

Chapter 9

TEACHING

The School of Medicine at the University of Auckland was established in 1968, but the Postgraduate School of Obstetrics and Gynaecology had been teaching undergraduate medical students and graduates since its establishment at National Women's Hospital in 1946. Therefore, it has taught many general practitioners, diplomates and specialists. In addition, the School has run refresher courses for general practitioners and nurses. It has occupied an important role in teaching on gynaecological malignancy.

The detection and treatment of cervical cancer and precancerous conditions of the genital tract was Dr Green's subject for most of the time he was a member of the academic staff at National Women's Hospital. On his retirement in 1982, the responsibility for teaching this subject was taken over by Dr Murray Jamieson.

TEACHING NOTES

As one of the academic staff and Associate Professor at the Hospital, Dr Green had teaching responsibilities at undergraduate and postgraduate diploma and specialist levels. Notes for class and study purposes, usually written or collated from existing material by the course lecturer, are disseminated regularly to the students. Various copies of Dr Green's teaching notes were produced at the Inquiry. One set, 'The early diagnosis of gynaecological malignancy', was dated February 1967. Two other copies of almost identical papers were produced, one dated November 1980 and the other June 1984. The 1980 paper had been altered in only two major respects.

First, the references had been updated to 1970 to include one of Dr Green's early papers published in the Australian and New Zealand Journal of Obstetrics and Gynaecology; and a whole new section had been added on the importance of early diagnosis in gynaecological cancer. Most of that section argued that as it was doubtful that every advanced cancer had passed through a less advanced stage, the case for screening in the early diagnosis of cancer was not proven. I consider that the last two versions of the paper originated in 1970, as none of the information contained in them has been updated since that time. Even in the 1970s the statement:

"I think we must conclude that the case for screening in the early diagnosis of cancer is not proven – owing to insufficient evidence, **evidence that cannot be obtained**" (Dr Green's emphasis)

was inaccurate according to Professor Skegg. If the information was inaccurate in the 1970s, then it ought not to have been included in papers distributed in 1980 and 1984.

Another paper dated February 1967, 'Cervical, Endometrial and Ovarian Cancer: Synopsis of Diagnosis and Treatment', was written by Dr Green. I have seen four versions of this paper, the second dated November 1970, the third, 1972 and the fourth March 1984. Once again they are almost identical to the original. Apart from a change in emphasis in the 1970 version of this second paper which modified comment concerning punch biopsy, its content remained virtually unaltered for a period of 17 years, except in minor matters not relevant to this Inquiry. This paper also should have been revised and brought up to date if it was to be distributed to students at the Postgraduate School. Both of the 1984 papers were distributed as part of the diploma material, according to the evidence of one general practitioner who had taken the course that year.

In his evidence Dr Jamieson assumed that these two papers would have been distributed in 1984 when he was absent from his teaching duties. It was not until 1987, therefore, that the papers were finally withdrawn from circulation. While I accept that written notes on one topic should not be given too much emphasis, they are not so insignificant in the hands of either undergraduate or postgraduate students as to require only occasional review. At least one postgraduate student in the diploma course in 1984 retained his notes for future reference. The practice of allowing this material to be distributed with minor modification only, over a period of 17 to 20 years, displays intellectual impoverishment.

TEXTBOOK MATERIAL

In 1962 Dr Green published a textbook which was revised from time to time until 1983. According to the preface to the 1983 edition, by its Fifth Edition published in 1975, it had "evolved into an exposition of those basic principles which should be familiar to anyone, students of obstetrics or otherwise, concerned with the care of pregnant women". The 1983 edition was edited by Dr Green and titled 'Introduction to Obstetrics, A Concise Text for Students by the Staff of the Postgraduate School of Obstetrics and Gynaecology, University of Auckland and National Women's Hospital'. In chapter 5, 'Cervical Cytology Test', the following statement can be found:

"This can be quickly and easily performed when the obstetrician does his first vaginal examination. About one or two unsuspected 'pre-invasive' cancers of the cervix will be detected in every 1,000 antenatal patients by this test. Further investigations (colposcopy, biopsy) are not urgently necessary unless true or invasive cancer is suspected."

