



1.16. This suggests that the figure is not statistically significant, but the statistical and epidemiologic fraternities prefer to give their results with the appropriate confidence intervals rather than tests of significance.

Gray also quotes Neil Collishaw of WHO's Tobacco or Health Unit, who points out that a major meta-analysis of 40 studies of passive smoking in lung cancer was published in the *British Medical Journal* in 1997. Unfortunately, positive studies are much more likely to be included in meta-analyses than negative ones. Meta-analyses need to concern themselves not only with published studies but also with other studies that for one reason or another have not been published. Much more importantly, meta-analyses need to review and check the raw data of all published investigations to ascertain whether the data have been analysed appropriately or manipulated to support a particular point of view.

In the hospital where we work, we see 5 or 6 new lung cancer patients each week, or about 250 a year. Yet over the past 20 years or more we have seen only 3 definite cases of primary lung cancer in life-long nonsmokers. It also needs to be emphasized that many smokers, especially those seeking compensation for work-related conditions, are economical with the truth when it comes to their smoking habits. One study indicated that 25% of the smoking histories obtained from subjects exposed to asbestos who were dying of lung cancer were completely incorrect.¹ Many of the men denied smoking when applying for benefits, but an about-turn took place once histories were taken from relatives after the subjects died. It is highly probable that some such alleged nonsmokers are included in most epidemiologic studies.

We loathe and detest tobacco companies for their evasion, lies and attempts to trick adolescents and oth-

ers into taking up smoking. However, the rejection of truth and the acceptance of unproven hypotheses to further one's concept of ethics or social justice is wrong too. Many studies involving secondhand smoke are not convincing, and answers about whether it causes lung cancer are far from established. Unfortunately, it has become customary to torture the data until they confess. We need more science, less hyperbole and less enthusiasm for unproven points of view. We support regulations banning smoking in airplanes, hospitals and public places, not because secondhand smoke causes lung cancer but because many nonsmokers suffer discomfort as a result of the habit.

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Reference

1. Berry G, Newhouse ML, Antonis P. Combined effects of asbestos and smoking on mortality from lung cancer and mesothelioma in factory workers. *Br J Ind Med* 1985;42:12-8.

[The author responds]:

I quite agree with the concern that any report of a scientific study should stick as close to the given facts as possible. However, in this instance I was reporting not on the WHO study itself, which had not yet completed the peer-review process, but on the way the popular press had already handled it. My reference to "egregious mistakes" was therefore referring to the *Daily Telegraph* reporter's interpretation of the WHO study. I was particularly concerned that the *Daily Telegraph* story did not contain either any comments from an objective scientific source or any reactions from antismoking advocates. Why was that? Nor did any of the subsequent reports in Canadian newspapers include such comments,

although in both Ottawa and Vancouver, experts were consulted. These are the points I made in the article. They are also the points that have been made in separate complaints to the press councils of both Ontario and BC. There was indeed hyperbole surrounding this story, but it was found in the pages of the *Daily Telegraph* and its Canadian cousins, not in *CMAJ*.

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Evidence for effectiveness of home care

We agree with Dr. Aidan Byrne, who indicated in his letter "Where's the evidence for home care?" (*CMAJ* 1998;159[2]:135-6) that health care services should be provided on the basis of evidence for their effectiveness and their costs. However, the evidence (or lack thereof) on the cost-effectiveness of home care is not as clearcut as Byrne suggests.

In 1996, the Saskatchewan Health Services Utilization and Research Commission conducted a comprehensive and rigorous review of the literature on the cost-effectiveness of home care.¹ This study was cited by Dr. Peter Coyte of the Institute for Clinical Evaluative Sciences, to whom Dr. Byrne refers for support for his position. We found that for institutional care (i.e., long-term or nursing home care), there was indeed a lack of evidence that home care is a cost-effective alternative. However, with reference to hospital care, we found that for specific services such as intravenous antibiotic therapy, there is no doubt: home care is a cost-effective alternative. For palliative care, intravenous therapy for pain management and intravenous rehydration therapy, the research indicates that