

APPENDIX 5

Dr W A McINDOE'S MEMORANDUM OF 14 DECEMBER 1973

The Medical Superintendent
NATIONAL WOMEN'S HOSPITAL

re Diagnosis and management of
precancerous lesions of the cervix

I have your memorandum of 21 November and the attached memorandum of Associate Professor G H Green dated 7 November.

Much of the first part of my reply is in summary form. Numbers of the points made, particularly in sections 1, 2 and 3, I have considered in more detail. This material is available in supporting memorandum. My reply follows.

- (1) It was not possible to approach this matter in any other way because of the personality and belligerent response of Associate Professor Green to comment and criticism.
- (2) It is quite incorrect to state that I have never made plain my feelings unless this can be interpreted that he not only will not, but does not, listen to any comment which does not suit him. I have endeavoured by all means possible in a mature and dignified manner to make my feelings plain and so note down specific instances of my attempts.
 - (a) At the Senior Staff meeting, 20.6.66, in tabled memorandum and by speaking at length to my memorandum.
 - (b) In personal memorandum to him, dated 15.4.69.
 - (c) In private on three occasions in his room in 1972. Professor Liggins interrupted one of these occasions when he came into the room and made a comment such as "are you two still at it".
 - (d) In private on two occasions in early 1972 in Ward 9 following the ward round when he saw fit to 'rebuke' me for comments I had made during the round.
 - (e) In private in commenting on management of [Patient Code 3Q], towards the end of February 1971.
 - (f) Letter to New Zealand Medical Journal in name of Dr SE Williams and myself, dated August 1972 (p 129).
- (3) **Comments on place of colposcopy and outpatient punch biopsy.** This is referred to, in particular, in two places in the memorandum of 7 November from Associate Professor Green.
 - (A) **FIRSTLY** page 1 (c). I quote:
".... It was always a calculated risk that invasive cancer could be overlooked, although it was hoped that colposcopy, clinical examination and repeated directed biopsies could minimise, if not actually avoid this. This has been advocated repeatedly by Dr JVM Coppleson in Australia and is now urged by American authorities (eg Stafl and Mattingly, Ostergard and Gondos, Selim et al, all 1973)."

That such possibility was quite beyond the methods of assessment then and

now available should have been apparent to him at the time of his earlier proposals (20.6.66). That the position is unchanged in this regard, and not as he suggests in the quotation above, will be apparent on a careful reading of the work of Coppleson (1971), Kolstad and Staffl (1972), those he quotes as American authorities writing in 1973 and others (viz Holly MR 1971, Griffiths and Younge 1969, Griffiths, Austin and Younge 1964), and the drawing of reasonable conclusions from these articles.

(B) **SECONDLY** page 9 (c), I quote:

"I am concerned that our record on the colposcopically directed biopsy method of exclusion of invasive cancer, as advocated by the authorities mentioned previously, may not be perhaps as good as these others suggest is possible. I propose to extend my own personal skill and experience in this direction as much as possible."

(a) Nothing but good can come from anyone attempting to understand and improve their personal skill at any technique. Would that others on the staff would make such attempts.

(b) I must however issue a note of warning and express concern since any technique in inexperienced hands can fall into disrepute, in particular if the person's attitudes to the technique and the way it is being applied are not soundly based.

(c) Further comments on the limitations of various methods of assessment, in particular cytology and colposcopy follow:

In the main it is not necessary continually to warn colleagues of the limitations of various assessments whether clinical or laboratory. I believe the position was fairly stated in the letter by Dr S E Williams and myself in the *New Zealand Medical Journal*, August 1972. I am indebted to Dr Williams for that part of this letter I now quote:

"Our purpose in writing is merely to affirm that diagnostic cytology is a valid and useful method of detecting the presence of malignant disease in many body sites." (The same comment can be applied to colposcopy and the place of this technique in the evaluation of abnormalities of the vagina and cervix.)

"Within the limits of all such subjective assessments of biological phenomena its '(or their)' reliability compares favourably with other diagnostic investigations in laboratory technology, diagnostic radiology and clinical medicine."

I come back to the words quoted from Associate Professor Green's memorandum, p.9.

"...our record...may not be perhaps as good as these others suggest is possible."