And in chapter 8, 'Uterine Retroversion and Cervical "Erosion"':

"A cervical smear test is taken at the post-natal examination if one has not been taken during pregnancy. Very rarely this may reveal a true invasive cervical cancer, but more often (about two per thousand) it leads to the diagnosis of carcinoma in situ; the importance of this in the development of invasive cancer is somewhat disputed at present."

Although both chapters were said to have been written by other gynaecologists, these statements reflect Dr Green's views. To suggest that further investigations are not urgently necessary unless actual or true invasive cancer is suspected, reiterates Dr Green's belief that the only true disease is invasive cancer. Little emphasis is placed on CIS and other abnormalities, presumably because of Dr Green's opinion that they rarely if ever progress to invasive cancer.

Any student reading that text would be lulled by the suggestion that there is no urgent need for further investigation. He or she may well place very little significance on a positive smear, notwithstanding the fact that many authors have published evidence which points to the conclusion that CIS will develop into invasive cancer in a proportion of cases. Its significance as a cancer precursor has been underrated in a student's text. Although Professor Bonham said that undergraduates had always been taught that carcinoma in situ was a cancer precursor, the message in parts of this student textbook undermines that teaching.

THE NWH MESSAGE TO OTHER PRACTITIONERS

One general practitioner who spoke to me privately mentioned the out of date notes on gynaecological malignancy distributed as part of his 1984 diploma course. His experience no doubt was shared by other diploma students. There have been other occasions, such

as in correspondence, when Dr Green's view on the nature of CIS has been passed on to general practitioners.

In 1965 Dr Green wrote to a general practitioner:

"I must admit that the longer I go on the bolder I get and we have now reached the stage where we are not even doing a cone biopsy in the younger age groups and merely basing diagnosis and follow-up on cytology and punch biopsy as indicated by colposcopic appearances."

Not only does this comment corroborate the evidence that Dr Green was choosing to diagnose rather than treat CIS even before 1966, but it also indicates to a practitioner a course of action which was not acceptable by general medical standards. In 1966 he wrote again:

"The more I see of Ca in situ, the less I think of it but I thought we'd better check once again."

And in 1967:

"I might say that not one of my nearly 500 cases (of carcinoma in situ) developed invasive cancer after [indecipherable] biopsy in 1958. On going back to the original slides, both the pathologists here and myself had to downgrade the original diagnosis to nothing more than mild dysplasia.

"What this means is not that mild dysplasia might progress to invasive cancer, but that invasive cancer is a totally different diagnosis to all these epithelial dysplasias we have been diagnosing as the result of cytology.

"In other words, if you follow enough dysplasias or carcinomas in situ, sooner or later one will develop invasive cancer in much the same way as will happen in any large group of women followed because they had a broken leg."

This general practitioner was known to Dr Green, had done a Diploma in Obstetrics and Gynaecology and had a substantial obstetrical practice. Later, after receiving a report on post-coital bleeding from this same GP, he wrote:

"I would not be specially concerned about the appearance of PC [post-coital] bleeding under the circumstances you mention, particularly as the cervix appears normal as usual and the smear is negative as usual and particularly as it didn't occur in any other stage in the cycle.

"I don't know whether I have told you this, but we have now reached the stage where we are quite happy to diagnose Ca in situ on cytology, colposcopy (including punch biopsy) and clinical features only, and to sit and watch the patients have positive smears year after year. In other words, if...appeared now, I would not even do a cone biopsy."

Professor Bonham was asked about this letter which he described as "an unusual letter I must say".

Question: *Would that letter have alarmed you if you had been aware of it at the time it was written?*

Professor Bonham: Yes.

From time to time when reading patients' files, I have come across similar correspondence with other general practitioners who had referred patients. Dr Green was quick to reassure any who were anxious, stressing the insignificance of positive cytology and counselling against hysterectomy. On no occasion could I find any suggestion that the general practitioners had been told that his views were minority views.

Dr Green was the Associate Professor of the Postgraduate School of Obstetrics and Gynaecology. He was known as a leading authority on the topic of gynaecological malignancy. He had published on many occasions and taught many students during the course of his career. The message he gave to general practitioners repeatedly over the years was

couched in confident authoritative terms. It must have created dangers for many of their patients.

