Letter from . . . Dunedin

CAT among the kiwis

A G HOCKEN

"Two households, both alike in dignity,
In fair Verona, where we lay our scene,
From ancient grudge to new mutiny,"

I suppose the beginnings were recognisable in medicine and medical education as long ago as 1875, when a poor frustrated Coughtrey, appointed the first professor of anatomy and physiology and trying to establish a medical school in the University of Otago, was battling with the university council. In the despair of his non-progress, in a relationship that was always fragile, he wrote that if the establishment of a medical school in Dunedin were not prosecuted with expedition then Canterbury would forestall Otago. At about the same time the dissolution of the Provincial Government in New Zealand yielded to the formation of the Central Colonial Government. Of the many political permutations and gyrations that the provincialists in Otago examined to try to preserve its affluence for themselves, desperation allowed the proposal of an alliance with the province of Canterbury. This was archly rebuffed by the latter, provincial governments were abolished, and New Zealand became one nation. Although so in government, it has not been so in spirit, and the divisive parochialism, engendered of fierce local pride that persists, was recognised by the minister when he reflected that his decisions of February would "not please parochial areas."

Nowhere are the manifestations stronger than between Otago (often allied with Southland, for they are of common stock) and Canterbury, immediately to their north in the South Island. Just how much these rivalries stem from the sectarian origins of English Anglican Christchurch and Scottish Presbyterian Dunedin, where Anglicans used to be overtly referred to as "the little enemy" in the community, is difficult to say—probably no greater than Plaid Cymru and the Scottish Nationalist Party influences in Britain today, I suppose.

The fierce calvinistic hold of Presbyterians on Dunedin began to break when gold was found in avaricious quantities in the early 1860s, attracting a diluting influx of fortune seekers. In that decade the city's population multiplied sixfold, Dunedin became the business hub of New Zealand, and into this affluent town and busy port the medical school was born in 1875. Like others before it, however, the gold boom was short lived, rich as it may have been. Indeed, the 1880s saw a severe economic depression in New Zealand. The twentieth century ushered in the quietening of the south. The centre of population moved, and today the city of Christchurch on the Canterbury plain has twice the population of Dunedin. For specialist services the Canterbury hospital authority drains a population over half as great again as that of the Otago authority. Despite these changes, the home medical school of preclinical and clinical

sciences has remained in the bosom of the university in Dunedin, although clinical schools of the University of Otago have been established in Wellington and Christchurch within the past decade.

Rivalry for facilities

So, the historical background to New Zealand's recent storm in medicine is the established, traditional, and (rightly) hallowed medical school, beset by the adversity of an economic affluence that has migrated to a flourishing population centre with a newly established clinical school. It would be unnatural not to assume that there were aspirations for that larva to emerge as the imago of the University of Canterbury Medical School at Christchurch. On this back cloth it will not be difficult for an outsider to see how rivalry for facilities has developed between those who feel the right to them by establishment, and those who feel the right to them by today's patterns.

Two promises have been made politically. Firstly, arising from the bizarre advice of the Ross Report in 1977, which advocated five cardiac surgical units in this nation of three million people, the Prime Minister personally made a promise to establish such a unit at Christchurch. This was difficult to understand at the time, when the already established South Island unit in Dunedin did not yet have a fully extending work load. The introduction of CT scanning to medical technology was explored in New Zealand in 1978 by the establishment of a body scanner in Auckland, the major population centre of New Zealand. So, the second promise was that of the then Minister of Health of scanners for Wellington, Christchurch, and Dunedin in about two years, after evaluation of the original instrument. Dunedin protagonists placed its own priority high in this matter, if only to update the only neuro-surgical unit in the South Island. Neither of these promises of equipment and specialist development has materialised. Meanwhile, in common with everybody else, New Zealand has slipped towards national impecuniousness, and fearful speculation, not to say suspicious speculation, has been rampant.

