**Revisiting New Zealand’s “Unfortunate Experiment”: Are medical ethics ever a thing done?**

Sharon Batt, adjunct professor, Department of Bioethics, Dalhousie University, PO Box 15000, Halifax, Canada B3H 4R2.

Review of Ronald W. Jones’, *Doctors in Denial: The forgotten women in the ‘Unfortunate Experiment.’* Dunedin, New Zealand: Otago University Press, 2017, 248 pages (Paper), US $28.95, NZ $39.95. ISBN 978-0-947522-43-8.

Medicine has a sad legacy of research scandals and discussions of how to reduce their frequency are central to medical ethics. Among the most infamous is the Tuskegee study, in which researchers at the US Public Health Service followed 400 African American men with syphilis for 40 years and withheld treatment, in order to understand the progression of the disease. Similar in many respects is a study of women with cervical cancer in situ (CIS), carried out in New Zealand, from 1966 to 1988, and the subject of a new book, *Doctors in Denial: The forgotten women in the ‘Unfortunate Experiment.’* Herbert Green, a professor and senior physician at the National Women’s Hospital (NWH) in Auckland did not believe CIS was a precursor to invasive cancer of the cervix and, to prove his point, continued to record the untreated lesions of dozens of women, even as their cancers progressed and some patients died. In *Doctors in Denial*, Ronald Jones describes the New Zealand case as an insider with a strong point of view.

Two questions come to mind. First, does Jones’s book on the New Zealand case add to the existing mountain of documentation, analysis and debate that this particular experiment has already generated?[[1]](#endnote-1) And if he does offer new insights, do they have any relevance to medical ethics in India, which has its own cervical cancer scandals? The answer to both questions, I argue, is an emphatic “yes.”

Before discussing Jones’s book, I consider first some valid concerns. In an editorial in this journal in 2012, Mala Ramanathan and Amar Jesani note that ethics teaching and scholarship in India tend to foreground international research cases from high-income countries, to the exclusion of home-grown scandals (Ramanathan and Jesani 2012). They point out that, to spur the development of a homegrown bioethics movement, India’s own local cases need to be written about, debated and discussed as part of bioethics teaching. Excessive focus on international cases, they caution, might breed complacency, sending the implicit message that such breaches only happen elsewhere. Furthermore, these cases from high-income countries might obscure local realities important to ethics in India, such as high rates of illiteracy, which complicate informed consent, and the different standards of care that limited national resources impose on India’s public system of health care.

At the same time, international examples may provide useful comparisons for addressing ethics scandals in India. Eric Suba of Kaiser Permanente in California deems three American-funded clinical trials carried out in separate Indian centres so indefensible he labeled them “Tuskegee 2.0” (Suba 2015). The trials compared cervical cancer screening to no screening among low-income women. Noting that President Clinton apologized in 1997 for the Tuskegee study, Suba calls on the funders, the US NIH and the Gates Foundation, to do likewise. Another study that invites international comparison has striking similarities to the New Zealand experiment. Beginning in 1976, Indian researchers followed the natural history of dysplastic cervical lesions in 1,163 women in New Delhi (Luthra, Prabhakar, Seth, Agarwal, Murthy, Bhatnagar, et al., 1987). Ramanathan and Jesani note that when the New Zealand scandal became public, a Cervical Cancer Inquiry conducted by a judge spawned a system of research ethics committees, a cervical screening program, and a Code of Patients’ Rights. In India, similar ethical problems were exposed, yet no new structures were put in place, the problems were quickly forgotten and little changed. The new structures and the debate in New Zealand thus created a lasting legacy that enhanced patients’ rights and set new standards for medical practice, these authors conclude. They urge health professionals and the public in India to follow the New Zealand example and take local transgressions seriously: write about them, learn from them and, above all, don’t bury and forget them.

In Ronald Jones’s telling, however, the “lasting legacy” of the scandal in New Zealand is as much myth as reality. Jones is a retired obstetrician and gynecologist who worked at the Auckland hospital where Herbert Green’s research took place. He was a crucial actor in the New Zealand drama – a whistleblower before the term was commonplace. His central claim is that New Zealand *has* forgotten the lessons of the case that haunted his whole career. Jones has not forgotten: for years, he kept meticulous records from many sources, which he uses to reconstruct not only what happened, but why.

