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An
**UNFORTUNATE
EXPERIMENT**

at
***National
Women's***

by SANDRA CONEY
and
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IN OCTOBER 1985, RUTH (NOT HER REAL NAME, FOR LEGAL REASONS which will become clear later in this story) returned from National Women's Hospital and told her workmates she felt she'd just been to Auschwitz. "I feel as if they've been experimenting on me," she said. Ruth's fellow teachers thought she was being ridiculous and said so and so she pushed her doubts to the back of her mind.

It was over 20 years since Ruth had made her first visit to National Women's Hospital. She had not been a teacher then, but a 27-year-old suburban mother of three small children. She had failed UE and with "the disadvantage of no education" remembers herself as "the sort of patient who meekly did what she was told."

She had been referred to the hospital by her general practitioner after a "suspicious" cervical smear. Having a cervical smear means that cells are collected from the surface of the neck of the womb using a sort of ice block stick, then smeared in a thin film across a glass plate so that their structure can be seen through a microscope.

At the hospital Ruth was told that though her smear was "suspicious", nothing more serious was going on. She came home and reassured her husband that she didn't have cancer and that there was nothing to worry about. "That", she remembers, "was the frame of mind they put me in from the beginning."

Six months later she had an examination of her cervix with the colposcope, a powerful magnifying instrument, and a single punch biopsy removed a fragment of tissue the size of a rice grain for scrutiny in the pathology laboratory. In the space of the next six months, Ruth had three colposcopies and three smears were taken. She felt confident that she was being carefully watched.

In mid-1965, Ruth became pregnant. Her GP was surprised when she told him about the pregnancy. "What do they think at National Women's? he asked. Ruth told him the doctor she saw at the hospital said it was fine and her GP agreed that he must know what he was doing. In March 1966, Ruth gave birth to her fourth child, a healthy eight-pound girl.

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PHOTOGRAPH BY JOHN REYNOLDS

THE DOCTOR Ruth saw at National Women's Hospital was Associate Professor Herbert Green. What Ruth didn't know was that Green was carrying out research on his patients and that her case had already been written up in a medical magazine.

Herb Green was an expert on cervical cancer. He was on the world circuit, attending conferences and publishing frequently on the subject in prestigious gynaecological journals. From 1956 to 1982 when he retired, he saw virtually every woman at National Women's Hospital with invasive cervical cancer and many of the women who had earlier or "precursor" stages, a total of some 1800 women.

Green was born in Balclutha in 1916. He qualified from Otago Medical School in 1945, where he had won his rugby blue. A Southland representative cricket player, he was a powerfully built man who towered over his colleagues. In 1948 he took a position as house surgeon at National Women's Hospital in Auckland. He immediately became involved in the treatment of cervical cancer.

National Women's was in its infancy. It had opened in 1946 to provide for the post-war baby boom.

The powerful Obstetrical and Gynaecological Society, wishing to consolidate its power by controlling the teaching of obstetrics and gynaecology, pushed for the establishment of a post-graduate school based at National Women's. With the support of the Auckland business community, it endowed a professorial chair. An Australian, Harvey Carey, took over the position in 1954. Carey was liberal in his views, and would ultimately fall foul of the obstetricians by advocating less medical interference in childbirth and opposing a specialist monopoly of the planned unit. Carey was also keen to test the use of cytology in the detection of cervical cancer.

National Women's Hospital had inherited responsibility for the treatment of cervical cancer from Ward 4 at Auckland Hospital. It took cases from the whole of the northern half of the North Island and by 1954 a specialised clinical team had been set up.

Invasive cervical cancer is described as "the most miserable of cancers". In the days before cytology it was not always detectable until at an advanced stage when there would be the unusual bleeding from the uterus or a visible growth on the cervix. The only treatment was by deep ray or radium, although in the early 50s surgery was introduced at National Women's as an additional treatment. In-

vasive cancer was thought to go through earlier or "precursor stages". These stages were called dysplasia, or abnormal cells, the most abnormal cell being called carcinoma in situ or CIS (pronounced kiss). CIS was believed to finally progress to invasive cancer.

A smear from the cervix might reveal cell changes in the earlier stages. The theory was that if cancer could be detected before it reached the advanced invasive stage, it might be possible to remove it and cure the disease.

