A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

October 29 1986

40-204

Mr. G. McLeish
12 St.Andrews Place
East Melbourne 3002

Dear Graham,

I wonder would you mind inviting GOGOV to do us a favour.

This year the Anti-Cancer Council changed its structure substantially. David Hill moved from full-time public education to specialising in behavioural science. Robin Marks has taken over as Director of Education.

Our information suggests that there are about 250,000 Victorian women in the "at risk" age groups (out of a total of 1.4 million) who have never had a Pap smear. Further, 85% of the cancer is occurring in this unscreened population of 250,000.

One of the first briefs we have given Robin is to develop a public and professional education program on cervical cancer, directed at previously unscreened women aged over forty. My present view is that this is our highest priority target for 1986/1987.

David Hill will need to do some psycho-social analysis of the target population before the final brief for the education program is developed. However, we would be very grateful to receive the benefit of the experience of GOGOV at a round table discussion. We would like to ask such questions as :-

is there a case for screening women over 65 (or 70)?

is it physically difficult to screen these women?

what is GP reaction likely to be to this sort of program?

I know you won't have time to discuss this in detail at the meeting on October 30. It would be very helpful to us if we could have a discussion with GOGOV, or such members of GOGOV as you nominate, in the second week of December.

Yours sincerely

Nigel Gray

Nigel Gray
Director

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Anti-Cancer Council of Victoria

Spare

October 29 1986 40-204

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VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

236-254 St. Kilda Road, Melbourne, 3004

MICHAEL DRAKE, DIRECTOR
M.B., B.S., F.R.C.P.A., F.R.C.Path., F.R.A.C.P., F.I.A.C.

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P.O. BOX 253B
MELBOURNE, 3001
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13th October, 1986

The Editor,
The Age,
250 Spencer Street,
MELBOURNE 3000

Dear Sir,

We write in response to the article reporting Professor Llewellyn-Jones' remarks on cervical cancer (the Age 9/10/86). We strongly support his opinion on the need for increased expenditure in the area of cancer prevention. However, on the basis of studies conducted by the Anti-Cancer Council of Victoria and the extensive records of the Victorian Cytology (Gynaecological) Service (VCGS), the State funded screening service which handles 85% of Pap smears done in Victoria, we would take issue on a number of points attributed to Professor Llewellyn-Jones.

Firstly, a sexually transmitted disease is one in which an individual with the disease transmits that disease to another person by sexual contact. There is no evidence that cervical cancer can be transmitted from one person to another by sexual activity. Certainly genital wart virus infections are sexually transmitted and there is good evidence that the virus causing these infections can also be a major cause of cervical cancer. However, it must be stressed that most women who are infected by the wart virus do not subsequently develop cervical cancer. Those women who do have genital wart virus infection should have regular follow-up including Pap smears secure in the knowledge that, should they belong to the relatively small group who may progress to cancer, such progression will be detected early and curative treatment will be available.

Professor Llewellyn-Jones was reported as saying that about 30% of Australian women have had a single Pap smear. In Victoria, studies suggest that the figure is more likely to be in the region of 70 - 80%. Similarly, it was reported that the cost of diagnosing a case of cervical cancer was approximately $100,000. Based on our figures, the cost of detecting cervical cancer in a women is substantially less than the figure quoted. The statement that most women having regular smears are from higher socio-economic groups is made frequently but does not appear to be entirely accurate. An examination of the VCGS records would suggest that, whilst there may be a slight bias to the so-called higher socio-economic groups, specimens are received from all sections of the community, particularly through the activities of family planning and community health clinics.

VCSACL

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Copy for NIG
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Cervix file
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MELBOURNE 3000

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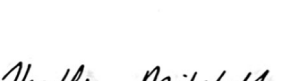
VCSACL

Well organized programmes with women being screened at 2 - 3 yearly intervals have been shown to prevent over 90% of invasive cervical cancers in those women taking part. Our aim in Victoria is to educate the public and professions about this disease in a manner which will eventually see its total prevention.

Yours sincerely,





MICHAEL DRAKE GABRIELE MEDLEY HEATHER MITCHELL
VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE


NIGEL GRAY ROBIN MARKS
ANTI-CANCER COUNCIL OF VICTORIA

VCSACL

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

August 9 1986

40-151

Dr Heather Mitchell
Victorian Cytology (Gynaecological) Service
P.O Box 253B
Melbourne 3001

Dear Heather,

I have skimmed through your article on Pap smear and mammographic screening and think it is both interesting and well worth offering to the MJA.

I have a few comments to offer which are really for your interest and do not constitute suggestions that you should make changes in the article, because I think you have produced a sensible epidemiological view and raised some useful questions.

Sitting in my position gives me a somewhat different view, albeit one not in disagreement with yours. To spell out a few points :

1. I am scared silly that Canberra will make a snap decision some time in the next year or two to allow an item number for the screening of **symptomless** women. Currently, mammograms are done on reference from a GP, based on the assumption that they are symptomatic.

2. I think that if mammography were allowed to be freely rebatable we would have a certain disaster on our hands. We could be confident that we would not meet the standards of the Swedes and that we might, in fact, do more harm than good with an expansion of unnecessary and excessive surgery.

3. Politicians would be very vulnerable to any campaign run in favour of mammography. The subject has enormous emotional appeal and they would be unable to resist any campaign, either well based or badly based.

4. I nevertheless think it probable that a number of pro mammography campaigns could arise over the next year or two, stimulated by any one of a number of insufficiently informed community groups or the medical profession.

5. My conclusion from the above is that I think the Anti-Cancer Council ought to quite quickly establish a few demonstration projects controlled by a specialist group (which we have offered to put together) funded through the Victorian Public Health Department, with money provided as program grants from the Federal Government. I think this proposition is likely to be viable because it represents a way for Canberra to back away from authorising an item number for mammography.

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Anti-Cancer Council of Victoria

6. If we did run demonstration units we would want to set up a variety of experiments within them. I am particularly anxious that we should look at experiments in two areas -

   (i) Experiments as to the best way to achieve good mammographic screening.

   (ii) Experiments involving the **management** of the patients so discovered. There are at least 200 surgeons operating on breast cancer in Victoria at the moment. I would be very anxious that the specialist group of cancers detected by mammography should be managed by a small group of surgeons working on standardised lines and preferably within a clinical trials structure. Setting up such a structure will be far from easy but is not impossible.

   For your interest, you might like to read the draft of the proposal I am cooking up to discuss with David White in the near future. It's semi private at this time as it hasn't been formally approved by any of our committees.

Best wishes.

Yours sincerely

Nigel

Nigel Gray
Director

Encl:

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P.O. BOX 253B
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30th July, 1986.

Dear Nigel,

This is an article on mammographic screening for breast cancer which I am planning to submit to the MJA. It developed from my recent talk at the Association of Community Physicians meeting.

I have taken the liberty of leaving it with your secretary. I would be interested in your comments.

Very many thanks,

Regards,

Heather Mitchell.

ORGANISED MAMMOGRAPHIC SCREENING PROGRAMS - A BENIGN OR MALIGNANT NEGLECT?

Medical practitioners exhort persons with symptoms that could relate to a malignancy to present themselves early for medical assessment. This is eminently understandable as diagnosis in the earlier stages of malignancy correlates with better survival statistics and often involves less radical therapeutic procedures. It is therefore understandable that the medical profession shows enthusiasm for screening to detect diease during an asymptomatic stage when an even better outcome for the patients could be considered likely. In their optimism, the profession appears to have overlooked several other vital concerns, namely that the psychology for subjects, the ethics for the medical practitioners and the necessary organisational structures for a successful screening program differ from their counterparts in the management of symptomatic disease. Until these issues are appropriately addressed the success of screening programs will be suboptimal.

No role for screening exists where the cause of a cancer is understood. The elimination of smoking would remove the vast majority of the morbidity and mortality associated with lung cancer; no population screening program to detect asymptomatic lung cancer is needed. Unhappily the etiological agents for the majority of cancers are not well defined and thus primary prevention is not possible. Some malignancies are not currently suited to secondary prevention through a population screening program, an example being cancer of the stomach. Cancer of the cervix is the only malignancy for which a population screening program has been introduced. It is profitable to consider the situation with respect to Pap smear screening before the introduction of any further programs, particularly mammographic screening for the early detection of breast cancer.

Pap Smear Screening for Cervical Cancer.

During the 1960s Pap smear screening was made available for Australian women. No national program was introduced and consequently a range of facilities now exist in each State. The recommendations concerning how often women with negative smear histories should be screened and the age at which screening should cease are not uniform. No randomised trials were undertaken to determine the advantages of one screening strategy over another, nor was a concerted public education program mounted to inform women of the benefits of the program. Because of the fragmentation of services within a variety of institutions, it is not possible in most States to assess the characteristics of women who have been screened and, by inference, details of the women who have not. As the uptake was initially slow, no difference in mortality

rates due to the screening program can be identified, as distinct from the secular trends which were lowering the mortality of the disease prior to the introduction of Pap smear screening for reasons which are not well understood. Incidence statistics for malignancies have only been kept in very recent years; an analysis focusing on this aspect is consequently difficult to perform. No audit of the screening program has been forthcoming within Australia because the very mechanisms which are essential to allow such an evaluation are mostly missing.