Jones acknowledges the positive institutional changes that followed the Cartwright report, and some salutary effects (the incidence of and mortality from cervical cancer is half what it was before the screening program was introduced and now compares to the best in the world). Yet, as his account makes clear, New Zealand’s medical community remains divided over Green’s research; indeed, opposing sides have become more entrenched. Jones also makes clear that the NWH already had institutional mechanisms in place in the 1960s to promote accountability on the part of physicians and researchers. Two committees reviewed and approved Green’s proposal to conduct a large study of the natural history of CIS. The hospital had a medical superintendent and a superintendent-in-chief, to whom concerns could be (and were) reported. The head of the obstetrics and gynecology department, Dennis Bonham, had the authority to intervene. Difficult issues could be, and were, raised with a number of hospital committees. Jones wants to know why these mechanisms failed: why did colleagues continue to support one rogue doctor, even as evidence mounted that his research premise was wrong? Why did they do nothing when the health of patients was in jeopardy?

In his search for answers, Jones shines a light on power relationships. In 1973, as a young obstetrician/gynecologist, he eagerly joined the staff of the NWH, which had developed an international reputation for excellence in obstetric and gynecological research, teaching and care. He soon discovered the hospital’s “dark secret”[[2]](#endnote-5) -- Green’s unorthodox experiment. At that time, CIS had been established as a condition that progressed to cancer in 20-30% of cases, a progression that timely detection and treatment could prevent. Initially he remained uninvolved, focused on securing his position; over time, however, deeply disturbed by the hospital’s tolerance of the research, he could not remain silent. He and two like-minded colleagues documented their concerns and tabled reports at hospital meetings. They appealed to the medical superintendent and three successive superintendents-in-chief. In 1984, they documented research irregularities and the suffering of some participants in a prestigious international journal. And yet the project continued, even after Green’s retirement, carried on by his followers. Not until 1987, when two feminists discovered the 1984 paper and wrote an exposé published in *Metro*, a local weekly magazine, did public outrage force the New Zealand government to appoint Judge Sylvia Cartwright to carry out the public inquiry. Her inquiry produced a scathing report, which recommended reforms to protect patients.

Much of this narrative is on the public record and might suggest the case is settled. Not so, says Jones. Powerful opposing factions jockeyed to discredit the report and these efforts continue. At a September 1988 meeting, a motion to support the report and to express sympathy for the women passed unanimously, but was overturned a week later. In 1990, the same *Metro* magazine that broke the story about the experiment published an article expressing “second thoughts.” In 2009, medical historian Linda Bryder published a book in which she in argues that Green did not experiment on the women, he simply provided them with an acceptable form of less invasive treatment.[[3]](#endnote-6) And as recently as 2014, Cochrane Collaboration co-founder Sir Iain Chalmers chastised the investigative quality of the Cartwright Inquiry via a video link to a meeting at the NWH.[[4]](#endnote-7) Shamefully, writes Jones, no apology has ever been offered to the women who suffered, or to the families of those who died.

Jones draws on his detailed knowledge of the hospital politics: the many players and their allegiances, the meetings and the memos, the hallway conversations, and the discussions over tea or scotch in private homes. Based on this insider evidence, he convincingly refutes the claim that Green simply provided an accepted, minimally invasive treatment that spared women the risk of side-effects. He analyses the divided perspectives within the hospital culture and the persistent bitterness over the Cartwright Report. Some years after the inquiry, to cite just one example, a younger colleague returning to New Zealand complained to Jones, “Bloody Cartwright has fucked up my whole career.”

The environment at the NWH when Jones arrived was patriarchal and hierarchical. A small group of senior physicians, including Green and Bonham, were gods, given to bullying and tantrums. Fiercely competitive and wedded to British elitism, the senior physicians clung to the privileges of clinical freedom and academic independence, which could translate into “the divine right of doctors to do whatever they felt was best for their patients.” Jones identified with a younger cohort, whose egalitarian perspective included a willingness to challenge hierarchies and injustices. These competing belief systems dictated collegial loyalties and friendships in ways that stacked the deck against those who wanted the experiment stopped. Bohnam consistently supported Green. Mont Liggins and William Liley, internationally renowned researchers in obstetrics who had the status to challenge Green, also protected him. The three were close friends and partners in a forestry venture and they apparently avoided discussing the awkward topic of Green’s research while together.

Jones, hired at the bottom of the hierarchy, quickly bonded with two colleagues: William McIndoe, an expert in colposcopy, who was also low on the totem pole, and Jock McLean, the head pathologist. Both spent their days examining abnormal cell specimens, including those of Green’s patients. When the trio was unable to stop the research internally, they shared their alarm with colleagues at conferences abroad and, ultimately, in their critical article about the experiment. But junior faculty and technical staff were expected to display blind loyalty to those above them and to uphold the hospital’s stellar public image. Colleagues froze them out and, as they watched women sicken and sometimes die, their political impotence took an emotional toll. Jones (whose wife was undergoing treatments for breast cancer which eventually killed her) describes himself as “a broken man, who could not run away.”