THE VALUE OF CYTOLOGY

In Dr Green's scientific papers there were repeated doubts about the efficacy of a population-based screening programme and his public comments similarly expressed his scepticism. He was not alone in voicing these doubts. Other members of the teaching staff at National Women's Hospital have also voiced their antipathy to the introduction of such a programme. There are good reasons for addressing their views and showing that much of their criticism can be repudiated by data collated from around the world over the past decade.

The views of the Postgraduate School in Obstetrics and Gynaecology have been influential right up until the present day. I suspect they are one reason why the Health Department has sidestepped the allocating of funds to a nationwide screening programme on the grounds that the profession in New Zealand is not united on the need for one.

It is of great concern that the members of the Department have failed to analyse accurately the available material and publicly continue to attempt to influence the profession and undergraduates with their unorthodox views. There has been a tendency to make inaccurate use of recent information on CIS, its incidence and its causes.

One example is a letter to the New Zealand Medical Journal, August 1985, co-authored by Petr Skrabanek, in which Dr Jamieson wrote:

"Sir – We are told in The Acts of the Apostles, that Herod Agrippa, being a bad man, was 'eaten of worms'. His grandfather, Herod the Great (Slaughterer of the Innocents), was not only eaten to death by worms but, as the Jewish historian Josephus reported, his privy member first rotted off.

"The infamous Roman dictator, Sulla, was also a salacious profligate and exceedingly fond of a gay transvestite Metrobius. According to Plutarch, 'by this mode of life he aggravated a disease which...corrupted his whole flesh...and converted it into worms....'

"We still believe that sinners meet their just ends, though maggots rarely hatch in their cancer sores nowadays. Persecution of innocents or Christians is no longer listed in the aetiology of cancer, although Sulla's leanings certainly are.

"Sex has always been suspect. In the past, innumerable vices caused blindness (see James Joyce), epilepsy, dementia and paralysis. Now cervical cancer has become 'rampant' and some southern authorities have promised New Zealand an epidemic of that disease (NZ Herald, 21 May, 1984). Every woman should be screened. We are told cervical cancer is a sexually transmitted disease.

"Our young people are 'becoming more permissive and promiscuous'. An epidemic of cervical cancer, especially among our younger women, follows inexorably from these premises. True, the victims are not eaten of worms, but gnawed away by cancer (or fear of it) they are. The wages of sex is a positive smear.

"There is a snag. In many countries renowned for their permissiveness, mortality from cervical cancer has been declining, regardless of the intensity of screening. In New Zealand, despite our increased permissiveness and horrendous extra-marital pregnancy rates, mortality from this cancer has decreased slowly from 7.9 per 100,000 women in 1953 to 6.9 in 1982 – but so far nobody has claimed that this is due to improved standards of chastity.

"In the same 30 years no more than an average of 90 women a year have died of cervical cancer, compared with almost 2000 persons who died in 1982 from accidents, poisoning, and drowning, or to the 364 suicides and 41 homicides in that year. Cervical cancer formed a tiny 0.9% of all female deaths and 4% of all cancer deaths in women in 1982. Even if half these deaths were prevented by screening (and we know this is impossible, even in theory), the effect of removing such a small proportion of deaths from the overall cancer toll would not be statistically detectable. But what about the young women cut off in their prime? In the years 1973-82, an annual average of eight women under 35 years old died of cervical cancer. Even if all young women were screened regularly (and according to some 1981 figures for screening in New Zealand, at least 35% of all women 20 years and older are screened every year) we still could not be certain of preventing these eight deaths, since we know that in young women cervical cancer often develops despite regular screening.

"Why then, do we fuss so much about cervical cancer? Every woman should have a smear, correct? Every woman should be reminded that there is a danger? Why? Is it because the fear of being eaten of worms is a healthy fear? Should one million New Zealand women over the age of 19, live in daily fear, though only 0.009% of them will enter the final statistics? Listening to and asking leading questions of a patient is far, far better than screening in the control of cervical cancer."

