforms had a lot to answer for in terms of the detrimental impact they had on the NCSP. Despite earlier testimony from the Ministry of Health to the contrary, he stated it was the Ministry who had ultimate responsibility for implementing quality control in laboratory services. He said:

“Another problem, which I think has been well demonstrated during this Inquiry, is that advisory committees in New Zealand, whether they advise the Ministry or in fact even when they advise the Minister, are often ignored, and many of the recommendations of advisory committees in relation to this programme were clearly not acted on and I don’t believe this Inquiry would be occurring if they had been acted on.”

He was also critical of the Ministry’s role in attempting to get rid of the Cancer Registry, describing how the Ministry initially opposed legislation introduced by Christine Fletcher.

“The Cancer Registry is an essential tool for monitoring a cervical screening programme,” he said, but “our Cancer Registry in NZ is I believe in a fairly marginal state of health… and is sadly not functioning in the way Christine expected it at that time.”

It was clear from his evidence that he believes that the Ministry is not providing adequate funding nor giving it sufficient priority within the National Health Information Service.

Testimony from Dr Euphemia McGoogan

The Inquiry heard from an overseas expert on cervical cytopathology, Dr Euphemia McGoogan. In presenting her evidence Dr McGoogan cast considerable doubt on the value of ordering a rescreening of the slides from Dr Bottrill’s laboratory given the amount of time that has elapsed, the biases involved in checking slides under such circumstances, and the fact that reading slides is not an exact science. Brought over by Dr Bottrill’s lawyer, the Scottish pathologist emphasised that the Sydney re-read of Bottrill’s slides could not be used by itself to determine whether there had been an unacceptable level of under-reporting by his laboratory.

Under cross-examination Dr McGoogan revealed some important contrasts between the screening programmes in New Zealand and the UK. In response to being told that both the NZ Ministry of Health and successive Ministers of Health had ignored advice they were given, she said it would be unthinkable for the advice of the national screening advisory committees in the UK to be ignored by either the health authorities or the Minister of Health.

“The national advisory committees are permanent committees and I would be most surprised if their advice was not followed and implemented. I cannot think of a situation where that has actually happened,” she said.

Laboratories in the UK are nearly all part of the public health system whereas most NZ laboratories are in

the private sector. Laboratories in the UK are overseen by two forms of quality assurance. The first is monitoring by quality assurance teams which has been in operation from the very outset of the establishment of the UK cervical screening programme. The second is more recent and involves all laboratories being required to have CPA accreditation.

Dr McGoogan also commented that "by the time the NZ programme was implemented the need for quality control and evaluation for a screening programme of any kind was well recognised."

Under extensive cross-examination on the subject of Bottrill's performance, Dr McGoogan admitted, "I would have expected a single pathologist working alone would have sought external quality assurance programmes to ensure his competence – if only to prove his competence."

Testimony of Christopher Mules

Christopher Mules had held a number of roles in both the Midland Regional Health Authority and the Transitional Health Authority (THA). At the time of the Inquiry he worked as a consultant in the health sector.

It came as no surprise that Mr Mules' brief of evidence made it quite clear that the RHAs and the THA were not going to accept any responsibility for what happened in Gisborne. In his evidence Mr Mules stated that "monitoring and evaluation of the NCSP remained the responsibility of the Ministry of Health … and it was the Ministry that had access to the information from the register which was the key to monitoring of laboratory service providers … for the RHAs the specific laboratory component of the NCSP was a relatively low priority because we believed that the Ministry was responsible for it."

It also became evident during the extensive cross-examination of Mr Mules that much of Midland's work with laboratories during the few years of Midland Health's existence was focused on Midland's efforts to reduce the costs of laboratory services. Private laboratories "grew and became very significant businesses," Mr Mules said. As "one of the major health policy challenges was how to gain control of expenditure in the so-called demand driven areas" Midland RHA was quick to identify the need "to address the issues of expenditure and quality which existed in the private laboratory area."

Mr Mules explained that Midland's laboratory expenditure per capita was higher than that of the other RHAs and was increasing at a faster rate. Recognising two aspects to controlling expenditure – the demand side (relating to requests made for lab services) and the supply side (relating to payments made for lab services) – "Midland implemented strategies intended to address the demand side … and actively pursued development of budget holding." They also decided that the prices paid for schedule tests needed to be adjusted.

Cross-examination of Mr Mules focused on Midland's determination to reduce laboratory expenditure, the lack of concern about quality assurance, Midland's "conscious decision not to incorporate in its Section 51 Notice a quality assurance provision," and the possible effects of Midland insisting on TELARC accreditation. The point was forcefully made that by early 1994 the only two labs in the Midland region that were not TELARC accredited were Gisborne Laboratory Ltd (Bottrill's lab) and Pathlab Waikato. It would not have produced a huge protest if Midland had insisted on TELARC accreditation for the cytology work.

Another Woman Dies

During the 7-week recess in the Inquiry, one of the Māori women who gave evidence to the Inquiry in April died. When the Inquiry hearings resumed on 3 July the Inquiry began by acknowledging this brave woman whose dying wish was to have her name and story made public. The AWHC also wished to acknowledge the courage of Mrs Ward who died on 13 June 2000.

Following representations from a number of Māori kuia, Ms Tracy Mellor, Team Leader of the Quality Improvement and Audit Team in the Personal Health operating group of the HFA, took the stand. Ms Mellor's evidence consisted of a detailed account of the steps taken by the HFA since March 1999 when the problems in Dr Bottrill's laboratory (GLL) in Gisborne first came to the attention of the HFA. The major focus of both her evidence and the cross-examination which followed concerned the events leading up to and the decision-making in regard to the re-reading of the 23,000 slides from Dr Bottrill's laboratory by the Sydney laboratory.

Towards the end of the cross-examination of Ms Mellor she was asked, "If it hadn't been for the Court case what if anything would have brought concerns about the Gisborne laboratory's reading of smears to the Health Funding Authority's attention?" Ms Mellor replied, "I think it is probably unlikely that it would have come to our attention."

Dr Julia Peters, Manager of the HFA's Public Health Change Management Team, was then called upon to give evidence. Dr Peters now has responsibility for national co-ordination and management of the NCSP as well as the breast screening programme.

Dr Peter's substantial briefs of evidence detailed the many projects on the NCSP begun by the HFA over the past 12 – 15 months, with the second smaller brief being an update of progress on the projects made between March and June 2000.

Familiar themes revealed

Cross-examination of Dr Peters con-firmed some of the many themes that have emerged during the course of the Inquiry. These include:

- the lack of experience in and knowledge of screening programmes of so many of those in charge of aspects of the NCSP including senior managers in the Ministry of Health and the HFA right through to the local screening co-ordinators;
- the vulnerability of the NCSP to the constant restructuring of the health system;
- the lack of resources and motivation within both the Ministry and the HFA to audit, monitor and evaluate the programme;
- the inability and/or unwillingness of HFA managers to insist that NCSP providers meet standards or fulfil requirements;
- the lack of any formal process whereby a consumer or NCSP provider can raise any concerns they may have about aspects of the programme.

Whistleblowing

In referring to the fact that in March 1999 when Mr Grieve's letter [raising the possibility that other women may be at risk as a result of Dr Bottrill's misreading of smears] came to the attention of the HFA's screening management team, there was not an established process in place to enable this type of information to be brought to their attention, Dr Peters was asked if there was now something in place. She replied that she was not aware of any formal mechanisms or processes for passing on concerns or information people may have about the programme.

NCSP Standards

Having spent a considerable amount of time working on submissions on the draft documents on policy and quality standards for the NCSP currently being developed by the HFA, the AWHC was concerned to see the many references made to the policy and quality standards documents during Dr Peters' cross-examination. When the Inquiry Chair, Ailsa Duffy, asked Dr Peters how achievable was the implementing of all the standards set out in the document, Dr Peters responded: "Well, provided that we can agree with providers on the standards and the funding, not particularly problematic only in that there are usually disagreements about standards."

The inference that gaining the agreement or co-operation of the various health providers involved in the NCSP takes precedence over the health, safety and well-being of the women taking part in the programme has become a theme of the Gisborne Inquiry. The AWHC trusts that the Inquiry team is as concerned about this trend as the Council is. With the ink hardly dry on the AWHC's submission on the HFA's policy and standards document, the Council is extremely concerned to learn that the HFA seems to have little intention of implementing all of the quality standards in the face of strong opposition from some of the laboratories and that they are open to negotiation on them.

This is despite the fact that Dr Peters assured the Inquiry on the 6th of July that the standards were going to be made mandatory in the contracts with the laboratories.

Further damming evidence of how little attention both the Ministry, and the various incarnations of the Health Funding Authority has afforded the NCSP, came from a document prepared by a member of Dr Peters' staff that stated: "Since the cervical cancer inquiry at National Women's Hospital in 1988 there have been no national quality standards developed, little monitoring or evaluation carried out, and no strategic review of the programme configuration or direction."

Furthermore, “the programme does not have adequate procedures and structures in place to ensure the safety of women.”

Under cross-examination Dr Peters admitted that this was a fair assessment of where things had got to. Responding to questions she confirmed that she was concerned that despite the fact that it’s now ten years since the inception of the NCSP no quality standards were yet in place, and it will be at least 12 years before results of an evaluation “carried out on a meaningful scale” will become available. She also agreed that “the Health Funding Authority would actually bite the bullet and cease dealing with a laboratory if accreditation either was not in place or was suspended.”