In the context of this national chaos, the Victorian system stands in a most credible way. A free centralised service, the Victorian Cytology Gynaecological Service [VCGS], was set up in 1965 with funds from the Anti Cancer Council and the Health Department of Victoria and has continued to operate, funded in more recent years by the latter institution alone. It is estimated that 85% of all screening smears performed in Victoria are still handled by the VCGS, and thus an evaluation of both the screening program and the disease it aims to detect is feasible. Two aspects of the VCGS system are particularly noteworthy. First, a follow-up program for women with abnormal smears is carried out with the referring doctor receiving one or more reminder letters if either follow-up cytology or information about subsequent management is not received. Secondly, quality control procedures have been in operation since the inception of the service. Information on biopsy specimens is routinely sought and entered onto a woman's record thus allowing an estimation of the cyto-histo correlation. If a significant divergence occurs the cytology is reviewed and where necessary the histology as well. In addition an internal review of smears is performed to maintain a high standard of inter-observer agreement. Within the context of asymptomatic women having a false-negative screening test which could remain undetected for a variable time period, quality control procedures appear vital particularly as the cytotechnology is not automated but rather depends on a labour-intensive procedure where human error is inevitable.

The VCGS operates a most cost-effective system with each smear costing $5.80 [1984-85 financial year: $1,675,000 expenditure, 289,000 smears examined]. This includes the costs associated with both the follow-up procedures and the quality control. The specialist rebate for a Pap smear is $17.20. If a hormonal assessment is also performed the rebate is $28.50. The extent of follow-up and quality control within the private sector is difficult to determine but it is probably not uniformly extensive. Thus the private sector service costs three to five times that of the government funded one. In the context of screening large populations, the importance of this should not be overlooked.

The population-based data of the VCGS can be used to evaluate aspects of the screening program and to study the natural history of cervical neoplasia. With the majority of screening being performed on women under 40 years of age (and therefore primarily detecting precursor lesions), the service is not well used by the women who constitute the incidence and mortality

statistics for invasive cancer. Some protection from normal smears appears to persist for 6 to 10 years (1). Thus even though the younger women are being reasonably screened only very limited protection is 'held over' to the age group where the majority of the deaths occur. 593 women died in Victoria during 1980-1985 with cancer of the cervix being mentioned on the death certificate, the diagnosis of which was made during or after 1975. For this group of women, Pap smear screening had been available for a minimum of 10 years before the disease was diagnosed. Excluding smears associated with the diagnostic workup, 85% of the women had no screening history with the VCGS at all. Less than 3% of the women had an adequate screening history [defined as 3 or more smears over the preceding 10 years, only one smear from each calendar year being counted]. It is therefore hardly surprising that the mortality from cancer of the cervix has not been reduced by the screening program.

Rational screening strategies should be based on an understanding of the natural history of the malignancy and its precursor lesions. Information from a population screening program allows this to be documented much more precisely than an understanding gained from anecdotal evidence and small case series. For cancer of the cervix, there seems little doubt that the commonly believed transition times of 10 years from dysplasia to carcinoma in situ and of 10-20 years from carcinoma in situ to invasive cancer are probably optimistic overestimates. (2) For a significant number of women, the transition times appear to be much shorter, possibly in the order of months to years.(3,4,5) It is both logical and sensible to have recommended screening intervals which reflect these estimates. The acquisition of this type of knowledge without a central data-base is extremely difficult; its lack translates into inappropriate screening strategies which reduce the potential effectiveness of the program.

It is somewhat depressing to consider that the taking of a Pap smear is considerably easier than the taking of mammograms. Women who present for contraception, management of pregnancy or the common gynaecological symptoms of vaginal discharge or bleeding can have a smear, albeit on occasions of a diagnostic nature, performed by the medical practitioner 'on the spot'. Postmenopausal women do not fortuitously attend medical practitioners for symptoms or services related to the breast. To have mammography performed, a conscious effort will have to be made either by the woman, or the medical practitioner will need to utilise such opportunities as they arise ('opportunistic screening'). Even then the radiological procedure will have to be performed in a specialised unit which in most instances will be geographically isolated from the doctor's surgery. If we have thus far failed to convince women of the importance of regular Pap smears in the post-menopausal years, do we have reason to be confident that they will be better consumers of a mammographic screening program? This would appear to be most improbable unless an intensive public education program succeeds in convincing each woman of the benefits of mammographic screening.

Mammographic Screening for Breast Cancer

Desperation appears to have forced the medical profession to consider the difficult option of population mammography as a way to reduce the very large problem of breast cancer. In Australia 5000 new cases are diagnosed each year and deaths exceed 2000. The incidence and the mortality rates have been stable in the United States during 1950-1982 (6). There is no objective evidence to believe that the situation is any different in Australia. Thus the disease is not declining of its own accord as for example gastric cancer is, nor are we getting any better at managing it. We have little understanding of the etiology or the natural history. The former makes primary prevention an impossibility at the moment, and the latter indicates the serious problems that will arise in determining optimal screening strategies and in managing questionable lesions. All this despite 400 publications on breast cancer being listed each week in Index Medicus (> 20,000 per year). The demonstrated 30% improvement in the mortality at 7 to 10 years in women diagnosed through mammographic screening (7,8) appears the brightest hope in an otherwise gloomy area, forcing people to reconsider what only a few years ago was unthinkable - the introduction of regular and repeated mammography for all women.

Currently it appears that two questions at least do have answers - whether screening for breast cancer is beneficial and whether mammography is safe. The National Academy of Sciences estimates that for a dose of 1 Rad, 6 new cases of breast cancer per one million women screened per annum will result after a 10 year delay and that repeated examinations will involve an additive risk. (9) Modern mammography delivers a dose of 0.05 to 0.3 Rad per exposure. Exposing people to radiation is never popular, but the cost:benefit ratio does appear favourable in this instance. An educational program would have to carefully address the understandable concerns which would be raised over this point.

The list of issues for which we currently do not have answers is somewhat more lengthy. It includes amongst others the following: the age at which screening should start, the ideal screening interval, the value of a simultaneous clinical examination, management policies for questionable lesions, the role of non-radiologists as primary film readers, and whether early detection is associated with less radical surgery. Answers to many of the above points will emerge from studies which are in progress in a variety of overseas countries. However two important issues remain and can only be addressed from within Australia.

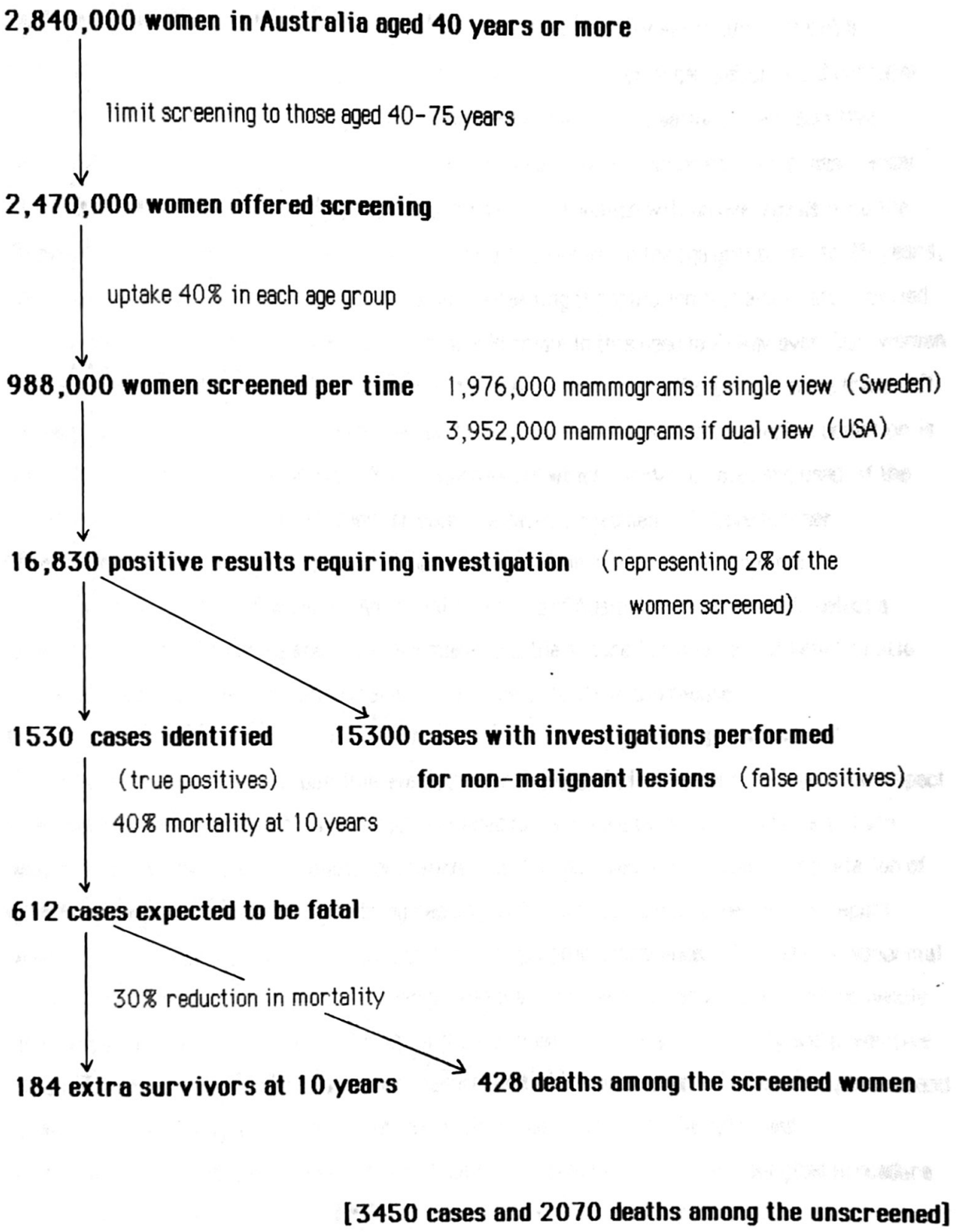
First will Australian women accept the screening program? In response to personal invitations, compliance rates of near 90% in Sweden and of 60% in the USA and the UK have been recorded. (7,8,10). Without this personal approach, the uptake of screening by this age group at least as indicated by the Pap smear program would not give cause for confidence in the likely response of

Australian women. What seems very clear is the urgent need for studies to begin addressing this issue prior to any general introduction of mammography.

