REPORT FROM THE MINISTRY OF HEALTH ON THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE CERVICAL SCREENING INQUIRY 2001: NOVEMBER 2008 TO MAY 2009

Purpose

1. This report records the progress made to implement the recommendations from the *Report of the Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in the Gisborne Region*, otherwise known as the Cervical Screening Inquiry 2001. The last report on this subject was provided in February 2008 (HR 20082228 refers).

Background

2. The Inquiry report was released in April 2001. It contained 46 recommendations for future action that the Government or its agencies should consider taking.

3. The then Minister of Health accepted all 46 recommendations and directed the Ministry of Health to implement them. For implementation of the recommendations, $3.96 million was allocated from within health baselines for 2001/02 and outyears (HR 20010396 refers).

4. Recommendation 46 of the Inquiry requires a process be put in place to ensure that the recommendations are implemented. In response to this recommendation the Director-General of Health previously supplied monthly update reports to the Minister of Health. As more recommendations have been completed or become business as usual, the length of the reporting period has been increased. In 2002, monthly reports were replaced with quarterly reporting. Following the Health Report of 29 June 2006 (HR 20060237 refers) the then Minister made a decision to move to six monthly reporting.

Public Access to Reports

5. In 2000, a website was set up to keep women informed of the purpose and progress of the Cervical Screening Inquiry (www.csi.org.nz). Once the Inquiry was completed, the website was updated with reports on progress with the recommendations of the Inquiry.

6. All reports are now published on the National Screening Unit website (www.nsu.govt.nz). All previous reports have been transferred to this website and, although the Inquiry website mentioned above is still functioning, it is not updated.

Progress to Date

7. One recommendation remains to be implemented. The Ministry has implemented 42 of the Inquiry's 46 recommendations, and one recommendation has been overtaken by subsequent progress. Following due consideration, two recommendations will not be implemented.

8. The Ministry expects to complete the implementation of the final recommendation by 30 June 2009.

Recommendations Recently Implemented

9. **Recommendation 31** refers to the electronic linkages between the National Cervical Screening Programme Register and laboratories.

10. Access to screening histories on the Register is available to all laboratories that are connected to Healthlink. Currently, only one laboratory is not connected to Healthlink and is working through technical connection issues. Despite the availability of online histories, some laboratories still prefer to receive smear histories by fax from the Register.

11. The National Screening Unit prepares smear history reports listed and collated by National Health Index number daily, generated from the Register, and faxes these to laboratories that have requested them.

12. This approach is preferable for some labs, as it enables them to work from a collated list of smear histories, organised by National Health Index number, rather than having to collate these details themselves from the register.

13. **Recommendation 27** refers to the two-yearly review of the Programme's Operational Policy and Quality Standards. Updating of the Standards is an ongoing process to reflect best practice. This process is now well established and considered routine business. The Standards are available on the website and are to be updated on a regular basis to reflect changes.

Recommendation Overtaken by Progress

14. **Recommendation 33** refers to the development of a population register for the Programme. Circumstances surrounding the provision of cervical screening services have changed markedly since 2001 and there are now systems in place that were not available when this recommendation was made. Advances made in primary care registers and systems of invitation and recall have addressed many of the issues that were intended to be resolved by a population register. The Programme continues to monitor and participate in developments that will help to increase coverage. Further information is given in the previous report (HR 20082228 refers).

Recommendations Not Being Implemented

15. **Recommendation 2** refers to the re-enrolment and re-screening of all women in the event that the national evaluation throws doubt on the accuracy of high-grade abnormality reporting rates. The findings of the Cervical Cancer Audit 2004 did not support the implementation of this recommendation.

16. **Recommendation 13** refers to the management of the Programme being under the control of a second or third tier manager within the Ministry who has a specialist medical qualification in public health or epidemiology. In 2002 the National Screening Unit appointed a programme manager and clinical leader to jointly manage the Programme at the fourth tier. This decision reflected the clinical governance that is required to effectively manage a national cervical screening programme. The Clinical Leader does have specialist medical qualifications in public health, and reports to the Group Manager of the Unit. The Programme Manager reports to the Cancer Screening Manager.

