Pot Populism and Vested Interests

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Medical practice has been turned on its head in the US, with the practitioner giving permission for a third party to advise on type and dose of cannabis. A gross perversion of sound and ethical medicine, moves to legalise 'medical marijuana' will see the same consequences here

The Queensland government has released a draft Public Health (Medicinal Cannabis) Bill and has invited discussion of its "framework for regulating the lawful supply and use of medicinal cannabis products" in that state. **The Bill is an exercise in sophistry: an attempt to justify the medical prescription of a complex herb without scientific examination by the Therapeutic Goods Administration (TGA) of its components, safety and efficacy.** The TGA is the statutory body created to protect the public from dangerous or useless medicines promoted by vested interests. The Bill's Discussion Paper actually confesses that "the quality, safety and efficacy of most medicinal cannabis products have not been verified to the exacting standards that apply to prescription medicines". The Bill subordinates medical standards to an anecdote-wielding lobby.

The Bill obfuscates on fundamental issues. First, its inclusive language suggests that all cannabis products are similar preparations of the buds and leaves of that plant and can, therefore, be expected to have similar therapeutic effects. **It does not explain that cannabis is composed of over 400 chemicals whose quantities vary from bud to bud, even from the same plant, and that prediction of composition for prescription is impossible.** The components include the psychoactive tetrahydrocannabinol, many cannabidiols which appear to have opposing effects, terpenes which give flavour and smell, phenols and other chemicals. The Bill does not point out that derivatives of cannabidiols appear to have greatest potential for therapeutic effect and that purified, quantified preparations are being investigated throughout the world for usefulness in pain, epilepsy, spasm and nausea. The Bill does not explain that consumption of the raw herb is as unscientific as consumption of the bark of the cinchona tree rather than its purified derivative, quinine, in the treatment of malaria. In apparent conviction that medical marijuana really works, nowhere does the Bill mention that even the pro-medical marijuana lobby admits to a 75 per cent placebo effect.

Second, the Discussion Paper obfuscates with regard to the side-effects of marijuana. It declares "potential risks" of "addiction" and "medical intolerance", but fails to mention measurable reduction in brain components and function, association with chronic psychosis and effects on the unborn of regular users, together with acute psychosis, neuronal suppression and hyper-emesis in the occasional consumer. Even the pro-marijuana industry admits to an addiction rate of 9 per cent in adults and higher in adolescents.

Third, though the Bill declares its dedication to research, it appears to ignore the results of the two-decade experiment of legalising medical marijuana in the US. That continuing social experiment first reveals that medical marijuana metastasises. Under the "Compassionate Use Act" it was legalised in California in 1996 but is now available for those purposes in twenty-three states and the District of Columbia (DC) with other states preparing for legislation. From confinement to medical use, marijuana has further spread to legalised consumption for all purposes in four states and DC.

The US experiment also reveals a spread in the reasons for consumption of medical marijuana. In accordance with popular imagination and argument, cannabis became available for "seriously ill Californians" suffering from cancer, anorexia, AIDS, chronic pain and spasticity but the law extended permission to the less obvious problems of glaucoma, arthritis and migraine and concluded with a capitulation to "any other illness for which marijuana provides relief".

Other results of the US experiment reveal who is receiving medical marijuana and why. **Data from nine Californian clinics has revealed 73 per cent of users to be males aged between eighteen and forty-four.**

Data from Colorado has confirmed 68 per cent of recipients to be males with a mean age of forty-two. As to the reasons for consumption, Californian data lists pain from back and neck injuries (82.6 per cent), sleep disorders (70.7 per cent), need for relaxation (55.1 per cent), muscle spasms (41.1 per cent), headaches (40.7 per cent), anxiety (37.8 per cent), nausea and vomiting (27.7 per cent), depression (26.1 per cent), poor concentration (22.5 per cent), anger control (22.4 per cent), more energy (15.9 per cent), diarrhoea (5 per cent), seizures (3.2 per cent) and itching (2.8 per cent). These results contradict the image of medical marijuana providing relief for the dying.