The second Australian issue that demands attention is the role of the private sector in screening programs. With the current rebate for bilateral mammography being $65, the potential costs of population screening are not inconsiderable. If screening was performed on the 2,470,000 women of Australia aged 40-75 years, the cost of the rebates for mammography alone would be in excess of 160 million dollars per screening occasion. If Pap smear screening in the public sector costs about one third of the rebate in the private sector, then possibly comparable savings could be anticipated. Additional costs would be incurred in managing the 5% of women with abnormal findings on an initial screening (11), and the 2% which could be expected from subsequent screenings. In addition we should learn from the Pap smear program and establish only one data-base within each State so that we can maximise our knowledge of the natural history and adapt our strategies and management policies accordingly as well as monitor the uptake of the program to highlight deficiencies.

Even the most ideal introduction and uptake of a screening program within Australia would not 'solve' the problem of breast cancer. If 100% uptake of the program occurred, a 30% reduction in mortality would still see about 1400 deaths from breast cancer per year in Australia. Figure 1 details a potential scenario in Australia if annual radiographs were recommended and an initial screening had already been performed. In the analysis given, 1982 age specific incidence rates for Australia are used to determine the expected number of cases of breast cancer. [The Health Insurance Plan study (7) demonstrated a 20% lower incidence rate in re-screened women compared to control women; the Swedish study (8) showed a 30% increase in incidence in the screened group compared to the control group]. For each case which is correctly diagnosed it is assumed that 10 other women will need further investigation, although not necessarily a biopsy. (12) At an initial screening 2.3% - 3.1% of women have been shown to require a biopsy. (11, 13) At subsequent screenings this proportion will be reduced and 2% has been chosen arbitrarily for this analysis as the literature is not precise on this point, in part the final percentage reflecting local radiological reporting practices. A 60% absolute survival rate at 10 years has been used for the calculations. (6,7,14)

Figure 1 Possible Scenario with Annual Mammographic Screening



If compliance with the program was 40% and the incidence among re-screened women was not increased above population rates, then 184 extra survivors could be expected at 10 years. Each life saved would have cost the community $350,000 in mammography rebate costs [988,000 x $65 / 184]. If an additional 30% of cancers were detected as in the Swedish study, then 1989 cases would be identified and there would be 239 extra survivors at a mammography cost of $270,000 per survivor. If a public sector organisation could perform the mammography at one-third the cost of the rebate in the private sector, the respective costings per survivor would be $117,000 and $90,000. With a crude rate for breast cancer in 1982 of 65.6 per 100,000 women, one in every 1524 women will on average develop the disease each year. By confining a screening program to women in the age groups 40 to 75 years, one in 645 women could be detected with annual screening if population incidence rates applied. Part of the large financial costs of a program would relate to this need to X-Ray over 600 women for each cancer detected. Less frequent screening may be more cost efficient but some trade-off in lower survival rates would be expected as the lead time gained by mammographic detection is estimated to be around 12 months (15). Regardless of which incidence rates are used, if the true:false positive ratio is 1:10, then for each life saved 83 women will have further investigations. Considerable additional costs per survivor would accrue from the investigations of these 83 women. An initial screening of Australian women would detect a greater rate of malignancies and therefore make possible a more favourable cost:benefit ratio but with repeated screenings of the same women, the benefits would reduce.

In considering this outline of possible events, several areas of vital concern emerge. The impact of screening on mortality would be directly related to its uptake by women, and this in turn would relate to the success of public education. Unlike Pap smears where an interpretation of exfoliated cells constitutes the screening report, with mammographic screening the report would consist of an interpretation based on the radiographic appearance. To study the abnormal cells which constitute the lesion a further procedure would be necessary, usually a fine needle aspirate or an open biopsy. Achievement of the maximal sensitivity, specificity and predictive value of the screening test would demand management of the questionable lesions in a planned and orderly manner using a combination of the skills of the radiologist, the cyto- and histo-pathologist and the surgeon. It would not be achieved by an automatic surgical procedure for all abnormalities.

The number of investigations performed on the basis of false positive mammography would influence both the cost of the program and the number of 'well' women who became 'patients' as a result of the screening procedure. The individual woman's view would have to be respected. Once a mammographic abnormality had been identified, even if the possibility of a malignancy was remote, it may still be too close for her comfort and she may wish the lesion to be surgically

removed unless effective reassurance and an alternative management plan could be reasonably justified to her. Considerable medicolegal pressures would exist to biopsy all abnormalities; this could be minimised by the team approach although a successful multimillion dollar law suit against an American surgeon who failed to biopsy a subsequently proven malignancy may make those directly involved justifiably anxious (16). An asymptomatic woman might inappropriately adopt the attitudes and role of a patient but we should not be surprised by this phenomena; rather we would need to try to sensibly limit the number of women who would be affected in this adverse way by a screening program which we as a profession were advocating. The Prevention Paradox of 'a preventive measure which brings much benefit to the population offers little to the individual' would be true for the number of women who underwent further negative investigations for each woman whose survival was improved by the diagnosis of malignancy being correctly predicted from mammography.

Mammographic screening is not a panacea for the difficult problem of breast cancer. If all concerned parties are convinced of its potential benefits, then it is worth putting the time and effort in to ensure the best program is designed and established and the mistakes made with introducing Pap smear screening are not repeated. An ad hoc introduction, for example involving screening mammography becoming a rebate item, would be at best a superficial approach to a very real problem and at worst a recipe for disaster. The setting up of a properly organised cost-efficient program with a single data-base in each State would require initiatives at the level of Government. If the motivation to have mammographic screening introduced was predominantly based on emotions or financial gain, then a disservice would be done to ourselves as a professional body and to the women of Australia. If the implementation of such a program is considered to be beyond either our capabilities as a profession or the financial resources of the nation, this should be made clear.

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A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

July 25, 1986 40-128/1

Dr. Gabriele Medley
Deputy Director
Victorian Cytology (Gynaecological) Service
PO Box 253B
Melbourne 3002

Dear Gabriele,

I am finding it rather difficult to reply to your last letter to me as I am genuinely surprised at your comment that the overall outcome is not "satisfactory to all concerned". It seemed to me that Heather has the job she apparently wants, which is also the job you want her to have, and the VC(G)S Board has approved the funding.

At the Board meeting I certainly gained the impression (which was a great surprise to me at the time) that in answer to Roger Pepperell's question as to whether there was enough money to fund her (i.e. that the Service could do without the ACCV money), we were given the clear impression that there was enough money to fund her, something I thought was implicit in the Accountant's comment that the Service had come in $18,000 under budget for last year.

If Michael wants to apply for a research grant he is of course welcome to do so. Applications close on July 1 each year.

In the interests of clarity, I think I had better lay out the whole thing from our point of view:

> The whole initiative within the Anti-Cancer Council started because Heather had been appointed to the Service late last year and I was informed that funding was needed before mid-1986..
>
> ACCV research grant money for the whole of 1986 had been given away a month or two earlier. Our budget was also fully committed, as were reserves, because we had, by that time, largely made the decision to establish an in-house epidemiology unit and an in-house behavioural science unit, at a substantial cost.
>
> Because of Michael's funding dilemma, I asked the Scientific Committee in February, to make some sort of special provision to fund Heather Mitchell. You may be aware that scientific committees really don't like giving funds outside their normal annual competitive systems. However, in an endeavour to be helpful they set up a working party to deal with the matter and gave it power to act. The only money available to that working party was a Research Fellowship, which had been set up last year but not filled, for the reason that no suitable applicant was available. The working party agreed to examine Heather's qualifications for a Research Fellowship; interviewed her; and offered her the Fellowship.

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I would like to emphasise that offering Heather a Fellowship meant that she was responsible for her own decisions and had complete independence so far as we were concerned. This is the same situation which would have applied to an NH&MRC Fellow, i.e. she would establish her own projects and be responsible for them. She certainly had no obligation to anyone at the ACCV, including myself, as to what work she chose to do or not to do.

Perhaps this does make a "radical alteration to the chain of responsibility" - I confess it didn't seem to be a very big issue to me as I thought she would be extremely happy to be her own boss and I didn't see any difficulties for either you or Michael in the system, as she was inevitably dependent on you for support and guidance. Regardless of the rights or wrongs of any changes in the chain of responsibility, the fact is that we offered Heather the only thing that we had to offer and it was done with the best of intentions.

It's also true that the Committee did discuss the issue of responsibility for the work. They concluded that it would be inappropriate to make a judgement about Heather's work after the 3 years of the Fellowship unless she had both freedom to do what she wished and could take full responsibility for it. In the course of that discussion, it became clear that they deemed it inappropriate to place a non-epidemiologist in the position of supervisor - I realise you disagree with this but in the discussions at the last VC(G)S Board Meeting, I was merely pointing out that this is what the Committee decided.

I have set all this out because it may be that you were not aware of the process that went on at our end. I hope it's not too longwinded.

Best wishes.