One of the reports attached to her evidence stated that “the ability of the situation to develop to the extent that it has can be largely attributed to the lack of quality systems and monitoring of the programme.” It goes on to say “the current ministerial inquiry is likely to highlight these deficiencies and so the HFA’s decision to undertake this work prior to the Gisborne problem being identified will hopefully be a mitigating factor.”

Dr Peters admitted “That’s an interesting sentence which escaped my attention.”

The Inquiry team also had many questions for Dr Peters on how current changes to the health system was going to affect the NCSP and sought repeated assurances from her that the programme would not be devolved to District Health Boards, that there would be an end to the division of responsibilities for the cervical screening programme, and that there would now be one central team or agency responsible for all aspects of the programme.

TELARC

The next person to take the stand was Graham Walker, programme manager of International Accreditation New Zealand (IANZ), formerly known as TELARC. Mr Walker had been with this organisation since 1992. His evidence concerned the state of Dr Bottrill’s laboratory.

Site Visit to Bottrill’s Laboratory

In October 1993, as a result of an inquiry from Mr Reeve, the manager of Dr Bottrill’s laboratory, Mr Walker visited the Gisborne lab to discuss the accreditation process. Following this visit and the receipt of a formal application from GLL, Mr Walker then undertook a pre-audit consultation in respect of the cytology and histology departments in order to assess the laboratory and identify any areas where it fell short of the accreditation requirements. Mr Walker stated “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."

As a result of this initial assessment a written report was sent to the lab outlining the areas Mr Walker had identified as not being in compliance with accreditation requirements. Mr Walker described his findings in no uncertain terms: “In the technical category [which covers good laboratory practice, competence of staff, equipment, environment, etc.] I had not either then or since visited another medical laboratory that has been as deficient in the major areas as Gisborne Laboratories. I can say this with a high degree of assurance because in my role I have personally visited all of the medical laboratories at least once, and many several times.”

Major Deficiencies Found

The major deficiencies Mr Walker identified were lack of participation in external inter-laboratory proficiency testing, lack of records indicating feedback on reading of slides and peer review of performance, lack of ongoing training through attendances at conferences and seminars, and the generally run-down state of the laboratory and its equipment.

Furthermore Mr Walker stated that “there were many signs of the laboratory effectively being wound down, and of limited capital expenditure… this perception was also enhanced by the relative age of the equipment, including the laboratory microscope, and the fact that there were few, if any records of annual maintenance of microscopes, etc … the bench-tops were cracked and broken, and had not been repaired, and the exterior appearance of the building was in a poor state of repair.”

In his brief of evidence, Mr Walker said that after sending the report to Gisborne Laboratories there was no response from them and there was no further contact with either Mr Reeve or Dr Bottrill.

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

The remainder of Mr Walker's evidence concerned the position of the Gisborne Hospital laboratory, which despite having been accredited since 1990, he described as having "always been in the borderline category for one or more of its departments," as well as outlining the history of the RHA's draft National Quality and Services Standards for Medical Testing Laboratories, and the impact of government funding constraints on laboratory standards.

Cross-examination of Mr Walker revealed that the Ministry of Health or the RHAs could have phoned the TELARC office at any time to check on the accreditation status of any laboratory, but the details of the results of any TELARC review would not have been made public as the accreditation and re-accreditation processes were confidential. Thus TELARC maintained it was in no position to warn anyone, including the health authorities, of any concerns they might have about a laboratory's standards of work.

As expected, Dr Bottrill's lawyer, Mr Hodson, cross-examined Mr Walker at some length, but failed to get him to change his story or soften any of his criticisms of Dr Bottrill's laboratory made as a result of his visits in 1993 and 1994.

Gisborne's Gynaecologist

The next witness was Dr Diane Van de Mark, a gynaecologist/obstetrician who gained her medical qualifications in the USA and then practised in Boston for nine years, before returning to New Zealand and beginning work at Gisborne Hospital at the end of 1997. In her evidence, Dr Van de Mark described her increasing concern about the "completely unacceptable level of invasive cervical cancer and high-grade cervical intra-epithelial neoplasia (CIN)" she was seeing in her practice.

Despite growing up in Wairoa and then attending Auckland University, Dr Van de Mark was not conversant with the New Zealand health system. As a result, her efforts to access information about the rates of cervical cancer in Gisborne compared to the rest of the country and the types of pre-cancerous lesions, which were very different to what she was used to, were ineffectual and very haphazard. Repeated cross-examination did not result in a clear picture of exactly who Dr Van de Mark had discussed her concerns with.

"I voiced concern to a lot of people. I was asked if I specifically remembered speaking to one, and I don't, but there were opportunities where it could have been discussed… I did discuss it, I remember, with Dr Duncan. I expressed concern on one occasion."

Dr Van de Mark went on to explain: "I was from a completely different system, and that is very important. I was from a different country, where screening was every year – that was one of my concerns: is this a result of having screening only every three years that I'm seeing so very many high-grade lesions and such large high-grade lesions."

Lack of Statistical Information

She tried to get information on the extent of the problem and was amazed at how difficult it was to get statistics. "The Cancer Register would provide information only if I paid for it, charging nearly $800 per request," she stated. [However, subsequent evidence would reveal that it was the NZ Health Information Service that charges for information, and not the Cancer Register.]

"In August 1998 I was interviewed for the *Gisborne Herald's* Daffodil Day supplement and talked about cervical and uterine cancer in our area… The article evoked several responses from health professionals, both to the newspaper and to me personally. However, the general tenor of the comments was that I was being unnecessarily alarmist and that statistics had not demonstrated a particular problem in our area. It was suggested that my remarks would serve only to make women lose faith in the NCSP. No one proposed that an investigation might be in order to find out if there was a real cause for my concern. No hard questions were asked." So, Dr Van de Mark then began compiling her own statistics. While admitting that she was basing her conclusions on

small numbers, she believed her "findings were cause for concern, and worthy of investigation."

A Challenge

Dr Van de Mark ended her testimony by saying: "I have seen far too much cervical cancer since I came back to New Zealand. I have also seen the extraordinary courage of women facing up to their diagnosis and treatment, and it has been impossible to remain unmoved. I mourn three beautiful, brave women I knew, who died in Gisborne of their disease. And I challenge all those who can play a part, the politicians, health administrators and clinicians of our country to bring about change so that this sad story is not retold."

Gisborne's NCSP Co-ordinator

Sharon Reid, Gisborne's Cervical Screening Co-ordinator, testified that she was appointed in 1991 as a data entry operator/systems administrator for the NCSP in Gisborne. When the manager of the regional programme resigned 18 months later, Ms Reid was appointed interim co-ordinator. "The arrangement continued on an informal basis" until 1999 when she left to take up a position with Hutt Valley Health as co-ordinator of Well Women, Māori for the Breast and Cervical Screening Programmes. During her cross-examination, Ms Reid revealed that:

- by the end of 1993 she was the only person employed on the CSP in Tairawhiti,
- this situation continued for many months,
- she received no training to equip her for her new role, and
- she had very little understanding of the vital role of statistical information in auditing or monitoring what was happening in Gisborne.

When her repeated requests for more resources, more funding were ignored, Ms Reid concentrated on enrolling women and seeing that they received follow-up care when they appeared with high-grade smears or cervical cancer.

Her requests for information also got no response. In 1995 in one of her reports she wrote: "Still trying to extract the incidence of and number of deaths from cancer of the cervix for the last three years. Does anyone have them, or where do we get them from." At some point it appears that she ceased trying to get statistical information and focused instead on the day-to-day operation of the screening programme and follow-up of individual women.

Smear Misread

In 1997 a woman with cervical cancer approached Ms Reid wanting information about her smears, which had been read as normal but should not have been. By this time Ms Reid was also aware of high numbers of women appearing with high-grade smears. In March 1996, Dr Bottrill's laboratory had been sold to Medlab Hamilton, so the women of Gisborne were now having their smears read in Hamilton or Palmerston North laboratories.

However, the significance of these events was lost on Ms Reid. She said: "I had personally hoped that it [the misreading of the woman's smears] was an isolated incident and that if it wasn't then certainly bigger people than me were going to bring it out into the open…I believed that all the different components of the cervical screening programme were doing their jobs…and rightly or wrongly I did nothing about it. That's all I can say. I didn't do anything about it."

Kaitiaki Group

As Ms Reid has also been a member of the national Kaitiaki group since 1998 she was also questioned at some length about the way it worked and why important information about the health of Māori women was proving so difficult to access by everyone including the Inquiry team.

Tairawhiti Health Care

The evidence of Dr Bruce Duncan, Clinical Director of Public Health at Tairawhiti Healthcare Ltd (THL) since 1997, contained an overview of the NCSP in Tairawhiti since it was introduced in 1991, the status of the NCSP register as it related to the Tairawhiti region, and what the THL Public Health Unit did from April 1999 up until the Inquiry.

Over the past year the Public Health Unit has been responsible for administering the Special Circumstances Grant provided by the HFA to deal with the increased demands on the programme, has appointed a special support person for women with misread smears as well as appointing a new screening co-ordinator – Judy Wilson – to replace Sharon Reid.

