

Sharp v Port Kembla RSL Club: establishing causation of laryngeal cancer by environmental tobacco smoke

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TO THE EDITOR: Consensus exists that the provision of medical advice must be based on the correct interpretation of the evidence base. It is logical to assume that consideration should also apply to the provision of medical opinion in cases of medical litigation. The recent article on *Sharp v Port Kembla RSL Club*¹ raises concerns which require wider debate.

It is not our purpose to discuss legal niceties nor to contest the epidemiological evidence of an increased incidence, in active smokers, of cancers at several sites, including the head and neck. Rather, we wish to concentrate on a central conclusion in the report, namely the assertion that "...a relationship between exposure to ETS [environmental tobacco smoke] and an increased risk of head and neck cancer...is supported by the available epidemiology".

The larger² of the two studies quoted showed a crude odds ratio of 2.4 (95% CI, 0.9–6.8). This result is statistically non-significant. The authors also claimed a dose response between "moderate" and "heavy" exposure of 1.8 (95% CI, 0.5–7.3) and 4.3 (95% CI, 0.8–23.5) for non-smokers and 2.5 (95% CI, 0.9–6.9) and 5.3 (95% CI, 1.8–16.1) for smokers. Statistical interpretation of these results leads to a conclusion of no evidence of an increased risk compared with people who were "never" exposed to ETS.

Leaving aside our considerable reservations regarding the overall design and analysis of this case-control study, the data as presented are at best suggestive. Signifi-

cant doubt must remain regarding the role of ETS in head and neck cancer.

That being so, two disturbing issues emerge which merit further debate.

Firstly, there is an ethical issue as to whether the requirements for the correct interpretation of the evidence base for medical opinion should be any different in the clinic or the courtroom.

Secondly, the judgment in this case highlights a dilemma in clinical practice. A clinician is not expected to practise according to non-significant differences in outcome. But, in the event of litigation, will the courts decide, as in this case, that bigger is better?

1. Stewart BW, Semmler PCB. *Sharp v Port Kembla RSL Club: establishing causation of laryngeal cancer by environmental tobacco smoke. Med J Aust* 2002; 176: 113-116.
2. Zhang ZF, Morgenstern H, Spitz MR, et al. Environmental tobacco smoking, mutagen sensitivity, and head and neck squamous cell carcinoma. *Cancer Epidemiol Biomarkers Prev* 2000; 9: 1043-1049. □

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IN REPLY: Our article¹ outlined evidence presented to the Supreme Court of New South Wales. The paucity of epidemiological evidence concerning an association between exposure to environmental tobacco smoke (ETS) and laryngeal cancer (two studies available) was offset by biological plausibility concerning the carcinogenicity of tobacco smoke. To that extent, the epidemiological evidence in question "supported" a clear inference of causality from other data. The views offered by Langlands and Gebiski do not alter this consideration, and are otherwise without merit for several reasons.

To restrict the inference reasonably drawn from epidemiological data to whether or not statistical significance is achieved is inadequate. To offer an overall

conclusion other than one based on all the data (in this instance, both studies) is unsound. To publish imputations concerning a specific study in a context denying right of reply by the authors concerned is unfortunate. To identify an ethical problem predicated only on a perceived discontinuity between evidence accepted by a court and evidence accepted by the medico-scientific community is spurious.

The Court in *Sharp v Port Kembla RSL Club* was provided with vigorous criticism of the epidemiological data. Most of the eight weeks of court time was occupied by a painstaking analysis of this and other causative issues. The Court then made a determination consistent with the medico-scientific evidence.

1. Stewart BW, Semmler PCB. *Sharp v Port Kembla RSL Club: establishing causation of laryngeal cancer by environmental tobacco smoke. Med J Aust* 2002; 176: 113-116. □

Gonorrhoea screening in general practice: perceived barriers and strategies to improve screening rates

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TO THE EDITOR: Donovan and colleagues bring attention to the restrictions placed by the Health Insurance Commission via the Medicare system on clinicians investigating patients for sexually transmitted infections (STIs).¹ In their study of Sydney general practitioners, they suggested that reform was required to the three-test pathology testing rule to improve gonorrhoea screening in high-risk individuals living in a region of epidemic gonorrhoea.