Carey knew that at nearby Greenlane Hospital Dr Stephen Williams' cytological smear tests of sputum had been successful in detecting unsuspected lung

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cancer. He knew too that in New York, Dr Papanicolaou, inventor of the "Pap Smear", was "booming away about his cause". Carey went to Williams, and as Williams recalls, begged him to do a trial run of 1000 cervical smears of women entering the hospital for other causes. "Of course", he remembers, "long before we had done 1000, at about the two hundredth specimen, we had turned up an extraordinary smear of carcinoma in situ with cancer cells spread right across the smear. There had been not the slightest sign of cancer on her cervix. Carey was dumbfounded. We did a biopsy tissue test of the cervix and discovered loads of CIS in the tissue."

With this success, the programme did not stop at 1000 smears. It continued and a full-time cytologist was appointed to National Women's to set up a laboratory and train staff. He was sent to the United States to study cytology at first hand, and on his return the Papanicolaou grading sequence was introduced. By 1957 the "Pap Smear" was offered to all doctors in New Zealand.

Carey was evangelistic in his belief in the benefits of screening. Remembers Williams: "Carey raced around like a bee in a fit. He wrote an article for the *Woman's Weekly* saying that cervical screening could save lives. He concluded that he could save five lives for every 1000 smears, a wildly exaggerated claim

as it turned out."

By 1964 the hospital cytology service was seeing 20,000 specimens a year. The year before, National Women's had shifted from its original Cornwall Hospital premises to new \$3 million purpose-built premises in Claude Road, Epsom.

It also had a new head, Londoner Dennis Bonham, elevated to the status of professor from a position as lecturer at University College Hospital, London.

A new cytology block was put out to tender in 1964, but by this time Herb Green had stepped in and said he was having doubts.

Green had joined the cervical cancer clinical team in 1955. He and another colleague had done a limited number of smears in 1948, but he had been out of the country when the major initiatives on cervical cancer were taken.

Green wasn't convinced of the idea of progression of the disease, that carcinoma in situ developed into the potentially fatal invasive cancer. He argued that invasive cancer was probably a quite separate disease. His theory was that if there was little or no progression, then CIS was not a harmful disease and screening for cervical abnormalities would not lead to a reduction in the incidence of invasive cancer. This was the position he would express for the next two decades.

When Ruth first visited National Women's in August 1964, she had no idea that there was any debate about cervical cancer or that her doctor held controversial views. She was quite sure she was in the best of hands. She was put on the waiting list for a cone biopsy, an operation which removed a cone-shaped core at the cervix which could be checked to see that all abnormal tissue had been taken.

But the day following her admission for the cone biopsy, after preparations for the operation had been made, Professor Green told her that he had decided against operating and she was discharged without any treatment.

Every few months after this Ruth was recalled to the hospital where she had further smears, colposcopic examinations and occasional punch biopsies.

The purpose of a punch biopsy is to diagnose what the disease is and how far it has gone. It enables the pathologist in the lab to scrutinise a small section of the cervix under a microscope, look at the cells and say what they are doing. Very occasionally a punch biopsy can cure CIS, but it is most unlikely as the sample is so minute. It has never been regarded as treatment for cancer.

Treatment involves more extensive surgery to remove the cancerous cells, the object of any treatment being to return to a negative (normal) smear later.

Ruth's first punch biopsy in 1965 showed carcinoma in situ, a diagnosis which would be consistently entered on her records for 15 years. Her smears were almost invariably positive (abnormal), and the reports described the cells as "suggestive" or "strongly suggestive" of malignancy. But this Ruth did not know.

Many years later, in 1985, Ruth would see her hospital file and finally know that from her first visits she already had carcinoma in situ. In 1964, and over the years, the words were never mentioned.

By May 1967 the colposcopist entered in her notes that he had observed that the abnormal area on Ruth's cervix had increased in size in the two years since the first colposcopic examination. By the end of that year he recorded "progression both in extent and degree". Throughout 1968 and 1969 Ruth's smear reports were "conclusive for malignancy". But still nothing was done.

In March 1970 Ruth was admitted for a curette of the uterus (a scraping out of the lining of the uterus) and wedge biopsies.

A wedge biopsy takes a rather larger piece of tissue than a punch biopsy but it is also used mainly for diagnosis although rarely it can be a cure. Ruth's pathology report showed carcinoma in situ in all the specimens and in one "micro-invasion of the cervix". This is the first sign that the cancer is penetrating deeper layers of cells and becoming invasive.

Despite this, Ruth was again discharged. She returned for smears right through 1970, each one showing cells still "strongly suggestive" or "conclusive for malignancy". Ruth still had the disease and still did not know it.