A mature worker must be concerned that the application of methods and techniques for which he is responsible be continually upgraded and subjected to critical review, ever ready to consider suggestions for improvement. He must in addition maintain a sensitivity in the application of these methods – the method must be applied with maturity and not elevated in importance out of its due place by over-enthusiastic advocacy.

I sense in the comment quoted immediately above a vain hope and a desire to apply colposcopy and directed biopsy in an inappropriate manner that may well bring a useful method of assessment into disrepute.

(d) **Principles I have followed in selection of patients for colposcopy assessment.**

Dr Coppleson and I have discussed on a number of occasions the selection

of patients who should be examined by the colposcope in the Australian and New Zealand practice situation. We are agreed that, as far as possible, patients examined should be those:

- (i) With positive or doubtful cervical smears
- (ii) Patients with the clinically abnormal cervix.

Also that this assessment should be performed separately from the initial gynaecological assessment. These points are made by Coppleson et al in their text, *Colposcopy* (1971) p 262, 263.

My practice at the hospital has been to run the colposcopy clinic as a referral service. With rare exceptions I have examined patients for a colleague from a hospital clinic or from his private practice. In addition patients who have been discharged from hospital or a hospital clinic with a Grade 2R cytology report not attended to, have been called up to my colposcopy clinic, the smear repeated, and the total situation reviewed in the light of my colposcopy findings. The patient has then been finally discharged, reviewed again at a subsequent colposcopy clinic appointment or referred back to the consultant concerned.

On all occasions I have endeavoured to interpret to the patient the views of the consultant concerned as far as I understand them. I have only advised a variation in management to the consultant when I have had clear and special reasons for doing so.

In the presence then of continuing grossly abnormal cytology (positive smear) and significantly abnormal colposcopy findings which would have been further investigated by appropriate excision biopsy in other clinics and the specimen submitted for detailed histology assessment, I have been powerless to intervene except on those rare occasions when I found clear evidence of invasive carcinoma.

It has taken considerable restraint on my part to maintain my position, particularly in more recent years when it has been clear to me that members of the staff on B and C Team sought out my opinion on problem cases and almost invariably acted on advice given.

- (4) **Question of unrevealed invasive cases**, page 8 (E) last paragraph. I quote:

“... This was the time of the greatest relative number of new patients being smeared and merely revealed increased prevalence figures for these lesions. Dr McIndoe has therefore made an unjustified assumption that it was the increased number of cone biopsies that was responsible for an increased number of invasive cancers discovered in the 1963-4 period at National Women's Hospital.”

There may be some substance to the earlier part of this comment — if so the implication is clear. In spite of this, as stated in my 10 October 1973 memorandum, “I believe more adequate biopsy would reveal a number of these to have invasive carcinoma at the present time.”

- (5) **Patients for further assessment**, page 8 (E) second to last paragraph. I quote:

“Dr McIndoe does not comment on many other cases which he has followed colposcopically and which should equally be the subject of his concern if we take his comments and his graph at their face value.” Then he notes for example: [Patient Codes 4D; 10L; 5Q; 7Y; 3V1; 4M; 8A1; 8C1; 4M1] ... 405 cases up to 1967.

In my memorandum of 10 October I stated “Brief notes on some of these patients are attached. A longer list of patients who should be carefully reviewed is available.” I submitted brief notes on seven patients, and entirely agree with the comment

above as I am concerned about many more patients and thus submit the names of two lists of patients, by no means complete, whose notes should be carefully reviewed:

- a) **List of patients Carcinoma in Situ – Invasive.**
(appended)
 - b) **Patients on follow-up – Continuing positive cytology.**
(appended)
- (6) **Comment on views of authorities quoted in Associate Professor Green's 7 November memorandum and others.**

- a) **Cochrane** page 2 (E), I quote:
"The ethicality of such a trial has since been urged by Professor A L Cochrane, head of the British M.R.C. Epidemiology Unit (1971)."

I would like more information on this point.

I am familiar with a proposal discussed with Professor Cochrane and a draft protocol prepared by him, date 26.2.70. I would be most interested to have details as to why nothing more has been heard of this proposal.

- b) **Doll** page 2 (B), I quote:
".... In any case, the present population and pathological data do not suggest that any reappraisal of the present management, possibly towards the aggressive ablative attitude seen in some North American Centres, will do anything to lower incidence, morbidity and mortality from cervical cancer in either Auckland Province or New Zealand. Sir Richard Doll has recently supported me in this opinion."

