

Anti-Cancer Council of Victoria



18 March 1992

1-0170

Dr. J. McCusker
 Medical Advisor (Benefits)
 Commonwealth Department of Veterans' Affairs
 Branch Office
 GPO Box 87A
 MELBOURNE VIC 3001

Dear Dr. McCusker

Reference: X76498
 Re: Mr. Ronald J. Grierson

I am responding to a request to provide an opinion concerning Mr. Ronald J. Grierson. I was asked to assist in this case just prior to departure for a couple of weeks overseas. Thus this opinion is somewhat delayed - a matter I mentioned on the phone and could do little about.

In reading the correspondence, I note that the patient was referred to me by Professor Don Metcalf who was not satisfied with his own expertise in the matter.

I can certainly claim to have covered the literature on tobacco and stomach cancer in a fairly comprehensive way, although I don't claim to know everything there is about the causes of stomach cancer.

My response to the situation is relatively simple. I presume the Veterans' Review Board will make up its own mind as to whether Mr. Grierson's smoking could be regarded as war-caused. Assuming that it is war-caused, then it is not unreasonable to turn to the report (page 20) by the Surgeon-General of the United States in 1989. This document makes the following comments:

"Cigarette smoking is now considered to be a probable cause ... of peptic ulcer disease ... and to be associated with cancer of the stomach".

This conclusion is the outcome of an exhaustive review of the literature and, confronted by it, I would find it hard to dogmatically assert that his cancer of the stomach could not be tobacco-caused.

In summary, I think one would have to accept the fact that there is a clear relationship between cigarette smoking and cancer of the stomach and that Mr. Grierson may well have experienced tobacco-associated stomach cancer.

I hope that this comment is helpful. It seems very short when I compare it to rest of his medical record!

It is not my practice to submit accounts for opinions of this nature.

I wish you well with your deliberations.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "Nigel Gray". The signature is written in dark ink on a white background.

Nigel Gray
Director

21 FEB 1992



Commonwealth Department of
Veterans' Affairs

BRANCH OFFICE

300 Latrobe Street
Melbourne Vic. 3000
Postal Address:
G.P.O. Box 87A, Melbourne Vic. 3001
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Facsimile (03) 602 5709

Reference
Contact
Telephone No.

X76498
Bill Swinson
284 6711

19 February 1992

Dr. Nigel Gray,
Director, Anti-Cancer Council of Vic.
1 Rathdowne Street, Carlton. Vic.3053.

Dear Dr Gray,

RE: Mr. Ronald J. Grierson

In hearing an application for review lodged by the abovenamed,
the Veterans' Review Board directed that the case be adjourned
so that additional information could be obtained.

As arranged by telephone with Dr. McCusker, I would be grateful if you
would provide an opinion in response to the matters mentioned in the
attached letter from the Senior Member of the Board. A copy of the
evidence previously submitted to the Board is also enclosed which may be
of help when you are completing your report.

When signing the report would you please set out, in full,
your medical qualifications as this is a requirement of the
Board.

When your report is complete please forward it, along with
the enclosures and your account, to the contact officer
mentioned above. The current schedule of fees is attached.

Yours Sincerely

Dr J McCusker
Medical Advisor (Benefits)
for DEPUTY COMMISSIONER

6/3
George Derham
of RSC Advocacy
rang to follow
up - the blake's
pretty crook.
650 5050

Anti-Cancer Council of Victoria



February 12, 1986

40-X-075

Deputy Commissioner
Commonwealth Department of Veterans' Affairs
GPO Box 87A
Melbourne 3001

Attention: C.Spiers (E33)

Ref: NX 82895

Dear Sir,

George E. Murdoch (Deceased)

I am able to provide a fairly simple response to the request presented to me over the signature of J. L. Bushby. I was asked two questions:

1. Is tobacco consumption aetiologically significant in the development of carcinoma of the pancreas?
2. If so, is there any relationship between the consumption of tobacco as consumed by the Applicant's late husband George Edmund Murdoch and his development of carcinoma of the pancreas?

With reference to Question 1. Tobacco consumption is aetiologically significant in the development of carcinoma of the pancreas. The basic international reference for this is a monograph entitled "The Causes of Cancer" prepared by Sir Richard Doll and Professor Richard Peto at the request of the Office of Technology Assessment, US Congress.

Three quotes are relevant -

- (i) In speaking about the effects of a reduction of tobacco use they say "The principal impact would be in incidence of cancer of the lung, which by late middle age is more than ten times greater in regular cigarette smokers than in lifelong non-smokers, but a material effect would also be produced on the incidence of cancers of the mouth, pharynx, larynx, oesophagus, bladder, probably the pancreas and perhaps the kidney."
- (ii) Later they say "The difference in incidence between smokers and non smokers is less marked for cancers of the bladder, pancreas and kidney than cancers of the respiratory or upper digestive tracts, but the accumulating evidence suggests that an average consumption of cigarettes approximately doubles the incidence of cancer of the bladder and probably also of the pancreas, while being associated with a more moderate increase in kidney cancer."

Anti-Cancer Council of Victoria



- (iii) Later in the article they estimate the contribution of tobacco smoking to cancer of the pancreas as follows:

Number of pancreatic cancers observed in the US, 1978: 11,010.

Estimated number had Americans not smoked: 6,585.

Approximate excess attributed to tobacco: 4,425.

In summary, I think it should be accepted that tobacco consumption is aetiologically significant in the development of cancer of the pancreas.

In relation to Question 2, it is difficult to be certain whether George Edmund Murdoch developed his cancer as a result of smoking or as a result of other unknown factors. I suggest that there would be a 40%-50% probability that the tobacco is causative in this case. I believe there is no way establishing causation with greater certainty than with this approximation. I can, however, be certain that it is not possible to be certain that tobacco did **not** cause his cancer of the pancreas.

I hope this is helpful.