RUTH WAS NOT the only patient Professor Green was studying. Between 1962 and 1974 he wrote numerous papers for the medical journals detailing his experiences with women with CIS and cervical cancer at National Women's.

It was experience with young childless women which started Herb Green asking questions about the diagnosis and treatment of cervical cancer.

By the early sixties, the idea of the progression of cervical cancer through precursor stages was generally accepted in the medical community. But the disease was not completely understood and there was room for argument. The causes of cervical cancer were not known. How often it progressed and how quickly, was the subject of debate. It was strongly argued that widespread screening programmes would reduce the incidence of cancer by detecting it earlier and the large programme underway in British Columbia, Canada, was being watched with interest.

Women with abnormal smears were customarily investigated further by biopsy to diagnose more accurately the stage of the disease. The standard treatment for the precursor stages was cone biopsy.

Cone biopsy is described as a "nasty operation". Haemorrhage needing emergency treatment is not an uncommon problem and the woman's chances of conceiving afterwards can be significantly reduced. The cervix can be so scarred that menstruation can become difficult and very painful.

For carcinoma in situ the standard treatment was hysterectomy, a major operation involving removal of the uterus or womb which therefore rendered the woman sterile.

Twenty-five years later Herb Green can remember in vivid detail some of the cases which distressed him most. A young poet had her university degree conferred in a ceremony in Ward 9 a week before she died of cancer of the cervix. "When you see a young attractive woman who'd make a wonderful friend for a man a little younger than myself, when you see her die, it's not nice. That's why I've been so vocal. This is bad for mankind. I realised at the time she wasn't the only one under 30, there were four," he recalls.

He remembers too another patient who gave him the clue which formed the basis of his theory. He calls her "the little girl who put me on the right track". Green performed a biopsy disclosing CIS, but the woman "refused a hysterectomy". "Two years later she had a baby. She's still alive, living somewhere round Whenuapai."

Green was concerned at any reduction in women's fertility. He was an opponent of abortion and with his gynaecologist colleagues Patrick Dunn and William Liley, later played a leading role in the early days of the Society for the Protection of the Unborn Child (SPUC). He took such an uncompromising view of abortion, calling it murder, that he was used to present the extreme anti-abortion view to Auckland Medical School students. At one stage he caused a furore at National Women's by refusing to work with doctors performing abortions.

On sterilisation he also held conservative views. He could see virtually no grounds for it, medical or social, arguing that abstinence would lead to the desired result. Once sterilised, he said, a woman had "thrown away a unique possession".

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was a harmless disease which hardly, if ever, progressed to invasive cancer.

Green's belief led him to treat some patients less extensively. He stopped performing routine hysterectomies in women with CIS and instead performed cone biopsies, checking by pathology (tissue diagnosis) that the complete tumour had been removed. By 1962 he was able to report that no patients treated this way had progressed to invasion.

Time had shown that Green was correct in arguing for more limited treatment of CIS patients. Many women were saved from unnecessary hysterectomies, and by the mid-sixties cone biopsy for CIS had become standard treatment.

Having made a breakthrough and having produced what looked like support for his hypothesis, Green pushed the limits of his theory further. Many other medical authors had published papers in the fifties and early sixties estimating that CIS progressed to invasion in a variable proportion of cases. Green proposed "to show that the lesion is probably benign in the great majority of cases" and to question the view that screening programmes could eliminate invasive cancer.

He began to treat small groups in unorthodox ways. At least five women, and possibly as many as 16, had hysterectomies without prior biopsies to diagnose what was happening to the cervix. Green had only looked at the cervix with the naked eye and taken a Pap smear. A Pap smear can reveal an abnormality, but a biopsy is necessary to accurately say what stage the disease is at. Earlier, Green had always argued that biopsies were vital for proper diagnosis. In these cases he'd omitted this step. One result was to provide him with intact cancer lesions to study in the laboratory.

In Green's words, these patients formed a "special series wherein invasive cancer has been ruled out as far as possible by clinical [looking and listening to the patients] and cytological methods before hysterectomy; serial section studies of lesions thus undisturbed by biopsy are being made and will be reported separately."

There were two dangers in performing a hysterectomy without biopsy. First, a healthy uterus might be mistakenly removed. Second, and possibly fatally, if the woman, in fact, has invasive cancer, it would be difficult to treat optimally with radiation therapy after a hysterectomy. In this treatment, radioactive rods are inserted through the cervix to sterilise the uterus and adjacent tissue. With the womb removed, the rods could not be put in place.