Yours sincerely

Nigel Gray
Director

cc: R.Pepperell, G.Clunie+

16 JUL 1986

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

236-254 St. Kilda Road, Melbourne, 3004

MICHAEL DRAKE, DIRECTOR
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GM/CK

14th July, 1986

Dr. Nigel Gray,
Director,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Nigel,

I write with reference to your last letter to Michael of July 7th, 1986 which, in his absence has been passed on to me.

I am very sorry that you have been caused embarrassment by the episode, and I must hasten to tell you that the overall outcome is by no means "satisfactory for all concerned".

From the initiation of our discussions, Michael specified that the need was for funding of a small epidemiology unit within the V.C.(G.)S., and it appeared to us, from our discussions with you, that you were in accord with the formation of such a unit. Your own suggestion, in fact, was that it could be linked with Bill Keogh's name. It was not until your letter of 21st May, 1986, that it became obvious that the concept had fundamentally changed, and that our epidemiologist would in fact become a Fellow of the Anti-Cancer Council, and that the chain of responsibility would be radically altered.

Contrary to the discussion at the recent V.C.(G.)S. Board Meeting, and your statement that your Committee felt "an epidemologist could not be responsible to a Pathologist", it is in fact extremely common for an epidemiologist to be responsible to a pathologist, or even a surgeon, physician or any other specialist, since such persons are usually employed in departments led by such specialists. A true Epidemiology Department, led by a Professor of Epidemiology is very unusual, particularly in Australia.

Since we have never had specific funding for Heather, but have paid her as part of the normal staff of the V.C.(G.)S., we will, of course, have to seek funding elsewhere in the long term for this activity; we believe that the special nature of Heather's work lends itself to a specific funding methodology. I would welcome your opinion whether there is any point pursuing the course we originally proposed, namely

VCSACU

that the Director of the V.C.(G.)S. should apply, in the usual way, for a grant from the Anti-Cancer Council of Victoria.

I believe Heather would be pleased to discuss her reasons for non-acceptance of the Fellowship at any time you should determine.

With kind regards,

Yours sincerely,

(Gabriele Medley)
Acting Director

VCSACU

Mr. GRAEME McLEISH

CERVICAL CA

12 NOV 1986

12 ST. ANDREW'S PLACE,
EAST MELBOURNE, 3002

TELEPHONE:
63 3111
20 6541

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
1, Rathdowne Street,
CARLTON SOUTH, 3053

10th November, 1986

Dear Nigel,

I have your letter dated the 29th OCtober, 1986. It was discussed at the recent meeting of the Gynaecological Oncology Group of Victoria.

As I retired as Chairman at that meeting, the new Chairman, Dr. Michael Quinn will be in touch with you about the matters raised in due course.

With best wishes.

Yours sincerely,

Graeme

Nigel Gray
Director

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A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

October 29 1986

40-204

Mr. G. McLeish
12 St.Andrews Place
East Melbourne 3002

Dear Graham,

I wonder would you mind inviting GOGOV to do us a favour.

This year the Anti-Cancer Council changed its structure substantially. David Hill moved from full-time public education to specialising in behavioural science. Robin Marks has taken over as Director of Education.

Our information suggests that there are about 250,000 Victorian women in the "at risk" age groups (out of a total of 1.4 million) who have never had a Pap smear. Further, 85% of the cancer is occurring in this unscreened population of 250,000.

One of the first briefs we have given Robin is to develop a public and professional education program on cervical cancer, directed at previously unscreened women aged over forty. My present view is that this is our highest priority target for 1986/1987.

David Hill will need to do some psycho-social analysis of the target population before the final brief for the education program is developed. However, we would be very grateful to receive the benefit of the experience of GOGOV at an informal round table discussion. We would like to ask such questions as :-

is there a case for screening women over 65 (or 70)?

is it physically difficult to screen these women?

what is GP reaction likely to be to this sort of program?

I know you won't have time to discuss this at the meeting on October 30. It would be very helpful if we could have a date in the second week of December for the discussion.

Yours sincerely

Nigel Gray

Nigel Gray
Director

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16 JUL 1986

The University of Melbourne

DEPARTMENT OF SURGERY

5th Floor,
Clinical Sciences Building,
Royal Melbourne Hospital,
Victoria 3050, Australia.
(03) 347 4170

GJAC:SD IN CONFIDENCE 14th July, 1986.

Dr Nigel Gray,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON. 3053

Dear Nigel,

Thank you for letting me see the papers relating to Heather Mitchell.

I find the whole affair quite extraordinary, and I think it reflects very badly on both the VC(G)S and Heather herself.

You may remember that I expressed some reservations at the time of her initial appointment because of the fact that she had been very specifically sent overseas to train in epidemiology in relation to rheumatology, and I know that Ken Muirden was particularly disappointed by her decision to refuse the NH & MRC Fellowship on her return. I believe that Heather does have some difficulty in determining priorities, and I think I can only believe that there has been some considerable misinformation at a variety of levels.

The bottom line is that I think we are well out of a highly unsatisfactory situation, and I am sure that the money saved can be put to better use.

With kind regards,

Yours sincerely,

Gordon Clunie,
Professor of Surgery.

A member of the Australian Cancer Society
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Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

July 7 1986 40-116

Professor G. J. A. Clunie
Department of Surgery
Royal Melbourne Hospital 3050

Dear Gordon,

I have rarely been so astonished as I was at the last Board Meeting of the VC(G)S. At that meeting it became clear that Heather Mitchell was going to resign from the Fellowship we have offered her, for a set of reasons which are summarised, as best I can manage, on the attached notes on the board meeting.

Gabrielle Medley was obviously pretty hyped up over the fact that the Fellowship didn't give supervision of Heather's activities to herself and Michael Drake. She made quite a long speech, which left me with the impression that we had been trying to manipulate them in some way.

The most recent correspondence is attached - I have a large file of correspondence if you want it.

Not only did Michael Drake tell me early in the piece that he didn't have funding for Heather, as a Board member, I have seen his accounts and I agreed with him then and still do.

However, the Board (with me being silent) has voted to fund her and we seem to have saved ourselves a couple of hundred thousand over the next few years. Finance Committee will be charmed as they are not too keen on the fact that this year's budget has a negligible surplus.

The fact remains that we have to continue to work with the VC(G)S very closely and I have been as temperate as possible in my correspondence.

Cheers -

Yours sincerely

Nigel Gray
Director

Encl: notes on board mtg. & recent corres.

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Notes on Meeting of Board of Management of VC(G)S
June 27, 1986

1. Gabrielle Medley indicated that she thought the research fellowship offered by the ACCV for Heather Mitchell was unsatisfactory, for several reasons :

   (i) That Heather Mitchell was bring pressured to do things which were not what she wanted to do, by the ACCV.

   (ii) That she wished to be an employee of the VC(G)S, not the ACCV. Both Michael Drake and Gabrielle Medley agreed with this.

   (iii) That she had been pressured to apply for the research fellowship.

   (iv) That she was being pressured to join the ACCV staff.

   (v) A proposal for funding of an epidemiology unit by the VC(G)S was tabled.

2. I emphasised that Heather had absolutely no obligation to do what the ACCV wanted done. I further said I was surprised that she had received any offers of employment - I knew Graham Giles was looking for epidemiologists but he hadn't told me that he was looking for Heather Mitchell. She could of course apply for anything we advertise but I hadn't thought that Graham was head hunting her as it was to everbody's advantage that she was established at VC(G)S.

3. Heather was given a research fellowship in her own right and would be responsible for the work done after three years. At that time she might well be able to apply as a full card-carrying epidemiologist for longer term research support. I pointed out that at the time of appointment she had few publications and practically none on epidemiology.

4. Gabrielle indicated that the Service had enough money to fund Heather and the Board agreed to do this.

   I was completely astonished by this as my whole reason for working to establish a research fellowship was Michael Drake's statement, made verbally and confirmed in his January 7 letter, that he had no funding for her beyond the middle of this year.

5. Gabrielle indicated that there was a letter in the mail from Heather to me indicating that she did not wish to proceed with the research fellowship.

Note: On April 4 1986 she was offered a research fellowship which was accepted on April 23.

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Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

July 7 1986 40-116

Dr Michael Drake
Director
Victorian Cytology (Gynaecological) Service
PO Box 253B
Melbourne 3000

Dear Michael,

I am sending a copy of my response to Heather Mitchell's resignation of the ACCV Fellowship, for your records.

I am very happy that the overall outcome is satisfactory for all concerned. I am, of course, a bit embarrassed, as I have been at great pains to emphasise to my own Executive and Medical & Scientific committees that we needed to set up a special Fellowship because the VC(G)S didn't have any funds for Heather beyond the end of the 1985/86 financial year.

I expect my embarrassment will be readily counterbalanced by the saving of a couple of hundred thousand dollars which will ensue.

Yours sincerely

Nigel Gray
Director

cc: G.Clunie++

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Anti-Cancer Council of Victoria

July 7 1986 40-116

Dr Heather Mitchell
Victorian Cytology (Gynaecological) Service
PO Box 253B
Melbourne 3000

Dear Heather,

I naturally read your letter of June 27, indicating that you have changed your mind about accepting the ACCV Fellowship, with a certain amount of disappointment. However, I am pleased, for your sake, that the VC(G)S is able to fund you satisfactorily. You are probably aware that our reason for establishing a Fellowship in the first place, was my understanding that the VC(G)S was unable to fund you.

I offer you my best wishes for a successful tenure with VC(G)S and will look forward to the development of your work. I am very confident that you will produce extremely interesting results in the years to come.

I think I should explain, however, that I really don't understand what "conditions associated with the money" are unacceptable, nor why you felt that there were pressures being placed upon you by us (as Gabrielle's comments to me seemed to indicate).

Best wishes and good luck.