Progress on Remaining Recommendations

17. **Recommendation 23** calls for the establishment of an appeal process for ethics committee decisions.

18. On 18 May, the Health Research Council announced it is implementing the proposed new appeals process for ethics committee decisions.

19. The Council Ethics Committee is now finalising the appeals process and terms of reference. The approved final documents will be made publicly available in the near future, by which time the appeal function will fully be in place.

Summary

20. Status of Cervical Cancer Inquiry's Recommendations as at March 2008:

Status of the Recommendation	Recommendation Number	Total
Implemented – has become "business as usual".	1, 3, 4, 6, 7, 8, 9, 10, 24, 25, 26, 27, 28, 29, 30, 31, 32, 37, 38, 42, 43, 45, 46,	23
Overtaken by progress	33	1
Implemented – no further work required.	5, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 34, 35, 36, 39, 40, 41, 44	19
Substantially implemented for full completion during 2009	23	1
Decision not to implement.	2, 13	2

List of recommendations

21. List of all 46 recommendations, including a brief comment on each.

Ref.	Recommendation	Comment
1.	**Evaluation of National Cervical Screening Programme.** The remaining two phases of the national evaluation designed by the Otago University Team must proceed. Until those phases are completed the Programme's safety for women cannot be known. It is imperative that this exercise is completed within the next six months. Particular attention should be given to the discrepancy between the average reporting rate of high-grade abnormalities of Douglass Hanly Moir Pathology (2.5%-3.7%) for the re-read of the Gisborne women's smear tests and the current New Zealand national average for reporting high-grade abnormalities (0.8%). Unless this exercise is carried out the possibility that the national average is flawed and that there is a systematic problem of under-reporting in New Zealand laboratories cannot be excluded.	The Ministry of Health and the University of Auckland completed a review of 371 women who had developed cervical cancer between 1 January 2000 and 30 September 2002. The *New Zealand Cervical Cancer Audit*. *Screening of Women with Cervical Cancer: 2000- 2002* (referred to as the Cervical Cancer Audit) published its findings in November 2004. The Audit found that the Programme operated to a generally high standard for women who are having regular cervical smears. It did not find systemic issues in the laboratory reading and reporting of cervical smears. The Audit made 31 recommendations, which the Ministry of Health has been addressing.
2.	**Re-enrolment and re-screening of women.** If the national evaluation throws doubt on the accuracy of the current national average then the Committee recommends that all women who are or who have participated in the programme should be invited to re-enrol and offered two smear tests 12 months apart. Women who have never enrolled on the Register or who have had their names removed from the Register should be invited through notices in the print media to also go through the process of having two smear tests twelve months apart.	This recommendation will not be implemented, as there was no indication from the Cervical Cancer Audit that recommendation 2 needs to be responded to.

Ref.	Recommendation	Comment
3.	**Evaluation of National Cervical Screening Programme.** A comprehensive evaluation of all aspects of the National Cervical Screening Programme, which reflects the 1997 Draft Evaluation Plan developed by Doctors Cox and Richardson, should be commenced within 18 months. This exercise should build upon the three phase evaluation referred to in recommendation one.	Parts 5, 6 and 8 have been included within the scope of Part 3 (Cancer Audit) – see recommendation 1 above. Parts 4, 7 and 10 are included within the scope of Programme Statistical Reporting. Refer also to recommendation 7 below.
4.	**Operational Policy and Quality Standards, and Evaluation and Monitoring Plan.** The Policy and Quality Standards for the National Cervical Screening Programme and the Evaluation and Monitoring Plan for the National Cervical Screening Programme prepared by Dr Julia Peters and her team must be implemented fully within the next 12 months.	The Standards were implemented in October 2000. An Independent Monitoring Group is contracted to provide quarterly and annual monitoring reports until January 2009. Independent Monitoring is now six monthly and undertaken by the National Cervical Screening Programme Advisory Group.
5.	**Full legal assessment of Operational Policy and Quality Standards.** There needs to be a full legal assessment of the Policy & Quality Standards for the National Cervical Screening Programme and the Evaluation and Monitoring Plan for the National Cervical Screening Programme to ensure that the requisite legal authority to carry out these plans is in place.	A report from Kim Murray (Barrister) was provided to the National Screening Unit in December 2001.
6.	**Legal assessment of National Cervical Screening Programme Authority.** The National Cervical Screening Programme should be thoroughly evaluated by lawyers to determine whether or not those persons charged with tasks under the Programme have the necessary legal authority to discharge them.	This issue was also included in the report from Kim Murray (Barrister) provided to the National Screening Unit in December 2001.
7.	**Statistical Reporting.** The National Cervical Screening Programme should issue annual statistical reports. These reports should provide statistical analysis to indicate the quality of laboratory performance. They should also provide statistical analysis of all other aspects of the Programme. They must be critically evaluated to identify areas of deficiency or weakness in the Programme. These must be remedied in a timely manner.	A statistical report for 1996-98 was published. *Cervical Screening in New Zealand: A Brief Statistical Review of the First decade* was published in February 2005. Six monthly and Annual Monitoring Reports against national indicators and targets are also produced and any issues are followed up by the Programme.