Dr Duncan's evidence revealed that the Tairawhiti CSP has the third highest enrolment coverage (95%)

of the 14 regional sites with around 11,300 women enrolled from an eligible population of 11,900. The five-year coverage rate (those women who have had a smear within the last five years) is the highest in the country at 89%. The Tairawhiti population is approximately 45% Māori.

Under cross-examination Dr Duncan provided frustratingly vague answers to many of the questions put to him, and resisted any inferences that Tairawhiti Healthcare should have picked up that something was wrong prior to 1999. But he made it very clear that he believed that it was the Ministry of Health's responsibility to audit, monitor and evaluate the NCSP, and it was the NCSP's responsibility to provide the various regions with useful data on cervical cancer rates, etc.

Difficulties Accessing Data

Dr Duncan said he too had problems accessing data and stated that he had asked for an age breakdown of cervical cancer in Tairawhiti and NZ from the NZ Health Information Service and that the analysis cost $800. He said: "When one is trying to encourage either oneself or other clinicians to do audits, one of the barriers that was identified very early on was getting information and data and not expecting clinicians to be hunting around for it. The mere putting in place of even small hurdles to getting that data put people off doing what could be fairly straight forward audits."

He was asked by Professor Duggan: "Do you not feel a certain level of dissatisfaction with this process whereby you are enrolling women and you don't know how successful enrolment is?" He replied: "I do now."

He was also asked if he believed that responsibility for "other facets of the programme, which on the basis of the information you had received lay with other people, would be effectively carried out by those other persons so therefore you didn't need to turn you mind to them?" Dr Duncan agreed that was a fair comment.

Documents were introduced through Dr Duncan that outlined events during the five years of negotiations between Tairawhiti Healthcare and Dr Bottrill's laboratory about a possible merger or purchase of the private laboratory. Attempts to cross-examine Dr Duncan on this issue proved fruitless due to protests from several of the lawyers that these events occurred prior to Dr Duncan's appointment and his opinion was not relevant. Thus, attempts to implicate Tairawhiti Healthcare as far as THL knowing about the run-down state of Dr Bottrill's laboratory, the lab's lack of accreditation and the implications this had for the reading of cervical smears were effectively thwarted.

NZ Medical Council Witnesses

Three members of the NZ Medical Council, Dr Tony Baird, Dr Ken Thompson and Georgina Jones, appeared before the Inquiry. Dr Tony Baird's evidence outlined the role of the Medical Council under the 1995 Medical Practitioners Act, the Medical Council's involvement with Dr Bottrill as the result of the complaint laid against him, the maintenance of professional standards under the Act and the proposed changes to the 1995 Act.

Dr Ken Thompson's brief of evidence concerned the events surrounding Dr Bottrill's appearance before the Medical Practitioners Disciplinary Committee (MPDC). As a result of Patient A's ACC claim, the ACC wrote to the MPDC advising that the ACC Medical Misadventure Advisory Committee had found: "That the misdiagnosis/ misreporting of cervical smears is considered to have been due to a failure by [Dr Bottrill] to observe a standard of care and skill that was reasonable in the circumstances and in this case was negligent." On 1 December 1995 Patient A authorised the MPDC to investigate Dr Bottrill. The matter was eventually heard on 20 February 1997 – but under the old 1968 Act as the events occurred before July 1996 when the 1995 Medical Practitioners Act came into effect.

MPDC finds Bottrill Guilty

The MPDC issued a decision on 5 June 1997 stating that they found against Dr Bottrill. "All four slides were under-reported but in particular the reporting of slides B and C was so seriously deficient that Patient One was denied the opportunity and therefore the advantage of earliest treatment. The Committee finds that Dr Bottrill's conduct fell substantially below that expected of a senior consultant pathologist."

Dr Bottrill was found guilty of conduct unbecoming, fined $400, ordered to pay $7,910 towards the cost of the inquiry and prohibited from practising for three years. By this time Dr Bottrill had, of course, retired.

MPDC's Decision Appealed

Both Patient A and Dr Bottrill appealed the MPDC decision, but the sentence was upheld by the Medical Council because "there was nothing before the Medical Council to suggest that this case was anything other than a very unfortunate episode involving one patient."

Ailsa Duffy, the Inquiry chairperson, made it very clear during cross-examination of Dr Thompson that "this Inquiry was not about examining the Medical Council's decision" and she opposed all attempts made by the lawyers to approach this issue from various angles.

The Medical Council's final witness was Georgina Jones, Registrar of the Medical Council. In her brief of evidence Ms Jones described the disciplinary process and registration under both the 1968 Medical Practitioners Act and the 1995 Act.

The Association of Community Laboratories (ACL)

Tauranga pathologist, Dr Ian Beer was part-owner of Medlab Bay of Plenty, and had been involved with ACL since 1994, and chairman of ACL since 1999.

In his brief of evidence Dr Beer described ACL as a voluntary association of community laboratories concerned with the developments, practices and interests relevant to community laboratories. All privately owned community laboratories in New Zealand are currently members of ACL, including Dr Bottrill's laboratory which was a member of ACL from 1991 until March 1996 when Dr Bottrill retired.

In 1993 ACL adopted Ethical Rules. One of these rules required that ACL members must be TELARC accredited. Dr Beer stated that ACL firmly believed all of its 14 members had complied with the accreditation requirements of its rules, and it was not until ACL received a copy of Mr Mules' evidence to the Inquiry that "it became apparent to ACL that Gisborne Laboratories Ltd had not complied with ACL's Rules." He went on to say: "ACL can only enforce its ethical rules if it becomes aware of a breach. Because ACL is a voluntary body its only effective remedy is to censure or expel a member for breaching ACL's rules."

Introducing Competition between Hospital and Community Labs

Dr Beer was, of course, extremely critical of Midland's attempts to introduce competition between the CHE laboratories and the private labs. The private labs "had to purchase all their equipment, lease or purchase their premises and pay commercial rates for all their assets. Hospital laboratories could not, at that stage, even identify their actual overhead costs let alone make provision for them," he said.

ACL was also critical of the RHA's focus on reducing laboratory expenditure, and lack of concern about quality issues. "ACL takes exception to Mr Mules' assertion that Midland relied on ACL's ethical rules to ensure community laboratories achieved appropriate quality standards in monitoring at the time they issued Section 51 notices in June 1993. The copy of ACL's ethical rules referred to by Mr Mules was not sent to Midland until September 1995," he maintained.

Dr Beer was highly critical of the HFA's lack of active management of the laboratory contracts, the lack of discussion between the two organisations on use of laboratory services and other issues, the short-term "roll-overs" of contracts due to strategies being reviewed, and the way the HFA aborted new contract negotiations before completion because of changes in its organisation.

ACL Resorts to Litigation

As a result of all this "laboratories have had no other option but to pursue litigation in some instances to ensure HFA's contractual obligations are met," he said.

Cross-examination of Dr Beer revealed that although the attempt to pursue litigation failed, a High Court settlement conference took place in April 2000 which resulted in the HFA agreeing to increase the price of a cervical cytology test by 40% to $21. "I guess we have to thank this Inquiry for the offer we received," he said.

Under cross-examination Dr Beer described the RHA as taking "a very commercial approach" with the 1996 laboratory contracts in an attempt to implement an efficient pricing system "The laboratories were being asked to open their books to the one and only funding agency," Dr Beer explained and ACL took exception to that because "it's not appropriate for the funding agency to be that intrusive in the business operation of a sovereign laboratory." Given that Dr Beer's own brief of evidence stated that 96% of the community laboratories' revenue comes from the HFA, it could be argued that the HFA had a reasonably strong case.

Cross-examination of Dr Beer by Dr Bottrill's lawyer drew attention to the fact that when ACL's ethical rules were introduced in 1993 only half of the community laboratories were TELARC accredited, and to the shortage of cytoscreeners.

Evidence of the Royal College of Pathologists

The College of Pathologists of Australasia were represented by Dr Andrew Tie, New Zealand Vice President, Professor David Davies, President of the College and Dr Deborah Graves, the College's Chief Executive. A detailed description of the role of the College, training and examinations, professional development and practice standards for pathologists, general issues in relation to cervical cytology in NZ, legislative requirements, as well as an outline of the College's involvement with events in Gisborne up to the setting up of the Cervical Screening Inquiry, were provided.

The College was anxious to point out that the letter they received from Mr Grieve, Patient A's lawyer, in March 1999 was the first formal correspondence the College received about the situation in Gisborne and they strenuously denied forwarding a copy of this letter to Dr Bottrill's lawyer.

During Mr Grieve's cross-examination of Dr Tie it was revealed that:

- Dr Tie and both Drs Teague and Bethwaite "are associated with Medlab Wellington";
- Both Drs Teague and Bethwaite gave evidence for Dr Bottrill at his High Court trial;
- Dr Teague later gave evidence "for the other side" during Dr Bottrill's subsequent Medical Council disciplinary hearing;
- The College's reply to the letter from Mr Grieve and later response to the idea of a reread of Dr Bottrill's slides were based upon the views of these three Medlab Wellington pathologists;
- Drs Tie and Teague had taken the view that a re-reading of Dr Bottrill's slides was not warranted and Dr Tie had stated this view very strongly in his column in the College newsletter;
- This series of events was not seen by Dr Tie to involve a conflict of interest at any point for any of the three pathologists involved.

