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Universities and tobacco money

Some universities are accomplices in the tobacco epidemic

In December 2000 Nottingham University announced the establishment of an international centre for corporate social responsibility, with initial funding of £3.8m provided by British American Tobacco (BAT). To protest aganst their university's acceptance of money from the tobacco industry, an MBA student refused to accept his "student of the year" award; Richard Smith, editor of the *BMJ*, resigned from his post as professor of medical journalism; a cancer research team decided to relocate; and a member of the European parliament relinquished her roles at the university.

Nottingham joins a long list of universities that have accepted funding from the tobacco industry. Other academic institutions have, however, taken the opposite stance and severed their ties with this industry. For example, Brigham and Women's and Massachusetts General hospitals in Boston, the MD Anderson Cancer Center in Houston, the Roswell Park Cancer Institute in Buffalo, and the University of Sydney all have policies precluding acceptance of research funds from the tobacco industry.[1] The University of Toronto's school of social work, the University of Alberta, and the University of Hong Kong have refused donations from the tobacco industry,[2 3] and several United States universities, including Johns Hopkins, Harvard, and the University of California, exclude tobacco stocks from their investment portfolios.[4]

Among research funding agencies, the National Cancer Institute of Canada, the National Heart Foundation of Australia, and some members of the Association of European Cancer Leagues will not fund researchers who receive support from the tobacco industry. Other agencies go a step further: the United Kingdom's Cancer Research Campaign will not fund researchers if their research institute or university faculty or school receives tobacco funds, and cancer councils in Australia will not fund individuals if anyone in their institution receives tobacco support.*

Many arguments are put forth in support of taking tobacco money: the supremacy of academic freedom; academia's constant need for more funds; the existence of ethical guidelines to protect research from undue influence; the fact that cigarettes are a legal product; the number of people who derive a livelihood from the tobacco industry; and the use of the money for a societal "good" rather than for direct promotion of the company's products.[5]

Opponents argue that by accepting money from the tobacco industry recipients not only benefit directly from the sale of cigarettes but also promote the interests of tobacco companies by facilitating their ability to sell cigarettes. The acceptance of funding provides these companies with respectability by association; recipients may also act as de facto spokespersons for the industry, defending its interests,[5] or, more subtly, remaining silent on issues that may impact negatively on the industry. This helps maintain the "legitimacy" of this industry and its products. Furthermore, opponents argue that ethical guidelines are not sufficient because they often relate only to research funding and not to other types of relationships such as donations and investments, and they do not address industry funded research or activities that deflect attention away from tobacco's adverse effects. Moreover, some maintain that by taking tobacco money, universities are shirking their responsibility as moral institutions[6] entrusted with contributing to a healthy, productive, and just society.

The arguments against accepting tobacco money are compelling, particularly to members of the health community,[7] who are acutely aware of the enormous health toll caused by tobacco and the even greater number of tobacco related casualties that await us.[8] Many are also aware of the unethical conduct of the tobacco industry and its long campaign of denial, obfuscation, and deceit over the harmful effects of its products.[9–11] This group may be best positioned to understand that, even if a particular university may come out ahead by accepting tobacco money and even if there is some advancement of knowledge, there is still a net loss for society through the support of this industry's interests.

Once one is prepared to accept that it is inappropriate for universities to take tobacco money, the next issue is whether this stance should be extended to other sources of funds. It is argued that tobacco is unique: it is addictive, toxic, and lethal to half its long term users, and the number of people harmed by tobacco worldwide is of epidemic magnitude.[8 12] Yet there are few, if any, corporate sources of untainted funds. What about receiving money from the alcohol industry, the pharmaceutical industry, or other "for profit" sectors that may have an economic interest in the activities of universities? As the pressure on universities to find private sources of funding intensifies, academia will be faced with difficult decisions about where to draw the line. These ethical issues must be debated. Sadly, the credibility of contributions to these discussions from Nottingham University's inter-

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national centre for corporate social responsibility will be suspect.

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*Details of these policies can be found at the following websites:
www.research.cancer.ca/download/manual00.pdf?submit=manual00.pdf
www.heartfoundation.com.au/research/r2_01_info_book.html
www.tobacco-control.org/tcrc.nsf/4723e4b3bbc9362e802566e300360f8e/aad41ecf44fc5c818025688f00527525?OpenDocument
www.nswcc.org.au/cncrinfo/research/notices/resgrants/guidelines.htm

