The Cartwright legacy: shifting the focus of attention from the doctor to the patient

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In her 1988 Report of the Cervical Cancer Inquiry, Judge Silvia Cartwright noted that “old habits and attitudes” had provided a sense of security for the medical professionals and administrators “buffeted by the cold winds” of the Inquiry. Her far-reaching recommendations sought to change the regulatory landscape for patient care and research. They were a full-frontal challenge to the medical establishment, and to the model of professional autonomy and self-regulation that held sway in New Zealand. The judge said that “[t]he focus of attention must shift from the doctor to the patient”, and made detailed recommendations to effect fundamental change. All too often, the recommendations of major inquiries garner brief media attention, before gathering dust and being quietly shelved by officials. Inaction may be well advised; lawyers undertaking a one-off inquiry, unfamiliar with the subject matter of the inquiry, may make recommendations that are ill-conceived or impractical. And even recommendations that “hit the mark” may still be ignored. Once the inquiry body is functus officio, and the media spotlight shifts to other issues, inertia, discrete lobbying from vested interest groups, and a lack of political nerve will often lead to cosmetic change but no significant reform. Yet from the vantage point of over two decades later, it is clear that the Cartwright Inquiry resulted in major and enduring changes to the legal and health systems in New Zealand. Why did this inquiry lead to such a seismic shift in the relationship between doctors and patients, and the medical profession and the community? What is Cartwright’s legacy in the early 21st Century?

Changing times

In the 1970s and 1980s, feminism, women’s health activism, and a broad range of social movements were challenging traditional norms and changing the fabric of New Zealand society. This was fertile ground for the Cartwright Inquiry. As Joanna Manning notes, “public attitudes to the medical profession were undergoing a transformation”, and the Inquiry and Report “both reflected and accelerated these evolving attitudes”. The teaching and practice of medicine was slow to react to societal changes, and the New Zealand legal system in the late 1980s provided no incentive for reform. Patients’ rights (in particular the right to make an informed choice about medical treatment) were slow to develop in New Zealand, in part due to the constraints of accident compensation legislation. Doctors (and other health professionals) were the beneficiaries of a system that looked to the state to compensate injured patients, and effectively barred claims for medical negligence. The combined effect of social change and underdeveloped legal protections for patients in New Zealand meant that the time was ripe for reform.
Shocking revelations

But timing alone does not explain the impact of the Cartwright recommendations. The shocking revelations during the Inquiry had a profound impact on the New Zealand public, and made reform inevitable. As Silvia Cartwright has noted, “[T]his was a drama unfolding in the nation’s living rooms.” David Skegg recalls that “public attention was riveted by what seemed like the daily revelations from the hearings”. Helen Clark, who became Minister of Health six months after release of the Report, described the revelations as “truly shocking”. It was shocking (and, despite recent attempts to rewrite history, remains so) that so many women received inadequate treatment for cervical carcinoma in situ at New Zealand’s leading obstetrics and gynaecology hospital, and that some suffered needlessly and died; that patients and their families were kept in the dark; that medical colleagues failed to act; that the system for ethical approval and monitoring of research was woeful; and that abhorrent practices, including students practising the insertion of intra-uterine devices on anaesthetised women without their consent, and the taking of vaginal smears from babies without parental consent, were tolerated.

“Adverse events” are often accepted as a byproduct of a complex healthcare system, and the public becomes inured to news of avoidable harm to patients. Sometimes it takes a major scandal to ignite public outrage, compel government action, and defuse professional resistance. Richard Smith wrote of the inquiry into deaths from paediatric cardiac surgery at Royal Bristol Infirmary that “All changed, changed utterly” (quoting Yeats). The same was true of New Zealand post-Cartwright.

Putting the patient first

One other factor was critical. Judge Cartwright modelled, both in the Inquiry process and in her recommendations, an approach that put the patient first. In chapter 7 of the Report, “Ethics and Patient Rights”, she quoted extensively from the testimony of the women, criticised the prevailing views of doctors and administrators at National Women’s Hospital, and contrasted the weaknesses of the ethical and legal framework for patient care and research in New Zealand with developments overseas.

The judge made a compelling case for patients to be treated with dignity, to receive all relevant information about their condition and treatment options, and to be fully protected as research participants. Her wide-ranging recommendations targeted both the individual patient-doctor relationship, and the legal and health systems more generally.

Decades before the language of “patient-centred care” and “consumer perspective” became fashionable, Silvia Cartwright saw the need to make consumer voice central to the monitoring of health care delivery, via elected representatives to hospital boards, independent advocates, and an independent Health Commissioner; to enshrine patients’ rights in legislation; to have much greater lay involvement in a rigorous system of ethical review of proposed research; and to make the needs of patients pivotal to medical education and to the complaints and disciplinary process.
Cartwright’s legacy

The path to implementation of the Cartwright recommendations was not smooth. Despite the “public climate of expectation of change”, and vigilance by the women’s health movement, five years after the Report release there was still much “unfinished business” (as described by Sandra Coney and colleagues in their 1993 book of that title). But significant reforms did follow and have proved enduring.

