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The growth of private medical cannabis prescribing in the UK over recent years has sparked significant debate, not only about patient access but also about its potential impact on clinical trials and evidence generation. Since November 2018, when medical cannabis was rescheduled to allow prescribing under very specific conditions, a notable private sector—exemplified by companies such as Nationwide Pharmacies—has emerged to meet patient demand. Yet, important questions remain about how this commercial incentive interacts with clinical research and regulatory frameworks.

## Untangling the Legal Framework: Class vs Schedule Confusion

A common source of misunderstanding is the distinction between "Class" and "Schedule" in UK drug law. These terms often get conflated, but they have very different meanings and implications for cannabis prescribing and research.

- **Class**
- **Schedule**

Schedule 1 drugs are deemed to have no recognised medicinal value and are thus more strictly regulated. Before the change in November 2018, cannabis for medicinal use was effectively inaccessible via prescriptions because it was Schedule 1. The reclassification to Schedule 2 allows specialist doctors to prescribe cannabis-based medicinal products (CBMPs), but only under tightly controlled protocols.

*Takeaway: Understanding that cannabis remains Class B under the 1971 Act—meaning it's illegal outside licensed contexts—but has been rescheduled to Schedule 2 for medicinal use, is key to the legal landscape of medical cannabis in the UK.*

## What Changed in November 2018?

Until November 2018, patients could not legally obtain prescription medical cannabis because it was a Schedule 1 drug, deemed unsuitable for any medical use. This year marks a historic shift, as the Home Office rescheduled
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cannabis-derived medicinal products to Schedule 2 in the MDR, allowing prescribing by specialist doctors.

Key points of the change include:

1. Cannabis-based medicinal products became available for prescription in the NHS, but only by specialists with the appropriate licence.
2. A limited range of licensed cannabis medicines (such as Sativex and Epidyolex) were permitted, alongside unlicensed cannabis products prescribed "off-label."
3. The government emphasised that this did not equate to full legalisation or wide availability but was an important nuance reflecting emerging evidence for some conditions.

This regulatory update opened a legal pathway but did not guarantee NHS access—largely due to the paucity of high-quality clinical trial evidence on efficacy and safety, and concerns over cost-effectiveness.

Takeaway: November 2018's rescheduling was a partial step towards medical access but did not mean cannabis was fully legal for general prescribing or that the NHS had to offer it broadly.

Why Cannabis Remains Illegal Under the 1971 Act

Despite medical prescribing being permitted under MDR Schedule 2, cannabis remains a Class B controlled drug under the Misuse of Drugs Act 1971. This means:

- Possession, supply, or production outside of licensed medical or scientific frameworks remains a criminal offence.
- Non-specialist doctors cannot prescribe cannabis medicines.
- Licensed producers and suppliers must meet strict controls.

The 1971 Act's classification balances public health concerns about recreational misuse against emerging legitimate medical uses. The government has so far resisted fully reclassifying cannabis to a lower class to avoid normalising recreational use or creating unintended legal loopholes.

Takeaway: Cannabis remains a Class B drug for general purposes, meaning most uses outside strict specialist prescribing are illegal and subject to criminal penalties.

Specialist-Only Prescribing and Limited NHS Access

One of the most important factors restricting wider medical cannabis use in the UK is the requirement that only specialist doctors—typically consultant-level clinicians with experience in certain fields such as neurology or pain management—can prescribe CBMPs.

- This restriction limits the patient cohort eligible for treatment and confines prescribing to complex cases.
- Many specialists remain cautious due to limited clinical evidence, fear of adverse effects, or lack of NHS guidelines endorsing medical cannabis for many conditions.
- NHS England's evaluation frameworks and cost concerns mean widespread NHS funding for cannabis medicines is rare.

As a consequence, many patients turn to private prescriptions to access cannabis medicines. Firms like **Nationwide Pharmacies** have grown rapidly in response to this demand by offering consultations and prescriptions in private settings, usually at significant cost.

The private sector fills an important gap but also raises concerns about consistency, equity of access, and the potential for "commercial incentive clinical trials" skewed by market priorities rather than robust scientific needs.

Takeaway: Specialist-only prescribing keeps NHS access very limited, pushing many patients towards private providers, with knock-on effects for clinical research priorities.

Private Prescribing Growth: Commercial Incentives and Evidence Generation Lags

The expansion of private medical cannabis prescribing, led by providers such as Nationwide Pharmacies, has been accompanied by strong commercial incentives:

- The opportunity to serve underserved patients excluded from NHS prescribing.
- The chance to retail a range of cannabis-based products including oils, capsules, and flower vapourisers.
- A lucrative market in a relatively unregulated segment compared to mainstream medicines.

While private prescribing has undoubtedly improved access for some, this growth has had complex effects on clinical trials of medical cannabis in the UK:

1. **Reduced urgency for NHS-supported trials:** Private prescribing can relieve some clinical demand pressure, possibly lowering incentives for large-scale, publicly funded randomised controlled trials (RCTs).
2. **Difficulties in standardising patient cohorts:** Private patients may be less homogenous, with varying doses and products, making trial recruitment and data comparability tougher.
3. **Commercial trial biases:** Some private companies have incentives to commission or support smaller studies favouring positive outcomes, which do not always meet stringent regulatory standards.

Consequently, the rate of generation of robust clinical evidence lags behind the pace of private prescribing adoption. This evidence deficit fuels ongoing NHS hesitancy to formally endorse cannabis medicines beyond a few narrow indications.

Many experts recommend increased collaboration between private clinics and academic researchers to improve data collection and trial quality, though regulatory and financial challenges remain.

Takeaway: While private prescribing fills access gaps, it also risks delaying or complicating high-quality clinical trials crucial for NHS adoption and evidence-based medicine.

https://www.tntmagazine.com/leisure-entertainment/leisure/why-is-cannabis-still-illegal-in-the-uk-the-history-behind-medical-cannabis-law/

Summary Table: Key Elements Affecting Medical Cannabis Use and Research in the UK

Aspect Current Status Impact on Trials/Access Legal Classification Class B (1971 Act), Schedule 2 (MDR for medicinal cannabis) Allows prescribing but limited to specialist doctors under licences Prescribing Eligibility Specialist-only; restricted NHS prescribing Limits patient pool; most patients turn to private prescriptions Private Prescribing Growth Expanding rapidly with companies like Nationwide Pharmacies Improves access but may reduce trial urgency and data homogeneity Clinical Trial Evidence Limited, slow generation of large-scale RCTs Affects NHS confidence and restricts full adoption

Conclusion

The rescheduling of cannabis-derived medicines in November 2018 opened the door for specialist prescribing in the UK but did not fully legalise cannabis or guarantee NHS access. The continuing classification as a Class B drug under the 1971 Misuse of Drugs Act balances medicinal use with public health concerns.

The limited NHS prescribing and high patient demand have fuelled growth in private medical cannabis prescribing, with companies like Nationwide Pharmacies at the forefront. While private prescribing improves patient access, it introduces challenges for evidence-based medicine, as commercial incentives risk slowing robust clinical trial development and colour the landscape of research priorities.

For medical cannabis to secure a firmer position in UK healthcare, improved collaboration between the private sector, academia, regulators, and the NHS is essential. Ensuring transparent, well-designed clinical trials will bridge the current evidence generation lag and enable more consistent, equitable access for patients in future.

In short: private prescribing has expanded patient access but complicated the path to producing the high-quality clinical evidence needed to transform medical cannabis into a mainstream NHS treatment option.

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