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EDITORIALS

Medical cannabis in the UK

Patients should not be criminalised for seeking benefits

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Do patients have the right to medicate themselves, or should they be punished for doing so? Should their doctors work with them to decide on the best treatment, or does the government know best? These questions are at the heart of the current debate on the use of cannabis as medicine.

In the UK, "cannabis based products for medical use in humans" were rescheduled on 1 November 2018. They were placed in schedule 2 of the Misuse of Drugs Regulations, alongside several opioid analgesics. In theory, this means they can now be prescribed. In practice, the NHS has warned that "very few people in England are likely to get a prescription for medical cannabis,"[1] because of the tight restrictions that have been put in place.[2-6]

Patient autonomy versus controlled prescription

Under the Misuse of Drugs Act, people face criminal prosecution for possession of schedule 2 substances without a prescription. According to some ethical arguments, this breaches their right to decide autonomously on their wellbeing.[7] As patients have the right to refuse treatment under the doctrine of informed consent, they also—it is argued—have the right to decide on the treatments they want to use. This does not mean they have the right to draw on the public purse to pay for any and all treatments they might want. But it does mean, for example, that they should not be criminalised for growing cannabis to treat themselves.

In the case of cannabis, evidence of varying strength shows some benefit in a wide range of conditions, including chronic pain, chemotherapy induced nausea, some forms of epilepsy, spasticity in multiple sclerosis, sleep disorders, weight loss or gain associated with HIV, Tourette's syndrome, anxiety disorder, and post-traumatic stress disorder.[8-11] People with other conditions—including glaucoma[12] and inflammatory bowel disease[13]—also report benefits. Preclinical evidence suggests that cannabis based medicines may have a role in treating some forms of cancer.[14 15]

The clinical evidence of benefits is very weak and patchy for some conditions. An advantage of rescheduling cannabis is that it will make it easier to research its harms and benefits (although leaving cannabis that is not prepared as a medicine in schedule 1—as the government has done—weakens this advantage). The research may eventually confirm that the harms of cannabis outweigh benefits to patients. But there are good arguments against criminalising patients for making their own judgments about risks and benefits while we all wait for better evidence.

The argument to maintain tight control of prescriptions is based on fear of the potential consequences of a more liberal approach.[16] Patient safety is an important concern. Use of cannabis is associated with general risks, including cardiovascular and mental health problems, as well as dependence.[9 11] There are also condition specific risks. For example, cannabis use may lower blood pressure, which is a risk for people with glaucoma.[12] As the evidence develops, we should ensure that patients have access to the best available information on both harms and benefits, and the uncertainties which surround them. They can then decide for themselves whether they wish to run these risks.

Another concern is that cannabis will be diverted from medical use to fuel the black market for recreational use. This fear was raised by 166 pain specialists in a recent letter to the *Times* newspaper.[17] They argued that prescribing cannabis may cause problems similar to an opioid crisis. These fears are probably overblown, and not just because cannabis is far less lethal than opioids.[18] Legalising medical marijuana, with relatively liberal access, has not caused major increases in cannabis use in the US.[19] Indeed, there are some indications that it has reduced harms associated with opioid analgesics, including deaths from overdose and workplace or traffic injuries.[20-22]

Access remains limited

The potential demand for medical cannabis in the UK is large. Thirteen per cent of respondents to a recent opinion poll "would actively ask their doctor or healthcare provider about accessing cannabis medicines."[23] The NHS, however, plans to limit prescriptions to children with rare forms of epilepsy and patients with chemotherapy induced nausea, and only after other treatments fail.[1] Even eligible patients are now struggling to get essential (and previously accessible) treatment.[24] The predictable consequence is that many patients will continue to get cannabis from the illegal market, as they have done under Australia's similarly restrictive regime.[25] So they will continue to fund the harms of organised crime, to use products of uncertain content, quality, and consistency, and to be treated as criminals for seeking to relieve their suffering.

The UK's new system prevents legal access to cannabis for patients who might benefit. It also severely limits the ability of their doctors to prescribe it. The right regulations for drugs are both an ethical and an empirical concern. The ethical questions

hinge on the actual effects of different approaches.[26] So we need to invest in research on policy as well as on the clinical aspects of cannabis.[27]

In the short term, we should relax restrictions on prescription and reduce the harms of criminalisation by moving all plant based cannabis products to schedule 4(ii), alongside anabolic steroids. As with steroids, people should not be prosecuted for possessing cannabis for their personal use. In the longer term, we will need to consider more ethical and effective ways to regulate the supply of currently controlled drugs.[28]

Competing interests: I have read and understood BMJ policy on declaration of interests and declare that I am a member of the Advisory Council on the Misuse of Drugs but am not representing its views here. I have had two craniotomies to remove ependymoma brain tumours, so might benefit in future if cannabis based medicines are found to be effective in treating such tumours.

Provenance and peer review: Commissioned; externally peer reviewed.

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