Why won’t defenders of the Cartwright Inquiry provide evidence to justify their use of the term ‘conventional treatment’ for carcinoma in situ?

Professor Ron Jones chides me for not having read the report of the Cartwright Inquiry.¹ The reason that I had not done so is straightforward: I have challenged Professor Paul in private and in public² to define and justify her use of the term ‘conventional treatment’ of carcinoma in situ. I felt sure that she would have pointed me to the relevant parts of the Cartwright Report if it contained the evidence I sought from her. The claim by Paul and others associated with the Cartwright Inquiry that a ‘conventional treatment’ existed in the late 1960s and early 1970s is of fundamental importance to judgements about the treatment of carcinoma in situ in Auckland during that era.

Prompted by Professor Jones’ criticism, I have now consulted the Cartwright Report in search of the evidence needed. To justify a claim that ‘conventional treatment’ was withheld from women with carcinoma in situ of the cervix, the first requirement is to show that there was international agreement on management of the condition. This requires research to find out whether such international consensus existed.

The relevant sections of the Cartwright Report are entitled ‘Management of CIS before 1966: Outside New Zealand’ (p 24–25) and ‘The International Debate’ (p 88–91). These short passages do not cite scientific articles, but simply quote the opinions of four witnesses (and one interviewee). In brief, there is no evidence in the Report, or in any of its Appendices, that any attempt was made to conduct the international review of management that might have justified use of the term ‘conventional management’.

Twenty years ago Professor Paul and the other medical advisers to the Inquiry could have sought systematically, analysed and published evidence of (i) international consistency of gynaecological practice in this respect; and (ii) empirical research evidence justifying such consistency. At the very least, they could have referred to Göran Larsson’s detailed review of treatment of pre-invasive and early invasive carcinoma of the cervix.³ This was published as a 40-page supplement in Acta Obstetricia et Gynecologica Scandinavica and contained a bibliography of over 400 articles.

The section on treatment opens with the following sentence: “There are marked differences in the treatment of preinvasive and early invasive carcinoma of the uterine cervix between different countries.” (p 114). The section on the treatment of preinvasive carcinoma refers to 216 publications from authors in the United States, Canada, New Zealand, Australia, England, the European mainland, and Scandinavia. Larsson’s review reveals dramatic differences of opinion about how the condition should be managed—ranging from extended radical hysterectomy to local electrocoagulation—and it refers to a debate about “whether conisation was overtreatment”. 

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¹ Professor Ron Jones
² Professor Paul
³ Göran Larsson
Professor Paul began over two decades ago suggesting that ‘conventional treatment’ had been withheld from women with carcinoma in situ in Auckland. On 24 July 2008 she wrote to me in an email (with ‘New Zealand study of untreated cervical neoplasia’ in the subject line of the message), because she wanted to know about the nature of my connection with Linda Bryder, who has recently published a book challenging the conclusions reached by the Cartwright Inquiry. Professor Paul invited me to send her my ‘views about what went on’.

In response I mentioned that I had held junior posts in gynaecology in the late 1960s and early 1970s, and I that I was not made aware of any generally accepted ‘conventional treatment’ for ‘carcinoma in situ’. Far from it: my specialist mentors exhibited a range of views about what should be done for which abnormalities. I concluded my email to Professor Paul with a challenge:

“What would you, as an experienced scientist with an obvious concern to involve women in decisions about their care, have written about screening for and treatment of cervical carcinoma in situ if you had been asked in the late 1960s and early 1970s to draft an evidence-based, honest information sheet inviting women to attend for cervical screening?”

Professor Paul did not respond to this invitation. I ended my correspondence with her when she suggested that I had an “understandable bias towards defending researchers who are attacked”.

In my 12 September 2009 letter published in The Listener I challenged Professors Charlotte Paul and Jo Manning to detail the elements of what they had referred to in their articles as ‘conventional treatment’ in the 1960s and 1970s. I asked them to cite the evidence upon which their definition of ‘conventional treatment’ was based, and the extent of international concordance with their definition. Paul’s and Manning’s 19 September response ignored my challenge.

Why do defenders of the Cartwright Inquiry like Professors Paul and Manning continue to refer to ‘conventional treatment’ for carcinoma in situ without defining it? Professor Paul fails again to define ‘conventional treatment’ in her 23-page chapter ‘Medicine in context’ in the recently published collection of Cartwright papers edited by Professor Manning. Instead, she compounds her earlier failures to address this challenge by repeating her references to ‘conventional treatment’ (p 124, 133 ) and ‘current best practice’ (p 138). Furthermore, she alludes to ‘international guidelines’ (p 120) without referencing them, and fails to draw attention to WHO guidelines that refer to continuing uncertainties.

Aspects of Paul’s chapter that are perhaps even more disturbing are her intemperate attacks (there and elsewhere) on the analysis published in Linda Bryder’s recently published book. Because I had read a pre-publication draft of the book (albeit not for the publisher), the publisher invited me to draft some text for the back cover. This is what I wrote:

‘Professor Bryder has addressed a question that has remained inadequately investigated for over a quarter of a century. What was the ‘generally accepted', 'conventional' treatment for abnormal cervical cytology which women in Auckland were allegedly denied in the late 1960s and 1970s? Her thorough review of international practice at that time makes clear that there was no generally accepted treatment, a fact that reflected the haphazard way in which screening for cancer of the cervix had been introduced and evaluated.’
Professor Bryder’s detractors have failed to acknowledge that she has done research that should have been fundamental to the Cartwright Inquiry. By contrast with the medical advisers to the Cartwright Inquiry, Bryder devotes 24 pages (Chapter 3) of her book to placing practice in Auckland in an international context, including a paragraph summarising Larsson’s findings.

The chaotic way in which screening for cervical cancer had been introduced was one of the reasons that Archie Cochrane awarded ‘the wooden spoon’ to obstetrics and gynaecology for being the medical speciality that had been most negligent in obtaining reliable research evidence to inform its policies and clinical practice - among other things, for its “determined refusal to allow ‘Pap smears’ to be randomised, with disastrous results for the whole world”.

Bryder puts it very well in the opening paragraph of the conclusion of her Chapter 3 (p 55):

“What then was the conventional treatment’ that the patients at National Women’s Hospital were apparently denied by Herb Green? According to Cartwright it was not hysterectomy, which had already been rejected throughout the world as a routine response to CIS in favour of cone biopsy or local excision by the 1960s. Yet many gynaecologists still believed that hysterectomy was the appropriate response to the problem, including star witness to the Inquiry Ralph Richart. A significant minority of gynaecologists was questioning the appropriateness of hysterectomy and cone biopsy, both of which were far from benign procedures. Kolstad might have queried Green’s clinical decisions, but he was the first to admit that there were no clearcut answers. Jordan might also have been critical of Green’s approach, but he did acknowledge the ‘dilemmas’ in deciding appropriate treatment for asymptomatic women when the treatment options themselves carried a ‘high morbidity’. Jeffcoate recommended cone biopsy only when smears repeatedly contained cells indicative of malignancy.”

I find it extraordinary that the world has had to wait for a historian to expose the sloppy job done in the past by epidemiologists in New Zealand. Bluster and unreferenced, ex cathedra references to ‘conventional treatment’ are simply not good enough. However hard they and others with vested interests in defending the methods used in the Cartwright Inquiry may try to brush aside this issue, an evidence-based defence of the use by Professor Paul and others of the term ‘conventional practice’ is fundamental to judgements about whether or not what happened at the National Women’s Hospital was a scandal.

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References:
   Auckland: Auckland University Press; 2009.