Yours sincerely

Nigel Gray
Director

cc: Dr. M. Drake

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master file

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HM/CK

27th June, 1986

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053
Victoria

Dear Nigel,

Further to my letter of April 23rd, 1986 to Miss A. Holzer (see enclosed) accepting the financial support offered by the Anti-Cancer Council for my work with the Victorian Cytology (Gynaecological) Service, it is with regret that I wish to inform you of my intention to decline this offer. It is only in recent days when I was given the opportunity of reading your last letter to Dr. Drake, that I have become aware of the full implications of the "Fellowship" as offered. Specifically it is, and has always been, my intention to remain an employee of the Victorian Cytology (Gynaecological) Service for the immediate future, responsible to the Director of this Service.

You will be aware that the form I filled in at your request was a Research Grant Application, and not an application for a Research Fellowship. This document, which was completed over a short time period (9 days), outlined the areas of epidemiological work that I could envisage performing over the next 2 - 3 years. I believed it was primarily the value of the work that was being judged and not an assessment of myself. To this extent I did not include a curriculum vitae, not having been asked to do so.

As some of these issues have become clear in recent weeks I have decided that the conditions associated with the money offered are unacceptable and I therefore notify you of my intention not to accept the offer of this Fellowship.

Yours sincerely,

Heather Mitchell

Heather Mitchell
Epidemiologist

Encl.
c.c. Miss A. Holzer

VCSABK

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MD/CK

23rd April, 1986

Miss Adrienne J. Holzer,
Secretary to the Council,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Adrienne,

Thank you for your letter of April 4th, 1986 offering financial support for my work with the Victorian Cytology (Gynaecological) Service. I am happy to accept, and hope that the work I do over the next three years will be of interest and benefit to the V.C.(G.)S., the Anti-Cancer Council and the women of Victoria.

Yours sincerely,

Heather Mitchell.

Heather Mitchell
Epidemiologist

LPMAAV

MASTER FILE

PROPOSAL FOR FUNDING OF THE EPIDEMIOLOGY UNIT OF THE VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

1. Salary of Staff Specialist Epidemiologist - $48 - 55,000, indexed for C.O.L. adjustments.

2. Research Assistant (Clerical) - initially up to 1/3 of a full-time clerk ($5,000).

3. On-cost items - superannuation, conference leave, travel etc. - $4,000.

As a non-recurrent expense funds for purchase of a personal computer and associated software - $18,000.

NOTE: Other costs such as space, major data processing facility and access to file, etc., technical and data processing staff assistance etc. would be provided for and absorbed by the Service.

i.e. Recurring expenditure - annual sum of approximately $60,000.00.

Capital expenditure - $18,000.00.

VCSABJ

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Patron-in-Chief: His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director: Dr Nigel Gray A.M MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

June 26, 1986 40-107/5

Confidential

Dr Michael Drake
Director
Victorian Cytology (Gynaecological) Service
P.O Box 253B
Melbourne 3001

Dear Michael,

Thanks for your note of June 20. I am sure we will sort things out. I certainly understand your wish to have an epidemiology unit within the service.

I hope the proposed method of employment doesn't lead to conflict of interest. However, it is consistent with our long term philosophy and the committee which made the decisiion was quite clear in its wish that Heather should be directly accountable for the work she does. I don't imagine she will be distracted from the work for the Service, for the simple reason that I am sure she appreciates that she's sitting on a goldmine. After three years in the job she may well have demonstrated talents which would justify a different form of appointment. However, by research standards, she's been given a relatively senior appointment and salary, in the face of a minimum of publications in the field - she has an excellent three year opportunity to prove that she's capable of delivering good work.

Cheers -

Yours sincerely

Nigel

Nigel Gray
Director

cc: GC+ (f.i.o)

A-JOL-VCOG

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MD/CK

20th June, 1986

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON 3053

Dear Nigel,

Thank you for your most recent letter regarding Heather Mitchell. I am most appreciative of the clear and unambiguous way in which you have set out the conditions associated with the granting of an Anti-Cancer Council Fellowship to Heather. It has certainly been most helpful to me in my own thinking.

At the outset I feel that I should stress that I have no anxieties regarding my own role as Departmental Head nor any fear that this role will be "denigrated" by Heather's activities. My sole concern throughout our various discussions and exchanges of correspondence has been to promote the interests of the V.C.(G.)S. I continue to believe that these interests would be best served by establishing an epidemiology unit within the Service and my recommendation to the Board will be that we work towards this end. I feel that the formation of such a unit would assist greatly in promoting the image of the Service and in maintaining the morale and enthusiasm of senior staff members. In this latter regard I believe that it is most important that the analyses of the data accumulated over 20 years by the efforts of many people should be seen as a collaborative effort and that the input of all senior staff members should be sought.

These statements should not be interpreted as a lack of appreciation of the financial support of the Anti-Cancer Council nor of your own efforts in gaining this support. As in the past I am most grateful both to you and your Council for this assistance. Nevertheless I would have to admit to some anxiety that the proposed method of employment of Heather may lead to some conflict of interest. I do believe that it is most important that she should not be distracted from the work of the Service as I consider that there is an urgent need to capitalise on the activities of the past 20 years - both for the good of the Service and, more importantly, for that of the community.

VCSAAP

You will note from the Minutes of the last meeting of the Board that, in good faith, I confused members of the Board as to the terms of Heather's Fellowship. Accordingly it will be necessary for the matter to be reconsidered by the Board at its next meeting to be held on Friday, 27th June. As I am on Sabbatical leave I will not be present at that meeting but I assume that Gabriele will ensure that the matter is placed on the agenda and I have no doubt that you will be able to reassure Board members that my personal fears and anxieties are without substance. Unfortunately, and equally in good faith, I have confused Heather regarding her future employment and she may well wish to reconsider her position. Presumably Gabriele will discuss the matter with her prior to the Board meeting and will be able to report to that meeting.

Again my thanks for your letter and for your continued assistance, and my kindest regards.

Sincerely,

(Michael Drake)

VCSAAP

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

May 21, 1986 40-060

Confidential

Dr Michael Drake
Director
Victorian Cytology (Gynaecological) Service
PO Box 253B
Melbourne 3001

Dear Michael,

I am putting this in writing in the interests of complete clarity. I think it's important that we have a clear understanding of what the ACCV is providing in the way of support for Heather Mitchell. The committee which considered this was very clear in its view. This view was:

1. That Heather should be paid at a NH&MRC salary level. They believed that they were being very generous in offering the salary of $45,975. It would be quite unacceptable to them for Heather to receive more than this once she is on the Fellowship. Thus, I think you have two clear options:

   If she starts her appointment as a Fellow on May 1 then her salary must be $45,975 from that date. Or, if you wish to defer her deflation from $48,000 to $45,975 until June, then you would have to fund her from other sources until June.

2. The Committee was definite that Heather was to be offered a Research Fellowship of the ACCV. She was offered this in her own right and will be reviewed, as would any Fellow, on the basis that she is responsible for the work she undertakes both in conception and implementation.

   This is not to denigrate your role as Department Head. You naturally have the right to agree or disagree as to what work is done in your Department as would, say, the Professor of Surgery. However, Heather will have to take full responsibility for what she has done when the moment of review comes in a couple of years' time.

My understanding is that she is not an employee of the VC(G)S and thus we are responsible for workers' compensation. There is no provision for superannuation in the Fellowship. As for the method of payment: we can pay her directly or via the VC(G)S, either is satisfactory.

This arrangement is an absolutely standard one for us. Any independent research worker receiving support carries total responsibility for the work done; after all, if the review after three years is unsatisfactory we can sack the

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Research Fellow but we can't sack the Professor.

I don't really think the arrangement should cause any difficulty and I hope all is clear and acceptable between us.

Yours sincerely

Nigel

Nigel Gray
Director

PS. Sorry this is late - I was away for a week and then needed to check with my Chairman.

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MD/CK

23rd April, 1986

Miss Adrienne J. Holzer,
Secretary to the Council,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Adrienne,

Thank you very much indeed for your letter dated 4th April, 1986 regarding the Anti-Cancer Council's offer to Heather Mitchell. I understand that Heather will be writing shortly to indicate her acceptance of this offer.

As I indicated in our recent telephone conversation, and indeed in several prior discussions with Nigel, I do have some concern regarding the nature of Heather's employment. However, I am very happy to accept the reassurances by both of you that Heather will remain a full-time employee of the Victorian Cytology (Gynaecological) Service responsible to the Board of that Service by way of the Director of the Service. In this regard I am most grateful for your indication that the salary and other funding could be paid to the account of the V.C.(G.)S. and be used subsequently to pay Heather and provide the other support specified in your letter. I assume that the V.C.(G.)S. remains responsible for Worker's Compensation but I would be grateful for some guidance regarding superannuation. Presumably Heather would be eligible to join the Hospitals' Superannuation fund and that the V.C.(G.)S. would make the employer's contribution. Perhaps you would be good enough to confirm this.

It would be most helpful if the appointment could be made as from 1st May, 1986, as Heather's current salary was not part of our budget submission for this year. I make this request on the basis of an earlier discussion with Nigel but I would fully appreciate the situation if the appointment had to be deferred. As indicated by you in your letter there will be a drop in salary but Heather is prepared to accept this. However, it would be appreciated if your Committee would allow us to continue to pay Heather at her current rate (approximately $48,000 per annum) until 30th June, 1986, as her current appointment is subject to review at that time.

EPIAAS

I am most grateful to the Anti-Cancer Council of Victoria for their assistance.

