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Australian Medical Association (NSW) Limited

*In reply please quote:
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6 April 2006

Ms Rachel Simpson
Director
Joint Select Committee on Tobacco Smoking in NSW
Parliament House
Macquarie Street
SYDNEY NSW 2000

SLO6/126
CSL24

From the President's Office

*A/Prof. John A Gullotta
B.Med. (Hons), B.Pharm (Syd.), MPS, FRACGP
Adjunct Associate Professor, Central Clinical School
Faculty of Medicine, University of Sydney*

JSC TOBACCO SMOKING

10 APR 2006

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Dear Ms Simpson

I write in reference to your letter of 27 March 2006 following my appearance at the Tobacco Smoking Committee on 21 March 2006.

On behalf of myself and Ms Emily Perry, I enclose the draft transcript of the hearing with AMA (NSW)'s requested amendments marked up in red. I also attach AMA (NSW)'s response to questions taken on notice at the hearing.

AMA (NSW) also wishes to make a written submission to the Inquiry and this is to follow.

Should you have any questions or concerns, please do not hesitate to contact myself or Ms Perry at 02 9439 8822.

Yours sincerely

A/PROF. JOHN GULLOTTA
President

**Appearance of A/Prof John Gullotta and Ms Emily Perry before
Joint Select Committee on Tobacco Smoking in NSW, 21 March 2006:
Question on Notice**

Can you provide evidence that nicotine replacement therapy is non-harmful?
(Asked by: The Hon Arthur Chesterfield-Evans MLC)

A study in the British Medical Journal's Tobacco Control journal found that nicotine replacement therapy products "are not without harm or risk, but their risks are well characterised and are very low compared with tobacco".¹

A clinical review published in the British Medical Journal states: "Long term use of NRT is not thought to be associated with any serious harmful effects." However, nicotine is a vasoconstrictor. The review therefore suggests nicotine replacement therapy should be used with caution during pregnancy, because of possible effects on placental function and fetal development, and in patients with acute cardiovascular conditions such as unstable angina, acute myocardial infarction or stroke. However, it concludes:

*Concerns over the safety of NRT in circumstances in which nicotine might be harmful—such as in pregnancy, cardiovascular disease, or in adolescents—therefore need to be considered in relation to the safety of the likely alternative, which is continued intake of nicotine from cigarettes.*²

This reinforces the need for a physician to supervise nicotine replacement therapy usage and can employ clinical judgment on the optimum dosage and delivery method.

¹ Grey et al, "Toward a comprehensive long term nicotine policy", *Tobacco Control* 2005;14:161-165
<http://tc.bmjournals.com/cgi/content/full/14/3/161>

² Andrew Molyneux, "ABC of smoking cessation: Nicotine replacement therapy", *BMJ* 2004;328:454-456 (21 February), <http://bmj.bmjournals.com/cgi/content/full/328/7437/454>

**Appearance of A/Prof John Gullotta and Ms Emily Perry before
Joint Select Committee on Tobacco Smoking in NSW, 21 March 2006:
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Could you provide studies of patterns of use by people with unrestricted access to nicotine patches?

(Asked by: The Hon Arthur Chesterfield-Evans MLC)

A longitudinal study following more than 90 000 people enrolled in US health plans found that utilisation of nicotine replacement therapy was highest in plans that provided "full coverage" as opposed to those involving shared cost.³ Heavily subsidised nicotine replacement therapy in New Zealand has also been shown to significantly increase smoking cessation interest.⁴

The Victorian-based Centre for Behavioural Research in Cancer's *Quit Evaluation Studies* series recommended that GPs are central to smoking cessation:

Increasing the role of general practitioners (GPs) in tobacco control offers significant public health benefits. Doctors are extremely well placed to offer advice or counselling to their patients on smoking cessation, or to become involved in at least minimal intervention such as detecting the smoking status of their patients. The majority of adults visit a GP at least once a year (ABS 1993), and people are likely to be more focused on their health (and thus the impact of smoking on their health) when attending a doctor (Ockene & Zapka 1997). Smokers cite doctors as the main source of advice they would utilize when asked how they would seek help to quit... even brief advice from doctors during routine care was found to increase the quit rate, while a slightly greater effect was observed with more intensive advice.⁵

³ Curry SJ, Grothaus LC, McAfee T, et al, "Use and cost effectiveness of smoking cessation services under four insurance plans in a health maintenance organization." *New England Journal of Medicine* 1998;339:673-679
<http://content.nejm.org/cgi/content/abstract/339/10/673>

⁴ Grigg M and Glasgow H, "Subsidised nicotine replacement therapy", *Tobacco Control* 2003;12:238-239
<http://tc.bmjournals.com/cgi/content/full/12/2/238-a?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&andorexacttitleabs=and&fulltext=New+Zealand+nrt&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resource=HWCIT,HWELTR>

⁵ Tessa Letcher & Robyn Mullins, "Doctors' advice to their patients about smoking: 2000 update", *Quit Victoria Quit Evaluation Studies Series*, <http://www.quit.org.au/downloads/QE/QE11/Chapter5.pdf>

**Appearance of A/Prof John Gullotta and Ms Emily Perry before
Joint Select Committee on Tobacco Smoking in NSW, 21 March 2006:
Question on Notice**

Can you give a quantitative view on medical evidence that, although nicotine is a stimulant, carbon monoxide makes you sleepy?