Ref.	Recommendation	Comment
8.	**Regular Statistical Information.** Meaningful statistical information should be generated from both the National Cervical Screening Register and the Cancer Registry on a regular basis. Attention must be paid not only to laboratory reporting rates but also trends and the incidence of disease, assessed by regions that are meaningful to allow some correlation between reporting profiles of laboratories and the incidence of cancer. Because cervical smear tests may be read outside the region in which the smear test is taken, a recording system needs to be devised which identifies the region where smears are taken.	See recommendation 7. It is the considered opinion of the National Screening Unit and University of Otago that it is not currently possible to correlate laboratory reporting with regional incidence of cervical cancer in New Zealand. The implementation of regional National Cervical Screening Programme contracted laboratories in 2009 may enable this recommendation to be met and will be included in the review of national targets and indicators.
9.	**Minimum Standards for Cytology Laboratories.** The compulsory setting of a minimum number of smears that should be ready by laboratories each year must be put in place. The proposal to impose three minimum volume standards on laboratories must be implemented. These are: each fixed site will process a minimum of 15,000 gynaecology cytology cases, each pathologists will report at least 500 abnormal gynaecological cytology cases, cytotechnical staff must primary screen a minimum of 3,000 gynaecological cytology cases per annum. This should be implemented within 12 months.	District Health Board and National Cervical Screening Programme Laboratory Agreements began incorporating minimum volume standards from July 2001. All laboratories have been meeting the minimum volume standards since December 2005.
10.	**Balanced Approach for National Cervical Screening Programme.** There needs to be a balanced approach, which recognises the importance of all aspects of the National Cervical Screening Programme. The emphasis on smear-taking and increasing the numbers of women enrolled on the Programme needs to be adjusted.	The Programme now has a more balanced approach.
11.	**Culture of the National Screening Unit.** The culture which was developing in the Health Funding Authority regarding the management of the National Cervical Screening Programme under the management of Dr Julia Peters needs to be preserved and encouraged now the Health Funding Authority has merged into the new Ministry of Health.	Communications Strategies are in place. It is now time for the National Screening Unit's strategic plan to be renewed, and this plan is in development. A specific strategic plan for the Programme is also nearing completion.
12.	**Management of the National Cervical Screening Programme.** The National Cervical Screening Programme must be managed within the Ministry of Health as a separate unit by a manager who has the power to contract directly with the providers of programme on behalf of the Ministry. The programme's delivery should not be reliant on the generic funding agreements the ministry makes with providers of health services. For this purpose the unit will require its own budget.	The National Screening Unit was established July 2001 and has the delegated power to contract directly with providers of the programme.