With best wishes,

Yours sincerely,

(Michael Drake)

EPIAAS

A member of the Australian Cancer Society
Patron-in-Chief His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

LR-CV-1

4th April, 1986

Dr. Michael Drake,
Director,
Victorian Cytology (Gynaecological) Service,
P.O. Box 253B,
MELBOURNE, 3001

Dear Michael,

I have enclosed a copy of the Council's offer to Heather Mitchell.

I realise there may be a slight drop in salary, but the committee agreed on that amount for three years and it is non-negotiable. Nor would the committee agree to any 'top-up' funding from other sources.

I do hope Heather will be able to see her way clear to joining the Council for the three year period and look forward to her reply.

If you have any queries please do not hesitate to contact me.

Best wishes,

Yours sincerely,

Adrienne J. Holzer
Secretary to the Council

Encl:

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
Cables: ACCOVIC MELBOURNE Telex: VCCG AA 34158

A member of the Australian Cancer Society
Patron-in-Chief His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director Dr Nigel Gray A.M. MB. BS. FRACP, FRACMA

Anti-Cancer Council of Victoria

LR-CV-2

4th April, 1986

Dr. Heather Mitchell,
Victorian Cytology (Gynaecological) Service,
P.O. Box 253B,
MELBOURNE, 3001

Dear Heather,

I am writing to inform you that the Medical and Scientific Committee has agreed to offer you an appointment as Research Fellow with the Anti-Cancer Council of Victoria.

It was agreed that the appointment be for a period of three years with review after two years.

The Fellowship will be paid in accordance with N.H. & M.R.C. top level of Research Fellow plus clinical loading of $10,198. Your salary therefore will be $45,975 per annum for three years. In addition you will receive a maintenance grant of $5,000 per annum, provision of a clerical assistant and provision of an appropriate personal computer with the facility to interface with the VC(G)S ICL ccomputer and appropriate software.

I look forward to hearing from you at your convenience.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

c.c. Dr. M. Drake

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
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copy to NJG

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

236-254 St. Kilda Road, Melbourne, 3004

MICHAEL DRAKE, DIRECTOR
M.B., B.S., F.R.C.P.A., F.R.C.Path., F.R.A.C.P., F.I.A.C.

GABRIELE MEDLEY, DEPUTY DIRECTOR
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P.O. BOX 253B
MELBOURNE, 3001
Telephone: 62-3831

MD/CK

23rd April, 1986

Miss Adrienne J. Holzer,
Secretary to the Council,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Adrienne,

Thank you for your letter of April 4th, 1986 offering financial support for my work with the Victorian Cytology (Gynaecological) Service. I am happy to accept, and hope that the work I do over the next three years will be of interest and benefit to the V.C.(G.)S., the Anti-Cancer Council and the women of Victoria.

Yours sincerely,

Heather Mitchell.

Heather Mitchell
Epidemiologist

28 APR 1986

EPIAAV

A member of the Australian Cancer Society
Patron-in-Chief: His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

LR-CV-2

4th April, 1986

Dr. Heather Mitchell,
Victorian Cytology (Gynaecological) Service,
P.O. Box 253B,
MELBOURNE, 3001

Dear Heather,

I am writing to inform you that the Medical and Scientific Committee has agreed to offer you an appointment as Research Fellow with the Anti-Cancer Council of Victoria.

It was agreed that the appointment be for a period of three years with review after two years.

The Fellowship will be paid in accordance with N.H. & M.R.C. top level of Research Fellow plus clinical loading of $10,198. Your salary therefore will be $45,975 per annum for three years. In addition you will receive a maintenance grant of $5,000 per annum, provision of a clerical assistant and provision of an appropriate personal computer with the facility to interface with the VC(G)S ICL ccomputer and appropriate software.

I look forward to hearing from you at your convenience.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

c.c. Dr. M. Drake

copy to NJG

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MD/CK

27th February, 1986

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Nigel,

I understand that Heather Mitchell will be hand-delivering her grant application this afternoon and I have asked her if she would be kind enough to deliver this letter also.

I know that Heather has been concerned by the haste with which she has had to prepare her submission and I must admit that I share her concern. It is important to realise that Heather did not join our staff until the end of last year and that she was immediately confronted by over 4 million smear records, supplemented by a mass of follow-up data, much of this material in a state of transition between two computer systems. The fact that she has made so much progress in such a short time is a tribute to her ability and application to the task. Nevertheless it is obvious that she requires more time to assess the material available to her and to familiarise herself with the operation of our cytology screening programme and with all aspects of cervical neoplasia and its precursors. At this stage it is extremely difficult to define with any precision her avenues of investigation and it would be most unwise of her to become committed to an inflexible three or five year research programme. Heather has emphasized this aspect in her submission and I would certainly endorse her comments. However, I know that you and the members of your subcommittee will understand the problems that Heather has faced in the preparation of a detailed submission at this stage.

The main purpose of this letter is to reiterate my belief that the V.C.(G.)S. should establish its own epidemiology unit and that the activities of this unit should represent the major research interests of the Service. It would be very helpful indeed if this unit could be identified as an entity and I would again recommend that the unit be linked by name to the Anti-Cancer Council of Victoria. I was most interested in your suggestion, in a recent telephone conversation, that Bill Keogh's name might be associated with the unit. I sincerely believe that this unit, modestly but adequately funded, could make a major contribution to knowledge concerning cervical neoplasia and

screening programmes for the detection of the disease. Accordingly I also believe that the Anti-Cancer Council would be proud to be associated by name with the unit and would feel that the use of Bill Keogh's name was entirely appropriate.

There would be significant advantages in establishing a clearly defined entity such as this. Undoubtedly we would anticipate continued support from the Anti-Cancer Council provided, of course, that the work of the unit lived up to our expectations. However, it would also facilitate the seeking of financial support from other sources. There seems little doubt that Government medical research funds will be directed more and more to aspects of preventative and community medicine and this, coupled with the increasing pressures on Government by women's health gorups, should ensure some financial assistance to the research activities of the V.C.(G.)S. I also believe that a direct approach could be made to the medical insurance companies and to women's groups within the community seeking support. The enclosed copy of a letter written to the Chairperson of the Women's Health Policy Working Party illustrates the possible avenues of support.

In making these points I would not like to infer that I am unappreciative of your help. Indeed I am most grateful for your interest and your efforts to expedite the granting of money to cover Heather's salary. However, I suppose that I am trying to emphasize that Heather will require additional support if she is to achieve an optimal return for her efforts. I believe that she will become frustrated if she has to cope single-handed with the vast accumulation of data currently available. I also have a certain sense of urgency as there are many units throughout the world evaluating the significance of H.P.V. in the genesis of cervical cancer. Whilst, in the final analysis, it is the knowledge that matters, it would be nice to be the first to promulgate at least some of the knowledge.

In summary, I would again ask that you and your Executive give consideration to endowing an epidemiology unit at the V.C.(G.)S. I fully accept that the endowment must, at the moment, be limited to the equivalent of Heather's salary, and indeed I would be most grateful if such assistance is given. Nevertheless I would anticipate that such endowment would indicate a commitment to further support provided, of course, that the activities of the unit were satisfactory.

EPIAAO

I finish by assuring you that my interest is not entirely a selfish one. I have a great respect for the Anti-Cancer Council of Victoria and I am most appreciative of past assistance. I sincerely believe that the opportunity exists for the Council to be identified with a sure winner.

With many thanks and best wishes,

Yours sincerely,

(Michael Drake)

Encl.

EPIAAO

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

February 5, 1986 40-X-046

MEMORANDUM TO: Medical & Scientific Committee

FROM: Nigel Gray

==========

Cervical Cancer

Attached (appendix 1) is a note I made, largely for my own benefit, in December. I would be grateful if the Committee would read this.

In January we had a meeting with Michael Drake to discuss cervical cancer, the Cytology Unit (VC(G)S), Heather Mitchell's future as epidemiologist with that unit, and the need for a publicity campaign to attract the unscreened women in the Victorian population. The notes on this meeting are attached (appendix 2). As an outcome, Michael Drake wrote me the attached letter (appendix 3) - this, together with appendix 2, sets out the situation quite clearly.

In early February we held a small meeting with David White, Professor of Microbiology at Melbourne University, to look for an up to date opinion as to the best way to identify papilloma viruses and to think about which people and which laboratories could/should be interested in (a) providing a virus typing service and (b) doing some research in this field. In summary, I would suggest the following :

1. That there exists an excellent opportunity for Melbourne to make a contribution to knowledge about the epidemiology of the carcinogenic wart viruses and the aetiology of cervical and other papilloma virus associated cancer.

2. That there is an important need to fund Heather Mitchell as epidemiologist to the VC(G)S; and to establish a virus typing facility.

3. It seems likely that the virus typing facility, which would have to meet a service need, would be best supervised by somebody with a strong research interest in the field.

Given that we are considering funding some other quite expensive initiatives, I would suggest that we should be looking to spend something slightly less than six figures on this project, if indeed we decide that it is worthy of our interest.

Following some general discussions it may be that the best way to proceed is to establish a small ad hoc subcommittee to make recommendations to the Standing Research Committee at its next meeting. The Standing Research Committee could recommend any funding immediately and could be empowered to seek expressions of interest from appropriate laboratories/workers.

NJG

Encls Appendices 1,2,3

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
Cables: ACCOVIC MELBOURNE Telex: VCCG AA 34158

February 5, 1986 49-ML-20

Issues in Cervical Cancer

One of the most important things we have to do in 1986 is get the cervical cancer situation straightened out.

The key component of our problem is that it now seems clear that squamous cell cervical cancer has a viral etiology. It **may** be that the **whole** etiology of the disease is explicable on the basis of HPV infection of a variety of subtypes. Such subtypes could well vary in their degree of agression; as did Type I polio in comparison to Type III.