In February the situation was exploded into clarity by the Minister of Health's announcement of the distribution of new capital equipment in the South Island. The furore so aroused is probably unique since the abolition of the independence of Otago, so sacrificing (as it was then seen) its husbandry to the prodigality of its avaricious and incompetently managed sister provinces of this one nation of New Zealand. The allocation of radiotherapy equipment to Auckland and Hamilton has gone unremarked, in Dunedin at least. The placing of a head scanner in Wellington was slyly commented on by the local political cartoonist as being singularly appropriate, so long as it was sited in Parliament building. The announcement, however, that there would be a body scanner for Christchurch and none

University of Otago, Dunedin, New Zealand

A G HOCKEN, MB, FRCPD, senior lecturer in medicine

for Dunedin, and \$900 000 worth of replacement cardiac radiology equipment for Dunedin and no cardiac surgery for Christchurch has produced a vociferous dismay, which the Minister of Health foresaw when he made the allocations.

The minister's announcement of the distribution of \$10m of equipment over three years among cancer treatment, cardiac surgery, and neurosurgery, among five major hospital board areas contained the laudable philosophy "that New Zealand is one." He sagely foresaw that it was likely "not to please parochial areas." In response to questioning about the querulousness his package was likely to unleash, he went on to say, that any objections "will not be informed criticism." His words, and worse, his actions, were taken to belie a statement attributed to him a week or so previously, in which he was reported to have said that the Government would do nothing to undermine professional standards in teaching hospitals. The deprivation of the established neurosurgical unit and the potential ill effect thereof on several interdependent services, is not seen in Dunedin as being compatible with that promise. But then neither were his present actions on the 1977 promise of his Prime Minister to set up cardiac surgery in Christchurch. His plea of limited resources with which to supply the nation as a whole has not been accepted.

Setback to neurosurgery

While some see the necessity of a CT scanner in Dunedin as an instrument to maintain modern technical standards for the country's premier medical school as a need in itself, the greatest dismay was directed to the setback such a deprivation would apply to the neurosurgery centre there. Dismay expanded into outrage when the Minister's stated intent to "phase out" neurosurgery from Dunedin and to place it in Christchurch was disclosed. While it was agreed that it might possibly be economically justifiable to relocate a regional service unit to the greater population centre, whatever disadvantages in morbidity and mortality a new team would incur, whatever personal disappointment that might mean for the established team, whatever service dismemberment it might mean for the combined neurology service of Dunedin, it had taken no cognisance of the educational implications for the medical school. The *Otago Daily Times* went so far as to opine that removal of neurosurgery was deliberate Government policy not only to phase out neurosurgery, but to undermine Otago Medical School at Dunedin, implying the intent to relocate the medical school in Christchurch.

The general public's attitude, reflected by the correspondence columns of the *Times* has been surprisingly unresponsive. The few letters reflect personal embitterment or outraged civic pride. There has been a solitary contribution applauding the Minister's distribution of goodies and offering counters to the criticisms of it. That appeared over a nom-de-plume, and, while this is a deplorably usual habit in the *Times*, from my assessment of the climate here, I think it was probably prudent if there is any verity in the nom-de-guerre used, "Physician at large!" The other voice to which that writer drew attention was the guarded approval, at the time, of the spokesman for the New Zealand Medical Association for the package, even though the Otago Division later recorded and published the unanimous dismay of its membership.

Educational implications

The voice of the university and medical school in Dunedin joined the general medical opinion in deploring the lack of consultation with field workers in medicine and medical education before the minister made his allocations and rearranged his regional services. Beyond this, however, they expressed

perturbation that the educational implications of any failure to maintain technical standards or run down of services has not been considered. Strong voices have indicated their view that scanning, today's technology, is needed to attract and hold today's teachers in order to educate today's medical students. There would indeed appear to have been no consultation with the Education Department, for which a case of relevance has been put forward in connection with the nation's major medical school. There is unanimity in expression for the standard of staff that can be attracted as teachers to an institution that does not support today's technology. The opinion that CT scanning is essential in the direct sense to the proper education of pre-clinical students, however, is not generally accepted in Dunedin.