The system for ethical review of clinical research and innovative treatments is now subject to a rigorous approval process, with independent regional ethics committees (with a lay chairperson and 50% lay membership) operating in accordance with a national Operational Standard, and using guidelines developed by a statutory National Ethics Advisory Committee. Mechanisms for monitoring compliance with ethical approval remain problematic, but Jan Crosthwaite concludes that “New Zealand now has good regulatory protections in place, although we should not think we are immune to the possibility of rogue researchers”.

The Code of Health and Disability Services Consumers’ Rights, enacted in 1996, gives patients legally enforceable rights, far surpassing the puffery of non-binding charters adopted in many other countries. The rights closely mirror the template proposed by Judge Cartwright, including rights to be treated with respect, to effective communication and adequate information, to make an informed decision, to receive care of an appropriate standard, and to make a formal complaint to an independent advocate or Commissioner. The Code has become ubiquitous, visible on the walls of hospitals and health clinics and, more importantly, familiar to health professionals and the public (with surveys showing much greater awareness of patients’ rights).

Most importantly, there has been an attitudinal shift within the medical profession. Communication skills, professionalism, and ethical reflection are now taught alongside clinical skills in the undergraduate medical curriculum. Informed consent, ridiculed by members of the profession in the immediate aftermath of the Inquiry, is now accepted as essential to securing the trust of patients and improving the outcomes of care. The focus has shifted to how to provide information in a way that meets the needs of patients, and has extended from the context of pre-surgery to the whole continuum of health care and disability service provision, including in the aftermath of an adverse event (“open disclosure”). Ensuring that patients are treated with dignity and compassion within an increasingly complex health system remains a challenge, with debate about how best to achieve this, but no one contests the need to do so.

The complaints and disciplinary system in 2010 is transformed from the unwieldy and health professional-dominated system of the past. A nationwide network of independent advocates is contracted by a statutory Director of Advocacy, and is highly effective in resolving consumer complaints in local communities.

The Health and Disability Commissioner (HDC) complaints system enables independent resolution of complaints, with a minority leading to published investigation reports in which substandard hospitals and rest homes are identified. The reports are generally welcomed by professional groups and used for education, providing guidance on complex issues such as follow-up of patient test results and coordination of primary and secondary care. The Commissioner has become a highly visible “patient watchdog”, commenting on problems in the health system.
A combination of much greater appreciation of the role of systems in patient safety, together with the rehabilitative approach fostered by HDC and the Medical Council (using tools such as competence reviews, under the Health Practitioners Competence Assurance Act 2003) has resulted in far fewer cases leading to disciplinary hearings before the Health Practitioners Disciplinary Tribunal (a multidisciplinary body entirely separate from the individual registration authorities). Clinical negligence cases seldom result in discipline; charges of unethical behaviour, such as sexual or financial exploitation of patients, and improper prescribing predominate.

Implementation of the national cervical cancer screening programme recommended by Judge Cartwright was particularly vexed, with flaws exposed in the Gisborne Cervical Cancer Screening Inquiry in 2001, but the current scheme has been described by David Skegg as “a triumph of preventive medicine”. The programme is estimated to be preventing at least 70% of the cases of cervical cancer that would otherwise be occurring in New Zealand, saving the lives of more than 100 women every year.

**A complex story**

The lessons to be learned from the Cartwright Inquiry remain contested territory. Yet even the revisionists, while seeking to downplay the significance of the Inquiry, hesitate to criticise the reforms described above. In retrospect, they can be seen to be timely and necessary.

It is, however, too simplistic to view the Inquiry as a triumph of external regulation over internal morality. As Charlotte Paul has described, the Cartwright story is more nuanced and complex, and over-reliance on the “blunt instruments” of external controls can undermine trust and be counterproductive to a “functioning internal morality”.

The role of the doctors who attempted to raise concerns with National Women’s Hospital (notably Bill McIndoe, Jock McLean and Ron Jones), and of the professional leaders who sought to make the reforms workable for patients and doctors (including Robin Briant as chair of the Medical Council in the 1990s), needs to be acknowledged. Sandra Coney applauds the “quiet but monumental shift in the attitudes” of doctors, who “on the whole … grasped the nettle and changed their practice”.

Challenges remain. Despite all the rhetoric about putting patients first, the current emphasis is on clinical leadership. There is still a need to strengthen consumer voice at all levels in the health system. It is remarkable that the new (albeit interim) Health Quality and Safety Commission has no consumer member. There is also a sense of complacency about the current framework for ensuring health practitioner competence, and lay involvement in registration authorities has fallen well behind regulatory reforms in some other countries (notably the United Kingdom).

Finding effective ways to raise concerns within the health system is a particular concern. Too often, health professionals who attempt to do so lack institutional support and are met by denial and resistance. Even external inquiry bodies learn to expect re-litigation of findings by interested parties, denigration by critics, and
revisionism by subsequent commentators who did not hear all the evidence and sometimes seem wilfully blind to it.

Much has been achieved, and the focus has largely shifted from doctor to patient, but Silvia Cartwright’s words of warning bear repeating:¹

“... Administrators and health professionals need to listen to their patients, communicate with them, protect them, offer them the best health care within their resources, and bravely confront colleagues if standards slip. If this does not happen, then the kind of events disclosed during this Inquiry may well happen again.”

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