While the letter was published in a medical journal, it was couched in terms that were somewhat less than scientific and likely to upset and confuse the general practitioner and lay reader.

1. The authors discuss the disease in the same breath as historical and biblical figures whose sexual appetites brought them to a horrible death. The analogies drawn are not likely to provoke debate on the central issue of screening.
2. The authors diminish the importance of cervical cancer by comparing the numbers of deaths from that disease with those from accidents or from other cancers. The argument appears to be that because there are far more deaths from road accidents each year, no attempt should be made to reduce deaths from this disease.
3. The statement, "since we know that in young women cervical cancer often develops despite regular screening", may or may not be accurate. If other institutions have also been in the habit of monitoring women who have demonstrated positive cytology without treating them, then the statement is almost certainly correct and down-plays the real risk. In New Zealand about one woman in 80 will develop invasive cancer by the age of 70. If present trends continue and effective controls are not introduced, Professor Skegg believes that about one woman in 28, born in the late 1950s, may develop invasive cancer.

Screening does not in itself treat the disease. It merely provides data which the competent gynaecologist will use as the basis for seeking further diagnostic tests and then offering treatment.

4. When the authors state that "only 0.009% of New Zealand women will enter the final statistics", the inference is that the risk of developing invasive disease is very low. In fact 0.009 per cent of New Zealand women over the age of 19 develop invasive cervical cancer **each year**. The suggestion that the risk is spread over a woman's lifetime is quite misleading.
5. The letter also shows a touching faith in the ability of the clinician alone to control the disease. The authors' closing statement, "Listening to and asking leading questions of a patient is far, far better than screening in the control of cervical cancer"

suggests that all precancerous lesions should be allowed to progress to invasion because at that point they can be clinically diagnosed.

The same message, questioning the value of screening, appeared in an editorial entitled, 'Cervical Human Papilloma Virus Infection and Colposcopy'.¹ According to Professor Bonham, this editorial, co-authored with him by Dr Green and Professor Liggins, was written at the request of the editor of the Australian and New Zealand Journal of Obstetrics and Gynaecology "with an editorial flair for a neutralising element". In part, the editorial says:

"Finally, it takes a recent finding (Bethwaite J et al NZ Medical J 1986; 747-751) that annual cytology screening for cervical cancer is uneconomic unless an individual woman's life is valued at \$NZ420,000 or more, to make us ask whether or not the huge capital investment involved in screening for the detection of a cancer which still causes only 0.4 – 0.5% of all deaths in Australia and New Zealand makes economic sense. Against a possible gain to society must be placed only a minute chance of personal good accruing to the individual woman – at the expense of appreciable anxiety and physical morbidity resulting from protracted diagnostic and therapeutic procedures. We suspect that it is conscious or subconscious realisation of this disparity in reward which keeps patients away from screening or follow-up clinics. Therefore, before we accept for universal application the recommendations of Pagano and colleagues, would it not be wise perhaps to review more critically the conflicting data on current screening programmes, discrepancies in epidemiological data and cohort trends, the role of tobacco and viruses (whatever happened to Koch's postulates?) and, above all, to seek more objectively the natural history of cervical cancer?"

This editorial quotes from Bethwaite's paper in a misleading way and perpetuates the type of confused information which has been published by the academic unit for a number of years.

1. Bethwaite's study² valued an individual woman's life at \$NZ420,000, calculated on the basis of annual smear tests, and at between \$NZ86,000 and \$NZ191,000 when smear tests were undertaken every three years (1984 prices). The economic evaluation supports smear tests every three years. The editorial incorrectly implies that annual smear tests were recommended.

The Skegg Report³ recommends routine screening every three years, adopting the estimate that the risk of cervical cancer could thereby be reduced by 90 per cent. The editorial places an exaggerated emphasis on the cost of routine screening.

2. Although Professor Bonham told me that "we should go for total screening", that is not the impression that I gained from reading the editorial. Dr Jamieson also appears to have changed his views about the value of screening, possibly during the course of the Inquiry. He was asked if this was the case:

"No, I don't feel I have. The information that made me reconsider the situation was the IARC [International Agency for Research on Cancer] report in late 1986 and my view is that we must attempt to arrange and organise as rapidly as possible a programme which will be effective and acceptable."

