The case for medicinal cannabis: where there is smoke there may well be fire

Chris Wilkins

In their informative article on medicinal cannabis, Newton-Howes and McBride (2016)\(^1\) rightly observe the introduction of medical cannabis regimes has largely been driven by political activism from patients and their families, and pro-recreational cannabis law reform organisations, such as NORML, rather than medical science. There are only a limited number of medicinal cannabis studies to start with and only a minority of these use the double-blind trial design which produces the standard of evidence sufficient to convince medical bodies.\(^2\) As Newton-Howes and McBride\(^1\) describe, one of the most recent systematic reviews (consisting of only 79 studies) found moderate-quality evidence to support use of cannabinoids for the treatment of chronic pain and spasticity, and low-quality evidence to support use of cannabinoids for nausea and vomiting due to chemotherapy, weight gain in HIV infection, sleep disorders and Tourette's syndrome.\(^3\) Newton-Howes and McBride\(^1\) also rightly note the use of herbal cannabis as a medicine is inherently problematic due to the fact it is largely delivered via smoking, there is no standardisation of dose, and little direction concerning the required dosage, apart from the crude ‘use to effect’. Cannabis also has some well-documented adverse side effects including increased risk of psychosis, particularly among young and daily users, and dependency. The risk of cannabis dependency is being taken increasingly seriously and may be higher than commonly thought. Thirty-one percent of those who used cannabis in the last year in the US were assessed to have a DSM-IV cannabis use disorder in 2012/13.\(^4\)

Cannabis users’ enthusiasm often muddies the medical debate

Newton-Howes and McBride (2016)\(^1\) also note the conflation of the debate over cannabis as a medicine versus cannabis as a recreational drug misdirects the discussion over the merits of cannabis as a medicine. Recreational drugs only have to create euphoria and other pleasant intoxication effects. As long as they do not create immediate serious health issues in the vast majority of users, in particular overdose and dependency, they can attract a large following of enthusiastic recreational users whose support for the drug may not be particularly critical due to their own controlled usage and positive experience. This applies to alcohol and tobacco as much as it does for cannabis. Medicines, on the other hand, must reach the much higher standard of positive therapeutic effect, including avoiding serious side effects, proven via a double-blind clinical trial. Support for recreational cannabis vs medicinal cannabis therefore represents two vastly different standards of debate and evidence. However, it should also be noted that the criminal prohibition of cannabis has had a chilling effect on the very medical research into cannabis that is now required to support the use of cannabis as a medicine. There are a number of novel aspects of cannabinoids as a chemical class which justify investigation of its therapeutic potential.\(^5\) Consequently, steps could be taken to remove barriers to...
Many cannabis users use cannabis as a medicine now

Regardless of the lack of medical evidence supporting the effectiveness of cannabis as a medicine, many cannabis users believe they are using cannabis for medicinal reasons. Pledger, Martin and Cumming (2016) found 41% of those who reported using cannabis in the past year in New Zealand also reported they were using cannabis for medicinal reasons. Forty percent of these medicinal users were using cannabis to alleviate pain, followed by anxiety (27%), depression (26%) and nausea (11%). A much larger study of cannabis cultivators conducted in Australia, Belgium, Denmark, Finland, Germany and the UK in 2012/13 (n=5,313) found 45% reported cultivating cannabis for medical purposes, either for themselves or others. The illnesses they reported using cannabis for included physical and mental illnesses. The most popularly reported were depression (43%, n=2,070), chronic pain (33%), anxiety (30%), headaches (24%), ADHD (15%), bowel problems (14%), arthritis (14%), PTSD (11%) and asthma (10%). This is a far broader list than conditions for which there is any medical evidence in relation to cannabis. More worryingly, there are also a number of mental health disorders (depression and other mood disorders) in this list for which the use of cannabis (at least herbal cannabis containing THC) may exacerbate the condition.

Seventy-six percent of those who reported cultivating cannabis for medicinal reasons said they had received a diagnosis for the condition from a doctor. This challenges the common perception that cannabis users only cite medical reasons to justify their recreational use. However, significantly, only a minority of those medical cannabis users with a diagnosis from a medical professional had discussed the use of cannabis as a medication with their doctors. Fifty-nine percent indicated their doctor had not recommended cannabis for their condition and they had not asked for it. Interestingly, 17% reported their doctor had suggested the use of cannabis. Alternatively, in 8% of cases the doctor had refused to recommend cannabis even though the respondent had asked for it, and in 9% of cases the doctor had advised the respondent against using cannabis.

More informed debate and engagement needed

Newton-Howes and McBride (2016) rightly call for doctors to become more engaged in the debate over the medical use of cannabis. This call could also be expanded to include politicians who currently appear to be reluctant to engage in such a highly polarised issue for fear of offending conservative elements among voters. The fact is change in regard to the legal status of cannabis, both for recreational and medical purposes, is gathering momentum around the world, to the point where New Zealand can no longer avoid serious debate. Polling in the US has shown that public support for the legalisation of cannabis has increased from 32% in favour in 2006, to 57% in favour in 2016.

Following the November elections in the US, another three States voted to legalise the recreational use of cannabis: California; Massachusetts and Nevada. The legalisation of recreational cannabis in California may well be a watershed moment for cannabis law reform. California is the largest US state by population, home to 38 million people, and is the fifth largest economy in the world. This guarantees a large impact both domestically in the US and on the international stage. The cannabis industry which develops in California will be an influential lobby group at both the federal level in the US and around the world.

In the same November elections in the US, Florida, Arkansas and North Dakota passed initiatives to establish medicinal cannabis regimes and joined 25 other US states who already have medical cannabis regimes. There are also legal medical cannabis regimes in Austria, Canada, the Czech Republic, Finland, Germany, Israel, Italy, the Netherlands, Portugal and Spain. The medical use of cannabis in Australia was also legalised at the federal level in November 2016.
As I have argued previously in this journal, it is important that New Zealand takes the opportunity to carefully examine the range of regulatory options available for a legal cannabis regime, rather than just adopting at the last minute the default commercial legal market option we are most familiar with from alcohol and tobacco, which also happens to be the most conducive to profit making by the related industry.11 Long experience with the commercial markets for alcohol and tobacco has shown they are associated with pricing cutting, marketing directed at young and heavy users, normalisation of use and industry opposition to stricter regulation.

The regulatory options for medicinal cannabis are narrower and can be structured around established prescription systems. An alternative approach is to accept that cannabis is more akin to a non-specific anxiolytic, and is in fact largely a dietary supplement. Dietary supplements elicit much less anxiety among regulators as they do not make any therapeutic claims. It could be argued that herbal cannabis has much more in common with common dietary supplements such as echinacea, ginkgo biloba and St. John's worth than modern medical pharmaceuticals. For example, the cannabis derived product Elixinol™ is sold as a ‘dietary supplement’ overseas, with its marketed benefits limited to the antioxidant properties of CBD.12 It is 18% cannabidiol (CBD) oil extract produced from pressing stalks and seeds of industrial hemp. It contains no THC and has no psychoactive properties. Although there is growing evidence supporting the therapeutic benefits of CBD, the US manufacturer of Elixinol™ does not make any therapeutic claims. Consequently, it could be easily classified and regulated as a dietary supplement in New Zealand.

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Nil.

Author information:
Chris Wilkins, SHORE & Whariki Research Centre, Massey University, Auckland.

Corresponding author:
Chris Wilkins, SHORE & Whariki Research Centre, Massey University, Wellesley Street, Auckland.
c.wilkins@massey.ac.nz

URL:

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