

keynote address  
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*Revisiting the Cartwright Inquiry*

Her Excellency Dame Silvia Cartwright  
 Governor General, New Zealand

*In 1987 and 1988, Dame Silvia was Chair of the Commission of Inquiry into the Treatment of Cervical Cancer and Other Related Matters at National Women's Hospital, customarily known as the Cartwright Inquiry.*

**Introduction**

Although the title of my speech today is 'Revisiting the Cartwright Inquiry' it is necessary at the outset to make it clear that what I have to say is in no way a comment on any part of my Report. For all its weaknesses or strengths it stands as the only authoritative response to the nine Terms of Reference that I was asked to rule on in 1987 and 1988.

I intend today to reflect from a distance of greater knowledge, wisdom, personal maturity, and with the advantage of all that has happened since on some of the issues raised during the course of the National Women's Inquiry.

First, I think it may be of interest to look back at what I was asked to respond to. Without detracting from these Terms of Reference let me summarise them:

1. Was there inadequate treatment of carcinoma in situ and if so, what were the reasons for that?
2. Was there a research programme into the natural history of CIS, and if so, was it approved by anyone before it began, and did patients know they were participants and, were there any expressions of concern about the research programme considered or investigated?
3. Is there a need to contact women who have been referred to or treated for CIS?
4. Were there adequate procedures for the approval of

research and/or treatment, and were patients' rights protected?

5. Are any improvements needed for the protection of patients participating in research or treatment?
6. What about informed consent?
7. What training in this condition is given to medical students and practitioners? Is there a need to improve this training or to retrain?
8. What is the nature of relationships between the academic and clinical units?
9. What else is relevant to the detection and treatment of cervical cancer and pre-cancerous conditions of the genital tract?

Imagine, for a moment, that you were a 43-year-old woman who had been a Family Court Judge for five years, who had never undergone any obstetrical or gynaecological treatment personally – not even, I must emphasise, a smear test. Then stand back and look at the breadth and complexity of these Terms of Reference.

I anticipate that those of you with medical training would be horrified at the task ahead. Let me reassure you. I knew little about medicine, was a little vague about the difference between obstetrics and gynaecology, and had not read the article in the

Metro magazine because of a dislike for matters medical. Consequently, I was not too worried.

Let me also reassure you. Until the evidence began to unfold I was certain that this was a storm in a teacup, a welcome break from the grind of coping with the drama and tragedy that is the daily diet of a Family Court Judge. I expected this to be a brief, interesting, and anonymous exercise.

### **What is a Commission of Inquiry?**

First, it is necessary to explain briefly what the basic role of a Judge is. It is best summed up in the Judicial Oath. Judges promise at swearing in, to 'do justice to all people without fear or favour, affection or ill will'. In courtrooms all round the country Judges listen daily to all of the evidence presented to them and rule impartially. They work hard to observe the rules of natural justice, to ensure that not only are their decisions just, but the public accepts that they are just. It is necessary to explain why a decision has been reached. Consequently the most important part of a Judge's job is not to give the decision, but to give the reasons for the decision.

It is also necessary to be alert constantly for any personal bias perhaps based on personal views or distaste for a particular witness or party to litigation. Generally Judges hear only the evidence the parties wish to present to the Court.

All of these qualities are required in a Commissioner of Inquiry. But the job is slightly different. As is obvious, the Judge's role is to inquire into events, often to take the initiative in following up lines of inquiry, and certainly to control the evidence that is put before the inquiry to ensure that it is relevant and that it will allow the Judge to reach an informed and impartial decision on the terms of reference.

So the Judge's role as a commissioner of inquiry is a much more active one. In the course of this Inquiry I read widely, often from material supplied to me by my medical advisers. I visited various hospitals. I heard the evidence of witnesses in Australia who could not or would not come to New Zealand. Through my lawyers and doctors appointed to assist me, I followed up leads and was provided with information from a vast array of sources, including the more than 3,000 patient files which were relevant to the Inquiry.

There is a subtle difference between a humble District Court

Judge, as I was then, conducting a Commission of Inquiry, and one conducted by a Judge of the High Court. A High Court Judge has far greater powers. Unlike a Judge of the High Court, I could not punish for contempt of the Commission. Consequently my job was that much more difficult.