Fourth, as if to persuade us that the use of medical marijuana in Queensland will be constrained, the Bill declares that each application for use will be vetted by a "Chief Executive Officer" who *may*, according to Section 23, have regard not only to the good character and standing of the prescribing doctor but also to whether the patient's medical condition and symptoms are suitable for cannabis, what form and dose of cannabis might be appropriate, whether alternative treatments might be suitable, whether cannabis can be integrated into an existing treatment in general and with specific regard for other drug dependence, all in accordance with whatever advice has been given by a specialist, whether the cannabis is imported or grown locally, and whatever other matters seem important.

The Bill does not reveal if this "officer" will be a medical practitioner and, if Australia follows the US, how this person will have any chance of fulfilling his or her duties. Are Queensland legislators aware that consumption of medical marijuana in Colorado has progressed since legalisation and now involves 2 per cent of its population? Extrapolating to Queensland, this would suggest the "officer" might receive 90,000 complex applications a year. Adding to the complexity of this gargantuan task is the natural variation in cannabis composition, which renders spurious the concept of "dose" and invalidates the word "prescription" in the Australian practice of medicine.

Apparently aware that the "officer" will need help, the Bill declares that an "expert advisory panel" will be constructed which *may* include experts from science, pharmacy, medicine, justice and law, ethics, culture or sociology, and agriculture. This committee, the Bill emphasises, is "particularly important" because cannabis "is not subject to the usual monitoring of pharmaceutical products undertaken by the TGA". How this small panel will replace the experienced TGA is not revealed.

As well as protecting the public, the panel may be called upon to help the Chief Executive Officer in evaluation of individual applications for medical marijuana! Note that its membership *may* include a medical practitioner.

The Bill appears to seek the appearance of wisdom and constraint by promotion of this eclectic handful of experts. But, as its members may be asked to advise on how to grow the plants, who is smoking the buds, how laws are being disregarded, and the ethics of investigating cultural effects, it is fantasy to assume they can replace the rigorous assessments of drug safety and efficacy developed by the TGA when their duty is to circumvent them.

Fifth, despite the experts at the top, it is not clear who will be "prescribing" marijuana at the bottom of the bureaucracy. The Bill declares that a "medical practitioner" may apply for approval "to facilitate the treatment of a patient with medical cannabis", and not surprisingly the CEO "may make inquiries" about his or her character and standing. Section 14 discusses such applications but is, however, enigmatic. It declares that "the applicant must obtain, from a person with authority to consent to treatment of the patient with medical cannabis, written consent to (a) treat the patient and (b) make the application".

This section does not make sense in Australian medicine, but does in the light of the US experiment. There, the medical practitioner does not "prescribe" marijuana in the manner Australians would understand, but merely writes a chit attesting that the patient is in possession of the drug for medical purposes. The chit is of use when confronted by the police and also to avoid sales tax at certain marijuana outlets. Diagnosis and "prescription" of type and amount of marijuana occurs, however, at the counter of a marijuana outlet at the hands of a "bud tender".

Recently in Colorado I visited an outlet and introduced myself as an Australian doctor who was wondering how the system worked. The attentive sales lady explained that I could just buy cannabis for recreational purposes but if I had a "prescription" I could get it much cheaper. In any case, if I explained my medical problems she would advise what preparation would be best. If I had, for example, back pain with some anxiety, she would suggest "Mountain Dew", but if my pain was accompanied by depression she would suggest "Mountain High". She pointed to rows of bottled buds and leaves, packets of biscuits and bags of colourful lollies and promised that if I did not improve in a few days she would improve the selection. I asked her if I could buy that "Mountain Dew" in other outlets and she quickly replied, "Oh no, we are all different. We grow cannabis in our own laboratory." I was permitted to peep into the laboratory and observe an acre or two of plants thriving under powerful lights. When I asked what had prepared her for such a responsible job of diagnosis and treatment she told me she had worked for some weeks as a secretary to an orthopaedic surgeon.

Medical practice has been turned on its head in the US, with the practitioner giving permission for a third party to advise on type and dose of cannabis. Could section 14 mean that an application to "facilitate use" may be submitted by a pharmacist wishing to sell marijuana as long as a medical practitioner provides an approving chit, as in the US? Section 66, regarding "who must make a plan" for the type and dosage of cannabis to be used by a patient, suggests an "approved pharmacist" may "make a medicinal management plan". Will Australian pharmacies soon boast arrays of bottled buds?