Bonham and Green did not escape judgement. Following the Cartwright Inquiry, the New Zealand Medical Council charged Bonham with “disgraceful conduct” for not intervening; Green was too sick to be charged, but the careers of both ended “in tatters.” To supplement his experiment on the women, Green took vaginal swabs from female newborns without parental permission and, consistent with his belief that CIS was not a precursor to cancer, he actively opposed a national cervical cancer screening program that had been proposed as early as 1959. The program, which finally began in 1991, was certainly a positive outcome of the Cartwright inquiry; but during the 32 years its implementation was stalled, an estimated 3,100 New Zealand women suffered avoidable cervical cancer.

How can this grim account be squared with the fact that the scandal and subsequent inquiry spawned both debate and tangible structural changes? Two recent analyses support Jones’s decision to highlight the internal culture at NWH rather than the external signs of progress. In the first, Carl Elliott suggests that we over-rate institutional structures as bulwarks against wrongdoing in medical research (Elliott 2017). Based on a compilation of research scandals in medicine, he concludes, “Dissenters who try to use internal institutional channels to expose the abuse of research subjects rarely succeed.” One reason is that witnesses to corruption or safety violations typically remain silent. They fear blowing the whistle will be futile, and they fear retribution. “Unfortunately, both of those fears appear well-founded,” Elliott writes. In the cases he examined, justice was done only when the media exposed a scandal.

A second analysis suggests that scandals in medical ethics are over-rated as agents of change. Sociologist Adam Hedgecoe used archival and interview material spanning several decades to study regulatory changes in research ethics review committees in the UK from the late 1960s to the late 1980s (Hedgecoe 2017) . Although numerous research scandals occurred in that jurisdiction in the study period, Hedgecoe found that policies governing prior ethics review of medical research evolved gradually, through a series of small changes initiated by physician groups and the Department of Health. Their goal was not to increase protection for patients. Medical researchers and government policy makers shaped institutional rules to serve their own interests: maximizing opportunities for obtaining research funds, or attracting research from the pharmaceutical industry to boost the national economy. When consumer organisations tried to strengthen written consent requirements, they met resistance.

Like Jones, Elliott and Hedgecoe dig beneath the surface of medical scandals and the structures created in the name of research ethics. Their analyses prompt us to rethink how we study these cases, structures and debates. They use archival, interview and ethnographic material spanning years or decades to understand the local history, politics, resources, values and actors inside the “black box” of ethics-related policy decisions. Structures are critically assessed; power relationships are exposed. Hedgecoe rejects what he terms “assumed isomorphism” – the temptation to extrapolate from one jurisdiction to another. Rather, these analysts construct complex narratives of the local culture and its connections to the international community. Local details are paramount, but certain themes do recur across time and place: Jones recounts that the university of Auckland wanted to apologize to the women damaged by Green’s experiment but refrained, based on legal advice; *BMJ Global Health* recently withdrew a critique by Eric Suba and colleagues about the US-funded research on cervical cancer screening in India, citing defamation concerns.

The American writer Archibald MacLeish famously wrote that democracy “is never a thing done. Democracy is always something that a nation must be doing.” If I were to sum up the lesson of *Doctors in Denial*, it is that medical ethics, too, are never “a thing done”; but rather, something that concerned parties everywhere must always be doing.

Sharon Batt, PhD, is an independent writer based in Halifax, Canada. She specializes in issues relating to cancer, patient participation in health policy, and ethics. Her latest book is *Health Advocacy Inc.: How Pharmaceutical Funding Changed the Breast Cancer Movement*, published by UBC Press.

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1. See the Cartwright Inquiry website, which includes many original documents: <http://www.cartwrightinquiry.com>. [↑](#endnote-ref-1)
2. This phrase and others that appear in quotes are from Jones’s book. [↑](#endnote-ref-5)
3. Linda Bryder’s book is titled, *A History of the ‘Unfortunate Experiment’ at National Women’s Hospital* (Auckland: Auckland University Press, 2009). It was not reviewed for this essay but is part of the ongoing controversy described in Jones’s narrative. [↑](#endnote-ref-6)
4. Two letters by Iain Chalmers in the *New Zealand Medical Journal* provide earlier, written accounts of his objections. See, Chalmers, Iain. Why won’t defenders of the Cartwright Inquiry provide evidence to justify their use of the term ‘conventional treatment’ for carcinoma in situ? *NZMJ*, July 30, 2010 123 (8-11) <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2010/vol-123-no-1319/letter-chalmers>; and Chalmers, Iain. Defendants of the Cartwright Inquiry are unable to provide a description of ‘adequate care’ for cervical carcinoma in situ. September 10, 2010, 123 (85-87) https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2010/vol-123-no-1322/letter-chalmers. [↑](#endnote-ref-7)