Yours sincerely

Nigel Gray
Director



Commonwealth Department of
Veterans' Affairs

BRANCH OFFICE

444 St Kilda Road
Melbourne VIC 3004
Postal Address:
GPO Box 87A, Melbourne VIC 3001

Telephone: (03) 267 4000
Facsimile: (03) 266 3914

Phone 34136
Contact C Spiers (E33)
Reference MW 82895

Telephone 2686 744

30 January 1986

Dr Nigel Gray
1 Rathdowne Street
CARLTON VIC 3053

Dear Dr Gray

MURDOCH V M
Widow of: MURDOCH George E (Deceased)
9 Hynam Avenue KANGAROO FLAT

In hearing an application for review of the abovenamed widow's claim for War Widow's Pension the Veterans' Review Board requested that the case be referred to you for your opinion.

Enclosed is:

- . a copy of the letter from the Senior Member of the Board giving details of the request;
- . a copy of the evidence submitted to the Board;
- . a Treasury Form 12 to enable you to claim payment for the report.

When signing the report would you please set out, in full, your medical qualifications, as this is a requirement of the Board.

When your report is complete, please forward it, along with the summary of evidence and your completed claim for payment, to this office in the enclosed envelope.

Yours sincerely

(C Spiers)
for DEPUTY COMMISSIONER

Enc

**LEGACY CO-ORDINATING COUNCIL**

BOX 368F G.P.O. MELBOURNE 3001

CHAIRMAN

E.K. (KARL) ROBERTSON

HON. SECRETARY

L.F. JOHNSEKR/MS
4 July 1985

Dr. Nigel Gray A.M. MB, BS, FRACP, FRACMA
Director
Anti-Cancer Council of Victoria
Keogh House
1 Rathdowne Street
CARLTON SOUTH, VIC. 3053

Dear Dr. Gray,

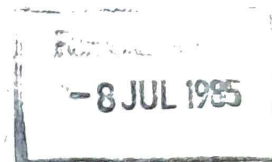
Thank you very much for your letter dated June 26, 1985 which arrived in good time for the meeting of Council's Legal Sub-committee last week.

It is most helpful and I have been asked to express our appreciation for your assistance.

I shall be away for the next fortnight and during my absence Mr. K.D. Green will be Acting Chairman. It is possible that he may be in touch with you over this period.

Yours sincerely

E.K. (KARL) ROBERTSON
CHAIRMAN



Anti-Cancer Council of Victoria



June 26, 1985

40-X-017

Mr. E. K. Robertson
Legacy Coordinating Council
Legacy House
293 Swanston Street
Melbourne 3000

Dear Mr. Robertson,

I write in response to your question concerning the relationship between war service and cancer. As I see the situation it is as follows:

1. The government appears, in its bill, to be attempting to break the promise its predecessor made to look after the veterans and, where doubt existed as to the cause of the illness, to give them the benefit of the doubt.
2. The government is proposing that an arbitrary 40-year period be established within which diseases may be attributable to war service; and beyond which they may not be.
3. In the particular case of cancer, an arbitrary decision that all forms of cancer become manifest **within** 40 years of the originating stimulus, is nonsense. We have, in most cases, no idea how long the latent period is between an exposure to an environmental carcinogen and the onset of cancer.

On this basis there is no way in which the government can select an arbitrary period and 40 years has no more logical basis than 10.

4. We **do** know that the latent period is usually quite long. For patients with asbestos related mesothelioma (a direct cause and effect relationship) in non smokers, the latent period has been observed to vary between 10 years and up to 50 years.

We also know that many environmental carcinogens are fairly weak in their activity and need to be applied to the target organ regularly over long periods, e.g. tobacco smoke.

The records of the Repatriation Department will contain many patients who started their smoking during war service and developed their lung cancer more than 40 years later. Admittedly these patients repeated the cigarette stimulus daily for the rest of their lives (in many cases). Given the addictive nature of tobacco, I have always thought there was a very clearcut relationship between the onset of smoking under war service; lifetime dependence on tobacco; and the ultimate outcome in terms of lung cancer and heard disease twenty, thirty, forty or fifty years later.

5. In conclusion I would re-emphasise that, in most cases, we simply do not know the latent period of any particular cancer and, on this ground alone, believe there is plenty of reason to contest the government's arbitrary attempt to assert that all cancers are manifest within 40 years of the environmental stimulus that causes them.

I hope this is helpful.

Yours sincerely

A handwritten signature in black ink, appearing to read "Nigel Gray". The signature is written in a cursive style with a long horizontal stroke at the end.

Nigel Gray
Director

Asbestos

Effects on health of exposure
to asbestos



Richard Doll and Julian Peto

1985.

...scope in all the common histological forms
... adenocarcinoma, small or oat-cell carcinoma,
... adenocarcinoma).† Asbestos, moreover, seems to
... its effect synergistically with tobacco smoke,
... increasing the incidence rate among people of given
... age by the same proportion in smokers and non-
... smokers alike. Whether the two agents act to multiply
... each other's effect exactly is uncertain; but the
... interaction is so strong and so nearly multiplicative
... that, on present knowledge, we must assume that the
... chance that the lung cancer in a particular man or
... woman who has been exposed to asbestos is
... attributable in part to that exposure, is unaffected by
... his or her past smoking habits. This is convenient
... from a legal viewpoint, as it means that evidence
... about tobacco use is not needed and it may be
... extremely fortunate from the point of view of practical
... prevention; for the relationship presumably extends, to
... some extent at least, to ex-smokers as well. If so,
... analogy with the effects of stopping smoking in the
... general population would suggest that an individual,
... who has previously been exposed to asbestos and who
... currently smokes, can materially reduce the likelihood
... that the previous asbestos exposure will ultimately
... cause a lung cancer, simply by stopping smoking. In
... other words, cessation of smoking is likely to confer
... an even greater avoidance of risk of lung cancer in
... people with a history of heavy asbestos exposure than
... in the population at large.