This debate and the views of some members of the academic unit at National Women's Hospital have demonstrated an apparent unwillingness to accept up-to-date information and incorporate it in teaching both students and general practitioners. But it is obvious that most other authorities, both inside and outside the Hospital, now accept the need for the introduction of a cervical screening programme in New Zealand.

SEXUAL TRANSMISSION OF CIS

Professor Kolstad was highly critical of the Skrabanek/Jamieson letter to the NZ Medical Journal. He said:

"I have been seeing thousands of patients with invasive cervical cancer and the absolute majority of the patients are housewives and of course not prostitutes."

He confirmed that cervical cancer is a 'sexually dependent disease' but noted that current evidence suggesting it is transmittable is now:

"... First marriage under age 20 or 21, two or more marriages, first coitus before age 20, two or more sexual partners, divorces, separations and unstable sexual relationships are found more frequently in patients with cervical cancer. The correlation with age and sexual initiation is even higher if the division is taken before and after age 17.

"Most investigators within this field today relate carcinoma of the cervix to a virus infection.... Today genital infection by human papilloma virus is in focus. However, from all these data it is absolutely incorrect to believe that patients with cervical cancer belong to a group of females which are sexually more active than females which do not acquire cervical cancer.

"I find the comments by [Petr Skrabanek] and Dr Jamieson in this matter most improper. The male factor has not been mentioned by [Skrabanek] and Jamieson. There are indications which seem to point to the fact that the so-called male factor is of greatest importance in the development of this disease."

The last point is the kind of educational message which the authorities at National Women's Hospital should have been disseminating to general practitioners and to the community. At the same time they could have been encouraging sexually active women to have regular smear tests; and working more positively with those authorities who have the evidence that supports the need for a population-based screening programme for cervical cancer in New Zealand.

It is of critical importance, if a woman is to co-operate in a screening programme, that she does not gain the impression that the risk of contracting this disease is somehow linked to promiscuity on her part. If she gains this impression and is monogamous, she will not accept the need for screening readily. If she contracts the disease she will be humiliated. New Zealanders need to know that the risk arises from both the male's and the female's sexual partners, as Professor Richart made clear during the hearings.

"The risk of a patient developing cervical cancer requires that she be exposed to the human papilloma virus. This she can do by having sexual intercourse with a man who has papilloma virus.... The difficulty is that very few women know the sexual history of their sexual partners. There are very few men who come home and tell their wives, 'I had an affair last night and I just increased your risk.'

"Because of that, it is virtually impossible for any woman to know what her risk is. Unless she is in a unique relationship of which few exist."

Women are entitled to know that they are at risk of developing squamous cell cervical cancer if they are sexually active and that the risk is related to the number of partners they and their male partners have had. This information must be available so they can make decisions about their sexual activity.

The academic unit at National Women's Hospital has a responsibility not only to its students but also to general practitioners and the women of New Zealand to present accurate unbiased information which will encourage the profession and women to work together to reduce the incidence of invasive cervical cancer.

It should not need saying that it is preferable for the precancerous disease to be detected at an early stage when it can be dealt with by local out-patient procedures, rather than waiting until a woman develops invasive cancer with all the social, economic, emotional and medical dangers that she will then face.

TEACHING STANDARDS AND TECHNIQUES

Dr Duncan, President of the Royal New Zealand College of Obstetricians and Gynaecologists, spoke highly of the part played by National Women's Hospital in the tuition of general practitioner obstetricians. In his view the Auckland and Otago Universities have both helped raise standards in this field. Furthermore, he confirmed that in 1980, following assessment by the Royal College, National Women's Hospital was given "recognition". The Hospital was acknowledged, along with the other obstetrical and gynaecological units in the Auckland group, "as offering a broad experience and divergence of views appropriate with specialist training". He added:

"The pass rate of New Zealand specialist candidates (including those trained at National Women's Hospital) is excellent."