1 Cohen J. Tobacco money lights up a debate. *Science* 1996;272:488-94.
2 Cohen JE, Ashley MJ, Goldstein AO, Ferrence R, Brewster JM. Institutional addiction to tobacco. *Tobacco Control* 1999;8:70-4.
3 Sibbald B. U of A refuses tobacco-sponsored scholarship donation. *Can Med Assoc J* 2001;164:81.
4 University of California positions on tobacco industry external funding and investments. *Tobacco-Related Disease Research Program (TRDRP) Newsletter* March, 2001;4:4. www.ucop.edu/srphome/trdrp/nslttr301.pdf
5 Campbell C. For and against: should Nottingham University give back its tobacco money? Against. *BMJ* 2001;322:1119.
6 Smith R. For and against: should Nottingham University give back its tobacco money? For. *BMJ* 2001;322:1118.
7 Action on Smoking and Health. *BMJ Editor dumps Nottingham University in reader uprising against British American Tobacco sponsorship*. London: ASH, 2001.
8 Peto R. Smoking and death: the past 40 years and the next 40. *BMJ* 1994;309:937-9.
9 Glantz SA, Barnes DE, Bero L, Hanauer P, Slade J. Looking through a keyhole at the tobacco industry. The Brown and Williamson documents. *JAMA* 1995;274:219-24.
10 Sweda Jr EL, Daynard RA. Tobacco industry tactics. *Br Med Bull* 1996;52:183-92.
11 Ong EK, Glantz SA. Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. *Lancet* 2000;335:1253-9.
12 United States Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. a report of the Surgeon General.* Rockville, MD: Office on Smoking and Health, 1989.

Cannabinoids for pain and nausea

Some evidence but is there any need?

This is an exciting time for cannabinoid research. The discovery of cannabinoid CB_1 receptors (expressed by central and peripheral neurones)[1] and CB_2 receptors (expressed mainly by immune cells)[2] and endogenous agonists[3] for these receptors has renewed the scientific community's interest. Independently of these developments society at large has continued an aggressive debate about the therapeutic use of cannabinoids, including demands for their more liberal availability.[4 5] Cannabinoids have been suggested to have therapeutic value as analgesics and in various conditions, including migraine headaches, nausea and vomiting, wasting syndrome and appetite stimulation in HIV-infected patients, muscle spasticity due to multiple sclerosis or spinal cord injury, movement disorders such as Parkinson's disease, epilepsy, and glaucoma.[6] When new therapeutic indications are suggested, two major factors should be taken into account: what are the adverse effects of the treatment and how does its effectiveness compare with that of existing alternatives?

In this week's issue two high quality systematic reviews shed light on the therapeutic potential of cannabinoids in the management of pain (p 13)[7] and the nausea and vomiting induced by chemotherapy (p 16).[8] Campbell et al sought and examined all randomised controlled trials that compared the efficacy and safety of cannabinoids with those of conventional anaglesics.[7] The nine trials included 222 patients, of whom 128 had cancer (five studies), two chronic non-malignant pain (two studies, one patient per trial), and the rest postoperative pain. Cannabinoids were no more effective than codeine in controlling acute and chronic pain and they had undesirable effects in depressing the central nervous system. These studies are mostly from the 1970s. Since then we have learnt to use non-steroidal anti-inflammatory analgesics alone and in combination with opioids in both cancer related and postoperative pain. There is thus no need for cannabinoids for these indications.

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In chronic non-cancer pain, however, we do need more effective analgesics than those currently available. Cannabinoids have anti-inflammatory effects, but it is difficult to believe that they would beat the anti-inflammatory drugs available today. Neuropathic pains, particularly those with spastic components, are one area where cannabinoids may have potential.

In the second systematic review Tramèr et al analysed the effectiveness of cannabinoids in chemotherapy induced nausea and vomiting among 1366 patients in 30 randomised controlled trials.[8] Across all trials cannabinoids showed some antiemetic efficacy compared with active comparators (prochlorperazine, metoclopramide, chlorpromazine, tiethylperazine, haloperidol, domperidone, and alizapride) and placebo. Cannabinoids were antiemetic when the control patients suggested a medium emetogenic setting. In highly emetogenic settings, however, they did not show any efficacy. Most of these studies were performed in the 1980s. The serotonin receptor antagonists were introduced in the 1990s and they have changed the practice of antiemesis in chemotherapy induced nausea and vomiting. The American Society of Clinical Oncology guidelines recommend no routine antiemetic before chemotherapy with low emetic risk, a corticosteroid for patients being treated with agents of intermediate emetic risk, and the combination of a serotonin receptor antagonist and a corticosteroid before chemotherapy with high emetic risk.[9] Serotonin receptor antagonists and corticosteroids have shown the highest therapeutic index whereas cannabinoids share a lower therapeutic index with dopamine antagonists, butyrophenones, and phenothiazines—that is, those agents against which they were compared in the systematic review.

As the currently available cannabinoids clearly loose the battle in both efficacy and safety with the

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