Reactions among local lay activist groups and pro bono publicos in both regions has been predictable. The philosophical response of North Canterbury Hospital Board referring to the projected gain of the scanner and neurosurgery against the non-acquisition of cardiac surgery was reported to be "win some, lose some." The Christchurch Cardiac Companions, however, were outraged, not only at the frustration of their aspirations for local cardiac surgical facilities, but also at the government threat to bring to bear practical measures to encourage the recognition of geographic regionalisation of specialist services. Conversely, in Dunedin the lay scanner steering committee has taken on a new life of vociferousness fed by their view of the duplicity of the Department of Health and nurtured by the snub to local pride and needs.

The South Island Movement, whose philosophical basis is political separation for South Island has also gone on record in support of the need for local CT scanning facilities. Their philosophy was presented in a petition to Governor Grey as long ago as 1867, but, apart from the establishment of Cook Strait, seems no nearer its objective than it was 120 years ago. The fire-ball response of these bodies in Dunedin speaks of sums to be raised by local effort to provide the capital cost of the scanner. The Government, almost pre-emptorily, had the Minister of Health allow that, while local bodies are quite entitled to purchase such equipment, they should not expect the Government to support maintenance and running costs. Personally, I am not sure that the enthusiasm that will stimulate the legendary generosity of the people of Otago and Southland for a worthy cause can be expected to be maintained for three years through recurrent public appeals for running costs. For we have been told that this \$10m has to last that time; then hospital boards may resubmit their cases for capital equipment. And, should, in that very short time, the money be raised locally to make the purchase, think not of the political beneficence of Rob Muldoon allowing him to be overcome with avuncularity and reward good work by taking over running costs—he hasn't any!

A combined approach by the Otago Hospital Board and the scanner steering committee to go over the minister's head with an appeal to the Prime Minister was a predictably sterile action. Indeed, initially the latter refused to see the deputation from hospital, university, and people with characteristic whimsy. One can imagine the mechant air with which he made the quoted dismissal, "I do not favour costly travel to Wellington by deputations." The matter was protracted a little by his offering a short conversation between conferences—a gesture of magnanimity to hospital board and medical school officers—before writing a decision that the Government would not change its stance. Indeed, he is reported to have gone on to say that Otago's dissatisfaction with its share of the South Island's facilities in general and the new hardware hand-out in particular was presumptuous. Even though the Minister of Health labours under the disadvantage of having his Prince Charming role overshadowed by Rob's part of both Ugly Sisters rolled into one naughty grin, it was an unenviable task trying to fit New Zealand's needy feet into that tiny glass slipper of limited resources. Therein of course lay his greatest problem. Unlike the original benefactor he has the disadvantage of two Cinderellas squabbling for the favours. While one's mind might be for-

given for recalling the opening lines of *Romeo and Juliet*, I think a better analysis would be the consideration of three numbered summaries:

(1) Dunedin, in Otago, is the seat of the University of Otago. It has an established (1875) clinical and preclinical medical school, now disadvantaged by a small population drainage area of 300 000 maximum. To attract competent staff to maintain the standard of teaching, a full complement of services and technology needs to be maintained.

(2) Christchurch, in Canterbury, is centrally located in the South Island. It is a vitally motivated business and industrial centre driven by ambitious local personalities, which drains a "specialist area" of 500 000 people. In Christchurch there is a clinical medical school of the University of Otago, which has

only recently supplemented the service hospital. Is it possible that continuing ambition is to extend that role?

(3) New Zealand is a nation of 3m people, whose living is mainly dependent on the cultivation of 60m sheep: a nation whose economic wheel is contained within that greater wheel, the unhappy world economy. As long ago as 1974 New Zealand was spending 5.9% (and climbing) of its GNP on health and diverted 70% of that into hospital care, the highest in the world, whose average was 52.2%. The inter-relationship and the consequence are plain. Technically advanced hardware is not made from sheep, and expensive equipment needs to be expensively imported. Thus there is a limited resource from which number three has to supply numbers one and two.