It is difficult to follow in the above what Doll has recently supported.

There is much to be gained by "reappraisal of the present management" excepting that this should be expanded to the "present **diagnostic steps** and management". Exclusion of invasive carcinoma at the outset by more adequate biopsy and further investigation of the continuing positive smear (e.g. [Patient Code 6N1]) and abnormal colposcopy findings is clearly required as advocated by Kolstad (1970) and the other authors referred to by Associate Professor Green in his November 7 memorandum.

The suggestion of an "aggressive ablative attitude" as the only alternative to adequate diagnostic steps is hardly appropriate.

- (c) **Knox**
I wondered a little why I did not find any supporting comment from Professor E G Knox, Epidemiologist of Birmingham in the memorandum of Associate Professor Green.

I understand Professor Knox's position concerning Population Evidence can be summarised in the following quotation:

"Recent assessment of population evidence has been clouded by widespread assumption that participants in discussion are either 'for' or 'against' screening.... My thesis is that this is still a subject for serious scientific consideration and that any hindrance to the debate will result in continuing ambiguity of conclusion, and this in turn to indecisive implementation." (1970)

Clearly those who are 'against' screening are as much a hindrance as those 'for' in the view of Professor Knox.

- (d) **Fidler**
Again I wonder a little that the comment attributed to Dr H K Fidler as

reported in the Auckland Star, 15.12.71, has not been fitted in somewhere. This comment is quoted again by Associate Professor Green in NZMJ December 1972, p 450, as follows:

"I quote from the reported remarks of Dr H K Fidler of Vancouver at the 1971 meeting of the Canadian Association of Pathologists in Saskatoon. *(I was present and can vouch for the accuracy of the reporting)* There is some evidence that screening helps locate cervical cancer early.

Nevertheless much more data is necessary for conclusive proof. In the meantime those who believe in screening should continue to do so and others should await more conclusive proof."

Perhaps this was adequately dealt with by JE Gieson in reply. NZMJ February 1973, p 124.

"Professor Green states that it is a pity I did not have the latest advice from British Columbia before mentioning that centre. It is a pity he overlooked the fact that I was also in Canada in 1971. In fact when I visited Dr Latour in Montreal he had just returned from the meeting in Saskatoon which Professor Green attended.

He made it clear that there were differences of opinion at that meeting. I spent two most rewarding days with Dr Fidler in Vancouver and know his opinion in these matters well. Professor Green quotes an isolated remark of Dr Fidler at the Saskatoon meeting to the effect that more data is necessary for conclusive proof."

(7) **Final Comment**

Many detailed comments could be added on the patients quoted by myself, Dr McLean and Associate Professor Green – and many others. These can be looked at in detail in a more searching enquiry.

There is little in the 7 November memorandum of Associate Professor GH Green which has allayed the concern I expressed in my memorandum of 10 October in the words, "I have not been entirely happy for a number of years with management..."

W. A. McIndoe

(A list of patients was attached)

APPENDIX 6

Dr M R McLEAN'S MEMORANDUM OF 10 MAY 1974

The Medical Superintendent
NATIONAL WOMEN'S HOSPITAL

re Diagnosis and management of
precancerous lesion of the cervix

I have given Professor Green's memorandum of 7th November 1973, deep consideration. There is nothing in it to allay the concern expressed in my memorandum of 18th October, 1973.

I reaffirm my concern over his extremely conservative approach to the diagnosis and management of cases purported to be carcinoma in situ of the cervix.

When patients are admitted to a public hospital they put themselves in the hands of the medical staff with the explicit understanding that they will be provided with at least adequate, and preferably optimal treatment for their complaint. Clinical studies and trials to establish optimal management are at times necessary. However, when in the course of a trial it becomes apparent that patients are at risk, there must be a reappraisal of the trial. Despite what Professor Green may say, the consensus of opinion at present is that any delay in the diagnosis and treatment of invasive carcinoma puts that patient at an increased risk. A survival rate of $96\% \pm 2\%$ for Stage 1A carcinoma of the cervix is very good at a statistical level — but not for the 4 or so women who die from the disease. At our present state of knowledge no one can deny that there is every possibility that with earlier diagnosis and treatment, these 4 or so patients could be alive.

In his memorandum Professor Green raises a large number of points, many of which are irrelevant to the point at issue. I intend to deal only with points I consider relevant.

