

WMA STATEMENT ON MEDICAL CANNABIS

Adopted by the 68th General Assembly, Chicago, October 2017

PREAMBLE

1. Cannabis is the generic term used to denote psychoactive preparations of the plant *Cannabis sativa*, which grows wild in many parts of the world and is known by numerous other names, such as: “marijuana”, “dagga”, “weed”, “pot”, “hashish”, or “hemp”.
2. Cannabis for medical use refers to the use of cannabis and its constituents, natural or synthetic, to treat disease or alleviate symptoms under professional supervision; however, there is no single agreed upon definition.
3. Recreational cannabis refers to the use of cannabis to alter one’s mental state in a way that modifies emotions, perceptions, and feelings regardless of medical need.
4. This WMA statement is intended to provide a position on legalisation of cannabis for medical use and highlight the adverse effects associated with recreational use.
5. Recreational cannabis use is an important health and social issue across the world. Cannabis is the most commonly used illicit drug in the world. The World Health Organisation estimates that about 147 million people, 2.5% of the world population, use cannabis compared with 0.2% using cocaine and 0.2% using opiates.
6. The WMA opposes recreational cannabis use due to serious adverse health effects such as increased risk of psychosis, fatal motor vehicle accidents, dependency, as well as deficits in verbal learning, memory and attention. Use of cannabis before the age of 18 doubles the risk of psychotic disorder. The ominously growing availability of cannabis or its forms in foodstuffs such as sweets and “concentrates”, which have enormous appeal to children and adolescent, requires intensive vigilance and policing.
7. National Medical Associations should support strategies to prevent and reduce recreational cannabis use.
8. Evidence for use of cannabis for medical use
 - 8.1 Cannabinoids are chemical constituents of *Cannabis sativa* that contain similar structural features; some of the chemical constituents act on human cannabinoid receptor cells. Conceptually, cannabinoids that activate these receptors (1) occur naturally in the human body like other endogenous neurotransmitters (endocannabinoids); (2) occur naturally in the cannabis plant (phytocannabinoids); or (3) are pharmaceutical preparations containing either synthetic cannabinoids, (e.g. delta9-tetrahydrocannabinol [dronabinol, Marinol™], or a related compound, nabilone [Cesamet™], or extracts of phytocannabinoids (nabiximols [Sativex™]).
 - 8.2 Amongst phytocannabinoids is naturally occurring *Cannabis sativa*, delta-9-tetrahydrocannabinol (THC), the main bioactive cannabinoid and the principal psychoactive constituent, while cannabidiol (CBD) is the second most abundant. CBD lacks significant psychoactive properties but may possess analgesic and antiseizure properties.
 - 8.3 The human endocannabinoid system is believed to mediate the psychoactive effects of cannabis and is involved in a variety of physiologic processes including appetite, pain-sensation, mood, and memory. The significant medical and pharmacological therapeutic potential of influencing the endocannabinoid system has been widely recognized.

8.4 The medical benefits of cannabis reported in scientific literature are widely debated globally. Cannabis has been used for the treatment of severe spasticity in multiple sclerosis, chronic pain, nausea and vomiting due to cytotoxics, and loss of appetite and cachexia associated with AIDS. Evidence suggest that certain cannabinoids are effective in the treatment of chronic pain, particularly as an alternative or adjunct to the use of opiates when the development of opiate tolerance and withdrawal can be avoided. Evidence supporting use of cannabis for medicinal purposes is of low to moderate quality, and inconsistent. The inconsistency can be partially attributable to the prohibition of cannabis. Its classification as an illegal substance in some countries has constrained safe and high-quality clinical research.

8.5 The short-term adverse effects of cannabis use are well documented. However, the long-term adverse effects are less well understood, particularly the risk of dependence and cardiovascular disease. There are also significant public health concerns for vulnerable populations such as adolescents, and pregnant or breastfeeding women.

8.6 Despite weak evidence of its medical benefits, cannabis for medical use has been legalised in some countries. In other countries medical cannabis is forbidden or under debate.

9. Medical professionals may find themselves in a medico-legal dilemma as they try to balance their ethical responsibility to patients for whom cannabis may be an effective therapy and compliance with applicable legislation. This dilemma can manifest itself both with patients who may medically benefit from the use of cannabis, and those who are not likely to do so, but pressure the medical professionals to prescribe it.

RECOMMENDATIONS

10. Cannabis Research

10.1 In the light of the low-quality scientific evidence on the health effects and therapeutic effectiveness of cannabis, more rigorous research involving larger samples is necessary before governments decide whether or not to legalise medical cannabis for medical purposes. Comparators must include the existing standards of treatment. Expansion of such research should be supported. Research should also examine the public health, social and economic consequences of cannabis use.

10.2 Governments may consider reviewing laws governing access to and possession of research-grade cannabis for the purpose of allowing well-designed scientific research studies to broaden the evidence base on the health effects and therapeutic benefits of cannabis.

11. In countries where cannabis is legalised for medicinal purposes, the following requirements should apply:

11.1 Requirements for producers and products:

11.1.1 Provision of cannabis plant products for treatment must be in accordance with the UN Single Convention on Narcotic Drugs from 30 March 1961, including the Convention's rules on production, trade, and distribution. Thus, it is essential that the cannabis included in the products delivered for medical treatment must be provided and handled in accordance with the requirements of the Convention.

11.1.2 Requirements must include that the cannabis plants meet appropriate quality demands for growing and standardization. The produced cannabis plant products must have a specific indication (interval) of ingredients, including the content of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) and strength indication of these.

11.2 Requirements for prescription and dispensing of cannabis for medical purposes:

11.2.1 Cannabis must be prescribed by an authorised physician/prescriber in accordance with the best level of evidence and the country's regulatory frameworks.

11.2.2 It is recommended that treatment with approved conventional drugs is undertaken before cannabis products are used for treatment.

11.2.3 Each individual physician must take responsibility for and make a decision regarding treatment with cannabis products, in accordance with the best available evidence and country specific registered indications.

11.2.4 Cannabis for medical purposes must only be dispensed at pharmacies or by authorised dispensers in accordance with the country's regulatory frameworks.

11.2.5 Effective control measures must be put in place to impede illicit use of medical cannabis.

11.2.6 Public health surveillance systems to monitor prevalence of cannabis use and trends in utilisation patterns are necessary.

12. In considering policy and legislation on cannabis, governments, NMAs, policymakers, and other health stakeholders, should emphasize and examine the health effects and therapeutic benefits based on the available evidence, while also recognizing various contextual factors such as regulatory capacity, cost-effectiveness, societal values, social circumstances of the country, and the public health and safety impact on the wider population.