Dr Tie stated that the College of Pathologists is concerned about the lack of a working liaison with some Government agencies including the Health Funding Authority and it believes it has not been consulted sufficiently by such agencies prior to decisions being made. Dr Tie also maintained that he and Drs Teague and Bethwaite were not aware of the fact "there was a very high incidence of cervical cancer in the Gisborne region going back to the mid to late 80s," and he defended the College's position in arguing that Dr Bottrill's error rate for false negatives was within the normal range and a re-reading of slides was completely unwarranted.

"The College's standpoint on the matter … was a reasonable one," he said and referred to the fact that Dr McGoogan [the Scottish pathologist who appeared before the Inquiry in May] also "felt that this was not the way to deal with such an inquiry."

The unavailability of statistical information has become a major theme at the Inquiry, and this came up repeatedly during the cross-examination of Dr Tie. However, Dr Tie confessed that he has "never been fond of statistics." Professor Duggan commented: "It's of interest to me that you are the second pathologist to sit in that chair and say you don't know anything about statistics."

Dr Davies then briefly took the stand and much of his cross-examination concerned Dr Bottrill's training as both men had trained as pathologists in England at the same time.

Dr Clinton Teague

The vast majority of Dr Clinton Teague's evidence concerned his 13-year involvement in a range of committees and working parties on cervical screening. This included "details of the remuneration or lack of it in the various positions [he] held." At the beginning of his evidence, he expressed very strong criticisms of the Ministry of Health: "My own dedication was to achieve a successful programme and to save women from cancer. Frankly I would have done all I did whether I was paid or not … But the Ministry at times appeared to both exploit the goodwill of all of us, and then often disregard what we tried to achieve or alter it without consultation."

At the end of his evidence, Dr Teague described the contact he had with Dr Bottrill in 1995: "I received a letter from Dr Bottrill dated 7 July 1995 requesting his laboratory statistics … I handed this request on to the Cervical Screening Programme for action. When the information was not forthcoming after many months I phoned again and was told that actioning

this request would delay work on data for the whole programme." It would be two years before he received these statistics.

"On the 10th July 1995 I received ten cervical smears from Dr Bottrill for review. These included four slides of a case in which there was medico-legal interest. I co-ordinated that review according to the protocol and the results of that review were sent to Dr Bottrill on the 14th August 1995."

Dr Teague then describes giving evidence for the complainant [Patient A] at a Medical Disciplinary hearing in February 1997 and giving evidence for Bottrill at a High Court hearing in March 1999. In July 1997 he finally received a copy of Gisborne Laboratories' reporting statistics. Dr Teague goes on to say: "In subsequent discussion with Dr Bottrill's counsel I indicated that I did not believe that these figures were indicative of systematic under-reporting as the percentages of abnormals fell well within the ranges reported by community laboratories."

Misread Smears

Dr Teague then described being contacted in 1998 by a general practitioner with concerns about two of her patients with possible misread smears by the Gisborne Laboratory. He urged the GP "to bring a complaint if she had concerns." He then contacted the Clinical Director of Hamilton laboratories to check it out and phoned "Dr Bottrill's counsel to inform them of this as it seemed to me that this information could be relevant to the case."

Cross-examination of Dr Teague continued over nearly three days. Dr Teague was another Inquiry witness who gave careful responses to questions that were often guarded, defensive and frustratingly vague. While he was now willing to acknowledge that there was under-reporting of cervical smears in Gisborne over the period 1990–96, he refused to agree that the level of under-reporting was unacceptable. "I would concur with Dr McGoogan that at present the degree of unacceptability, shall we say, requires further evaluation," he said.

Mr Grieve spent much time cross-examining Dr Teague on his part in the setting up of the NCSP, the development of laboratory standards, and on the issue "of how the pathology community was going to deal with issues relating to competence of one or more of their numbers."

Failure of Internal Morality

Mr Grieve put it to Dr Teague that "there has been in this case a failure of the pathology community…and a failure of internal morality too, in the sense that when information relating to Dr Bottrill's competence became known to them, they failed to act appropriately, in particular failed to put the needs of the patients first, above the interests of colleagues." He questioned Dr Teague extensively about his actions after he received ten slides in July 1995 from Dr Bottrill for review which included the four from Patient A, and after he received the results of the cytology review panel. Dr Teague was extremely reluctant to admit to having looked at the slides himself or to having formed an opinion about them. Throughout two days of cross-examination he refused all attempts to make him responsible in any way for not taking action to alert health authorities that there may be a problem with the reading of cervical smears in Gisborne. In response to the question "Did you have any concerns about the health and safety of the women whose smears were being read by Dr Bottrill?" Dr Teague replied: "If I had, sir, I would have done something about it."

Gisborne GP Contacts Dr Teague

Mr Grieve's cross-examination then turned to the issue of what happened as a result of the phone call in 1998 that Dr Teague received from the Gisborne GP, whose patient was dying from cervical cancer after having several of her smears misread by Dr Bottrill. Dr Teague denied advising the GP against making a complaint (a filenote of this conversation was recorded by the GP in Patient 9's notes and is part of the latter's brief of evidence to the Inquiry).

Dr Teague also justified his call to the Hamilton laboratory as his need to confirm whether there had been further misreads by Dr Bottrill (a lab staff member described the slides as "malignant as hell"). As for as the reason for his call to Dr Bottrill's lawyer – "because I thought that it was important that they should know," he said.

Mr Grieve then cross-examined Dr Teague about his response to the letter Mr Grieve wrote to the College in April 1999 and his lack of support for a re-read of Dr Bottrill's smears.

Cross-examination on these issues continued until Ailsa Duffy finally called a halt to it. The focus then

turned to the adequacy of the NCSP's three statistical reports and whether they could have been used to indicate under-reporting of cervical smears. Once again these reports were described as inadequate, and yet again the point was made that if it hadn't been for the Court case the problems with under-reporting of smears in Gisborne "might not have come to light."

Familiar Themes

Further questioning confirmed earlier testimony regarding:

- the adverse impact that the health reforms had on the NCSP and the huge problems that resulted when the NCSP was devolved to 14 different Area Health Boards;
- the importance of incorporating histology onto the NCSP register;
- the delay in all laboratories getting TELARC accreditation;
- the Ministry of Health's role in and responsibility for what happened during the setting up of NCSP;
- the lack of auditing and monitoring of the NCSP.

After three days cross-examination of Dr Teague was finally concluded.

Dr Ron Jones Gynaecologist

He was followed by Dr Ron Jones, a National Women's Hospital gynaecologist who had been engaged by the HFA to provide follow-up care to the Gisborne women. His evidence concerned interim results of his findings following colposcopic assessments of the women. Towards the end of his evidence Mr Jones made the following comments:

"For some years a number of us have promoted the importance of establishing a mandatory prospective audit … of cases of cervical cancer. This would involve:

1. Establishing whether women presenting with cervical cancer have previously had cervical smears according to the National Guidelines (i.e. whether there has been a failure of the NCSP).
2. Whether there has been a failure in the process of interpreting the cervical smear (as is alleged to have occurred in this case).
3. Whether there has been a failure to properly manage the known cytological abnormality (i.e. failure of colposcopy, histopathology, surgery, etc.).

If such a process had been in place, this Inquiry would not be taking place," he said.

The addendum to Dr Jones' evidence was a very emotional document. In it he launched a stinging attack on those he saw as responsible for the events which have led to the current Inquiry.

"The majority of individuals appearing before this Inquiry have never experienced direct contact with women with cervical cancer, and in this group I include Public Health professionals, MOH/HFA personnel and those working in or associated with laboratories. Those of us who deal with real women with cancer, understandably have different perspectives and a more emotional approach to the gross failure of the government sponsored screening programme in Gisborne. There is a world of difference between sitting behind a computer screen tinkering with cancer data or sitting on an ethics committee with a cup of tea, to actually facing a woman with cancer. I have a sense of déjà vu as I sit here today. A number of us are for the second time in little over a decade involved in a major cervical cancer inquiry."

Under cross-examination Dr Jones was asked if the colposcopies he had undertaken as a result of the Health Funding Authority investigation into the Tairawhiti region support the re-reading exercise carried out in Sydney. "Very much so," Mr Jones responded. "There are a number of women who had persistent high-grade abnormalities which had persisted from the time they were taken in Gisborne originally and which were confirmed as part of the re-read exercise, which were still present at the time we did the colposcopic examination – it was 17%. More importantly still, there were a number of women with invasive cancer who were detected as a result of the re-reading exercise. Now these were women without clinical symptoms, so these women have had their cancer diagnosed at a much earlier stage and they are important beneficiaries of this inquiry."

Under cross-examination Dr Jones revealed that he was highly critical of the stance taken by the College of Pathologists in not supporting a re-read of the slides from Bottrill's lab. "It is a cause for concern because … had the Health Funding Authority not created a committee to investigate, and relied on the advice of the College, then it is theoretically possible that this investigation might not be taking place," he

said. The College's lawyer made several unsuccessful attempts to get him to soften his stance, but the constant revisiting of Dr Jones' opinion of Mr Tie's article in the College newsletter served only to reinforce the criticism.