Ref.	Recommendation	Comment
13.	**Management of the National Cervical Screening Programme.** The National Cervical Screening Programme should be under the control of a second or third tier manager within the Ministry. The Manager of the unit should hold as a minimum specialist medical qualification in public health or epidemiology. As a consequence of the Programme's link with the Cartwright Report it has always had a female national co-ordinator. While there are understandable reasons for having the Programme managed by a woman it is not necessary for cervical screening programmes to have female managers. The cervical screening programme in New South Wales is managed by a male medical practitioner. The time has arrived for the National Screening Programme to be treated as a medical programme which is part of a national cancer control strategy. In the past its link with the Cartwright report has at times resulted in its purpose as a cancer control strategy being compromised for non-medical reasons.	In 2002 the National Screening Unit appointed a programme manager and clinical leader to jointly manage the Programme at the fourth tier. This decision reflected the clinical governance that is required to effectively manage a national cervical screening programme. The Clinical Leader does have specialist medical qualifications in public health, and reports to the Group Manager of the Unit. The Programme Manager reports to the Cancer Screening Manager.
14.	**Amend section 74 of the Health Act 1956.** The Health Act 1956 should be amended to permit the National Cervical Screening Programme to be effectively audited, monitored and evaluated by any appropriately qualified persons irrespective of their legal relationship with the Ministry. This requires an amendment to section 74A of the Health Act to permit such persons to have ready access to all information on the National Cervical Screening Register.	The Amendment to the Health Act 1956 contains provisions to permit the effective monitoring, audit and evaluation of the Programme.
15.	**Kaitiaki Regulations.** There needs to be reconsideration of the Kaitiaki Regulations, and the manner in which those regulations currently affect the Ministry of Health gaining access to aggregate data of Māori Women enrolled on the National Cervical Screening Register. The Ministry of Health and any appropriately qualified persons engaged by it (be they independent contractors, agents or employees) require ready access to the information currently protected by the Kaitiaki Regulations in order to carry out any audit, monitoring or evaluation of the Programme.	On 25 June 2002, Cabinet decided to retain the status quo.
16.	**Legal right to access information from the Cancer Register.** The present legal rights of access to information held on the Cancer Registry need to be clarified. The Ministry and any appropriately qualified persons it engages to carry out (external or internal) audits, monitoring, or evaluation of cervical cancer incidence and mortality require ready access to all information stored on the Cancer Registry about persons registered as having cervical cancer.	The Amendment to the Health Act 1956 contains provisions to permit screening programme evaluators to access all information on the Cancer Registry that relates to a relevant woman.

Ref.	Recommendation	Comment
17.	**Amend Health Act 1956 to enable access to medical files.** The Health Act 1956 requires amendment to enable Ministry of Health and any appropriately qualified persons it engages to carry out (external or internal) audits, monitoring or evaluation of cervical cancer incidence and mortality to have ready access to all medical files recording the treatment of the cervical cancer by all health providers who had a role in such treatment.	The Amendment to the Health Act 1956 contains provisions to permit the effective monitoring, audit and evaluation of the Programme.
18.	**Change guidelines under which ethics committees operate.** There needs to be change to guidelines under which ethics committees operate to make it clear that any (external and internal) audit, monitoring and evaluation of past and current medical treatment does not require the approval of ethics committees.	The Operational Standards for Ethics Committees have been amended.
19.	**Review of operations of ethics committees.** There should also be a review of the operation of ethics committees and the impact their decisions are having on independently funded evaluation exercises and on medical research generally in New Zealand.	Ethics committees have been reviewed and a new ethics committee structure put in place. The National Ethics Advisory Committee undertook this work over 2002/03, and culminated in the presentation of advice to the Minister of Health in December 2003 (refer to Health Report 20045250). The Ministry has implemented almost all of the National Ethics Advisory Committee's recommendations.
20.	**Provide guidelines to ethics committees regarding Privacy Act & Code.** Ethics Committees require guidance regarding the application of the Privacy Act and the Privacy Health Information Code. Ethics Committees need to be informed that the interpretations of legislation relating to personal privacy are for the agency holding a patient's data to decide. They would, therefore, benefit from having at least one legally qualified person on each regional committee.	The Operational Standards for Ethics Committees have been updated, see also recommendation 18 above.
21.	**Guidelines to ethics committees for observational studies.** Ethics committees require guidance regarding the weighing up of harms and benefits in assessing the ethics of observational studies.	The guidelines were released in December 2006.
22.	**National ethics committee – multi-centre studies.** A national ethics committee should be established for the assessment of multi-centre or national studies.	A national multi-region ethics committee was established in December 2004.