I was obliged to control the proceeding without having any real powers to enforce my directions. Fortunately for the good conduct of the Inquiry, while I am certain that the very skilled lawyers representing various parties were well aware of the limitations on my powers, no major attempt was ever made to take advantage.

This is not to say that I was always treated with the courtesy that would normally be accorded to a Judge. It was clear to me from the outset that I had to earn the respect of counsel, and of the parties. Whether I did or not was immaterial to me personally, but even with my relatively brief judicial experience, I was well aware that it could make all the difference to the comfort of the witnesses and to the quality of the outcome.

### **The Process**

Imagine again that you have been asked to undertake say, a difficult medical or surgical procedure. You have been given a small number of qualified personnel to assist. But you have to find the rest personally, ensure that premises are located and equipped, calm the fears of the patient and her family, and do all this urgently because lives may depend on it.

Imagine, too, that you are still part-way through an existing procedure which no one can take over from you and that you cannot even begin this task until you travel back from New Plymouth to Auckland several days later. Moreover, the skilled personnel who have been assigned to assist are completely unknown to you – you have never worked with any of them before.

That, in short, was the initial task for me, to set up effectively a Courtroom but not in any Court building with any trained Court personnel, and to locate and persuade specialised assistance from all around the world to come to New Zealand for what was thought to be a short period of time and help me conduct a Commission of Inquiry.

Of course, I could write a book on that experience alone. I do recall frantically making international telephone calls from

the toll-barred phone in my Chambers at the District Court in Auckland, persuading the retired and, I believe, stroke-affected civil servant assigned to me to run the administration, at least to get me an electric jug so I could have a cup of coffee.

I recall finding premises, drafting rules of procedure, ensuring that advertisements calling on patients and former patients to come and talk to me were placed in relevant periodicals. And above all, I recall hurrying from my Chambers in the District Court, down to the newly acquired Commission of Inquiry rooms to walk in to the first day's meeting between counsel, the parties and me, and being horrified by the number of lawyers present.

I recall not being able to see a single woman, apart from the two counsel assisting me and one other woman lawyer, anywhere in the room. They were there, but hidden behind the 'professionals'. I recall, too, having a discussion with the then Minister of Health concerning the availability of legal aid for some of the parties and explaining, as carefully as I could, that I was unable to prohibit lawyers from being present.

I recall the huge media presence and the way in which some had no hesitation in photographing me from behind my desk as I walked towards my chair.

It was therefore essential that I lay down clear rules of procedure for counsel, for the admission of parties to the Inquiry, for where everyone would sit, for where the media would film and photograph from, to ensure the privacy of women patients and their relations, while at the same time abiding by my directions which were to hold an open, public inquiry.

One of the first difficulties was obtaining the relevant files from National Women's Hospital. The Hospital was unwilling to provide them and, indeed, had two of its specialist gynaecologists taken off all other duties to work through the files to prepare the Hospital Board's defence. It became necessary, under the Hospitals Act, to seek a Gazette Notice from the Minister of Health requiring the Hospital to give me copies of the files.

Of course, that then meant that I had to find staff and photocopiers to photocopy every slip of paper on more than 3000 files, many of which went back 10, 15 and 20 years.

The legal process was also complex. Lawyers are, however, accustomed to negotiating such matters and arranged an order of priority for questioning witnesses. Counsel assisting me arranged the order in which the witnesses would be called and the witnesses themselves determined how long they would remain in the witness box. For that depended entirely on how quickly they were prepared to answer questions put to them.

I have always thought lawyers were prolix, but I had never dreamed that the medical profession would exceed even their worst efforts. That is why one of the central figures in the Inquiry was in the witness box for nine days. He simply would not answer a question directly.

That is not to say that there are not difficulties with the legal profession. One very senior lawyer who represented a party with a cameo, but important role in the Inquiry, came only for a small portion of the proceeding. Clearly very grumpy and considering it undignified to pay much respect to a Judge of the District Court, he refused to stand when he spoke to me, incurring the great wrath of counsel assisting. Moreover he would loudly make derogatory comments that, for example, the whole Inquiry was a waste of taxpayers' money.

In this he was often joined by an Opposition Member of Parliament, also a lawyer, who occasionally came into the Inquiry room, stood talking to this lawyer with his back to me. All of these are gravely disrespectful of the Bench, if not of me personally.