Dr Annabelle Farnsworth – Director of Cytopathology at Douglass Hanly Moir (DHM) Pathology, the large privately owned laboratory in Sydney which re-read approximately 23,000 slides from Dr Bottrill's laboratory – was next to appear before the Inquiry team. Her evidence described how DHM was approached to undertake the re-screening exercise, detailed exactly how this was done and how it compared with the regular cervical screening work of the laboratory, and outlined the results of the re-read.

Just Testing?

Dr Farnsworth reported that when the first trial box of 100 slides were sent over from New Zealand to test out the logistics of the process they found a high number of high-grade smears. "Initially I thought it was possibly a test to see whether we were competent at cytology and I rang Jim Du Rose [from the HFA] to let him know that we had found some high-grade lesions," she said. "We continued to find abnormalities at a rate that was quite unusual… the obviousness of the abnormal material on the abnormal slides and the actual appearances of the cells astounded us. These appearances continued throughout the whole re-reading exercise. We had not anticipated any of this."

The laboratory continued its re-screening exercise, aware of the high rates of high-grades, inconclusives and low-grades that were being reported, but deliberately blind as to the how this correlated with the original reading of the smears. Nor did they know what the incidence of cervical cancer in the Gisborne area was during the re-read. "At no time did we change our procedures but rather kept processing the slides by the original protocol and reading them as per our normal cytological criteria," Dr Farnsworth said.

"The abnormalities that were detected were not difficult to find. They were not found as a result of extensive searching but rather were very apparent. There are no new cytological criteria that were used that would not have been available in New Zealand in 1991 – 1996," she reported. The laboratory later learned that their reportage of high-grade smears was five times the rate that Dr Bottrill had reported.

For the Women of Gisborne

Under cross-examination Dr Farnsworth emphasised that the original purpose of the re-read was for the women of Gisborne. The exercise was not undertaken as a scientific study nor was it known that there would be a Ministerial Inquiry when they began the re-reading exercise.

Dr Farnsworth was questioned at length about the correlation between the large numbers of high-grade smears and the results of subsequent colposcopic examinations of the women concerned. The expectation that the large numbers of high-grades would result in an avalanche of women presenting with high-grade lesions at colposcopy did not eventuate. This was because many of the women had already found their way into the system, had received adequate follow-up care either in Gisborne or elsewhere, while many others experienced a natural regression of the lesion. Dr Farnsworth referred at this point to the largest study of the biological progression/ regression of such pre-cancerous lesions – "the original New Zealand experiment" – and said that the events in Gisborne have now unfortunately provided another such scientific study.

Lack of Statistical Information

Dr Farnsworth also described her concern and frustration at not being able to obtain information on the incidence of cervical cancer in the Gisborne region, as she believed that this "would be a logical explanation as to why we were seeing this rate of high-grade smears." She finally received the information she wanted in June 2000. However, such a delay did not really surprise her. "It is not unique to New Zealand, I can promise you," she said.

Dr Farnsworth outlined a number of reasons why there might be a high incidence of cervical cancer in Gisborne including a lack of screening, poor smears being taken, a lack of follow-up for abnormal smears, none of which appeared to apply to Gisborne. The only other possibility was that the smears were being misread.

Despite the high rate of Gisborne women who had had smears Dr Farnsworth described them as an unscreened population "where you had essentially a

group of women who had developed the disease much more in its original form."

The Slide Cover-slips

Questioned about the state of the slides, Dr Farnsworth described them as beautifully stained, which made them easy to read. However, she said that 50% of them had to be recover-slipped as the existing cover-slips only covered approximately 75% of the material. A further five to ten had the cover-slips on the wrong side of the slide.

One of the other results of the Sydney re-read was that the figures revealed that Dr Bottrill, as well as having a high false negative rate, also had a low false positive rate. Such a low false positive rate increased the likelihood that Dr Bottrill was under-reporting. Dr Farnsworth said that if "one saw a very low false positive rate in association with a high false negative rate, one would be very concerned for that screening population."

Dr Wain

Dr Gerard Wain, Director of Gynaecology Oncology at Westmead Hospital in Sydney followed Dr Farnsworth. Dr Wain's evidence concerned the review of the medical files and records of nine patients that he had been asked to do, as well as describing the introduction of cervical screening in Australia, particularly in relation to the implementation of quality standards for laboratories.

Dr Wain's evidence confirmed what Dr Farnsworth had said in relation to the Gisborne women. These women had not been effectively screened at all. He described the level of under-reporting as "extreme… completely unacceptable… as bad as it gets."

Cross-examination of Dr Wain was focused on his assessment of the patient files and what this meant for the women of Gisborne and the NCSP, as well as on events in Australia during the establishment of Australia's screening programme and how this compared with New Zealand.

James DuRose

Jim DuRose, Quality Improvement & Audit Co-ordinator for the Health Funding Authority appeared next. He had the responsibility for the management of the HFA's "Review of Cervical Cytology practice in NZ Community Laboratories 1990 –99" and his evidence detailed the process undertaken during the review and the results of that review, which took place during August 1999 – May 2000.

Part of the review process involved sending out a questionnaire to the 17 community laboratories and having the responses independently assessed by five pathologists from NZ and three from overseas. An Evaluation Panel was then convened by the HFA to consider the following:

- the questionnaire assessment profiles compiled from comments from the eight assessors;
- the analysis of abnormality reporting rates for 1991 – 1999;
- the histology/cytology correlation analysis completed from the Register for 1996 – 98;
- age adjusted rates for incidence of cervical cancer 1990 – 1995.

A decision was made by the Evaluation Panel to obtain further clarification from six laboratories – three with respect to current practice and three with respect to past practice – as their rates of reporting of abnormalities were outside the benchmarks set by the Panel. Further investigations revealed that coding errors had occurred in three of the laboratories and changes in reporting practices in another. As result of their investigations, the Evaluation Panel, as well as the Advisory Group that was set up in March 2000, came to the conclusion that "based on the available evidence, there are no major concerns with respect to any laboratory's practice."

The final report of the HFA review confirmed that there were no major concerns with respect to the health and wellbeing of women, and that current practices in cervical cytology match up reasonably well with the NCSP's draft policy and quality standards.

Results of Lab Questionnaire

The key results from the questionnaire sent out to the community laboratories included the following information:

- all laboratories had screener(s) in place and there was no indication of any pathologist routinely performing primary screening;
- all have been using some form of rescreening since 1992 and all attempt to feedback to screeners identified errors on individual cases;

- as of 1999 all but one laboratory was undertaking 100% rapid review rescreening for internal quality control
- the pathologists in all laboratories are reviewing the majority of abnormal smears;
- all laboratories have been TELARC accredited since 1995 and have participated in the Royal College of Pathologists of Australasia Cytology Quality Control Programme since 1995.

Mr DuRose was cross-examined at length on the assessment of the laboratories, particularly the six whose identities were kept secret throughout the course of the Inquiry, but were subsequently revealed on the front page of the *New Zealand Herald* on the 2nd of October. The ongoing monitoring and audit of these six laboratories was of consider-able concern to the Inquiry team. Mr DuRose seemed to find it extraordinarily difficult to give precise or definitive answers to the questions he was asked, which resulted in the same questions being asked repeatedly by various lawyers and the Inquiry team, and many areas of concern were revisited over and over again.

One issue that concerned the Inquiry was ascertaining what safeguards the HFA put in place to "keep a watching brief on laboratories to ensure they're not under-reporting" while the standards for laboratories were still regarded as interim standards and not yet fully implemented. But Mr DuRose was unable to reassure the Inquiry team.

Professor David Skegg

During Professor Skegg's second appearance at the Inquiry he explained his failure to get approval from the Tairawhiti Ethics Committee to his review of the screening histories of the Gisborne women who had developed cervical cancer since 1990. The ethics committee had insisted that the consent of the women concerned would be required to access information from the National Cervical Screening Register and to access their personal medical records. Given that some of the women had died and others may be difficult to trace, this essentially made it impossible to undertake a full review or complete it in time for the results to be of use to the Inquiry. The ethics committee also expressed concern that neither of the two investigators was based in Gisborne!

During cross-examination, Professor Skegg stated that in his opinion ethics committees often failed to look at the costs of not doing research. "I doubt whether the committees have considered the likelihood that at least ten women a year will die because we are not doing this evaluation," he said, referring to both his review and the planned evaluation of the whole programme.

He explained that even the parts of the 1997 NCSP evaluation plan that the Ministry had finally agreed to, had not happened due to the fact that eight months after submitting the proposal to the Otago ethics committee approval had yet to be granted.

"I believe that the continued failure to monitor adequately the quality of the NCSP is entirely unacceptable," he stated. "It seems unethical to exhort apparently healthy people to undergo medical procedures, when adequate steps cannot be taken to monitor the quality of the process or the outcomes achieved."

Given his criticisms of ethics committees in general and of the decision made on his study by the Tairawhiti ethics committee in particular, Professor Skegg was cross-examined at some length by the latter's lawyer. He convincingly rebutted all attempts to cast doubt on his testimony.