Sixth, though the Bill would suggest that general practitioners will be at the forefront of facilitating use of marijuana, it is silent on their vulnerability to patient pressure, especially in isolated country towns. Moreover, though this may not apply to Australian practitioners, vulnerability to corruption has also been revealed at the front line in the US. In Colorado, for example, at one stage 20 per cent of doctors wrote 80 per cent of "prescriptions", but only fifty physicians were responsible for 85 per cent of these prescriptions and, of these, fifteen were responsible for 49 per cent, with one single doctor registering 6 per cent of all patients. At $100 to $300 per prescription, there was real money to be made.

If the government intends to constrain use of marijuana, it should restrict its "prescription" and supervision to specialists in special units where dispassionate, arm's length use and monitoring can be effected. The tyranny of Australian distance could be overcome by videoconferencing with general practitioners and patients. Moreover, research assessment of subjective responses to marijuana therapy is more likely to be reliable when performed by physicians more remote from patient pressure.

Seventh, is there obfuscation in the declaration of the Queensland government that it "does not intend to legalise or decriminalise recreational use of cannabis"? According to the *Macquarie Dictionary*, "intend" means "to have in mind something to be done or brought about": "not intend" is, therefore, not as definite as "will not". The Queensland government must be aware of the steady progress of cannabis towards legalisation for recreation in the US, but the Bill is silent on how the government will resist that progress here. Once legalised for medical purposes, the pressure of the cannabis lobby will increase relentlessly.

Who are the cannabis lobby? Of course, there are people committed to the genuine belief that marijuana is therapeutic, and others are at least committed to establishing the truth. After all, who would deny relief to the dying, or therapy to a convulsing child? At a recent pro-medical-marijuana conference in the US, believers attested to therapeutic powers over ailments ranging from blindness to cancer, but the real power for legalisation throbbed in the associated Medical Marijuana Investors' Conference, which was held in a vast auditorium and displayed the latest technology for industrial-scale production, distribution and marketing, and the latest ideas in investing. Billions are promised to follow legalisation for recreational use, which is expected to expand in the US in the investible future, and in Australia. Millions are already flowing. In the first year of legalisation in Colorado, 148,000 pounds of cannabis were sold through 827 licensed outlets (**almost quadruple the number of McDonald's restaurants in Colorado**) with an average price of $350 per ounce, revealing sales exceeding $828 million incurring $64 million in sales tax alone.

Big Agriculture is behind US medical cannabis and so is Big Business, and then there is Big Government reaping taxes all along the way from production to sale. In fact, the government of Colorado is now trying to restrict the number of prescriptions for medical marijuana because it gains 25 per cent more tax on recreational sales.

The conviction of wealth energises the industry's proclamation that "Nature Knows Best". It is no setback to the industry that trials are finding scientific derivatives of marijuana to be less therapeutic than desired. The industry counters these failures with the declaration of the existence of an "entourage" effect found only in the natural herb. A "mysterious, natural, holistic" therapeutic synergy is claimed from the 400 or more components regardless of their individual, varying quantities (and contamination by fertilisers, insecticides and fungi). Scientific isolation of components fails because it is "unnatural".

In Queensland, as in other states of Australia and federally, legislation reflects the pressure of the cannabis lobby for drastic change in the way medicine is performed. Scrutiny by the TGA will be circumvented on the basis of anecdotes. To promote wisdom and constraint, the investigating practices of that organisation will be replaced by the opinions of an eclectic group who will also be available to advise on the applications of individuals. While the Bill declares its interest in research, it appears to ignore the widely published findings of the similar, but now lengthy, social experiment in the US. It declares it does not intend to proceed to recreational use but does not mention how it will oppose Big Agriculture, which is already talking of expansion to this country.

The Bill is a capitulation to vested interest. It rejects lessons that have been achieved through much suffering: there was no TGA to protect children when thalidomide was promoted by Big Pharma.

Dr John Whitehall wrote "The Comforting Myths of Medical Marijuana" in the October 2014 issue.