The licencing of cannabis oil for medical use and the International Conventions

Preamble

One may well ask how so many countries are licencing the use of cannabis oil for medical purposes, apparently in conflict with the International Conventions of which they are signatories.

In this short document we first outline the three relevant international Conventions. Then we analyse the actions and reasoning of various countries, and the response of the controlling bodies.

The three International Conventions

1. *The Single Convention on Narcotic Drugs, 1961*

   This document is an international treaty to prohibit production and supply of specific (nominally narcotic) drugs and of drugs with similar effects *except under licence for specific purposes, such as medical treatment and research*. This was the first international treaty where cannabis was regulated. The International Narcotics Control Board (INCB) was established under the auspices of the United Nations to implement the treaty.

   The Single Convention repeatedly affirms the importance of medical use of controlled substances. The Preamble reads as follows:

> The Parties,
>
> Concerned with the health and welfare of mankind,
>
> Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes,
>
> Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind,
>
> Conscious of their duty to prevent and combat this evil,
>
> Considering that effective measures against abuse of narcotic drugs require co-ordinated and universal action,
>
> Understanding that such universal action calls for international co-operation guided by the same principles and aimed at common objectives,
>
> Acknowledging the competence of the United Nations in the field of narcotics control and desirous that the international organs concerned should be within the framework of that Organization,
>
> Desiring to conclude a generally acceptable international convention replacing existing treaties on narcotic drugs, limiting such drugs to medical and scientific use, and providing for continuous international co-operation and control for the achievement of such aims and objectives,...

Note that "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes". Articles 1, 2, 4, 9, 12, 19, and 49 of the treaty contain provisions relating to "medical and scientific" use of controlled substances. In almost all cases, parties are permitted to allow dispensation and use of controlled substances under a prescription, subject to record-keeping requirements and other restrictions.

The Single Convention unambiguously condemns drug addiction, however, stating that "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind". It takes a prohibitionist approach to the problem of drug addiction, attempting to stop all non-medical, non-scientific use of narcotic drugs. Article 4 requires nations to limit use and possession of drugs to medicinal and scientific purposes.

The Single Convention's penal provisions frequently begin with clauses such as "Subject to its constitutional limitations, each Party shall . . ." Thus, if a nation's own legislation prohibit instituting the criminal penalties called for by the Single Convention, those provisions will not be binding on that country.

2. *The Convention on Psychotropic Substances of 1971*

This convention was introduced to regulate addictive substances that were not covered by the Single Convention. It is instructive to note that countries decided not to include control of these substances in the Single Convention. Perhaps countries realised already by 1971 that the Single Convention was ineffective in combating drug abuse: Witness the explosion of drug abuse in the hippie era of the 1960's, after the adoption of the Single Convention in 1961.

A further reason for the new convention was that the developed countries had strong pharmaceutical industries whose production was threatened by the naturally-grown plants that were being produced in the developing countries. The 1970's was still very much part of the era where the developed countries used institutions like the United Nations to dominate the world economy at the expense of the developing countries. This can be seen in the fact that the 1971 Convention has different treatments of naturally grown plants and manufactured preparations.

A March 2003 European Parliament committee report noted the disparity in how drugs are regulated under the two treaties:

> *The 1971 Convention, which closely resembles the Single Convention, establishes an international control which is clearly less rigorous for the so-called 'psychotropic' substances, generally produced by the pharmaceutical industry. . . The parallel existence of the Single Convention and the 1971 Convention have led to certain illogical effects such as the fact that a plant (cannabis) containing at most 3% of a principal element is dealt with more severely than the pure substance at 100% (tetrahydrocannabinol or THC).*

3. *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*

   This Convention deals with illicit trafficking and does not affect the legitimate use of drugs for medical purposes.

Advances in medical research

There is today considerable difference of opinion over whether cannabis is "particularly liable to abuse and to produce ill effects" and whether that "liability is not offset by substantial therapeutic advantages," as required by Schedule IV criteria. In particular, the discovery of the cannabinoid receptor system in the human body during the late 1980s revolutionized scientific understanding of cannabis' effects, and much evidence has come to light about the drug's medical uses. The Canadian Senate committee's report notes,

> *At the U.S.'s insistence, cannabis was placed under the heaviest control regime in the Convention, Schedule IV. The argument for placing cannabis in this category was that it was widely abused. The WHO later found that cannabis could have medical applications after all, but the structure was already in place and no international action has since been taken to correct this anomaly.*

Cannabinoid receptors, located in the brain, are part of the Endocannabinoid system which is involved in a variety of physiological processes including appetite, pain-sensation, mood, and memory.