During other cross-examination, Professor Skegg stated that while he now believed his review was not necessary to provide an answer to the first term of reference regarding whether there was an unacceptable level of under-reporting of smears by Dr Bottrill, "because the situation really is worse that I had anticipated," he believed that the information to be gained from such a study was still desirable because the level of under-reporting may in fact result from factors other than Dr Bottrill's errors. He went on to comment that "if the Sydney re-read is taken at face value it would have to raise concerns about every laboratory in New Zealand."

Reservations on DuRose Survey

Professor Skegg also expressed grave reservations about the validity of Mr DuRose's evidence. The survey of the laboratories "appears to have been planned on the run … I don't believe there was a protocol developed in advance and I noted Mr DuRose's comment that it had to be done almost in an atmosphere of secrecy."

"I was not comforted by Mr DuRose's evidence to the extent that we could deduce that what has happened

in Gisborne is totally exceptional and that there might not be some other areas where similar problems could exist or could have existed in the past," he said. As a result of such criticisms, Professor Skegg was of course cross-examined extensively by the HFA's lawyer. He provided persuasive arguments to support his opinion.

The Cancer Society

Dr Brian Cox was the first of the Cancer Society's witnesses, introduced by Betsy Marshall. In her opening remarks, Ms Marshall described the Cancer Society's role in lobbying for a cervical screening programme and the Society's active involvement in and support during implementation of the NCSP in the wake of the Cartwright Inquiry.

In his evidence, Dr Cox gave an extremely detailed account of his involvement in the establishment of the NCSP first as a member of the Ministerial Review Committee of the programme in 1989, then as a member of the Cervical Screening Advisory Committee (CSAC) from 1991 to 1996 and as an "occasional advisor on specific aspects of the NCSP during the past decade." The underlying and by now very familiar themes of Ministry of Health officials ignoring the expert advice they were given and the growing levels of frustration and concern among committee members echoed the testimony of previous witnesses. Attached to Dr Cox's evidence were the minutes, and the many letters and memos from every one of these meetings. It was indeed fortunate that Dr Cox had kept them all as the Ministry of Health officials who had appeared at the beginning of the Inquiry had been unable to locate these documents.

Dr Cox resigned from CSAC in May 1995. "At this time I felt that despite numerous attempts by the CSAC to ensure appropriate monitoring and evaluation of the cervical screening programme this had not been completed. I felt that the Ministry of Health appeared to want to manage the NCSP for political reasons rather than making sure it was effective," he said.

"We Were Driven Spare"

Describing the mounting unease he said, "We were driven spare … and some of us were feeling professionally unsafe and we were aware of the incident that had occurred overseas and that something somewhere was going to happen, possibly to the extent that an inquiry such as this would eventuate…"

Cross-examination of Dr Cox dealt with a wide range of issues, including the need for a full evaluation of the NCSP rather than the partial evaluation currently being under-taken by the Ministry of Health, the statistical information that should be obtained from the programme in order to audit and monitor its effectiveness on an ongoing basis, the minimum number of smears a laboratory should read to maintain standards and staff competence, and the problems experienced gaining approval from various ethics committees for data collection, and access to data on the Register to evaluation of the programme, etc.

Dr Cox was asked what it meant for the NCSP given that there are so many obstacles to carrying out research of an evaluative nature on the operation of the programme. "Well it makes it difficult to justify its existence in the sense of that ethical commitment that I gave earlier which is a basic … it's one of the ethical differences between public health medicine and other branches of medicine. So, if we are unable to be fairly sure that we are actually getting those benefits, we certainly have the capacity to cause harm by offering screening to people," he replied.

Dr Cox was also questioned about his response to the DuRose study of laboratories. He replied that he agreed totally with the reservations and criticisms made earlier by Professor Skegg.

Dr Gabrielle Medley

Dr Medley, a Melbourne pathologist and Director of Cytopathology at Prince Henry Hospital, appeared next to answer questions about the DuRose review of laboratories. Dr Medley was one of the eight assessors on the Evaluation Panel referred to in Mr DuRose's evidence.

Under cross-examination Dr Medley described the Evaluation Panel's role as being to identify areas of concern regarding the past or present performance of any of the 17 laboratories with the management of those areas of concern being the task of the Advisory Group. She was questioned extensively about how the review or "risk assessment" exercise was undertaken and how much weight the Inquiry could attach to its conclusions. At the end of her cross-examination, she replied in response to questioning by Inquiry team chair-person Ailsa Duffy "I'm telling you that the study identified areas of concern. Those areas of concern have been addressed. That they appeared to

be practising within acceptable practices at the time in our judgment but I am unable to say to you that there is no possibility that in any of these laboratories there may have been a systemic error causing systemic under-reporting and I think it would be inappropriate of me to say otherwise."

A Voice From Women's Groups

Director of Women's Health Action, Sandra Coney's evidence focused on the active involvement of women's health groups over the past decade in supporting the establishment of NCSP and lobbying for action on the much needed improvements to the programme. In detailing her personal contribution as both a consumer representative on the Ministerial Review Committee and the Expert Group (she was the Auckland Women's Health Council's representative on the Expert Group) and her other work for the NCSP, her evidence confirmed everything that Dr Cox had said in his evidence about the obstructive behaviour of the Ministry of Health during the early 1990s, the damage done to the NCSP by the health reforms, the unwillingness of successive Ministers of Health to allocate the necessary funding for a proper evaluation of the programme, and the need to place the NCSP outside the Ministry of Health preferably in a Cancer Control Agency .

Unfinished Business

Sandra Coney's evidence was especially significant because her testimony was the only consumer voice representing women's health groups that was heard at the Inquiry. Cross-examination began by referring to the Women's Health Action Trust book, *Unfinished Business*, edited by Ms Coney and published in 1993. The chapter on cervical screening which was written by Ms Coney identified the main themes back then as being:

- the unrealistic timeframe for implementing the programme;
- a failure to appreciate the complexity of the task;
- a failure to establish co-ownership of the programme between government, health care providers and women;
- insufficient attention to Māori women's views of the programme;
- a failure to explain the NCSP to health care providers and women;
- an ideology of devolution within the Department of Health.

She confirmed that her views had not changed in the seven years since she wrote that chapter and the only thing she would add to the list was the adverse impact that the health reforms had had on the NCSP.

The Inquiry team took the opportunity to question Ms Coney on a wide range of issues including the lack of an evaluation of the NCSP, the impact of the health reforms, the future of the NCSP under the current restructuring of the health system, the problems with ethics committees and the need for a National Ethics Committee, the importance of and the role of consumer consultation and representation, the DuRose review of the laboratories, informed consent, the NCSP newsletter, the use of national health index numbers and population enrolment.

A number of women travelled to Gisborne to support Ms Coney. It provided a unique opportunity to see and hear first-hand how the Inquiry was proceeding.

Dr Brian Linehan

When Dr Brian Linehan, managing director of MedLab Hamilton and – since 1996 – of Bottrill's laboratory, gave evidence it quickly became obvious that he was unable to answer many of the questions put to him about the operation of the two laboratories.

Dr Linehan described his qualifications as a pathologist, his experience and the many professionals positions he had held. He also provided details of his purchase of Gisborne Laboratories in 1996, the process of obtaining Telarc accreditation for MedLab Gisborne, as it subsequently became known, the laboratories' response to the events leading up to the Gisborne Inquiry and the effect of the Inquiry on community laboratories.

He was obviously critical of the way in which the Sydney re-read of slides had been undertaken and the fact that his labs have "contributed an enormous amount of time in endeavouring to assist resolving the issues," despite having had "no involvement in or responsibility for the alleged under-reporting of cervical smears in Gisborne."

He complained about the fact that the Sydney laboratory had renumbered all the Gisborne lab's slides in such a way that the original numbering was obscured.

Chris Hodson, lawyer for Dr Bottrill, opened the cross-examination of Dr Linehan with questions

about the equipment at Gisborne Laboratories (GLL) when he purchased the lab in 1996, the documentation he included with his evidence, which showed that some effort was being made by Dr Bottrill in 1994 to move towards becoming accredited, and the quality assurance programme in clinical chemistry that GLL was involved in.

Dr Linehan stated out that equipment in Dr Bottrill's laboratory "was adequate and functioning but calibration was required," and that Dr Bottrill's microscope was still in use in the haematology department. Although Mr Hodson was keen to place doubt on earlier testimony that had been highly critical of the state of GLL around 1994-96, his efforts were at times singularly unsuccessful.

In response to questions about staff at GLL, Dr Linehan stated that the fact that there was no cytology screener did not pose a problem as all screening was carried out in the Hamilton laboratory following his purchase of GLL. It was when questions were asked about current practice at MedLab Hamilton when there is a need to look back on a Gisborne woman's previous smears that Dr Linehan came really unstuck.

Gisborne Women Still at Risk

After giving a series of extremely vague responses to questions Dr Linehan was asked if he, in effect, was saying that because of what he called logistic problems and difficulties in the amount of time involved, the women of Gisborne do not have their smear history reviewed by the Hamilton laboratory. He replied that they certainly are not reviewed in the way that they are reviewed for Hamilton women. The horrified reaction from the Gisborne women sitting at back of the room to this piece of evidence was obvious to all.

Dr Linehan objected to Mr Grieve's statement that this meant the Gisborne women are still getting a less than optimal service from his laboratory, but the damage was done and no amount of assurances on his part could alter the implications of his appalling admission.