Lung cancer attributable to asbestos, like carcinomas
attributable to other known causes, does not generally
occur until several years after the initial exposure. The
first few cases in an exposed population may appear as
soon as five to nine years after first exposure, but the
excess risk of developing the disease continues to
increase for a further 20 years and possibly for longer.
Thus, no single "latent period" can be said to exist
and the belief that it does has, on occasion, led to
some seriously misleading predictions.

As with other environmentally induced cancers, the
mean period from first exposure to the appearance of
the disease is unrelated to the intensity of exposure,
except in so far as heavy exposures shorten the
expectation of life and consequently the time during
which cancers can occur. We cannot, therefore, aim to
reduce exposure to such an extent that the individual
will inevitably die of something else before the disease

† In some series asbestos-associated cancers have included an
unusually high proportion of adenocarcinomas which are not
normally found to be common in smokers (Kannerstein and Churg,
1972). This, however, may be due to the inclusion of a high
proportion of cases examined at autopsy, when adenocarcinomas in
the periphery of the lung are included, whereas they are frequently
missed in series based on biopsies.

is able to appear. Unless, unexpectedly, there turns out
to be some threshold dose below which asbestos does
not act as a carcinogen, all we can hope to do is to
reduce the attributable risk* at each interval after first
exposure to such a level that the balance of the risk
and benefit associated with its use is socially
acceptable.

Mesothelioma

Mesotheliomas of the pleura or peritoneum are
normally so rare, other than after occupational or
other unusual exposure to asbestos, that any case that
occurs after well attested and substantial asbestos
exposure is commonly accepted as due to that
exposure, subject only to the qualification that the
time since the exposure occurred must be long enough
to permit the disease to have been produced. This
qualification is important as the delay between first
exposure and effect is longer for mesotheliomas than
for most other cancers; it is seldom less than 15 years,
and possibly never less than 10 years. Any period less
than 15 years must, therefore, throw doubt on the
relationship of the disease to the exposure in question.
As with lung cancer (and with other cancers due to
other causes) increasing exposure increases the risk of
developing the disease, but does not affect the length
of the induction period. Periods of 30, 40, or even 50
years are common, and according to Peto *et al* (1982),*
who sought a model that would fit several of the
largest sets of data, the risk continues to increase
indefinitely with the time since exposure first occurred.

The relationship of mesothelioma to asbestos differs in
several ways from the relationship for lung cancer. The
hazard appears to be more strongly dependent on the
type of asbestos and to be largely or wholly unaffected
by smoking. As a result of these and other differences
the ratio of the numbers of mesotheliomas and lung
cancers produced by any given exposure to asbestos
varies at least 10-fold from about 1-10 to 1-1 (see
Chapters 4 and 6).

Other cancers

The evidence relating other types of cancer to asbestos
is less clear and is discussed in detail in Chapter 3.

* We shall have occasion to refer to risk in this report many times.
Unqualified, it means the chance that a particular event will occur in
a given period. Qualified as attributable, it means the risk caused by
a particular hazard, usually exposure to asbestos. The life-long risk
is the chance that the event will occur before death can be expected
from other causes. Relative risk is the ratio of the number of events
observed in a special population to the number expected from the
experience of some standard population with which it is compared;
when used in this sense the period of time is understood to be the
period of observation, unless otherwise defined.

* Peto J, Seidman H, Selikoff I J (1982)
Mesothelioma mortality in asbestos workers: implications
for models of carcinogenesis and risk assessment.
British Journal of Cancer 45 124-135

DEPARTMENT OF VETERANS' AFFAIRS

Repatriation General Hospital
Banksia Street, Heidelberg West, 3081
STD Code 03 Telephone 490 2111

Contact

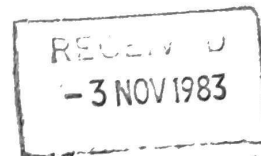
Telephone

Ext. 2224

File

2nd November 83

Dr. Nigel Gray,
Medical Director,
Anti Cancer Council of Victoria.



Dear Nigel,

CYTOGENETICS AND MALIGNANT DISEASE

I am writing on a subject which some might say is none of my business, so please forgive me. With A.C.C. help, Dr. Margaret Garson has developed a very competent cytogenetics service available to every cancer unit in this state.

In the course of the R.C.P.A. annual scientific meeting last week, I asked Dr. Garson whether she had access to any new technological devices to assist in her very laborious chromosome analysis studies. She replied that she had seen an excellent device in Sweden which is capable of sorting and arranging chromosomes but despaired of being able to procure such an instrument for the local scene. In her view, no Public Hospital could afford to make funds available for this sort of development, however desirable, at a time when financial stringency is curtailing the capacity of such institutions to meet their basic commitments to the sick in our community.

I think her assessment is pretty right. I also believe that the sort of automated equipment she envisages could greatly increase the amount of information which could be gathered in this area - information which has some promise of improving our criteria on which to make the most appropriate use of the treatments available in malignant disease.

It seems to me that provision of such equipment to a central cytogenetics laboratory is desirable and that, if it was to be made the subject of a special appeal, it might capture sufficient public interest to ensure raising the \$100 000 or so required. (Maybe we should rather think in terms of 0.1 megabuck !).

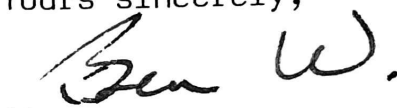
As a laboratory worker aware of such a need I would certainly be prepared to make a contribution to any such appeal.

.../2

I am hoping that Dr. Garson will feel encouraged to prepare a preliminary case to justify the place of such equipment in her laboratory; this gratuitous note is to offer support for something which can, I believe, help her laboratory offer even greater service.

With kind regards.

Yours sincerely,

A handwritten signature in cursive script that reads "Ben W." with a period at the end.

(Ben M. WADHAM).