It was clearly Dr Duncan's view that undergraduate, postgraduate and specialist teaching at National Women's Hospital is largely orthodox. While I have reservations about the teaching and dissemination of inaccurate information on the nature and treatment of cancer precursors, I would not disagree with that view given his comment about the pass rates for specialists. However, it would be preferable if the review of the Auckland group planned by the Royal College in the next few years was brought forward. It would reassure the public and the medical profession that any mediocrity in the teaching programme is confronted and that written, clinical and other teaching in this area is rigorously reviewed to ensure it is up to world standard.

Recertification

The Royal NZ College has had a requirement for the recertification of all Fellows 10 years after their admission to the College. Although an appropriate programme is still being developed, I would endorse this method as one means of ensuring that specialists who are Fellows of the Royal NZ College maintain up-to-date information.

Clinical teaching

Formal lectures are only part of the undergraduate and postgraduate teaching programme offered by the Postgraduate School of Obstetrics and Gynaecology. There is practical training and in the latter years of a medical degree students are introduced to clinical work.

The fact that National Women's is a teaching hospital escapes many of the patients who enter it. Even if they were aware of that role, it might not mean as much to a person who is not associated with the academic world as it does to someone who is. In fact very few patients who have been admitted to National Women's Hospital for examination or treatment of carcinoma in situ of the genital tract have had any real choice about which hospital they enter. Their admission to NWH cannot be taken as acquiescing to teaching procedures.

Therefore, there is a special obligation on the academic and other teaching staff of the Hospital to ensure that their patients are fully aware of the Hospital's teaching responsibilities and that they are happy to co-operate as teaching subjects. I have anecdotal evidence from patients to suggest that, provided they are asked and accorded as much privacy and dignity as possible, they have no objection to being teaching subjects.

Professor Bonham spoke of the difficulties involved in teaching students how to examine patients. He referred to the patient's right to privacy which conflicted on occasions with the need to train practitioners in examination techniques. It appears that a variety of teaching methods have been used at the Hospital over the years. They include teaching undergraduates by examining anaesthetised patients and the use of surrogate or conscious volunteer patients.

Professor Bonham believes that to teach a student with a conscious patient will create tensions for the patient, hence the decision to examine under anaesthetic. He conceded that vaginal examinations under anaesthetic were still undertaken, but only on those patients for whom a vaginal examination was required in the normal course of treatment.

However, a nurse who gave evidence anonymously told me that while she was a theatre charge nurse from 1983 to 1986, unconscious patients were examined vaginally by up to four students. She was not told whether the vaginal examination was part of that patient's treatment or not. Her concern centred on the possible discomfort the woman might experience later, and her anxiety that the patient's permission had not been sought. When she voiced her concerns, they were dismissed by her supervisor.

Professor Bonham said that student examinations were limited to those involved in the patient's clinical management. A maximum of two students would examine the patient while she was anaesthetised. I accept that this is the practice at present. He did confirm, however, that a patient's consent to this procedure was not sought. He was asked:

"Is it not thought appropriate to do that?" (seek her consent)

His answers were:

"I think it could be. We keep adding to the logistics of staff problems...."

"We may, however, be producing undue concern among patients, but it is hard to say...."

"Because to get informed consent would take....about a 10 minute explanation...."

"If the Commission believes that this is necessary, we would be happy to make the necessary arrangements, given the appropriate logistical funding."

Teaching examination techniques on anaesthetised patients without their consent is not a new issue at National Women's Hospital. In 1978 the Nurses Society of New Zealand made representations to the Auckland Hospital Board condemning the practice. Their allegations concerned teaching sessions involving the insertion and removal of intra-uterine contraceptive devices on patients under general anaesthetic for other purposes, without patient consent or knowledge. According to their evidence, no public comment was made by the Hospital Board as a result of the representations. The Nurses Society, however, publicised the matter and a newspaper article commented on the issue. Although a television interview was taped, it was never transmitted, apparently because of adverse reaction from a member of the Postgraduate School.

When asked if students were ever involved in inserting intra-uterine devices on anaesthetised patients, Professor Bonham said that this was not the case. Students practised on a uterus that had been removed. However, I have been left with the uneasy impression that non-consenting anaesthetised patients have been used as subjects for teaching this technique. There are times when existing practices continue because no-one has reassessed the need for them. It is totally unacceptable that the Hospital Board and the School of Obstetrics and Gynaecology continued this practice with no real attempt to evaluate it after 1978, though I have been told that it has ceased since the matter was raised once more before this Inquiry.