Ref.	Recommendation	Comment
23.	**Appeal process for ethics committee decisions.** The procedures under which ethics committees operate need to be re-examined. Consideration should be given to processes to allow their decisions to be appealed to an independent body.	The Health Research Council has announced it is implementing the proposed new appeals process. The Council Ethics Committee is finalising the appeals process and Terms of Reference. The approved final documents will be made publicly available in the near future and will be distributed widely.
24.	**National Cervical Screening Programme Complaints System.** The National Cervical Screening Programme requires its own system to deal with complaints regarding the Programme's delivery. It also needs to have in place a user-friendly system which can respond to complaints of Programme failures, such as under-reporting. The difficulty that witness A experienced in having her medical misadventure recognised as a failure of the Programme and a failure of Gisborne Laboratories must be avoided in the future.	The National Screening Unit complaints process has been implemented. See also recommendation 45.
25.	**Electronic Link Cancer Registry & National Cervical Screening Programme Register.** The National Cervical Screening Register needs to be electronically linked with the Cancer Registry.	A process for linking and matching data has been implemented.
26.	**Performance Standards for National Cervical Screening Programme Register and Cancer Registry.** Performance standards should be put in place for the National Cervical Screening Register and the Cancer Registry. The currency of the data on both Registers needs to be improved. The Cancer Registry should be funded in a way that enables it to provide timely and accurate data that is meaningful.	A new chapter of the Operational Policy and Quality Standards 'Providing a Regional Service' was completed in July 2003. The chapter includes performance standards for the Register. The new chapter was included in the District Health Board Agreements from 2003/04.
27.	**Standards for the National Cervical Screening Programme should be reviewed every two years.** Standards for the National Cervical Screening Programme should be reviewed every two years and more frequently if monitoring indicates that some of the standards are inappropriate.	Updating of policy and quality standards is an ongoing process to reflect best practice. This process is now well established and considered routine business. The Operational Policy and Quality Standards are available on the website and are to be updated on a regular basis to reflect changes.

Ref.	Recommendation	Comment
28.	**The Government must ensure sufficient cytotechnologists and cytopathologists and training sites.** The Government in consultation with other bodies or agencies needs to ensure that there are sufficient trained cytotechnologists and cytopathologists and that there are appropriate training sites for them. There should also be a review of training requirements and maintenance of competence of smear test readers and cytopathologists.	The Vocational Registration Programme in Cervical Cytology has been implemented. Canterbury Health Laboratory (Canterbury District Health Board) has been appointed as the Cytology Training Service Implementation of National Screening Unit Workforce Development Strategy and Initiatives commenced and ongoing.
29.	**Amend Medical Laboratory Technologists Regulations 1989.** The Medical Laboratory Regulations 1989 should be amended to permit only registered medical practitioners with specialist qualifications in pathology and appropriate training in cytopathology or appropriately trained cytoscreeners to read cervical smear tests.	The Health Practitioners Competence Assurance Act 2003 was passed. The Act contains provisions that will give effect to the intent of the recommendations from the Inquiry including the establishment of new registration authorities and the development of gazetted scopes of practice.
30.	**Impose legal obligations on storage of slides.** Legal obligations in addition to those mandated by IANZ must be imposed on all laboratories reading cervical cytology requiring them to retain records of patients' cytology and histology results (including slides, reports and any other material relating to the patient) in safe storage for a period of no less than five years from the date on which the results were reported. Secondly all laboratory owners must be made legally responsible for ensuring that a patient's records are readily accessible and properly archived during the five year storage period irrespective of changes in the laboratory's ownership through a sale of shares or a sale of the laboratory's business. The vendor of the shares or the laboratory's business should carry a primary legal responsibility to store the records, though the option to transfer this legal responsibility as a condition of the sale to the purchaser should be permitted. Similar provisions should apply to laboratory amalgamations. In this case the newly merged entity should be responsible for storing the records.	The archiving requirements given in Chapter five of the Operational Policy and Quality Standards exceed the requirements of a minimum of five years. Beyond the requirements of the Standards, laboratories must keep slides and tissue in accordance with current guidelines recognised by IANZ. Routine diagnostic testing has been excluded from the Standard for the Non-Therapeutic Use of Tissue.
31.	**Ensure electronic linkage between National Cervical Screening Register and Cytology Labs.** The cervical smear test and histology histories of women enrolled on the National Cervical Screening Register should be made electronically available online to all laboratories reading cervical cytology.	Access to screening histories on the Register is available to all laboratories that are connected to Healthlink. Currently, only one lab has elected not to belong to this service. Despite the availability of the online histories, some laboratories still prefer to receive smear histories by fax from the National Screening Unit.

