

Letters to the Editor

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An exploratory study of physicians experiences with patients who use marijuana for medical reasons

SIR—Recently, there has been increasing interest in the use of marijuana to treat many medical symptoms and illnesses. These include pain from cancer, nausea from chemotherapy, the wasting syndrome of AIDS, glaucoma, epilepsy and certain neurological and psychiatric disorders.¹

Surveys of American oncologists^{2,3} have led to different conclusions about oncologists' support for the use of marijuana in the treatment of nausea from chemotherapy. Swartz and Beveridge³ indicated from their survey limited support for the use of smoked marijuana or oral, synthetic THC but there were clear preferences for other drugs. Similar studies have not been done in Canada. In the hope of stimulating research on the role of physicians in the promotion or discouragement of medical marijuana use, we sent an anonymous survey to 60 doctors in Ontario, 20 each of oncologists, ophthalmologists and neurologists, selected at random from listings of practising physicians published in collaboration with the Canadian Medical Association.

The questionnaire asked respondents to indicate if they were aware of any patients using marijuana for specific conditions encompassed by their specialty or other reasons. For oncologists the condition specified was nausea associated with chemotherapy, for ophthalmologists the condition was glaucoma, and for neurologists multiple sclerosis. The response options were none, 1–2, 3–5, 6–10 and more than 10 patients. Respondents were also asked if they believed marijuana could be helpful and if they had recommended it to any of their patients.

Completed questionnaires were received from 30 (53%) of 57 doctors actually surveyed (3 questionnaires were returned "address unknown"). There were 7 ophthalmologists, 13 neurologists and 10 oncologists. One ophthalmologist was aware of at least one patient using

marijuana for glaucoma and two others thought marijuana was helpful for glaucoma but none had recommended it. Five neurologists were aware of patients using marijuana for multiple sclerosis, chemotherapy induced nausea or nausea due to other causes (usually 1–2 patients). One neurologist was aware of at least one patient using marijuana for an adrenal condition. Only this respondent believed marijuana could be of help for MS and nausea and had recommended it to 1–2 patients with these conditions. Six oncologists were aware of patients using marijuana for nausea associated with chemotherapy or cachexia (usually 1 or 2 patients). Four of the six and two others believed it was helpful. However, only two had recommended marijuana to cancer patients, one or two in each case.

In summary, 13 or nearly half of the doctors responding were aware of at least one patient using marijuana for medical reasons, including glaucoma, multiple sclerosis, chemotherapy induced nausea, cachexia, and adrenal neurodystrophy. Only nine doctors believed that marijuana was helpful to patients for any condition, and only three recommended it.

Our response rate of 53% is good for mailed surveys with one follow-up. Mail surveys with more follow ups can get better results however. Our respondents probably had more interest and experience with medical marijuana than the non-responders. We do not claim that we have a representative sample.

It seems that very few Ontario doctors are likely to be using medical marijuana in their practices in the near future. However, further research is needed including larger surveys of the specialists represented here, as well as HIV-AIDS specialists and general practitioners.

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References

1. GINSPOON, L. & BAKALAR, J. B. (1997) *Marijuana, the forbidden medicine*, (New Haven and Yale, London, Yale University Press).
2. DOBLIN, R. & KLEIMAN, M. A. (1991) Marijuana as an emetic: a survey of oncologists experiences and attitudes, *Journal of Clinical Oncology*, 9, 1314–1319.
3. SWARTZ, R. H. & BEVERIDGE, R. A. (1994) Marijuana as an antiemetic drug: how useful is it today? Opinions from clinical oncologists, *Journal of Addictive Diseases*, 13, 53–65

Spiritual dimensions of alcohol and other drug problems

SIR—Miller's recent review of the spiritual dimensions of alcohol and other drug problems,¹ like his previous articles on this topic, provokes much thought. Have we become too deterministic, preoccupied with biological processes and forgotten a significant area of human history and personal experience? We probably have, for the time being. There is no doubt that the characteristics outlined under "promising directions", such as acceptance, humility and forgiveness can markedly effect health outcomes. Seeking ways to use these forces is obviously desirable, and many experienced clinicians have learnt to activate and support spiritual processes.

But how much good will this do when a series of uncontrolled intervention trials, that may counteract any spiritual interventions we could envisage, have been running for some years? These trials are disguised by many names but they boil down to this: the rich get richer, income disparity widens and the poor are blamed for their poverty. Powerlessness, hopelessness and hostility are both created and nurtured and the human spirit, far from being nurtured, is beaten and cowed. Galbraith discusses this process as the "culture of contentment":² similar issues were covered in the 8 part BMJ series, *Socioeconomic determinants of health* recently.³ Wilkinson³ offers good evidence that in developed countries, including Australia, the UK and the USA, growing income disparity rapidly produces poor health. During 1982–92 as income disparity increased, there was no improvement in mortality rates in UK young men (20–40 years) and deaths from suicide, AIDS, violence and cirrhosis all increased. He notes "international data where death rates from accidents, violence and alcohol related causes seem to be particu-

larly related to wider income inequalities ... (which) may reflect changes in social cohesion". Hopelessness, hostility and lack of trust, generally associated with poor spiritual growth, all proliferate.

Rather than *spiritus contra spiritum*, suggesting spirituality is a fundamental human trait which alcohol (or drugs in general) illegitimately displaces, intoxication-seeking may also be a human trait.⁴ When anger, distress and pain associated with life circumstances all grow, the need for peace, no matter how fleeting, may increase to the point of overcoming personal and social sanctions and intoxication is sought.⁵ Alcohol flows into the void created when the spirit diminishes, rather than it having a more active role. The observation by retired WHO Director-General, Halfdan Mahler, that "the domain of personal health over which the individual has direct control is very small when compared to the influence of culture, economy and environment"⁶ is as relevant to spiritual as to physical health: we would do well to consider our shared human spirit as well as spiritual issues in the clinic. Improved outcomes may then come from population strategies which increase hope, social cohesion and justice. We could remind our leaders that with respect to drug use problems, just as with health in general, they could certainly do better than at present.

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References

1. MILLER, W. R. (1988) Researching the spiritual dimensions of alcohol and other drug problems, *Addiction*, 93, 979–990.
2. GALBRAITH, J. K. (1992) *The Culture of Contentment* (London, Penguin).
3. WILKINSON, R. G. (1997) Socioeconomic determinants of health. Health inequalities: relative or absolute material standards? *BMJ*, 314, 591–594. (Seven further articles followed, beginning 5 April and weekly thereafter.)
4. SIEGAL, R. (1989) *Intoxication: life in pursuit of artificial paradise* (New York, Dutton).
5. KHANTZIAN, E. J. (1997) The self medication hypothesis of substance use disorders: a reconsideration and recent applications, *Harvard Review of Psychology*, 4, 231–244.
6. Quoted in; HAWKS, D. (1991) Prevention and the locus of control, in: N. HEATHER, W. R. MILLER & J. GREELEY (Eds), *Self-control and the Addictive Behaviours* (Sydney, Maxwell Macmillan).