General Points

Histological diagnoses are somewhat subjective but throughout the fields of histopathology, provided (a) the pathologist is trained and experienced in the particular field, (b) the slides are of good quality and (c) the conditions for studying the slides are good — histological criteria amongst pathologists are remarkably uniform and consistent. There is usually a simple explanation for significant inconsistencies and this is the case with Professor Green's 1965 survey. If required, I will enlarge on this.

Professor Green's efforts to resolve the problem of the natural history of carcinoma in situ of the cervix are admirable, but because of the very nature of the problem itself, it is irresolvable in the strictly scientific sense of proof. A similar situation exists with atypical hyperplasia of the endometrium and its relationship to invasive carcinoma (Bettinger, W.R., 1971, *Amer.J.Obstet.Gynec.*, 109, 194).

I have already touched on the general consensus over the question of delay in treating cancer and the patient's prognosis. There may be exceptions to this general rule but these are only apparent in retrospect. None of us know enough about cancer to say at the time of diagnosis, except in general terms, what course a particular cancer will run. Therefore all cancers must be treated in a manner generally considered optimal for that particular cancer. With reference to a particular patient, Professor Green has no ground for saying that delay in treatment of Stage 1A patients will not put that patient at a disadvantage.

I was under the impression that Professor Green's application in 1970 to the British Medical Research Council for a research grant to aid a project of the type under discussion was declined as being unethical.

Points on Histology

In certain patients, controversy at pathology and other clinical levels is inevitable, and differing viewpoints, reasonably discussed and debated can do nothing but benefit patients. Professor Green's interest in histology and his seeing his patients' slides is admirable. However for many years, Professor Green has entered in an authoritative manner into the field of histopathology – the histological diagnosis of cancer and related lesions of the cervix – in which he may have seen many cases, but scarcely a field in which he has had adequate training and background, a field in which he is not an acknowledged expert.

Over many years he has challenged my diagnoses, (and those of other pathologists), nearly always on inadequate grounds. In the vast majority of such cases, my diagnoses have subsequently been shown to be correct. Challenging of this nature is a serious matter as it raises the question of my competency to undertake my duties as a histopathologist in this hospital. This matter may need to be looked into further.

I stress there is a difference between reasonably questioning a diagnosis on adequate grounds, which is acceptable, and unreasonable challenging on inadequate grounds.

Comments on Individual Patients

Professor Green's answers to my comments on specific patients in my initial memorandum hardly allay my concern. His aim seems to be to justify his actions – I doubt the relevancy of this. I have no doubts, that in his own view Professor Green has acted in the best of faith. However this does not alter the fact that his mode of management has put patients at risk. His themes of retrospective rediagnosis to suit the situation, and that delays in diagnosis and treatment have not altered the outcome, hardly constitute an adequate explanation.

His mode of management of these patients has done nothing to contribute to an understanding of the natural history of carcinoma in situ of the cervix, except possibly to make one all the more wary of it and certainly to emphasise the importance of accurate diagnosis.

In the case of [Patient Code 3Q], in that Professor Green saw the current histology as it became available, and in view of his comments, one could well ask why was she not passed to D Team early on.

There are some aspects of [Patient Code 6Z's] case that may be debatable, but Professor Green seems to be the only one who disputes the histology.

Similar points can be made about Professor Green's comments on the other patients.

My diagnosis of "Carcinoma in situ of cervix – possible invasive carcinoma nearby" is a diagnosis infrequently made, on morphological appearances. It has subsequently been substantiated in the course of follow up in a significant number of cases.

Emotional Points

Towards the end of his memorandum, Professor Green raises a number of points and complaints that I consider emotional and which are not strictly relevant to the point at issue.

I had not intended to enter into a personal controversy with Professor Green and I feel to discuss these points and complaints here would deviate attention from the main point.

CERVICAL CANCER REPORT

I would be pleased to either (a) discuss these with you or (b) make them the subject of a separate memorandum.

Summary

In summary, I reaffirm my concern with Professor Green's mode of management of certain cases purported to be carcinoma in situ of the cervix on the basis of inadequate biopsies. Despite what Professor Green may say all of these patients have subsequently been shown to have invasive carcinoma of the cervix on authoritative histological diagnosis – not necessarily just my own. Because patients are at risk, I consider that Professor Green's present mode of management of these patients needs to be reappraised.

M. R. McLean,
Pathologist-in-Charge.