Using my much exercised skills as a mediator in the Family Court, I finally managed to persuade the senior lawyer to behave himself in public when, much to my consternation, as soon as the Inquiry resumed, one of the other lawyers on behalf of all the profession present, stood in front of the television cameras and made a lengthy condemnatory speech concerning his colleague's behaviour.

### **The Patients**

It is a well known phenomenon that when speaking in public about a matter which has been stressful, even the most controlled individual will sometimes display emotion. So it was that when the Inquiry ended and my Report was presented publicly at a press conference in the Beehive there was a distinct quiver in my voice and tears in my eyes when I said 'I will never forget the patients'.

That is not entirely true – many of the women I met are now but hazy memories to me. But many more I recall clearly down to the way they looked, the extent of their disease, how they spoke of their family, and how they were coping with what was for most, a sudden revelation that, in fact, they had long had a cancer precursor or now, invasive cancer.

This was a particularly trying part of the Inquiry. Informed consent was not a well developed concept at National Women's Hospital. One or two of the women intuitively felt that there was something more wrong with them than they were being told. The vast majority, however, genuinely believed that they were in danger of contracting this disease but were being monitored to ensure that there was no need for any treatment.

Those who already had invasive cervical cancer and did not know it were a particular challenge. It was necessary for me to balance the needs of those women against my judicial duty to ensure that all information was made available to the parties to the Inquiry. Moreover it was not appropriate for me, a Judge, to tell them of their medical condition.

I developed two strategies. First, when my medical advisers had, through reading her file, located a patient who was coming to see me, and whose condition required immediate assessment and treatment, I would ask her, after giving her evidence to me in private, to meet the clinical medical adviser, Professor Eric Mackay. What he said to those women in the privacy of his room I do not know for sure. But I am certain that each of them more clearly understood the nature and extent of her condition and was guided towards the appropriate assessment and treatment.

The second strategy involved isolating the files of those women, whether I had met them or not, who required immediate assessment and treatment in the opinion of my medical advisers, providing the Minister of Health with full details confidentially, and asking him to trace them urgently. This was all done without notifying any of the parties to the Inquiry lest an argument be mounted that I was making a predetermination before all evidence had been heard.

Let me describe my reaction to the women patients I met. They were, of course, from widely differing backgrounds, cultures, and age groups. There were older women who took

a motherly approach to me, reassuring me as if it were their duty that there was nothing wrong with them and they had always received the best possible care at the Hospital.

There were women in their 30s and 40s many of whom had suffered broken relationships at least in part because of the drain on the family emotionally and financially, of constant visits to the Hospital often from very long distances. There were women who could no longer have sexual relationships with their partners, there were women who now knew they were dying and were worried about their children. There were women who were dealing positively with their lives, there were poor women, there were women who did not understand English sufficiently to comprehend what they were being told.

Listening to their experiences as part of the evidence heard privately in my room, counsel assisting and I were frequently overcome with grief for what they had experienced and would experience in the future. The assistant who typed back the tapes would herself be in tears and when evidence about these women was heard in public in the Inquiry room there were a number of occasions when everyone in the room, including the members of the press, were overcome with sadness.

I was not fully aware of it at the time but there are international standards developed over many years, particularly through the United Nations, for the treatment of patients and for the protection of their rights. Most in the medical profession will be very familiar with the standards that I referred to in the Report – the Declaration of Helsinki is one example. But when one examines all of these international standards it is clear they have been developed so that patients' humanity is respected.

And what was so overwhelming to me and to those assisting me and many of the parties and lawyers at the Inquiry was that these women's humanity was not respected. They were not treated as intelligent, autonomous human beings entitled to a say in their health care and well able to make informed decisions which took into account all the factors which were important to them, such as their family responsibilities, their financial position, what sort of treatment, if there were a choice, whose side effects would be preferable to them.

It was noticeable that many of the women who were included in the idiosyncratic treatment and research were in a vulnerable socio-economic group. They lacked the resources of a good

education, adequate income, family support, or even language which would help them challenge their management. Often they were treated patronisingly and with little respect for the impact that the treatment or research would have on their lives and their families'. Decisions were made for them with little or no consultation.