(Asked by: The Hon Arthur Chesterfield-Evans MLC)

According to Dr Renée Bittoun of the University of Sydney, nicotine can have both a stimulant and a relaxant effect. She states:

Nicotine has long been noted for its biphasic effects. It is a stimulant at low doses and a relaxant (and possible blocker) at high doses. Smokers often avail themselves of these effects by lightly puffing on cigarettes for a lower dose or strongly inhaling for a higher dose and a relaxing effect.⁶

Carbon monoxide is a by-product of any burning organic matter, including tobacco. Inhaled CO displaces oxygen from the red blood cells whose role is to transport oxygen around the body, including the brain. The American Lung Association states the following about the physiological effect of CO inhalation:

Breathing low levels of CO can cause fatigue and increase chest pain in people with chronic heart disease. Breathing higher levels of carbon monoxide causes flu-like symptoms such as headaches, dizziness, and weakness in healthy people. Carbon monoxide also causes sleepiness, nausea, vomiting, confusion, and disorientation. At very high levels, it causes loss of consciousness and death.⁷

According to Quit Victoria, CO is strongly linked with the development of coronary heart disease. It is also thought to contribute to cancers and other diseases of the respiratory tract, as well as lung disease. It has also been suggested to impair vision.⁸

Additional information on the chemical effects of CO can be seen in the 2004 US Surgeon General's Report *The Health Consequences of Smoking*.⁹

⁶ Bittoun R. *The Management of Nicotine Addiction*. The University of Sydney, 1998

⁷ American Lung Association,

<http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=35375&tr=y&auid=1090696>

⁸ Quit Victoria, *Tobacco in Australia: Facts and Issues*, <http://www.quit.org.au/quit/FandI/fandi/c05s1.htm>

⁹ http://www.cdc.gov/tobacco/sgr/sgr_2004/pdf/chapter6.pdf

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Could you comment on how much smokers understand about the risks to their health and compare that to the understanding drinkers have of the risks of cirrhosis of the liver?

(Asked by: The Hon Arthur Chesterfield-Evans MLC)

The majority of smokers have very limited knowledge about the full range of risks to their health from tobacco use. This is demonstrated in a recent Quit Victoria survey, which found:

Although over 75% of people recall... that smoking causes lung cancer, less than one quarter are able to identify that smoking causes heart disease.

Less than 1 out of every 10 smokers is able to recall that smoking causes throat cancer, stroke or vascular disease, while less than 5% recall that smoking can cause oral cancer.

Almost none of those surveyed could recall that smoking can cause SIDS and pregnancy complications.¹⁰

Further, 0.1% of those surveyed knew smoking caused emphysema and none knew about the link between smoking and fertility problems.¹¹

¹⁰ Quit Victoria, "Research reveals smokers in the dark about health risks", Media Release, Tuesday 14 February 2006, <http://www.quit.org.au/media.asp?ContentID=7944>.

¹¹ The Cancer Council, *TAGlines* newsletter [yet to be published, privately provided to AMA (NSW)]

**Appearance of A/Prof John Gullotta and Ms Emily Perry before
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Question on Notice**

What are the comparable risks of smoking and alcohol to health?
(Asked by: The Hon Arthur Chesterfield-Evans MLC)

Tobacco

Smoking is associated with and conclusively linked to a range of health effects including:

- Bladder cancer
- Cervical cancer
- Esophageal cancer
- Kidney cancer
- Laryngeal cancer
- Leukemia
- Cataracts
- Oral cancer
- Pancreatic cancer
- Stomach cancer
- Nasal sinus cancer
- Breast cancer
- Hip fractures
- Atherosclerosis
- Cerebrovascular disease
- Coronary heart disease
- Respiratory diseases
- Lung cancer and emphysema
- Diminished health status/morbidity
- Abdominal aortic aneurysm
- Low bone density
- Peptic ulcer disease
- SIDS
- Middle ear infections in children
- Diabetes
- Fetal death and stillbirths
- Fertility problems
- Low birth weight
- Pregnancy complications and pre-term delivery
- Chronic obstructive pulmonary disease
- Pneumonia
- Respiratory effects in utero
- Chronic respiratory effects (asthma, bronchitis, pneumonia)
- Changes to testosterone levels in young males¹²

Alcohol

The short-term/acute effects of alcohol include relaxation, elevated mood, decreased inhibition and judgment, decreased reaction time and co-ordination, impaired vision and perception, aggression, slurred speech, sleep disturbances and memory impairment.

