Letters

Legal Status of Marijuana

To the Editor.—The American Medical Association's Council on Scientific Affairs should be commended for its report, "Marijuana: Its Health Hazards and Therapeutic Potential" (1981;246:1823). Not only does the report outline evidence of marijuana's potential harms, but it distinguishes this concern from the legitimate issue of marijuana's important medical benefits. All too often the hysteria that attends public debate over marijuana's social abuse compromises a clear appreciation for this critical distinction.

Since 1978, 32 states have abandoned the federal prohibition to recognize legislatively marijuana's important medical properties. Federal law, however, continues to define marijuana as a drug "with no accepted medical use," and federal agencies continue to prohibit physician-patient access to marijuana. This outdated federal prohibition is corrupting the intent of the state laws and depriving thousands of glaucoma and cancer patients of the medical care promised them by their state legislatures.

On Sept 16, 1981, Representative Stewart McKinney and I introduced legislation designed to end bureaucratic interference in the use of marijuana as a medicant. We believe licensed physicians are competent to employ marijuana, and patients have a right to obtain marijuana legally, under medical supervision, from a regulated source. The medical prohibition does not prevent seriously ill patients from employing marijuana; it simply deprives them of medical supervision and access to a regulated medical substance. Physicians are often forced to choose between their ethical responsibilities to the patient and their legal liabilities to federal bureaucrats.

Representative McKinney and I hope the Council will take a close and careful look at this issue. Federal policies do not reflect a factual or balanced assessment of marijuana's use as a medicant. The Council, by thoroughly investigating the available materials, might well discover that its own assessment of marijuana's therapeutic value has, in the past, been more than slightly shaded by federal policies that are less than neutral.

NEWT GINGRICH
House of Representatives
Washington, DC

In Reply.—We agree that a dispassionate examination of the health effects of marijuana is much needed. This examination must begin by making the important distinction between "marijuana" and Δ°-tetrahydrocannabinol (THC), the active ingredient in marijuana now being assessed as a possible antiemetic agent and for use in treating glaucoma.

At this time, it is THC in liquid oral dosage form that is being evaluated by the National Cancer Institute (NCI) and scores of physicians nationwide. It appears to be an effective antiemetic for cancer patients receiving certain powerful chemotherapy agents, with the exception of pediatric or geriatric patients who do not tolerate well the psychotropic effects. The THC is manufactured with careful quality control so that the quality and quantity of the drug may be relied on by physicians and patients. Although shortages have resulted from the government's underestimation of demand, the drug has, nonetheless, been widely available to patients under the NCI distribution plan approved by the Food and Drug Administration.

The use of THC in treating glaucoma is also being studied. This course of clinical investigation is less compelling, however, because of adequate drugs that are already available to treat this disease. Moreover, the results with THC have been disappointing.

The clinical investigations of THC—not marijuana—that are evaluating the safety and efficacy of the drug for these two indications are being handled in a highly orderly and timely manner within the dictates of the law governing new drug approval. We do not believe that legislation can or should supplant the scientific process for such approval.

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The Inhibitory Quotient

To the Editor.—The description of the inhibitory quotient (IQ) by Paul D. Ellner, PhD, and Harold C. Neu, MD (1981;246:1575), was welcome, as it formalizes the thought processes that must occur whenever quantitative susceptibility data are interpreted by the clinician. It is important, however, to realize several limitations of the use of the IQ in practice.

The authors are careful to point out the need to consider specific tissue levels achievable, but fail to mention that considerable variation is seen between patients in CSF penetration.[1] Indeed, marked variability even of serum levels is seen with certain antimicrobial agents, underscoring the need for assay procedures to ensure therapeutic levels.[2] Antibacterial activity of aminoglycosides, tetracyclines, trimethoprim, and sulfonamides is diminished under the acid-base and redox conditions often encountered in infected tissue.

A fourfold to eightfold ratio between serum level of drug and minimum inhibitory concentration (MIC) is suggested as adequate. Although bactericidal activity of an eightfold dilution of serum has been associated with good patient response,[3] the presence of antimicrobial substances in serum such as antibody and complement makes the correlation between serum level-MIC and bactericidal titers of serum exceedingly difficult. In some experimental infections, a therapeutic effect is seen when serum concentrations are maintained at less than MIC levels[4] (ie, an IQ of 0). Interpretation of such a ratio is also

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