And yet it remains my view that the generosity of these women and their families, and their concern for the well being of others would have ensured that many would willingly have agreed to be included in the research provided it was fully explained to them and that it was scientifically and ethically valid. The profession lost so much credibility amongst women because they did not respect their basic rights as human beings.

The Inquiry was significant not only because of the idiosyncratic treatment or research but also because it uncovered appalling abuse of or indifference to the human rights of women. Internationally there is an increasing understanding that women's invisibility or their low status or importance in the community has a detrimental impact on their health and that of their families. This has led to health policy treatment or research which has paid insufficient attention to women's rights to adequate treatment, to give informed consent, to be entitled to privacy and confidentiality; all issues which arose in the Commission of Inquiry back in 1987 and 1988.

Several years after the Inquiry I was elected to a United Nations Committee concerned with international human rights of women. During that time I thought often of the lessons I learned during the National Women's Inquiry, and much that I learned there has been applied to the development of better human rights' policies concerning health care for women in all parts of the world.

### **The Medical Profession**

Of course the most obvious comments relate to the way in which one man with a hypothesis he wished to prove was, for many years, able to continue his research without effective intervention by his colleagues.

The damage was so much the greater because National Women's Hospital played such an influential role in dissuading successive Governments from introducing a national cervical screening programme producing evidence that following

women with suspected CIS had not reduced the rates of invasive cancer in New Zealand.

The critical omitted fact was that many of the women had not been treated; their condition might have been detected, but without treatment naturally the rates of cervical cancer would not reduce markedly. And even worse, was that this approach to the treatment of pre-cancerous lesions was taught not only to a generation of medical students, but also to some foreign students who exported these views to their own countries.

Medical colleagues' ethical obligations are explored in some detail in the Report and I will not repeat them here, except to say that Dr Alistair Campbell's evidence that doctors often 'confused etiquette with ethics' summed it up for me. There has always been a strong loyalty amongst medical colleagues and that is proper and advantageous to the practice of medicine.

When it impacts on the safety of patients, however, the doctor's duty is clear. His or her first responsibility is primarily to the patient and only secondly to the colleague. This is a counsel of perfection and every profession grapples with how to deal with 'whistle blowers' or with standards that palpably are not as high as they should be.

And it is necessary to emphasise that as I sat listening to the evidence of doctor after doctor, and considered the ethical implications of what had occurred, I did begin to understand that after years of practice in an atmosphere where patients, (or as with lawyers and judges, clients and litigants) respect and even fear the professional, it is not easy to remain humane.

The lawyer who does not adequately explain a range of remedies to a client, the Judge who bullies the witness, the doctor who is godlike in directing the patient – these are all familiar figures and all to be deplored.

What I could never come to terms with, however, was the lack of empathy of some of the doctors for the suffering of the individual women and the arrogance of some of those doctors who appeared before me. I am the first to concede that I knew little about medicine and nothing about obstetrics and gynaecology when I began the Inquiry. But Judges do not have expertise in every subject under litigation.

Whether Judges are called upon to preside over a murder trial,

rule on liability when a bridge collapses, untangle a complex commercial web of company law, or even mediate between parents over the custody of their children, Judges do not have at their fingertips expertise on the subject matter of the trial. That is not their job.

As I have said, it is the responsibility of Judges to listen to the evidence, weigh it and reach determination and the National Women's Inquiry was no different in this regard.

But I must say by the end of the Inquiry I felt I had been patronised with great expertise, sometimes even to the extent of having words spelt for my benefit. Whether that would have occurred had the Commissioner been a male Judge is something I could only speculate about.

At a personal level I have had many amusing moments since the Inquiry concluded. For example, the day after I had presented my Report I had an appointment for a mammogram. The night before, television, newspapers and radio were full of stories about the lack of privacy and dignity afforded to women patients at the hospital. My mammogram over, I was beginning to dress myself again behind the curtain in the tiny cubicle at the clinic when the doctor flung open the curtain, revealing my semi-naked form to an interested waiting room and said 'Your mammogram is fine, you can go home now'.

Then, when my husband chaired the Medical Practitioners Disciplinary Tribunal, one of his medical Tribunal members remarked once 'There is only one thing wrong with you and that is your surname'.