The long-term / chronic effects of excessive alcohol consumption include brain damage, cancer, hepatitis, liver cirrhosis, pancreatitis, heart disease, mental illness (e.g. alcohol dependence, depression, anxiety). It is a depressant that slows the activity of the central nervous system and can impair the development of children and adolescents.

Comparison

Although studies indicate alcohol has some health benefits for middle-aged and older people, there is no safe level of tobacco consumption.

As the Quit campaign says: *Every cigarette is doing you damage.*

¹² US Surgeon General, *The Health Consequences of Smoking*, 2004, http://www.cdc.gov/tobacco/sgr/sgr_2004/index.htm; University of Seoul study, published in *Human Reproduction* <http://www.ashaust.org.au/pdfs/PassvTesto0504.pdf>

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Can you give a quantitative view on the accident rate arising out of the physical coordination and concentration required to light a cigarette while driving?

(Asked by: Mr Richard Torbay MP)

In 2003 Monash University's Accident Research Centre reviewed several studies that found smokers have an increased risk of being involved in motor accidents, and actual distraction caused by the act of smoking is a likely factor:

Smoking... can distract drivers as they remove their hands from the wheel to light a cigarette, hold it for an extended period of time and put it out. Several studies have found that smoking while driving increases the risk of being involved in a crash...

... the association between smoking and increased crash risk could be the result of three factors: distraction caused by smoking, behavioural differences between smokers and non-smokers, and carbon-monoxide toxicity.

The review concludes that "it is clear that smoking while driving is a hazard". It cites one study that showed smoking was a source of distraction in nearly 13,000 distraction-related crashes over a five-year period.¹³

A Canadian study found that people who smoked while driving smokers were 150% more likely to have a motor vehicle accident.¹⁴

13 Kristie Young, Michael Regan, Mike Hammer, "Driver Distraction: A Review of the Literature", Monash University Accident Research Centre, November 2003, Report No. 206, accessed at <http://www.monash.edu.au/muarc/reports/muarc206.pdf>

14 Brisson RJ, "Risk of automobile accidents in cigarette smokers." *Canadian Journal of Public Health*. 1990 Mar-Apr;81(2):102-6
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=retrieve&db=pubmed&list_uids=2331646&dopt=Abstract

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**Could you provide evidence of a decline in smoking patterns of young people?
(Previously advised but not asked)**

The general pattern of smoking rates among school students in Australia since 1984 (when surveys commenced) has been characterised by:

- a decline through the 1980s;
- a reversal of that decline during the early to late 1990s; and
- another decline to historic lows from the late 1990s to the mid 2000s.

In a 2002 NSW Health study of smoking rates among teenagers, 42% of students aged 12-17 reported ever having smoked, compared to 67% in 1984. Around 13% reported having smoked in the past week, down from 22% in 1984.

Despite these declines, however, there is no room for complacency. Over 250,000 children in Australia take up smoking each year.¹⁵ And, alarmingly, 64% of “recent smokers” in the student survey referred to above smoked at least three times a week and a further 33% smoked every day.¹⁶

The Committee should note the comments in the National Drug Strategy’s *Smoking Behaviours of Australian Secondary Students in 2002* as to the factors contributing to reduced adolescent take-up of smoking, including the role of smoking bans:

There is some support for the suggestion that smoking bans in public spaces may reduce the likelihood of adolescent smoking. First, the presence of smoking restrictions in public space has been found to make it less likely that adolescents experimenting with tobacco will progress to regular smoking. Second, adolescents who work in smokefree environments have been found to be less likely to be smokers than adolescents who do not work in these environments. These findings suggest that restricting smoking in a greater range of social environments may strengthen the message that smoking is socially unacceptable and make smoking less socially desirable for adolescents.¹⁷

¹⁵ “How many children take up smoking each year in Australia?” *Australian and New Zealand Journal of Public Health*, Vol 27 no 3, June 2003

¹⁶ Tables 4 & 5, “The health behaviours of secondary school students in New South Wales 2002”, *NSW Public Health Bulletin Supplement 2004* <http://www.health.nsw.gov.au/pubs/2004/pdf/assad2002.pdf>.

¹⁷ *National Drug Strategy Smoking Behaviours of Australian Secondary Students in 2002*, Canberra, 2004, <http://www.nationaldrugstrategy.gov.au/pdf/mono54.pdf>