We should look at the historical patterns of the disease to see whether the falling incidence which was apparent before the introduction of the Pap smear is **entirely** consistent with the viral hypothesis; together with the fluctuations in incidence rates since then.

An alternative explanation is that historical cervical cancer has some other carcinogen as its primary cause which is of a non-viral in nature. It is a little strange that historically, as promiscuity increased, cervical cancer was naturally decreasing **prior** to the introduction to the Pap smear. A little bit more thought and discussion needs to go into this and we need to re-examine the historical trends.

The second major issue of importance is the Australian cervical cancer case control study currently being developed. When this study was initiated it may well have been thought that a prime objective was to give support to the contention that the disease was due to a transmissable agent. In 1986 the most important thing to discover is whether the subtypes of HPV which infect our case control study population are all the same; if they vary, in what way do they vary; and which sub-types are associated with which type of disease pattern.

As a consequence, this case control study may need to concentrate less on finding the male partners of the cases and controls and more on identifying the viral type involved in each individual person. This may require obtaining a fresh Pap smear and perhaps some other specimens for analysis now or later.

We should not forget, when we do this, that Peter Reade says that wart virus changes are apparent in the dental cancer material (which could be subject to typing). Hence, our cervical cancer study patients (and controls) could probably provide suitable specimens of dental origin for study.

In summary, Melbourne is a good city in which to work out the epidemiology of wart virus.

The third thing we need to get right in 1986 is the directions in which our smear publicity campaign should take. There are various groups of dogmatic gynaecologists who espouse various rigid propositions. There is also the attractive and interesting need to widely smear the younger population in order to determine the future pattern of disease which will ensue from today's

pattern of primary infection. This need must be balanced with the need to smear the 40 and 50 year olds among whom most of the cancer deaths continue to occur.

One prime target, based on cost benefit, is presumably the need to smear the 'never smeared' patients in the older age groups in order to get rid of the incidence of cervical cancer. We know how to do this and there is no doubt we could make a big change in the mortality rate if we clean up the unsmeared population. By comparison with this objective in (terms of mortality), screening the younger population is relatively unimportant. Nevertheless, screening the younger population is of considerable importance in the long term and from the research point of view. Because of the nature of our centralised laboratory and the possibility of typing the viruses causing the trouble we have an important opportunity to contribute to world knowledge. We should not be deterred from this by the service needs of the cytology unit - we need to put research money into the right places in order to make sure that we gain knowledge very quickly over the next couple of years. The aggressive cases of cervical cancer recorded by Heather Mitchell indicate that at least some patients can go from normal to severe displasia within a year or two - this means we can learn a lot about the patterns of the various HPV infections in quite a short time. There may be few cities in the world which are so well placed as Melbourne to achieve this.

To meet these needs we need to get good epidemiologists thinking about the problem and there needs to be a small group discussion over the next few months to clarify the tasks which need to be done and the ways in which we approach them. The power of the purse will give the ACCV the opportunity to call some of the shots, although I imagine most of the necessay research could be set up for less than six figures.

Probably the first action needed is to look at a study to answer the question: What types of wart virus are to be found in a prospectively studied (a) subjects (to be defined) from Michael Drake's material, (b) patients with squamous cell carcinoma of cervix?

NJG

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB. BS. FRACP. FRACMA

Anti-Cancer Council of Victoria

February 5, 1986 40-X-042

Dr. Michael Drake
Victorian Cytology (Gynaecological) Service
Prince Henry's Hospital
236-254 St Kilda Road
Melbourne 3004

Dear Michael,

Thanks for your note of January 17. My own opinion is almost identical to your own in every respect. I think the best way for me to proceed is to tell the Medical & Scientific Committee of our discussions, and some others I have had, about the viral technology and to suggest that they set up a small working party to make recommendations about finance and a modus operandi to the Standing Research Committee, which meets within a few months. My initial suggestion would be that we should invite them to fund Heather Mitchell's salary.

Your Board Meeting is on February 14 and our Medical & Scientific Committee is on the following Monday.

I may have a little trouble getting to your Board meeting as we are reviewing a major project on that day and I can't be sure that we will be clear in time. Nevertheless, this letter should be helpful if I am unable to make it - I will confirm on the day.

Cheers -

Yours sincerely

Nigel

Nigel Gray
Director

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE
236-254 St. Kilda Road, Melbourne, 3004

MICHAEL DRAKE, DIRECTOR
M.B., B.S., F.R.C.P.A., F.R.C.Path., F.R.A.C.P., F.I.A.C.
GABRIELE MEDLEY, DEPUTY DIRECTOR
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P.O. BOX 253B
MELBOURNE, 3001
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MD/CK

17th January, 1986

Dr. Nigel Gray,
Director,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Nigel,

Following our extremely pleasant and interesting discussion on Tuesday afternoon I have given further thought to Heather Mitchell's future. I have also had some discussions with Heather and she has indicated that she is anxious to remain at the V.C.(G.)S. and to continue her analysis of the data accumulated over the past 20 years. She is also keen to become involved in the various new lines of investigation that are opening up, largely as a result of our observations on human papilloma virus infection and its sequelae.

I believe that there is a very real need for the cytology service to develop its own small epidemiology unit and that the activities of this unit should represent its major research interest. As you know object one of the V.C.(G.)S. is "to provide in Victoria facilities for research and investigation with respect to the cytological examination of gynaecological specimens associated with cancer detection and to undertake such research and investigation".

Our experience with the H.L.A./H.S.V. project, so generously funded by the Anti-Cancer Council, convinced me that we just do not have the the expertise to supervise "basic" or "laboratory" research programmes. It is for this reason that I feel that we should not embark on H.P.V. typing, at least while the techniques remain semi-experimental and in a state of flux. I believe that they would be much better developed under the supervision of experienced virologists and virologically oriented biochemists. Of course the techniques will eventually become simplified and standardized and able to be introduced into any relevant laboratory. We are, of course, very good at observing morphological features and interpreting these. Such observational activities have considerable research potential but do not really require special funding. However, there is no doubt that our major strength at the moment is that we possess a vast amount of detailed information regarding the genesis of cervical cancer and the conduct of cytological screening programmes and that this information is all accessible to analysis by our in-house

computer. In addition, we have access to well over 1,000,000 women throughout Victoria and excellent rapport with most of the medical practitioners in this State. I believe, therefore, that the V.C.(G.)S. has the capacity to make a major contribution to the body of knowledge regarding cervical cancer and can also contribute in a rational way to fundamental decisions regarding screening programmes. Heather Mitchell is central to these activities and I am hopeful that we can retain her in our organization and gradually develop support services for her. As stated above she has indicated that she would like to do so and hence I must now address the problem of funding.

I was most appreciative of your suggestion that finance may be made available by way of funds allocated to Graham Giles although I was left a little uncertain as to the implications of such funding. I believe that it is most important that Heather remains a full-time employee of the V.C.(G.)S., directly responsible to the Director of that Service, and that her time and efforts be devoted primarily to the data derived from the screening programme or projects generated by that programme. Otherwise there is a danger that her energies will become diffused over too many projects. Of course there would be scope for collaboration between Graham and Heather and indeed this is already taking place in a very productive manner.

I believe that the ideal arrangement, as far as the cytology service is concerned, would be to establish an epidemiology research unit within the V.C.(G.)S., the major financial requirements of such a unit being Heather Mitchell's salary plus modest support facilities. It is probable that funds could be derived from a number of sources, including the Victorian Health Department, although, like you, I am a little doubtful that they would regard such research oriented activities as part of routine operating costs. Obviously a grant from the Anti-Cancer Council would be optimal and I am not quite clear whether this was implied in your comments of last Tuesday. Alternatively it may be that you would require me to make a formal grant application for consideration by your various committees. Naturally I would be prepared to do this but I would be most grateful for your guidance. The unit could be linked by name to the Anti-Cancer Council and its activities could be guided by a group including people such as yourself and Graham Giles. However, I am most anxious that it should remain a part of the cytology service.

I believe that I should prepare some statement for the Board of Management for discussion at its meeting on Friday, February 14th, 1986 and hence I would be most appreciative of your comments in the next week or so.

VCSAAS

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I believe that I should prepare some statement for the Board of Management for discussion at its meeting on Friday, February 14th, 1986 and hence I would be most appreciative of your comments in the next week or so.

VCSAAS

With best wishes,

Yours sincerely,

(Michael Drake)

P.S. As I indicated there are a number of references to the spread of H.P.V. infection from mothers to their infants. Some of these are as follows:

1. Tang, C.K., Shermeta, D.W., Wood, C.: Congenital Condylomata Acuminata. Am J. Obstet. Gynecol. August, 1978.

This is an interesting paper in that it describes an infant who was born with genital warts, the mother having the same disease. The evidence suggested that the child acquired his mother's disease during foetal life by transplacental haematogenous infection. The remainder of the references I am aware of refer to infantile laryngeal papillomatosis.

2. Duff, T.B.: Laryngeal Papillomatosis. J. Laryngol. Otol. 85, 947-956 (1971).

3. Cook, T.A.: Laryngeal Papilloma: Etiologic and Therapeutic Considerations. Ann. Otol. 82, 649-655 (1973).

4. Boyle, W.F., Riggs, J.L., Oshiro, L.S., Lenette, E.H.: Electron Microscopic Identification of Papova Virus in Laryngeal Papilloma. Laryngoscope 83, 1102-1108 (1973).

5. Arnold, W: Ätiologische Aspekte zur Frage der Entstehung der Larynxpapillome. Laryngol. Rhinol. Otol. 55, 102-111 (1976).