Cannabinoid receptors are of a class of cell membrane receptors under the G protein-coupled receptor superfamily. As is typical of G protein-coupled receptors, the cannabinoid receptors contain seven transmembrane spanning domains. Cannabinoid receptors are activated by three major groups of ligands: endocannabinoids, produced by the mammillary body; plant cannabinoids known as "Phytocannabinoids" (such as Cannabidiol, produced by the cannabis plant); and synthetic cannabinoids (such as HU-210). All of the endocannabinoids and phytocannabinoids are lipophilic, similar to other fat soluble compounds.

There are currently two known subtypes of cannabinoid receptors, termed CB_1 and CB_2. The CB_1 receptor is expressed mainly in the brain (central nervous system or "CNS"), but also in the lungs, liver and kidneys. The CB_2 receptor is expressed mainly in the immune system and in hematopoietic cells. Mounting evidence suggests that there are novel cannabinoid receptors that is, non-CB_1 and non-CB_2, which are expressed in endothelial cells and in the CNS. In 2007, the binding of several cannabinoids to the G protein-coupled receptor GPR55 in the brain was described.

Fixing the mistakes of the past

By now it is quite clear to many developed countries that cannabis has many legitimate medical uses. At the time of writing, 23 countries have legalised the medical use of cannabis, including five of the seven G7 countries (USA, UK, Canada, Germany, France).

It is easier for an individual country to find a way to legalise the medical use of cannabis within the existing convention regime than to get all the signatories to agree to change the convention. Also, it appears that those countries that have legalised the use of cannabis are deriving significant economic benefits during this period when many other potential competitor countries have not yet

acted to legalise the medical use of cannabis. Hence, the conventions remain unchanged - yet cannabis is being legalised for medical purposes by more and more countries every year.

The reasons advanced by countries who have legalised cannabis for medical purposes are:

a. The preambles to the Single Convention and the two subsequent conventions state that the conventions are "concerned with the health and welfare of mankind" - and the legalisation of cannabis for medical purposes is aligned with this concern.

b. The Conventions allow the use of cannabis for medical use. Most countries merely deviate in their implementation of this allowance.

c. The Conventions are subservient to national legislation.

d. The Conventions have proved spectacularly ineffective in addressing their main aim, namely the elimination of drug trafficking and drug abuse. Their main effect seems to have been a rather bloated bureaucracy.

e. The Conventions were part of the cold-war system of domination of the developing countries by the big-pharma interests of the developed countries, and are no longer legitimate in today's geopolitical climate.

f. There has been no significant diversion of legally manufactured drugs from the legal trade into illicit channels. Why stifle the legal trade?

g. The Conventions provide that each signatory must implement "the most appropriate means of protecting the public health and welfare". Whatever these means were, would be left to the judgement of the signatory concerned whose bona fide opinion on this matter could not be challenged by any other signatory.

Examples

1. *Great Britain*

   In 1998 Great Britain licenced G W Pharmaceuticals (www.gwpharm.com), a company that is listed in both London and New York, to deal in cannabis products for medical use. G W Pharmaceuticals has since expanded its operations to 27 countries, where it has obtained licences to sell Sativex, its main cannabis-based product.

   The International Narcotics Control Board has not sanctioned Great Britain for licencing G W Pharmaceuticals. It has also not sanctioned any of the other countries where G W Pharmaceuticals has been licenced to sell Sativex.

2. *South Africa*

   In 1993 South Africa changed its Schedule of prohibited substances to exclude dronabinol (a cannabis derivative). South African Druggists (now part of Aspen) was given a licence, and has two products on the market: Elevat and Marinol. It is rumoured that Aspen is making billions of Rands of profit on these two products. Aspen's turnover for the past year was R36 billion (almost three times the GDP of Swaziland).

The International Narcotics Control Board has not sanctioned South Africa for licencing S A Druggists/Aspen.