General

"Service to Widows of Ex-Servicemen and their Children"

MELBOURNE LEGACY

FOUNDED 1923 BY THE LATE LIEUTENANT-GENERAL SIR STANLEY SAVIGE, K.B.E., C.B., D.S.O., M.C., E.D.,

Patrons:

HIS EXCELLENCY, THE GOVERNOR OF VICTORIA, THE HONOURABLE SIR HENRY WINNEKE, K.C.M.G., K.C.V.O., O.B.E., K.ST.J., Q.C.
LIEUTENANT-GENERAL, THE HONOURABLE SIR EDMUND HERRING, K.C.M.G., K.B.E., D.S.O., M.C., E.D., K.ST.J., Q.C.

All Communications
to be addressed to
the Executive Officer.

"LEGACY HOUSE"
(The David H. Dureau Memorial Building)

In Reply Please Quote:

293 Swanston Street, Melbourne, 3000

TELEPHONE: 663 3564 and 663 3012

Telegraphic Address: LEGACY MELBOURNE

LJO/MC. 19491.

19th January, 1981.

14 JAN 1981

Dr. Nigel Gray,
Director,
Anti-Cancer Council of Victoria,
90, Jolimont St.,
EAST MELBOURNE, 3002.

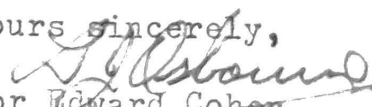
Dear Dr. Gray,

re: Claim for a War Widow's Pension.
Mrs. Marjorie J. CANHAM - 24, Cresswell Cresc.,
Mitcham, 3132.
Widow of - CANHAM, John Frederick.
57545. Cpl. 5 ACS R.A.A.F.

You will be pleased to learn that a Repatriation Commission has now determined that the death of the late Mr. J.F. Canham was service related. Mrs. Canham will now receive a War Widow's Pension with appropriate medical benefits.

We submitted your letter of the 19th September, 1980, to a Repatriation Commission in support of the appeal and thank you for your generous co-operation.

Kind regards.

Yours sincerely,

for Edward Cohen,
Chairman,
Pensions Committee.

DEPARTMENT OF VETERANS' AFFAIRS

Victorian Branch
444 St. Kilda Road
Melbourne 3004Office of the Deputy Commissioner
Phone: 268 6455
CON.749

30th September, 1980.

Dr. Nigel Gray, A.M.,
M.B.B.S., F.R.A.C.P., F.A.C.M.A.,
Director,
Anti-Cancer Council of Victoria,
90 Jolimont Street,
EAST MELBOURNE. 3002
Victoria

Dear Dr. Gray,

In Mr. Stephens' absence on leave, I refer to his letter of 25th August, 1980, which was in reply to your letter of 19th August, about the Federal Court decision in the case of Law.

I now have advice from my Central Office that the Repatriation Commission has lodged an appeal to the High Court against that decision and therefore the Commission will not be in a position to publicly discuss or make any decision relating to policy until such time as the outcome of the appeal is known.

You may be assured, however, that a thorough examination of Commission's policy in this area will be conducted in the light of the High Court decision.

Yours sincerely,

(R. H. COMPORT)
Acting Deputy Commissioner

RECEIVED

- 20 OCT 1980

To _____
From _____



*Full bench
no
w/o
Mrs.*

DEPARTMENT OF VETERANS' AFFAIRS

Victorian Branch
444 St. Kilda Road
Melbourne 3004

Office of the Deputy Commissioner
Phone: 268 6455

Con 749

RECEIVED

20 AUG 1980

To _____
From _____

25 August 1980

Dr Nigel Gray
Director
Anti-Cancer Council of Victoria
90 Jolimont Street
EAST MELBOURNE VIC 3002

Dear Dr Gray,

I have your letter dated 19 August 1980, enclosing a cutting from the Age about the decision of the Full Bench of the Federal Court relating to the late Mr James Law.

As the question you ask is one of policy I have referred your letter to my Central Office for advice and will be in touch with you at an early date.

Yours sincerely,

(T M Stephens)
DEPUTY COMMISSIONER

DEPT OF VETERAN AFFAIRS



Sir Edward Dunlop

I have read this reply from the Repatriation Department in which they give some quite fascinating figures which reflect the vagaries of their tribunals over the years. It seems to me that these figures provide a basis of a fairly strong presentation to the Minister, which could include the following :-

1. Lung Cancer. We know that 90-95% is attributable to smoking. We believe that stresses of war either aggravated or induced smoking. We also know the army tended to encourage it. It seems to me therefore that with the above facts before them the tribunals have been monumentally inconsistent in their approach. We should invite the government to decide that anyone who was exposed to stresses during wartime (i.e. service overseas rather than the Victoria Barracks) ought to be eligible.

2. Bowel Cancer. Again there can be no rational basis for many of the decisions made, with x% being successful and y% missing out. I presume that ^{some of} those who were successful were able to demonstrate that their gut was insulted in the course of the war. Surely the Repatriation Department would want to form a consistent policy on this and we could offer them a very simple one. -

Anyone who travelled out of the country and was subject to nutritional or infection based assaults on the gut ought to be eligible. Those who stayed at home may not be. This policy would at least give the benefit of the doubt in a consistent way to those whose guts were affected by war service.

3. The other cancers also reflected inconsistencies. We haven't got many leads to etiology but we could press the Department for a consistent policy on the simple ground that they are persecuting a lot of elderly citizens through their appeal system; they are wasting a lot of citizens' time; and they are spending a lot of taxpayers money by allowing appeals to run right up through the tribunal system. In the long run it may not cost a lot more to destroy the appeals system completely and let ~~and let~~ all the veterans have the benefit of a consistent approach which does in fact give them the benefit of the doubt, i.e. they should all be eligible.

After all, there aren't too many left.

September 19, 1980

Mr. L. J. Osbourne
Pensions Officer
Melbourne Legacy
"Legacy House"
293 Swanston Street
MELBOURNE 3000

Dear Mr. Osbourne,

Mrs. M. J. Canham, a volunteer for the Anti-Cancer Council, has asked me to comment on the case of her husband Mr. John Canham (File MX80588 E.37) who died from cancer of the large bowel on 19/1/60.