In the Kimberley region of Western Australia, where we practise, syphilis, gonorrhoea and chlamydia continue to be endemic. Best-practice guidelines for primary healthcare providers in WA state that investigation for other possible STIs is essential to the care of patients with STIs or HIV infection.²

Health policy should be based on best-practice standards. For patients with confirmed or suspected STIs, this means that Medicare funding should meet the full costs of all tests for suspected STIs (as indicated by clinical need and best-practice guidelines) to enable and facilitate effective control of these infections at the population health level.

Correspondents

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An Australian legal precedent exists for medical practitioners regarding testing for STIs. In the New South Wales Supreme Court case of *BT v Oei*, it was found that a doctor has a duty of care to offer testing for other STIs to a patient with one STI or a suspected STI.³ In that case, a sexual partner of an HIV-positive patient brought successful legal action against her partner's doctor for failing to diagnose HIV infection in her partner. The doctor was found negligent in failing to offer an HIV test to a patient with ongoing symptoms who had been found to be infected with hepatitis B virus and whose only risk factor for this infection was unprotected sex. The doctor's duty of care was found to extend to the patient's sexual partner, who became infected with HIV after unprotected sex with her partner.

Given that best-practice guidelines and a legal precedent exist which confirm that a medical practitioner should offer testing for other STIs to a patient with one STI or a suspected STI, what are the medicolegal implications of the Health Insurance Commission's three-test rule?

COMMENT: The Journal sought a comment from the Commonwealth Department of Health and Ageing, but after three months had yet to receive a response.

1. Donovan B, Knight V, McNulty AM, et al. Gonorrhoea screening in general practice: perceived barriers and strategies to improve screening rates. *Med J Aust* 2001; 175: 412-414.
2. Guidelines for managing sexually transmitted infections. Perth: Sexual Health Program, Communicable Disease Control Branch, Health Department of Western Australia, 2001.
3. *BT v Oei* [1999] New South Wales Supreme Court Case No. 1082. □

Separating politics and scientific research on heroin prescription

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TO THE EDITOR: Hall et al¹ argue that a hydromorphone trial would break the current deadlock in Australia over prescription heroin research. But would it? If hydromorphone was demonstrated to be an effective intervention for treating refractory heroin users, researchers would then wish to compare both hydromorphone and prescription heroin against the gold standard, oral methadone.

The Prime Minister has stated publicly that proceeding with a prescription heroin trial "would send a wrong message". This claim is still unsupported by evidence. Clinicians and researchers should steadfastly oppose political interference in medical research from however august a level, especially when there is such a strong rationale for the trial and when researchers have so scrupulously followed scientific process. Such interference would not be tolerated in other areas of medical research and should not be tolerated in this field.

The results of a recent large randomised controlled trial² of prescription heroin in the Netherlands, while yet to be published in a peer-reviewed journal, provide strong additional support for an Australian trial. In contrast, Hall et al¹ cite no previous evaluation of the efficacy of hydromorphone in managing heroin dependence.

In Switzerland, prescription heroin is reserved strictly for treating refractory patients and accounts for fewer than 5% of all treatment provided.³ The importance of attracting and retaining this group in treatment is probably far greater than their small numbers might suggest, as there is reason to believe that they contribute disproportionately to the immense social costs of heroin use in the community. (By analogy, the heaviest-drinking 10% in a community account for half the total alcohol consumed.) Those who inject heroin very much more frequently than the community mean are probably responsible for a disproportionate share of crime and enlisting new recruits.

Prescription heroin was selected as the experimental intervention in studies in Switzerland, the Netherlands, Germany and Spain and is now being considered seriously in Canada. The reasons advanced by Hall et al¹ are all cogent arguments for conducting a trial of hydromorphone *additional to* an evaluation of prescription heroin.

Hall et al are concerned about lack of community support for a heroin trial in Australia, but in a recent national opinion poll⁴ 45% of respondents expressed support, while 47% were opposed.

The case for an Australian heroin trial, with or without additional trials, remains compelling.

1. Hall WD, Kimber J, Mattick RP. Breaking the deadlock over an Australian trial of injectable opioid maintenance. *Med J Aust* 2002; 176: 72-73.
2. Sheldon T. Netherlands considers prescribing heroin to addicts [news]. *BMJ* 2002; 324: 385.
3. The Swiss drug policy: a fourfold approach with special consideration of the medical prescription of narcotics. Bern: Swiss Federal Office of Public Health, 1999.
4. Newspan and *The Australian*. Heroin trial poll. Available at: <http://newspan.com.au/cgi-bin/display_poll_data.pl> (accessed 4 April 2002). □