Ref.	Recommendation	Comment
32.	**Develop Standards for accuracy of laboratory coding.** Standards must be developed for ensuring the accuracy of laboratory coding and this aspect of the National Cervical Screening Register must be subject to an appropriate quality assurance process.	Bethesda 2001 (a systematic method of reporting cervical smear results for laboratories) was implemented in July 2005. Laboratory coding is standardised throughout the country and will be updated as part of some Ministry of Health projects. See also recommendation 27.
33.	**The National Cervical Screening Programme should develop a population-based register.** The National Cervical Screening Programme should work towards developing a population based register and move away from being the utility based register that it is now.	This recommendation has been overtaken by progress. Advances made in primary care registers and systems of invitation and recall have addressed many of the issues that were intended to be resolved by a population register. The Programme will continue to monitor and participate in developments that will help to increase coverage.
34.	**Legal mechanisms should be in place to allow the ACC, Medical Council and the Health & Disability Commissioner to share relevant information with the National Cervical Screening Programme.** There should be a legal obligation on the Accident Compensation Corporation, the Medical Council and the Health and Disability Commissioner to advise the National Cervical Screening Programme's manager of complaints about the professional performance of providers to the Programme when complaints are made to those various organisations about the treatment of a patient in relation to the Programme.	The Accident Compensation Corporation is required to report complaints to the Medical Council under the Injury Prevention, Rehabilitation, and Compensation Act 2001. Under the Health and Disability Commissioner Amendment Act 2003, the Health and Disability Commissioner may refer a complaint to the Director-General of Health if it appears that the complaint is a result of inadequacies of the healthcare provider that may harm the health and safety of the public. Under the Health Practitioners Competence Assurance Act 2003, the Health and Disability Commissioner is required to raise with the Medical Council matters where there is a potential risk of harm to the public from a health practitioners' practice. In addition, under the Health Practitioners Competence Assurance Act 2003, the Medical Council must inform the Director-General of Health of possible harm posed by the health practitioner.

Ref.	Recommendation	Comment
35.	**Medical Tribunal to supply information to National Cervical Screening Programme.** Consideration should be given to the addition of an express requirement in the provisions governing medical disciplinary proceedings which would oblige the Tribunal seized of the facts of any given case specifically to consider whether there are any grounds for concern that there may be a public health risk involved. If that concern is present the Tribunal should be required to inform the Minster of Health.	This recommendation is covered by the comments on recommendation 34 above.
36.	**The Accident Compensation Corporation and the Medical Council should exchange relevant information regarding claims for medical misadventure.** There should be an exchange of information between the Accident Compensation Corporation and Medical Council regarding claims for medical misadventure and disciplinary actions against medical practitioners.	Implemented through the Injury Prevention and Rehabilitation Act 2001.
37.	**Liaison with the College of Pathologists.** It is recommended that the Programme liaise with the Royal College of Pathologists of Australia. In its submissions the Royal College advised that it believed that the collaborative relationship the college had with the Federal Government in Australia might be a model worth consideration by the Inquiry. It was suggested that it was appropriate to use medical colleges as an over-arching body to provide advice on issues. The benefit of this is, if the College is asked to provide an opinion on issues such as professional practice, quality or standards, it has access to the views from multiple professionals and also a critical evaluation of current literature in contemporary standard practices. It is suggested that the National Cervical Screening Programme, which has achieved a great deal, would benefit from greater professional input at a College level. In particular, it is suggested that a National Cervical Cancer Register and a Cervical Cancer Mortality Review process be a means of continually evaluating the Programme's effectiveness. The Committee supports the College's submission and recommends that it be acted upon.	Regular meetings are held with the Royal College of Pathologists.
38.	**Information to Women.** The Programme must provide women with information to enable them to make informed decisions about screening and provide them with information regarding potential risks and benefits. Until the Programme has been monitored and evaluated in accordance with the current three phase national evaluation the Programme has an obligation to inform women that the quality of the performance of some of its parts has not been tested. Women should also be informed that screening will not necessarily detect cervical cancer.	This information is available, and actively provided to women. Resources have been updated for the Amendment to the Health Act 1956.