It soon became evident to the Inquiry team that they would need to hear from Janet Wilson who had worked for Dr Bottrill during the 1990s and was now manager of the Gisborne laboratory. She was asked to appear on the following day. In the meantime the Inquiry decided to hear from Brian Morris, laboratory manager at Gisborne Hospital.

Gisborne's Two Laboratories

Mr Morris' testimony was in complete contrast to Dr Linehan's. He stated that he met Dr Bottrill on his first day at work at Gisborne Hospital in August 1979 as Dr Bottrill was doing some locum work at the hospital. He described how Dr Bottrill's laboratory made use of the hospital services when Dr Bottrill's instruments had a malfunction or when his laboratory did not provide the service. Under cross-examination he said that Dr Bottrill visited the Gisborne hospital laboratory on almost a daily basis as he "would deliver specimens to various disciplines."

Moonlighting

In response to questions about the locum work carried out by pathologists from Gisborne hospital for Dr Bottrill's laboratory, Mr Morris revealed that Dr Padwell, the senior pathologist at Gisborne hospital, often did private cervical smears for Dr Bottrill, otherwise known as "moonlighting." When asked about the extent of this, Mr Morris said "I remember Dr Padwell describing to me how he'd take home a tray of slides and read them while he was waiting for his wife to cook tea." He confirmed that "Dr Padwell was doing the primary screening while he was waiting for his supper." This went on for months until there was "a falling out between Dr Padwell and Dr Bottrill."

State of Dr Bottrill's laboratory

Mr Morris was then asked about the state of Dr Bottrill's laboratory. He described how he had visited the laboratory on many occasions because his wife worked there from 1988 to 1993. He said "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 medium was made using domestic pressure cookers; there wasn't a proper autoclave; the windows were very small windows… I was just aware of the poor condition of the benches and the equipment they were using." Mr Morris also stated that when Dr Lapham took over as pathologist at Gisborne Hospital Laboratory after Dr Padwell left a decision was made for smears to be sent to Palmerston North to be read due to the small number of smears (around 2,000) being read.

Janet Wilson then took the stand to provide answers to the questions about the day-to-day operation of Dr Bottrill's laboratory that Dr Linehan had been unable to answer. Ms Wilson is now laboratory manager for MedLab Gisborne and has worked at the laboratory since 1986.

The Filing System

Under cross-examination Ms Wilson said that smear reports were filed alphabetically by year and that there was also a day book which recorded the woman's name and the number that was allocated to her smear slide. When MedLab Hamilton took over in March 1996 "the cytology department was disbanded so the equipment was removed … [but] the records and reports, they all stayed in Gisborne." Ms Wilson also confirmed that the information on Dr Bottrill's computer was not loaded on to the Hamilton computers when MedLab Hamilton took over the practice and that the computer did not, to her knowledge, hold any kind of a database.

The Shed

She also described how the older slides were all packed into slide boxes and stored in a shed adjoining the building while the newer ones were stored in cupboards in the lab. After MedLab Hamilton had removed much of the equipment Ms Wilson went out to the shed and tidied up the boxes of slides sorting them all into chronological order so that she could locate them more easily should she be required to. However, she said that prior to the Sydney re-read there were no requests from MedLab Hamilton for any of the slides or for previous smear histories.

Dr Linehan Returns

Following Ms Wilson's appearance Dr Linehan was recalled to the stand. Under cross-examination he confirmed what he had said earlier in regard to the intense competition with Gisborne hospital laboratory following his purchase of Dr Bottrill's laboratory, saying that "after we took over we ended up with about half the work that had previously gone to Dr Bottrill's laboratory," and that it took about three years to recover the work. It was then put to Dr Linehan that given these numbers it would have been relatively easy to look back at the Gisborne women's smears whenever a high-grade smear was identified. This could have resulted in "something being done about this Gisborne tragedy much earlier." Dr Linehan's response to this was to point out that it would have been just as easy for the Gisborne hospital laboratory to have done this, "or any laboratory they sent slides to."

No Look Back

When confronted with the fact that TELARC accreditation requires a look back at smears, Dr Linehan said that he wasn't "familiar with the details of the internal audit in the anatomic pathology department."

He was then cross-examined about what exactly he knew about Dr Bottrill's practice and was asked about the statement in his brief regarding the danger of pathologists working in geographical and professional isolation. He was referred to Dr Bottrill's evidence in which Dr Bottrill stated that he told Dr Linehan that he felt the accreditation system was of limited use in a small laboratory like his because it concentrates very much on documentation." Dr Linehan said he did not recall this conversation, but he was sure he would have said something positive about the process and added: "I would probably have sympathised with him over the expense involved." This produced an outcry from the audience.

Ailsa Duffy asked for silence and the cross-examination continued. However, it was obvious by this time that Dr Linehan was not going to admit to anything being amiss in the practice of either laboratory. He was also not prepared to make any negative comments about the state of Dr Bottrill's laboratory when he was visiting with a view to purchasing it.

Prior to breaking for lunch a discussion took place on whether the Inquiry would continue with the cross-examination of Dr Linehan or hear from the women waiting in the audience. After strong protests from several of the lawyers it was agreed that the women would give their evidence as previously arranged.

Further Testimony From the Women

Ms Winmill gave her account of having had annual smears and then finding she had cervical cancer just as she and her husband had made the decision to start a family. Her hysterectomy now made it impossible for her to have children. A number of Ms Winmill's slides were misread, not all of them by Dr Bottrill's laboratory.

Three other women came forward and gave evidence that afternoon. Their accounts of what happened to

them and effect it had on their relationships with their partners, their families and their feelings about themselves were incredibly moving. In the midst of all the expert evidence, it is the voices of these brave women that is the main theme of this Inquiry.

Dr Bottrill

Dr Bottrill's evidence described his training as a pathologist in England, and his work as the sole pathologist at Whangārei Hospital from 1961 until 1966 when he was offered the position at Gisborne Hospital. Dr Bottrill did not read smears while he was working at Whangārei Hospital, but started reading smears in 1967. The following year he started his private laboratory with Mr Reeve and spent half of his time in private practice and half of his time at Gisborne Hospital until 1974 when he started fulltime private practice.

He also outlined his membership of various professional organisations and described in some detail how his laboratory carried out the reading of cervical smears from 1990 – 96. Dr Bottrill stated that although he did not wish to give up cytology altogether, he advertised for a part-time cytoscreener in the mid to late 80s but got no response. In the mid 1980s he began reviewing 10% of his own work and would liaise with the pathologist at Gisborne hospital which Dr Bottrill saw as forms of quality assurance.

"It Was My Operation"

Under cross-examination Dr Bottrill was prepared to admit that he had misread a great many smears. He was not, however, prepared to admit that the under-reporting was a consequence of the lack of proper training either as a cytopathologist or as a primary screener, his lack of continuing education, the failure to get his laboratory accredited in a timely fashion, his failure to institute appropriate quality control measures or to participate in an appropriate external quality assurance programme. Dr Bottrill also denied that he had failed to discharge his ethical obligations to his patients. Instead, he blamed his misreading of slides on the effects of his 1990 coronary by-pass operation.

When confronted with the testimony of three experts (Dr McGoogan, Dr Annabelle Farnsworth and Dr Clint Teague) that "without specialised training, pathologists should not work as primary screeners," Dr Bottrill responded by saying: "There's a lot of hindsight going into this, isn't there? What is recommended as being ideal for the 1990s has very little relevance to what was done in the 1970s… my comment is that if you don't have a screener and you have been doing the job for years you might just as well go on doing the job."

When asked if given the lack of a primary cytoscreener he should have sent the smears elsewhere, Dr Bottrill disagreed. "I was interested in cytology and to the best of my knowledge I was quite good at it until recently," he replied.

Despite a very focused cross-examination Dr Bottrill stuck to his belief in his work and remained adamant that he would not change anything, even knowing what he knows now about his unacceptable level of under-reporting of slides and the impact this has had on so many women.

The Cancer Society

Janice Hobbs, the Cancer's Society's second witness followed Dr Bottrill. Ms Hobbs is co-ordinator of the Gisborne East Coast Cancer Society, a position she has held since 1993. Her evidence outlined her work for the Cancer Society and her attempts to draw the attention of the appropriate authorities to the possibility of a problem in Gisborne with misread smears. In her evidence Ms Hobbs made it very clear that in June 1997 both Sharon Reid, manager of the Tairawhiti Cervical Screening Programme, and the national co-ordinator were aware of the fact that Dr Bottrill had been found guilty of misreading four cervical smears from a patient in the Tairawhiti district. She also said she voiced concerns about the possibility of there being other women in this situation with Sharon Reid.

The next witness to appear was Betsy Marshall, the third and final witness for the Cancer Society. Ms Marshall's evidence outlined her involvement with cervical screening from 1983 onwards. She also described in some detail the work of the committees set up to oversee the establishment of the NCSP. Her evidence concurred closely with that already given by Dr Brian Cox and Sandra Coney, adding damning additional information on the:

- ambivalence of the Department of Health towards implementation of the Cartwright Report with particular reference to the NCSP;
- inadequacy of information and data in critical areas such as budget and screening coverage;

- inadequacy of staffing within the Department of Health in terms of levels and expertise;
- communication difficulties between advisory committees and the Department of Health;
- lack of information regarding staffing responsibilities with the Cervical Screening Implementation Unit;
- initial implementation of the NCSP before full development of policy;
- the vulnerability of the NCSP to political change and instability;
- the effect of devolution and decentralisation within the health system on the NCSP.