The implications for patients who, without their prior consent, are teaching subjects while anaesthetised extends beyond National Women's Hospital. It may well be that the time has come for professional ethics to prohibit such a practice, and for legislation to be clarified to ensure that this does not recur. I regret to say that I cannot rely on the assurances that have been given to me.

Clinical teaching in the future

It is obvious that the patient has not always been adequately protected. In teaching situations, especially those involving physical examinations or procedures, where additional

health professionals are attached to the clinical or therapeutic team, the patient's permission should be sought. A clear distinction should be made between teaching vaginal examination or insertion of intra-uterine devices where the patient has been admitted for either of those purposes, and subjecting her to these procedures when they are not part of the reason for her hospital care. For example, it is untenable for a woman to have an IUD fitted and removed by a student or students without her permission if she has been admitted to hospital for a hysterectomy.

Great care should be exercised in asking a woman to take part in an unnecessary procedure. Her consent will not overcome the problem of the vulnerability of a patient wishing to co-operate with the staff who are responsible for her care.

One patient, who had worked in the medical records section of the Hospital, obviously felt uncomfortable at being asked to be examined when other students or doctors came to the Hospital. No person who is an employee of a hospital, or who might be known to the teaching staff or students, should be invited to take part in any teaching programme.

Special care must be taken in seeking the consent of a patient to her inclusion in teaching practices if she is to be anaesthetised. No more than two students, be they nursing, medical or other health professionals, should undertake the procedure. The woman's written consent to the precise procedure and names of those actively participating must be sought well before she is prepared for her anaesthetic so she has time to consider her response. Vaginal examinations involving conscious patients also demand that the woman's consent be obtained in the same way. Normal courtesies, including the introduction of the students, maximum privacy and respect for the patient must be observed.

Some patients who gave evidence before me, spoke of invitations to take part in clinical teaching sessions. On the whole they agreed to participate and at least one patient seems to have actively enjoyed her role. Others have been embarrassed by examinations of the genital area in the general ward and in front of students. Others considered the offer of a cloth to cover the patient's face so that she would not be embarrassed as absurd. As one said, "It was not my face that I was worried about." These practices seem to be largely abandoned now, never it is hoped, to be reinstated.

This is an appropriate time for the School of Obstetrics and Gynaecology and nurses' associations to consult representatives of their consumers, in particular women's health groups, the Ministry of Women's Affairs and other interested bodies, to establish a scheme for teaching examination techniques which will be acceptable to patients. Surrogate patients have been suggested as teaching subjects. If women are prepared to offer themselves in this role, secure in the knowledge that they will be treated sensitively, they will be doing a real service for actual patients who may prefer not to take part in a teaching programme. The acquisition of sound clinical skills through well run teaching programmes is important for the future care of all patients.

ARCHIVAL MATERIAL HELD AT NWH

The 1966 trial and possibly some of the supplementary trials (vaginal smears of neonates, study of fetal cervixes) have resulted in the accumulation of a large and probably unique amount of histological and sociological information on precancerous and cancerous conditions of the genital tract. The material should be retained and made available for review, properly conducted research and teaching purposes. Some suggested areas are:

Cytology

1. Studies of women with histories of negative smears in the three years preceding presentation with invasive disease.

2. Studies on the significance of persistent mildly abnormal cervical smears. This may have advantages in deciding at what point on a cost-benefit basis a woman should receive colposcopic examination.

Histology

1. The study of the epidemiology of papilloma virus infection and its association with CIN (cervical intraepithelial neoplasia) or CIS and invasive disease. The large number of women with records of serial biopsies over many years is unique. Modern DNA hybridisation techniques allow the presence of viruses to be identified in material stored as paraffin blocks. This material may prove to be of vital importance in the search for information to help prevent, detect or treat the disease.
2. The study of the outcome for patients with a histological diagnosis of microinvasive disease which has not been managed by hysterectomy.
3. A study of the histology of vaginal and vulval cancers in order to identify the histological sub-types such as verrucous carcinoma which responds poorly to radiotherapy.