I do not have the detailed records of the patient in front of me but do have an unsigned opinion from a Departmental Medical Officer, a copy of which is attached.

I believe this Medical Officer's opinion ignores a number of factors which ought to be presented for the benefit of Mrs. Canham's appeal. These are:-

1. The Medical Officer's opinion states categorically that the cancer of the colon which caused Mr. Canham's death was not the result of any specific happening during service. It then goes on to present a relatively orthodox view of the current theories about what causes cancer of the large bowel.

As I see the position in 1980; the cause of cancer of the large bowel is not known. We know of some predisposing factors but we do not know what is THE cause or causes.

As I understand it the onus of proof is on the Department to establish that the patient's cancer was not due to war service.

2. Despite the implications of the Departmental Medical Officer's view cancer of the large bowel is not likely to be due to war service, statistics made available to me by Mr. T. M. Stephens indicate that 452 cases of cancer of the digestive organs, out of a total of 1954, were accepted by the Department as being related to war service. I enclose a copy of the letter in which Mr. Stephens kindly offered me this information.

3. The Departmental Medical Officer's opinion makes no reference to the fact that Mr. Canham was treated by radiotherapy for a teratoma of the left testicle while a member of the armed forces. Mrs. Canham informs me that he received substantial radiotherapy treatment for his teratoma, following the operation and while still a member of the armed forces. She further informed me that the field covered by the x-ray treatment covered the lower left-hand side of his abdomen producing slight discolouration of the skin and a permanent loss of ability to grow hair on the area exposed.

X-rays are well known to be carcinogenic and I am surprised (to say the least) that the official opinion does not consider the possibility of irradiation of the large bowel, under the auspices of the Repatriation Department, might have contributed to his primary carcinoma of the colon. I note that his cancer was of the transverse colon which is not directly in the area which was obviously irradiated during treatment of his teratoma. However there is nothing in his record to tell me what portions of the abdomen were masked and I believe it is highly likely that at least part of the colon was subjected to substantial doses of x-ray. I am surprised therefore that the claim that the colon cancer might have been related to events occurring during his war service could be rejected with such confidence.

I believe that it would be reasonable to take this matter to further appeal.

Yours sincerely,

Dr. Nigel Gray
Director

cc: Sir Edward Dunlop

Dr. Nigel Gray, A.M., MB,FB,FRACP,FACMA,
Director,
Anti-Cancer Council of Victoria,
90 Jolimont Street,
EAST MELBOURNE.
Victoria 3002

30th May, 1980.

Dear Dr. Gray,

I received your letter dated 28th May, 1980, regarding cancer patients who have been cared for by this department.

Replies to the questions you asked are:-

1. Provision does exist for the treatment at departmental expense of all malignant conditions suffered by ex-service people no matter in which war or conflict they served, and whether or not the condition is accepted as due to war service.
2. Unless the cancer condition has been accepted as service related and a pension is paid to the veteran there are no special benefits to dependants of those patients. Where the condition is service related and a pension is paid, the wife, or children under 16, receive a pension according to the appropriate scale.
3. (a) In Victoria we have been keeping some records of the disposal of claims for the acceptance of cancer and attached is a paper which sets out the details relating to those cases where claims have been lodged that the condition is related to war service. Please note that the figures quoted are not persons but are in fact the disabilities, i.e., one patient may have one or more of the conditions listed either accepted or rejected. These figures may be of help to you.

(b) The figures of the number of people who are receiving treatment under the provisions referred to in reply (1) above are not readily available but my staff are seeing what we might be able to provide and I will be in touch with you again.
4. There is no policy basis for decisions in favour of or against accepting certain cancers as war caused and each case is dealt with on its particular circumstances.

Yours sincerely,


(T. M. STEPHENS)
Deputy Commissioner

RECEIVED
JUN 1980

Encl.

and the member, in referring to the removal of his left

STATISTICS - CANCER CONDITIONS.

NEOPLASM	NOT KNOWN TO BE DECEASED		KNOWN TO BE DECEASED		TOTAL	
	ACCEPTED	REJECTED	ACCEPTED	REJECTED	ACCEPTED	REJECTED
Digestive Organs	67	303	385	1199	452	1502
Lung	57	190	403	829	460	1019
Skin	1046	370	471	632	1517	1002
Genital Organs	27	139	41	348	68	487
Urinary Organs	15	94	50	227	65	321
Leukaemia	4	34	49	112	53	146
Others	254	472	359	1137	613	1609
TOTAL	1470	1602	1758	4484	3228	6086

and the member, in referring to the removal of his left

Dr. Nigel Gray, A.M., MB,FB,FRACP,FACMA,
Director,
Anti- Cancer Council of Victoria,
90 Jolimont Street,
EAST MELBOURNE.
Victoria 3002

30th May, 1980.

Dear Dr. Gray,

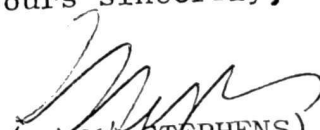
I received your letter dated 28th May, 1980, regarding cancer patients who have been cared for by this department.

Replies to the questions you asked are:-

1. Provision does exist for the treatment at departmental expense of all malignant conditions suffered by ex-service people no matter in which war or conflict they served, and whether or not the condition is accepted as due to war service.
2. Unless the cancer condition has been accepted as service related and a pension is paid to the veteran there are no special benefits to dependants of those patients. Where the condition is service related and a pension is paid, the wife, or children under 16, receive a pension according to the appropriate scale.
3. (a) In Victoria we have been keeping some records of the disposal of claims for the acceptance of cancer and attached is a paper which sets out the details relating to those cases where claims have been lodged that the condition is related to war service. Please note that the figures quoted are not persons but are in fact the disabilities, i.e., one patient may have one or more of the conditions listed either accepted or rejected. These figures may be of help to you.

(b) The figures of the number of people who are receiving treatment under the provisions referred to in reply (1) above are not readily available but my staff are seeing what we might be able to provide and I will be in touch with you again.
4. There is no policy basis for decisions in favour of or against accepting certain cancers as war caused and each case is dealt with on its particular circumstances.