### **The Impact on Me Personally**

When I began to understand the significance of the Inquiry shortly after the evidence and submissions began, I brought to my Chambers a copy of Justice Mahon's Report in the Erebus Royal Commission. A few years earlier the Privy Council had upheld a ruling of the Court of Appeal that Justice Mahon, as Royal Commissioner, had acted in excess of his jurisdiction and contrary to national justice and the costs order made by him against Air New Zealand was overturned.

I should comment that his main rulings were never upset – this was a side issue. Nonetheless that ruling to a Judge was something akin to the sorts of accusations that were being levelled against certain doctors at National Women's Hospital.

They went to the very core of his professional responsibility and Justice Mahon felt obliged to retire from the High Court Bench too early to receive a full pension. He died shortly afterward.

Increasingly I became aware that the Inquiry I was to conduct could have an equally disastrous impact on me if I did not manage to conduct it fairly and responsibly – no mean task for a relatively junior Judge dealing with very senior members of the Bar and of the medical profession, and in the full blaze of publicity. Indeed when the Inquiry ended one of those who had featured in it and who remains involved in medical politics to this day, remarked in a medical publication that I could meet the same fate as Justice Mahon. His hopes were not realised.

There were challenges to my rulings both during and after the Inquiry concluded. Most were based on the same prejudices that had seen the research programme continue at the Hospital with disastrous results for some 20 years.

Metro magazine, which had published the initial story, apparently now angry with the two authors, wrote a new story called 'Second Thoughts' featuring a photograph of me and some of the women involved in the Inquiry as parties or patients, as supporting evidence of my bias in favour of them. The fact that the photograph was taken 12 months after my Report had been produced seemed to be of little moment. Even one of the lawyers at the Inquiry challenged me about that photograph, asking if I thought it had been unwise. Well, of course, I agreed with him and suggested that we immediately stop dining together in a public restaurant in case similar inferences were drawn.

Life does move on. Bias in its pejorative sense comes from a predetermination about events, something that I can honestly claim not to have had, given my total ignorance of the events which gave rise to the Inquiry before I embarked on it.

What I did not expect was the heat of the publicity concerning the Inquiry and its ongoing impact and the consequential disappearance of my privacy as an ordinary, everyday New Zealander.

To say that I was surprised when the Government undertook to implement my recommendations is something of an under-

statement. I really believed, as had happened in an earlier Inquiry I had conducted, that the Minister would glance at my Report and file it away.

I do not believe that I did a better job than Justice Mahon did in the Erebus Inquiry. When I attempted to re-read my Report in preparation for today's speech I cringed, not at the conclusions but at some of the ways in which I expressed myself. But what happened, I believe, is that this was a drama unfolding in the nation's living rooms, a drama in which there were goodies and baddies, and for all time, I was placed with the goodies, at least by the public, if not by the medical profession.

I do not regret having been asked to undertake the National Women's Inquiry. I learned many lessons:

- I learned how to maintain a calm environment when emotions are running high.
- I learned how to control a complex procedural and legal issue.
- I learned as much harm can be done by well-meaning,

but misguided individuals as by those who are malevolent.

- I learned that those who have been harmed without their knowledge can, nonetheless, be warm and generous to those who have hurt them.
- I learned more than I can say about the generosity of human nature.

Had I not conducted this Inquiry I know my life would have been very different and I do not believe that today I would have been Governor-General of New Zealand. I was propelled into the limelight and, like a duck, have spent the last 15 years paddling furiously in order to appear calm on the surface.

I am often asked what I think of the developments since the National Women's Inquiry; for instance, the problems over the National Screening Programme and the various medical scandals that have emerged from time to time. My answer is always the same – this was an engrossing task for me but I have rarely gone back to my Report since I delivered it and I have certainly not had time to follow in detail what has occurred as a consequence of it. That too, is the job of a Judge: to reach a determination and then move on to the next case.

## call for responses

### Revisiting the Cartwright Inquiry

The Editor invites readers to submit responses to the Governor General's keynote address given at the New Zealand Bioethics Conference, and published in this issue of the NZBJ. Authors are invited to take up specific issues or broader themes raised by Dame Silvia's remarks. Responses may be in the form of full articles, a 1,000 word response or in letter form. Please address responses to:

**The Editor, New Zealand Bioethics Journal, PO Box 913, Dunedin.**