Teaching

1. A study of the patient interviews and evidence presented by consumer groups and the Ministry of Women's Affairs to help understand the views of women towards disease of the genital tract and its detection and management.
2. A study of the accumulated comment of all the authorities in gynaecological disease, its diagnosis and management, in research and in ethics.

CONCLUSIONS

While the opinions of the NWH Department of Obstetrics and Gynaecology on the value of cytology are less likely to be quite so influential after the close examination of the issue during this Inquiry, it is important that present and future members of the Postgraduate School try to avoid undermining a cervical screening programme in the future. They might direct their efforts instead towards some of the administrative and practical detail which will need to be resolved.

Many undergraduate and postgraduate students of obstetrics and gynaecology received their initial information about gynaecological malignancy from this teaching source. It is critically important, therefore, that future teaching take account of more up-to-date information and analyses the international and New Zealand data more accurately. It should avoid undermining the importance of taking a cervical smear if the disease is to be detected, diagnosed and treated at the early stage, when it is thought to be almost 100 per cent curable, rather than at the later invasive stage.

Teaching standards

1. There is a need to reassess teaching on precancerous conditions, gynaecological malignancies and diagnostic techniques to ensure that formal and clinical teaching is consistent with those of world authorities and the concessions made during this Inquiry. A special effort must be made to achieve excellence in teaching at all levels. The Head of Department is due to retire shortly. A replacement of world class would do much to invigorate the Department's image and morale.

2. There would be much better communication and dissemination of current views if academic staff were actively encouraged to participate in programmes or research relevant to their specialities.

Disseminating information to previous trainees

As various witnesses remarked, the current Inquiry has served to inform both the medical profession and the public about the treatment and management of CIS and about ethical issues. There is a wealth of written opinion from medical experts, ethicists, women and patients, from which much vital social and scientific information could be gleaned. The Royal NZ College has offered to disseminate those findings which relate to current opinion on the aetiology, pathology and management of CIS and invasive cancer. That suggestion would reinforce the more ephemeral messages received from media reports and I would endorse it.

However, the College should not exclude information of a broader nature arising from this Inquiry. Its members need to know of the ethical implications of clinical freedom and peer review and research which have been discussed in such detail over the last year. The scientific lessons are not the only ones to be learnt. Dissemination would be most effective if a variety of techniques were used. These might include articles and comment in medical and nursing journals, regional seminars to discuss particular scientific or ethical issues or the organisation of a population-based screening programme, television and radio debates and comment, as well as special attention to these issues in undergraduate and postgraduate lectures during the next two or three years.

Students

It is important to stimulate student thinking on ethical issues. There is little or no formal teaching on ethics at the Auckland School of Medicine although this subject has been widely discussed publicly over the past few years. The Otago School of Medicine is developing and implementing a programme which introduces medical ethics from year two of the medical degree in a framework which allows a wide range of topics to be discussed. The Auckland School should consider a similar course, stimulated perhaps by the involvement of members of the public (including patients), recognised ethicists and health consumer groups.

The public does not see medicine purely as a scientific pursuit. Increasingly, it is demanding evidence that doctors think through the many dilemmas which surround its practice and that they involve the public in ethical decisions.

Research

The Royal NZ College may be prepared to encourage study or teaching using the detailed information upon which my findings are based. There is also a huge quantity of pathological data available for research at National Women's Hospital. It should not be lost to the profession and the patients it serves. Social scientists and ethicists will discover a large amount of raw material on patients' attitudes and the social consequences of treatment which should not be overlooked.

Patients

Any patient who is to be examined or to undergo any procedure related to teaching, must be informed of the nature of the procedure, the number of students to be present as observers and the names of those who are to participate actively.

If the examination or procedure is not part of the patient's planned treatment, if it is to be undertaken by more than one person, or if the patient is to be unconscious, her written consent must be sought, after she has been provided with all relevant information.

1. Aust NZJ Obstet Gynaecol 1987; 27:131
2. NZ Medical J 8 October 1987:747
3. NZ Medical J 14 August 1985:636