I wonder how Solomon would have handled this one?

Clinical Topics

Critical assessment of the clinical TNM system in breast cancer

REPORT FROM THE YORKSHIRE BREAST CANCER GROUP

Summary and conclusions

If useful conclusions are to result from trials of treatment in breast cancer it is vital that the system of classification is accurate and reproducible. In 348 patients with operable breast cancer the TNM classification (1974 version) was examined. Surgeons, radiologists, and pathologists varied considerably in measuring tumour size (T), surgeons and radiologists agreeing in only 39% of cases, surgeons and pathologists in 54%, and radiologists and pathologists in 59%. Surgeons and pathologists agreed on the state of the regional lymph nodes (N) in 68% of cases. Thus the 1974 version of the TNM system is an inaccurate method of classifying breast cancer. The revised 1978 version, however, incorporating histopathological findings, should improve the accuracy of classification, and it is strongly recommended that future trials use this new version.

Introduction

In breast cancer various methods have been suggested of providing an accurate assessment of spread of the disease and thus of prognosis. Currently the TNM system is probably the

one most commonly used as the best means of establishing uniformity in the staging of breast cancer.¹ The TNM system emphasises the importance of accurate information and is based on clinical assessment of tumour size (T), the state of the regional lymph nodes (N), and presence or absence of distant metastases (M). Attention is currently focused on the desirability of multicentre trials of adjuvant treatment in breast cancer,²⁻⁴ and the TNM system is generally used for patient classification. Accurate staging and classification are vital if trials of treatment are to be meaningful, and when comparing results from different centres.⁵

Reservations as to the accuracy of the TNM system in breast cancer have recently been expressed by Irving *et al.*,⁶ and we have shown⁷ that surgeons disagree when asked in routine practice to estimate the size of a tumour. The clinical assessment of axillary nodes is notoriously difficult and unreliable when compared with histological methods.⁸⁻⁹ Further, a significant proportion of women with clinically operable breast cancer may have occult metastatic bone deposits found only by bone scan.¹⁰⁻¹¹

Each category of the TNM system is thus open to doubt as regards the accuracy of the information recorded, and the validity of the system should be questioned.

We examined data from a prospective, unselected series of women with breast cancer classified by the TNM system (1974 version). These patients formed part of a larger study of prognostic factors in breast cancer, and we had not originally intended to study the TNM system itself until we became aware that our data collection indicated serious problems in categorising patients with this method.

Patients

All patients in this study presented with previously undiagnosed breast cancer to the clinics of the surgical members of the Yorkshire Breast Cancer Group (YBCG) between May 1975 and December 1977. The series comprised patients believed clinically to have

Members of the Yorkshire Breast Cancer Group: Mr F G Smiddy (chairman), Leeds; Mr E A Benson (secretary), Leeds; Mr T G Brennan (Leeds); Dr R Cartwright (Leeds); Dr D Clayden (Leeds); Dr S C Cartwright (Leeds); Dr J A Dossett (Leeds); Mr M Edwards (Northallerton); Dr H G Frank (Leeds); Professor G Gowland (Leeds); Mr R Hall (York); Dr J M Hamilton (Leeds); Mr W G Harris (Huddersfield); Mr D S Hopton (York); Professor C A Joslin (Leeds); Mr V S D Logan (Dewsbury); Dr D MacKinnon (York); Mr W A F McAdam (Keighley); Dr M McCracken (Leeds); Mr T S Matheson (York); Mr V K Modgill (Halifax); Mr J J Price (Bradford); Mr M Whittaker (Bradford); Mr A Wilkinson (Hull); Mr G Wilson (Leeds); Mr K Wilson (Halifax).

The Yorkshire Cancer Research Campaign provided support for the clinical research assistant—Dr M McCracken.