Ms Marshall's evidence makes fascinating reading as she detailed meeting by meeting, memo by memo and letter by letter, the efforts of the various advisory committees to ensure the survival of the NCSP. "Over and over, during the years when advisory committees should have been focused on the effective implementation and operation of the NCSP, we were unable even to rely on its continued existence," she stated.

In reference to the MoH's evidence that they were unable to locate any of the minutes of the meetings of the Expert Group, she said "I have what I believe to be a near complete set of minutes. These have been available for inspection by all parties at the offices of the Auckland Division of the Cancer Society since before the commencement of these hearings."

Ms Marshall also stated that she believed that "the implementation of the NCSP has been compromised by the absence of a fully resourced, national co-ordination unit with the appropriate range of expertise, working within a stable environment."

Ministry Takes Measured Approach

Mr Murray, lawyer for the Ministry of Health, began the cross-examination of Ms Marshall with an explanation that the lack of cross-examination by the Ministry and the failure to call other evidence did not mean that the MoH accepted all the criticisms of the Ministry. "We have taken a measured approach," he explained "and chosen carefully what is productive to deal with by way of cross-examination and made a decision that a lot of this material is in the record and can be dealt with very adequately by way of submissions." Inquiry Chair Ailsa Duffy replied "I have assumed that if you are not challenging evidence it means that you're accepting it. And this is one of the things that has concerned me, because I realise there is very little cross-examination coming from the Ministry of Health."

Mr Murray reassured her that "the Ministry is a big organisation, it can take some criticism that perhaps a private individual can't" and that the MoH has chosen to rely on their final submission to rebut the evidence put forward by others. "You run a risk if you fail to do that," Ms Duffy warned.

Mr Murray then said he wasn't going to cross-examine Ms Marshall. The questions from other lawyers and the Inquiry team explored in further detail Ms Marshall's evidence, clarifying points she had made, and focusing on what needed to happen to ensure the future health and stability of the NCSP.

What Laboratory Standards?

Dr Julia Peters then returned to the stand. The Inquiry team were keen to have an update on the process of implementing standards for laboratories. Once again Dr Peters could give no firm indication on implementation dates or on when laboratories would be expected to comply with the standards or on when monitoring would be undertaken, and her answers were frustratingly vague.

The Privacy Commissioner

Following discussion of the legal implications of Section 74A of the Health Act, the Commission of Inquiries Act, the Crown Law opinion on the issue and whether a way could be found for Professor Skegg to undertake his study of Gisborne women who had developed cervical cancer since 1990, the Privacy Commissioner Mr Bruce Slane took the stand. Mr Slane spoke to his submission, which took the view that if the Committee of Inquiry wanted the information that would be gained from the Skegg study, the Privacy Act would not prevent the Inquiry from obtaining it.

Following questioning of Mr Slane, Dr Peters was recalled and was cross-examined extensively on the current status of the NCSP as regards implementing standards, the production of statistical reports, monitoring and evaluation, staffing and resources for the NCSP, the implications of current health restructuring for the NCSP.

The NCSP Register

Sandra Matcham, Register co-ordinator for the NCSP, was the next witness. Ms Matcham had held this

position since 1994. Her evidence described the history of the NCSP Register including the configureation of the 14 regional databases into one national database. Cross-examination of Ms Matcham was focused on the process of entering data on the Register, its reliability and production of statistical reports.

The Cancer Register

Victoria Sheldon and James Fraser from the NZ Health information Service appeared next to answer questions about the Cancer Register and the availability of up-to-date cervical cancer data.

Teenah Handiside, who was the national cervical screening co-ordinator from 1995-96, then took the stand. Cross-examination of Ms Handiside focused on the lack of commitment within the Ministry to the NCSP, the lack of status and authority attached to the position of NCSP co-ordinator, the Ministry's failure to evaluate and monitor the NCSP, the development of laboratory standards, and policy.

Ms Handiside's at times emotional testimony added another nail to the coffin of the MoH's credibility in regards to its lack of understanding of and commitment to the NCSP and the lengths it was willing to go to in order to devolve as much responsibility as possible for the NCSP to the four RHAs. Her evidence described the constant restructuring within the Ministry, the high turn-over of staff and the resulting lack of institutional memory within the department, and it echoed the testimony given by other witnesses.

Further Evidence From Dr Linehan

Dr Brian Linehan was then recalled to give evidence, having had to be summonsed to appear and bring the additional information requested by the Inquiry. He gave evidence that in the four years from March 1996 to July 2000 MedLab Hamilton had received close to 11,000 slides from the Gisborne area of which 168 (1.5%) were found to contain high-grade abnormalities. He stated: "the report that I've just produced for you was run for the first time yesterday at my request and at considerable difficulty in order to meet the requirements of this inquiry."

He was then asked why such reports weren't generated as a matter of course by MedLab Hamilton, which also processes slides from the Bay of Plenty and Taranaki. "I think you would have to ask one of the cytopathologists that. I have no personal interest in the matter," he replied.

The Kaitiaki Group

The next witness was Ms Timaringi Huriwai, convenor of the Kaitiaki group that oversees access to data on Māori women on the NCSP Register. Ms Huriwai stated that she joined the group in November 1998 and since that time there had been eight applications to the Kaitiaki group all of which had been approved. Under cross-examination Ms Huriwai said that in her view the delay in the publication in November 1999 of data on Māori women for the year end December 1995 had nothing to do with the Kaitiaki group. However, she did acknowledge that there had obviously been delays under the previous member-ship of the Kaitiaki group, because the new group had to spend a great deal of time at their first meeting on old applications.

Another Ministry of Health Official

Dr David Lambie, Deputy-Director General, Corporate, in the Ministry of Health appeared next. His evidence described the background to the 1993 health reforms, the funding agreement negotiations, and monitoring issues.

Dr Lambie who has been employed in various management roles in the Ministry for ten years continued with the now familiar position adopted by Ministry of Health officials. He refused to accept responsibility for any of the problems revealed throughout the course of the Inquiry. Dr Lambie also proved to be a consummate master of giving lengthy replies to questions that did not answer the question put to him.

Hammering Ethics Committees

Professor Donald Evans, chairperson of the Otago Ethics Committee finally got to appear before the Inquiry. Professor Evans was there as a representative and delegate of the Regional Ethics Committees of New Zealand, which had sought leave to respond to the criticisms leveled at the ethics committees. Criticisms had focused on:

- the refusal of the Wellington Ethics Committee to give permission for the Wellington region's aggregated anonymous data to be included in the NCSP's first statistical report;
- the insistence of the Tairawhiti Ethics Committee that the women's consent must be gained (or if she had died her family's consent) for Professor

Skegg to carry out his study of the records of 61 Gisborne women who had developed cervical cancer over the past decade;
- the insistence of the ethics committees that part of the long-awaited audit of the NCSP could not proceed unless the women on the Cancer Register received a letter from the Register asking them to consent to being included in the process.

Professor Evans was questioned extensively about how the ethics committees functioned, what they based their decisions on. He was subjected to a prolonged barrage of very hostile questioning by most of the parties.

The Director General of Health

Dr Karen Poutasi, Director General of Health, then appeared briefly to answer questions about the future of the NCSP in the wake of yet another round of health system restructuring.

Inquiry Chair Ailsa Duffy made it very clear that Dr Poutasi was there to answer questions about the future of the NCSP. No questions on the history of the NCSP would be permitted.

Dr Poutasi gave the assurances asked for about the location, staffing, resourcing and auditing of the NCSP.

How much weight can be attached to her very general responses to the issues put to her remains to be seen.

The Ministry's Finale

On the final day of the Inquiry, a panel of four witnesses from the Ministry of Health appeared before the Inquiry team to answer final questions about the Ministry's role in the NCSP. They were Dr Bob Boyd and Judith Glackin who had both appeared before, and two former screening co-ordinators, Sue Dahl and Gillian Grew. They were questioned again about the Department of Health's relationship with the expert group, the failure to insist that laboratories be TELARC accredited, the lack of laboratory standards and the MoH's failure to audit and monitor the NCSP.

It was both symbolic and fitting that the Inquiry should end with the Ministry still denying responsibility for any of the failures of the NCSP. The four witnesses were staunch in their defence of the Ministry. The following response given by Ms Glackin to a question from Inquiry Chair Ailsa Duffy about the HFA's view that there was a lack of standards against which to measure the laboratories is just one example of many demonstrating their attitude.

"I think in the course of this Inquiry there's been a lot of discussion about what standards were in place. I suspect this is perhaps not a comment about the non-existence of standards so much as the Health Funding Authority's view that they needed to do this work," she said.

Final Submissions

The Inquiry then adjourned until 18 September when the lawyers as well as the non-legal representatives of the parties who had given evidence presented their final submissions to the Inquiry. An AWHC member attended for two days and reported that the focus of final submissions seemed to be on each lawyer's attempt to exonerate his or her client and point the finger of blame at the others.