Yours sincerely,


(T. M. STEPHENS)
Deputy Commissioner

RECEIVED
JUN 1980

Encl.

and the member, in referring to the removal of his left

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STATISTICS - CANCER CONDITIONS.

CLASS	NOT KNOWN TO BE DECEASED		KNOWN TO BE DECEASED		TOTAL	
	ACCEPTED	REJECTED	ACCEPTED	REJECTED	ACCEPTED	REJECTED
Digestive Organs	67	303	385	1199	452	1502
Lung	57	190	403	829	460	1019
Skin	1046	370	471	632	1517	1002
Genital Organs	27	139	41	348	68	487
Urinary Organs	15	94	50	227	65	321
Leukemia	4	34	49	112	53	146
Others	254	472	359	1137	613	1609
TOTAL	1470	1602	1758	4484	3228	6086

and the member, in referring to the removal of his left

No. 5 REPATRIATION BOARD

CANHAN John (Deceased)

File No: MX 80588

REASON FOR DETERMINATION

This is a claim by the widow for acceptance of her late husband's death as being service-related. He died on 19.1.1980 and the certified causes were respiratory arrest, terminal cancer, chronic obstructive airways disease, moderate cardiac failure. The claimant contends "that events on, stress and strain of, and illnesses on, war service" contributed to her husband's death.

The late member served in the Air Force from 9.6.1942 to 11.6.1946 and saw active service outside Australia.

The claim falls for consideration under Section 101 of the Repatriation Act and the Board is required to determine whether the incapacities that led to death have:-

- resulted from an occurrence that happened during service;
- arisen out of or are attributable to service; or
- been contributed to in any material degree, or been aggravated, by service.

Service documents reveal that on enlistment the member declared he had not previously suffered from any significant illness or injury and the medical classification was "Fit I". During service he suffered from several conditions. At a medical examination on 5.12.1945 prior to proposed discharge, the examining medical officer noted a "large mass in testicle" and the member gave a history of four weeks gradual enlargement of the left testis. Subsequent medical investigation resulted in a diagnosis of teratoma and the left testis was removed on 2.1.1946. Right urinary calculus and non-functioning right kidney were also diagnosed. At the Final Medical Board prior to discharge, the member referred to a broken bone right foot, rash on back of both hands, strain back, stone in right kidney, removal of left testicle and malaria. The medical officer recorded heart and lungs as normal, blood pressure 125/80, left testis absent, right normal, and testicular sensation normal. There was no enlargement or tenderness of inguinal or femoral lymph nodes and no enlarged gland palpable in axillae or neck.

The medical history since service ended shows:-

- at a departmental medical examination on 9.1.1947, the liver was not palpable, a chest X-ray showed no metastasis and the member, in referring to the removal of his left

No. 5 REPATRIATION BOARD

2

CANHAM John (Deceased)

File No: MX 80588

REASON FOR DETERMINATION

- testis said he had no symptoms except fatigue in the evenings and tachycardia after exercise;
- on 9.3.1951, on review of the teratoma of left testicle, a Surgeon said he could find no evidence of recurrence. A chest X-ray report of 16.4.1951 stated that no metastases or other abnormality was seen in the chest;
- clinical notes on admission to Repatriation General Hospital, Heidelberg, on 23.11.1979 refer to the member's recent admission to the Medical Unit for pneumonia when he was found to be anaemic, and, on barium enema, to have a carcinoma of colon. Investigation revealed carcinoma with secondary disease present in both lobes of liver and infiltrating peritoneal nodes;
- on 14.1.1980 member was admitted to Maroondah Hospital, his condition deteriorated and he died on 19.1.1980.

In discussing the nature and cause of the incapacities that led to death, and the relationship to service, a departmental medical officer has said, in effect:-

"In this case, the primary cause of the member's death was terminal cancer. The cancer of the colon which caused his death was not the result of any specific happening during service and was not first manifest during service. In cancer of the colon and rectum there is a familial incidence suggesting a genetic predisposition, which is more pronounced when there are multiple polyps, and is most apparent in the syndrome known as familial polyposis coli. Pre-cancerous conditions include polyps - 50% of cancers of the colon and rectum arise from pre-existing adenomatous polyps or villous tumours; familial polyposis; and ulcerative colitis. High rates are seen in the Westernised parts of the world, with very low incidence in the indigenous population in Africa. Incidence rates in immigrant groups tend to move towards those of their new environment. Ulcerative colitis is exceedingly rare in tropical areas. There is a growing evidence of bowel cancer with the adoption of western ways of life, particularly dietary change. Epidemiologically, there is a close association with highly processed foods, being rare in all less developed communities. The western type diets are known to alter the bacterial flora of the gut from that of primitive African tribes. During his service, the member developed a malignant

REASON FOR DETERMINATION

teratoma of his left testis and a non-functioning right kidney was found. The left testis was removed and no metastases from this teratoma ever developed. His left kidney also functioned well throughout his life and neither of these disabilities played any part in causing his death. In 1972 his right kidney had recovered and its function was actually better than the left. The obstructing ureteric calculus must have been passed during 1946 and no others developed. From 1962 he had diabetes mellitus but there is no suggestion that this disability contributed to his death. In October 1979 he developed acute pneumonia, and while in hospital for this, he was found to have microcytic anaemia and a palpable liver. Investigations into the cause of these conditions included a barium enema, and this was how his cancer of the transverse colon was found. It was already inoperable, but a palliative resection (right hemicolectomy) was done on 26.11.1979. Secondaries in the liver and peritoneum rapidly progressed, especially in the liver, leading to deep jaundice and terminal mental confusion due to liver failure. In spite of the death certificate, I am sure liver failure was the mode of death. This certificate also mentions chronic obstructive airways disease, but respiratory function tests on 16.11.1979 proved that he had no airways obstruction. The cause of the cancer, in this case, is unknown. The member did not have polyposis or ulcerative colitis. Probably, 'Western type' diet played a part. There was nothing in his service to which this cancer may be related. No cancer which does not become manifest till over 33 years after service ended, can have any significant relationship to service. Cancer of the colon is not caused by 'stress and strain' especially stress and strain experienced over 33 years previously, and it is not caused by previous malaria, ureteric calculus or testicular teratoma. The condition was not present prior to enlistment and any constitutional tendency the member had to develop this cancer in later life was not altered by his service. It was not caused by his service-related disabilities viz, urinary calculus with non-functioning right kidney, left orchidectomy for teratoma, or by their treatment."