I also enclose a copy of a "letter to the Editor" which appeared in the Archives of Dermatology. This includes a few additional references.

VCSAAS

VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

236-254 St. Kilda Road, Melbourne, 3004

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9 JAN 1986

MD/CK

7th January, 1986

Dr. Nigel Gray,
Director,
Anti-Cancer Council of Victoria,
Keogh Houise,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Nigel,

Many thanks for your letter of December 12th, 1985 regarding the possibility of a meeting to discuss a number of matters relevant to our cytology programme. I understand that we will be meeting at 3:00 p.m. on January 14th, 1986.

Like you I found our discussion on cervical cancer held at the time of Richard Doll's visit extremely interesting and certainly it illustrated the value of Heather Mitchell's activities; indeed, as I have stated at several Board Meetings, I feel that her appointment is one of the most significant events in the development of the Cytology Service.

As suggested by you I would certainly welcome the opportunity of discussing Heather Mitchell's future. As you know I rationalised her appointment by reference to the medical vacancies that existed at the time. However Prue Allan joined our staff in October and John Dowling will commence early in February and hence this source of finance will cut out altogether. We can meet some of the costs of Heather's salary from a fund that is fuelled largely by the New Zealand Contraceptive and Health Study and also our teaching activities on behalf of the R.M.I.T. However, the amount of money in this particular fund is fairly limited and support from this source is not possible on a long term basis. As previously discussed I believe that it may be possible to attract support from Government sources but I would certainly welcome your advice on this matter.

The question of virus typing is also of great interest to us. I believe that this activity should be allied with the DNA quantification studies that I referred to at the last Board Meeting. Thus, in a fairly simplistic way, it would appear that the DNA hybridisation studies should enable us to determine the nature of the infecting organism whereas the DNA studies should indicate the patient's response to such infection. Although it may be necessary to commission another laboratory to carry out the viral typing the techniques are now being simplified and it may well be possible for us to carry these out as an in-house procedure.

VCSAAL

I was extremely interested to hear that David Hill is ready to launch a pap smear campaign during 1986. Naturally I would support this wholeheartedly as we have always tried very hard indeed to maximise the coverage of the population. Obviously, as I indicated at the last Board Meeting, we would need to make some preparation to deal with the increased numbers of smears but this would simply be a matter of planning. Again it is a matter that I would be most interested in discussing with you.

I look forward to seeing you next week.

With best wishes,

Yours sincerely,

(Michael Drake)

VCSAAL

A member of the Australian Cancer Society
Patron-in-Chief: His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director: Dr Nigel Gray A.M MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

December 12, 1985 40-X-043/6

Dr. Michael Drake
Victorian Cytology (Gynaecological) Service
Prince Henry's Hospital
236-254 St.Kilda Road
Melbourne 3004

3 pm Tue Jan 14.

Dear Michael,

I thought the discussion on cervical cancer on Tuesday was very interesting and very exciting. There are certainly some attractive research opportunities available at the moment and it might be a good idea for us to sit and chat about them quite soon. I thought topics which could merit discussion include:

1. Heather Mitchell's future; the source of payment, etc.

2. The possibilities inherent in virus typing and registration of patients with particular HPV infections.

   I certainly think the Anti-Cancer Council would be interested to commit some funds to this sort of activity and we have a precedent, in that we are already funding something similar, i.e. determination and registration of oestrogen receptors in breast cancer patients.

   I would be interested to have a good tutorial on the subject of virus typing some time. I am sure you and Gabrielle are au fait with it but I suspect there would be one or two experts in Melbourne with whom it would be worth discussing the subject in some detail, on the grounds that it might be a good idea to take up the option mentioned by Gabrielle, i.e. the possibility of commissioning such typing in one of the labs specially geared for it.

3. David Hill is funded and ready to go on a pap smear campaign during 1986. Clearly your input is required. Obviously any successful campaign will increase your workload!! Kathy Mapperson has extracted the relevant material from David's last survey. In summary, it seems that about a quarter million women out of a total of 1.4 million, have never had a smear.

It's a very interesting time in history. What about sitting down together soon?

Yours sincerely

Nigel

Nigel Gray
Director

cc: G.Clunie, D.Hill, G.Giles

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VICTORIAN CYTOLOGY (GYNAECOLOGICAL) SERVICE

236-254 St. Kilda Road, Melbourne, 3004

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HM/CK

27th June, 1986

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053
Victoria

Dear Nigel,

Further to my letter of April 23rd, 1986 to Miss A. Holzer (see enclosed) accepting the financial support offered by the Anti-Cancer Council for my work with the Victorian Cytology (Gynaecological) Service, it is with regret that I wish to inform you of my intention to decline this offer. It is only in recent days when I was given the opportunity of reading your last letter to Dr. Drake, that I have become aware of the full implications of the "Fellowship" as offered. Specifically it is, and has always been, my intention to remain an employee of the Victorian Cytology (Gynaecological) Service for the immediate future, responsible to the Director of this Service.

You will be aware that the form I filled in at your request was a Research Grant Application, and not an application for a Research Fellowship. This document, which was completed over a short time period (9 days), outlined the areas of epidemiological work that I could envisage performing over the next 2 - 3 years. I believed it was primarily the value of the work that was being judged and not an assessment of myself. To this extent I did not include a curriculum vitae, not having been asked to do so.

As some of these issues have become clear in recent weeks I have decided that the conditions associated with the money offered are unacceptable and I therefore notify you of my intention not to accept the offer of this Fellowship.

Yours sincerely,

Heather Mitchell

Heather Mitchell
Epidemiologist

Encl.
c.c. Miss A. Holzer

VCSABK

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MD/CK

23rd April, 1986

Miss Adrienne J. Holzer,
Secretary to the Council,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH 3053

Dear Adrienne,

Thank you for your letter of April 4th, 1986 offering financial support for my work with the Victorian Cytology (Gynaecological) Service. I am happy to accept, and hope that the work I do over the next three years will be of interest and benefit to the V.C.(G.)S., the Anti-Cancer Council and the women of Victoria.

Yours sincerely,

Heather Mitchell.

Heather Mitchell
Epidemiologist

A member of the Australian Cancer Society
Patron-in-Chief: His Excellency Rear-Admiral Sir Brian Murray, KCMG, AO, Governor of Victoria
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

June 26, 1986 40-107/5

Confidential

Dr Michael Drake
Director
Victorian Cytology (Gynaecological) Service
P.O Box 253B
Melbourne 3001

Dear Michael,

Thanks for your note of June 20. I am sure we will sort things out. I certainly understand your wish to have an epidemiology unit within the service.

I hope the proposed method of employment doesn't lead to conflict of interest. However, it is consistent with our long term philosophy and the committee which made the decisiion was quite clear in its wish that Heather should be directly accountable for the work she does. I don't imagine she will be distracted from the work for the Service, for the simple reason that I am sure she appreciates that she's sitting on a goldmine. After three years in the job she may well have demonstrated talents which would justify a different form of appointment. However, by research standards, she's been given a relatively senior appointment and salary, in the face of a minimum of publications in the field - she has an excellent three year opportunity to prove that she's capable of delivering good work.

Cheers -

Yours sincerely

Nigel

Nigel Gray
Director

cc: GC+ (f.i.o)

A-JOL-VCOG

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24 JUN 1986

MD/CK

20th June, 1986

Dr. N. Gray,
Director,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON 3053

Dear Nigel,

Thank you for your most recent letter regarding Heather Mitchell. I am most appreciative of the clear and unambiguous way in which you have set out the conditions associated with the granting of an Anti-Cancer Council Fellowship to Heather. It has certainly been most helpful to me in my own thinking.

At the outset I feel that I should stress that I have no anxieties regarding my own role as Departmental Head nor any fear that this role will be "denigrated" by Heather's activities. My sole concern throughout our various discussions and exchanges of correspondence has been to promote the interests of the V.C.(G.)S. I continue to believe that these interests would be best served by establishing an epidemiology unit within the Service and my recommendation to the Board will be that we work towards this end. I feel that the formation of such a unit would assist greatly in promoting the image of the Service and in maintaining the morale and enthusiasm of senior staff members. In this latter regard I believe that it is most important that the analyses of the data accumulated over 20 years by the efforts of many people should be seen as a collaborative effort and that the input of all senior staff members should be sought.

These statements should not be interpreted as a lack of appreciation of the financial support of the Anti-Cancer Council nor of your own efforts in gaining this support. As in the past I am most grateful both to you and your Council for this assistance. Nevertheless I would have to admit to some anxiety that the proposed method of employment of Heather may lead to some conflict of interest. I do believe that it is most important that she should not be distracted from the work of the Service as I consider that there is an urgent need to capitalise on the activities of the past 20 years - both for the good of the Service and, more importantly, for that of the community.

VCSAAP

You will note from the Minutes of the last meeting of the Board that, in good faith, I confused members of the Board as to the terms of Heather's Fellowship. Accordingly it will be necessary for the matter to be reconsidered by the Board at its next meeting to be held on Friday, 27th June. As I am on Sabbatical leave I will not be present at that meeting but I assume that Gabriele will ensure that the matter is placed on the agenda and I have no doubt that you will be able to reassure Board members that my personal fears and anxieties are without substance. Unfortunately, and equally in good faith, I have confused Heather regarding her future employment and she may well wish to reconsider her position. Presumably Gabriele will discuss the matter with her prior to the Board meeting and will be able to report to that meeting.

Again my thanks for your letter and for your continued assistance, and my kindest regards.

Sincerely,

(Michael Drake)

VCSAAP