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 larger[2] 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. Significant 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 article[1] 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 Gebski 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.

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