The Board notes the certified causes of death but accepts the unopposed departmental medical opinion as being consistent with recorded facts and providing a satisfactory explanation of the mode of death. The opinion establishes that there is no causal link between the member's service and the disability which was the primary cause of his death.

No. 5 REPATRIATION BOARD

4 CANHAM John (Deceased)

File No: MX 80588

REASON FOR DETERMINATION

The Board is satisfied beyond reasonable doubt that the member's death was not related to his service, or to his accepted disabilities or the treatment thereof, and the claim is, therefore, refused.

Attached is a clipping from "The Age" of August 15. Two issues seem to arise from this :-

1. The Repatriation Department has had no consistent policy on the relationship between war service and cancer. This applies to all cancers, not only lung cancer.

I have corresponded with Mr. Stephens (Deputy Commissioner) on this matter and he provided me with the following -

Of a total of 9314 patients suffering from cancer 3228 were accepted as being possibly war caused (which means that they were given benefits) and 6086 were rejected as being war caused (no benefits given).

Of a sample of lung cancer patients 460 were accepted as war caused and 1019 were rejected.

Mr. Stephens states -

"There is no policy basis for decisions in favour of or against accepting certain cancers as war caused and each case is dealt with on its particular circumstances."

It seems to me that all patients with lung cancer are now entitled to expect the Department of Veterans' Affairs to adopt a consistent policy.

Sir Edward and many members of our committees have raised this situation on a number of occasions and it might be worthwhile for us to set up a small ad hoc working party which includes some volunteer legal opinion, to examine this situation.

2. A second issue of importance is that a Federal Court appears to have found that a patient died of lung cancer because he smoked. We should perhaps also investigate whether this opens the way for individual patients to claim compensation from the tobacco industry for their lung cancer. The American Cancer Society has supported patients in the courts on this issue and it has frequently been suggested that we should examine the situation in greater detail.

I might note that I had the opportunity of discussing the whole issue of tobacco promotion and tobacco disease with the Prime Minister shortly before he took office and that in that interview he made the serious suggestion that this would be a worthwhile project.

In summary, it might be worth referring both of these issues to the same working party.

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"I am not necessarily critical. I am questioning what happened, because I don't think we have got all the facts, and the answers we have been given are not good enough."

"The electorate is not fools. They're not fools at all," he said.

Documents before the Broadcasting Tribunal showed that Mr Taley received advice that the News Group was in breach of the act but that he relied on separate advice from the tribunal that no prosecutions should occur.

Senator Withers was sacked from the Cabinet two years ago after a Royal Commission on the Queensland electoral redistribution said he was guilty of political impropriety for suggesting that the names of a seat should be changed.

Smoker's widow gets war pension

By BILL BIRNBAUER

Thousands of Australian widows might be able to claim war pensions following a decision by the Full Bench of the Federal Court yesterday.

In a unanimous decision, the bench decided that a war widow's pension should be paid to a woman whose husband started smoking as a prisoner of war and died of lung cancer 30 years later.

Mr James Law, who was a corporal in the 2/3rd machinegun battalion, died in 1976 of carcinoma of the lung with myocardial infarction a contributory cause. He did not smoke when he joined the army in 1940 but began smoking heavily after serving as a prisoner of war in Java.

In March, Mr Justice Toohy in the Federal Court upheld an appeal by Mrs Nancy Law, of Perth, against a Repatriation Review Tribunal ruling that she was not entitled to a war widow's pension. The Repatriation Commission then appealed against Mr Justice Toohy's ruling.

The commission's appeal was regarded as a test case by the Federal Government which agreed to pay Mrs Law's legal fees and the pension pending the outcome of the appeal. The Government was eager to test in court recent amendments to the Repatriation Act.

The Full Court found that amendments to the act introduced in 1977 and 1979 placed on the commission the onus of proving beyond reasonable doubt that a widow had no claim.

"Where the death of an erstwhile member of the forces might have arisen out of war service or might be attributable to it, a pension cannot be refused unless it is proven beyond reasonable doubt (by the commission) that his death was not so related to his war service," the Full Bench ruled.

"The finding by the (Repatriation Review) tribunal that there was no evidence to indicate that Mr Law started to smoke because of the conditions and demands of his particular service, or because of the conditions in general pertaining to prisoners of war, was erroneous in point of law.

"While there was no direct evidence from Mr Law, he being dead, there was evidence of circumstances which raised a real possibility that he did start to smoke because of those conditions. The tribunal could not be properly satisfied that Mr Law had not started to smoke for the reasons stated."

June 24, 1980

Your Ref G.84/1/64

Mr. T. M. Stephens
Deputy Commissioner
Department of Veterans' Affairs
Victorian Branch
444 St. Kilda Road
MELBOURNE 3004

Dear Mr. Stephens,

Thank you very much for your letter of May 30 in which you answered some questions I asked you on the subject of repatriation benefits for cancer patients.

Your comments were most helpful.

We are examining our policies on this matter at the moment.

Yours sincerely,

Nigel Gray
Director

cc: Sir Edward Dunlop

DEPARTMENT OF VETERANS' AFFAIRS



Victorian Branch
444 St. Kilda Road
Melbourne 3004

Office of the Deputy Commissioner
Phone: 268 6455
G.84/1/64.