Ref.	Recommendation	Comment
39.	**Letters to Medical Practitioners.** Medical practitioners need to be reminded that cervical smear tests are not a means of diagnosing cervical cancer. They need to be alert to signs of cervical cancer, and they should not place too much reliance on a patient's smear test results to discount the possibility of cervical cancer being present.	Letter sent December 2001. An article was published in the June 2006 edition of Screening Matters.
40.	**Appropriately trained personnel should do cervical screening.** Primary screening of cervical smears should only be performed by individuals who are appropriately trained for that task. Consideration should be given to requiring pathologists to train as cytoscreeners if they want to function as primary screeners.	Primary screening policies and standards are covered in the Operational Policy and Quality Standards. Pathologists are specifically excluded from primary screening. Refer also to 28 above.
41.	**All pathologists undertaking cytology should be appropriately trained.** If cytology is a significant component of a pathologist's practice then he or she must participate in continuing medical education in that subject.	Pathologist continuing education requirements are covered in the Operational Policy and Quality Standards.
42.	**Cytopathologists must participate in continuing education in cytopathology.** If cytology is a major component of a pathologist's practice, it is desirable that he or she should have added qualifications in cytopathology; either a fellowship slanted towards cytopathology or a diploma in cytopathology. Consideration should be given to making this a mandatory requirement.	Pathologist qualification requirements are covered in the Operational Policy and Quality Standards. These policies and standards are made mandatory through the agreements with the laboratories. The Health Practitioners Competency Assurance Act 2003 also enforces qualification requirements.
43.	**Pathologists ought to be more open-minded.** Pathologists should be more open minded and critical of laboratory performance. They should be alert to the possibility that their practice or the practice of their colleagues may be sub-optimal.	Pathologists have demonstrated their open-mindedness through participation in advisory and working groups, and participation in external quality assurance programmes.
44.	**The Medical Council should ensure that systems are in place to support the early reporting of errant medical practitioners by their colleagues.** The Medical Council should ensure that systems are in place whereby medical practitioners are not deterred from reporting to it their concerns about the practice of an individual medical practitioner. Complainants should be assured that their reports will not result in them being penalised in any way.	The recommendation has been given effect by the Health Practitioners Competence Assurance Act 2003. Section 34 of the Act protects health practitioners who report concerns about other health practitioners from civil or disciplinary proceeding, unless the reporting was done in bad faith.
45.	**National Cervical Screening Programme should have a system for identifying deficiencies.** The screening programme should have in place a system over and above the audit of monitoring reports, to identify deficiencies in the process. A form of survey of users so that they can be proactive rather that reactive in the delivery of the programme would be useful.	The National Screening Unit complaints process has been implemented. User feedback is received through advisory and working groups. See also recommendation 24.

Ref.	Recommendation	Comment
46.	**There should be a process for monitoring the implementation of the Committees Recommendations.** A process to ensure that the recommendations made by the Committee are implemented should be put in place.	Reports on the Ministry's progress in implementing the recommendations include: • Dr McGoogan's six-Month Report (December 2001). • Dr McGoogan's second and final report (June 2003). • Office of the Controller and Auditor-General first report (14 February 2002). • Office of the Controller and Auditor-General second report (8 December 2003). Section 112O of the Amendment to the Health Act 1956 requires that the programme is independently reviewed at least once every three years. The Ministry of Health also provides the Minister of Health with six-monthly updates, detailing progress made on the recommendations.