Dr. Nigel Gray, A.M., MB,FB,FRACP,FACMA,
Director,
Anti- Cancer Council of Victoria,
90 Jolimont Street,
EAST MELBOURNE.
Victoria 3002

30th May, 1980.

Dear Dr. Gray,

I received your letter dated 28th May, 1980, regarding cancer patients who have been cared for by this department.

Replies to the questions you asked are:-

1. Provision does exist for the treatment at departmental expense of all malignant conditions suffered by ex-service people no matter in which war or conflict they served, and whether or not the condition is accepted as due to war service.
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4. There is no policy basis for decisions in favour of or against accepting certain cancers as war caused and each case is dealt with on its particular circumstances.

Yours sincerely,


(T. M. STEPHENS)
Deputy Commissioner

RECEIVED
JUN 1980

To _____
From _____

Encl.

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Your Ref G.84/1/64

August 19, 1980

Mr. T. M. Stephens
Deputy Commissioner
Department of Veterans' Affairs
444 St. Kilda Road
MELBOURNE 3004

Dear Mr. Stephens,

You have been kind enough to provide me with information as to the Department's approach to veterans who have developed cancer.

I take it that the issue which was tested in the courts, and is referred to in the attached clipping, will be the subject of consideration by the Department. I am writing to ask whether it is likely that the Department will adopt a firm policy on this issue or whether it will continue to judgeteach case on its merits.

I would be grateful for your comments on this issue - as you are probably aware we and many of our committee members have been concerned for some years over the fact that there is no consistent policy in this area.

Best wishes.

Yours sincerely,

Nigel Gray
Director

Enc.

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"I am not necessarily critical. I am questioning what happened, because I don't think we have got all the facts, and the answers we have been given are not good enough.

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By BILL BIRNBAUER

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"Where the death of an erstwhile member of the forces might have arisen out of war service or might be attributable to it, a pension cannot be refused unless it is proven beyond reasonable doubt (by the commission) that his death was not so related to his war service," the Full Bench ruled.

"The finding by the (Repatriation Review) tribunal that there was no evidence to indicate that Mr Law started to smoke because of the conditions and demands of his particular service, or because of the conditions in general pertaining to prisoners of war, was erroneous in point of law.

"While there was no direct evidence from Mr Law, he being dead, there was evidence of circumstances which raised a real possibility that he did start to smoke because of those conditions. The tribunal could not be properly satisfied that Mr Law had not started to smoke for the reasons stated."

July 7, 1980

Your Ref G.84/1/64

Dr. T. M. Stephens
Deputy Commissioner
Department of Veterans' Affairs
444 St. Kilda Road
MELBOURNE 3004

Dear Dr. Stephens,

Thank you for your follow up note of June 26 giving me more information on the situation of veterans who suffer from cancer.

This has been most helpful to me.

Yours sincerely,

Nigel Gray
Director



DEPARTMENT OF VETERANS' AFFAIRS

Victorian Branch
444 St. Kilda Road
Melbourne 3004

Office of the Deputy Commissioner
Phone: 268 6455

G.84/1/64.

Dr. N. Gray, A.M., MB.BS., FRACP, FACMA,
Director,
Anti-Cancer Council of Victoria,
90 Jolimont Street,
EAST MELBOURNE.
VICTORIA 3002

26th June, 1980.

Dear Dr. Gray,

I received your letter dated 24th June, 1980,
acknowledging the information forwarded in mine of 30th May, 1980.

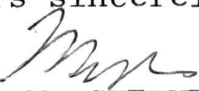
I have now had some other figures presented to me and
these relate to veterans who in addition to having made a claim for
acceptance of a condition as due to war service received treatment
under the provision referred to in (1) of my 30th May, 1980.

These figures also relate to veterans and not only
disabilities as was the case in the earlier figures I referred to
you. For instance, these 5385 veterans may have had recorded
one or more disability in each case. The figures for veterans therefore
are:-

"Veterans not known to be deceased who are eligible for treatment under Regulation 65A	3647
Deceased veterans who were eligible for treatment under Regulation 65A	1638
Total records	5385"

If you, or your statistical officer, require any further
information I suggest they contact my Officer-in-Charge, Statistics
Section, Mr. R. Maloney, 268-6568.

Yours sincerely,


(T. M. STEPHENS)
Deputy Commissioner

RECEIVED

1 JUL 1980

To _____
From _____

June 24, 1980

Sir Edward Dunlop
14 Parliament Place
MELBOURNE 3000

Dear Sir Edward,

Herewith a response from the Department of Veterans' Affairs in which item 4 is of particular interest.

It seems to me that they are very vulnerable on the subject of lung cancer where there is no rational basis for their patterns of decision. This sort of information might be useful when you lobby the Minister.

Yours sincerely,

Nigel Gray
Director

Enc.

May 28, 1980

Director-General
Department of Veterans Affairs
444 St. Kilda Road
MELBOURNE, 3000

Dear Sir,

Over the years the Anti-Cancer Council of Victoria has been contacted by quite a number of cancer patients who have been cared for under the aegis of your Department. We have occasionally been involved in their appeals but this has more generally been done by other individual doctors.

We are anxious to review the position for cancer patients and their dependents as part of our regular interest in the welfare of cancer patients in the community at large.

I would be most grateful if you could give me some information about the Department's experience over the years. I am reasonably familiar with the appeals provisions of the Act. It would be most helpful if you could provide answers to the following questions:

1. Could you confirm that all cancer patients are entitled to treatment and supporting therapy under the aegis of your Department.
2. Could you clarify the position of dependents of cancer patients - do they have entitlement to the special benefits only after decision by a tribunal or is there a fixed policy.
3. Could you tell me what percentage of cancer patients are accepted as having their disease "war caused" and is there a preponderance of any cancer in this group, e.g. lung.
4. Is there a consistent policy basis for decisions in favour of or against accepting certain cancers as war caused or is this purely a matter of tribunal opinion on the individual case.

I hope this request is not a burden to you and would be most grateful for your assistance.

Yours sincerely,

Nigel Gray
Director

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