

The challenges (in the UK) posed to the clinician by medical cannabis

Dr David Fox FFOM FRCP

October 2026





Agenda

- Why me
- Common OH scenarios
- The prescription landscape
- Side effects
- Assessment of impairment
- The value of an employer policy
- Final thoughts

common OH scenarios

- Can an employee vape cannabis at work?
- Is an employee prescribed cannabis fit for work?
- The employee “may” have been a regular user of recreational cannabis before being prescribed “medical cannabis”
- Representation from a prescribing organisation supporting its use
- The employer has no clear Drug & Alcohol policy commenting on whether it is acceptable for employees to be taking “medical cannabis”





Understanding “Medical Cannabis”

- THC: psychoactive, may affect judgement, reaction time and coordination
- CBD: non-psychoactive and not usually impairing
- Terpenes: aromatic compounds with uncertain occupational impact
- Products include oils, capsules, sprays and dried flower



The UK lens

- “Licensed” medicines: e.g. Epidyolex®, Sativex®
- “Licensed” medication prescribed for 1 of 3 reasons (NICE)
- Medical cannabis (CBPM): Cannabis Based Product for Medicinal use
- “Unlicensed” CBPMs prescribed by specialist clinicians
- Products vary in THC and CBD content
- “medical cannabis” seems to be the phraseology in use for CBPM

From there, growth has been almost entirely on the private prescribing side. According to the latest public figures, prescription items dispensed in English community pharmacies rose from 282,979 in 2023 to 668,511 in 2024 (up 136%) to 1,701,064 in 2025 (up 154%), equating to a more than 6000-fold increase since 2019.

Concentrated prescribing to a handful of doctors

Since 2019, nine prescriber identifiers have collectively accounted for more than half of all CBPM items recorded in England. The top ten combined account for 805,255 items, 52.2% of the all-time total of 1.54 million.

Thirty-seven identifiers account for 80% of all items ever dispensed. At the other end of the distribution, 121 of the 314 identifiers in the dataset have issued fewer than 100 items in total across the entire period.



Non “NICE” reasons for a prescription

- Anxiety
- Chronic pain
- Sleep disorders
- ADHD
- Evidence for the effectiveness in these situations remains mixed
- Lancet Psychiatry review reported limited evidence for several mental health conditions
- Guidance recommends all other evidence treatment approaches have been explored before prescribing cannabis
- Potential benefit reported for some sleep-related conditions.

A cannabis-based medicine has been approved in Germany for chronic lower-back pain after outperforming opioids on some measures in a large, late-stage clinical trial – providing new evidence on how cannabinoids could compare with conventional painkillers.

Cannabis-based medicines have been explored as another option, particularly for patients who have not responded to conventional treatments. However, NICE does not currently recommend routinely offering cannabis-based medicines for chronic pain.

It found some evidence that CBD reduced chronic pain, but described the effect as “modest” – an average improvement of around 0.4 points on a ten-point scale. It also found “no evidence” that medicinal cannabis reduced opioid use.

NICE said the potential benefits were “small compared with the high and ongoing costs” and concluded that the products were not an effective use of NHS resources.

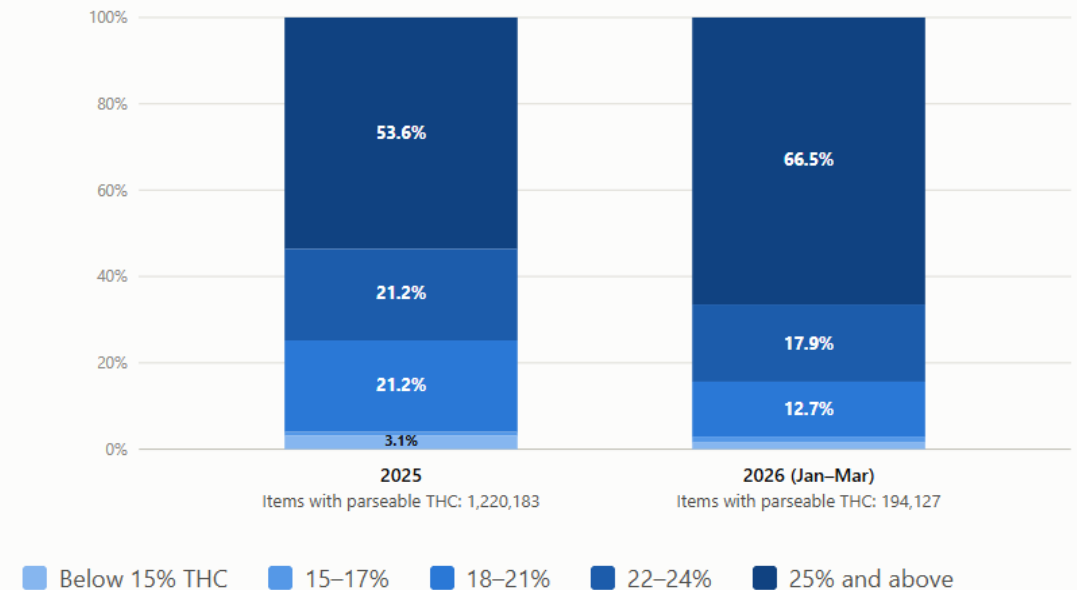


Potential side effects relevant to work

- Reduced concentration and memory
- Drowsiness, fatigue, dizziness
- Slower reaction times
- Possible anxiety, paranoia, hallucinations or behavioural change
- Concerns greatest with THC-containing products
- Effects depend on dose, THC level, frequency and individual sensitivity
- Varies between individuals

THC potency distribution of UK medical cannabis items, 2025 vs 2026 to date

Share of items dispensed at each THC potency band. Products above 22% THC accounted for 75% of 2025 items and 85% of 2026 items dispensed so far.



Source: NHS Business Services Authority FOI-03941 (July 30, 2026) and FOI-03965 (August 14, 2026), combined. Analysis covers items with parseable THC percentages captured under the NHSBSA's new-methodology data collection introduced May 2025 (STRENGTH_THC column). Bands aggregate individual THC percentage values from the raw data.

Impairment

- Drug tests cannot determine timing of use or prescribed versus illicit source
- Drug tests do not measure impairment
- “There is currently no universally accepted workplace test that reliably determines cannabis-related functional impairment at a specific point in time; therefore fitness-for-work assessments should rely on clinical and functional assessment rather than biological testing alone.” – medical cannabis and road safety (DfT)
- Fitness decisions should not rely solely on test results



The Medical Cannabis Clinicians Society, a not-for-profit organisation which provides advice to clinicians on prescribing cannabis, states in its recommendations guide that medical cannabis generally has a lower percentage of THC, the substance linked with psychosis, than street cannabis. Because of this, it says, such side effects are less likely. However the same guide also adds that **there is no conclusive evidence that cannabis is effective in treating depression** and limited evidence for some other mental health issues including anxiety and PTSD.



UK Legal/Driving landscape

- UK drivers may legally drive if prescribed cannabis and not impaired
- Driving while impaired remains an offence (RTA)
- Evidence links THC exposure with increased crash risk
- Guidance exists regarding driving after dosing
- Duration of impairment remains uncertain
- Coroner case

A major study published in the Lancet in March concluded that: "Given the scarcity of evidence, the routine use of cannabinoids for the treatment of mental disorders and SUDs (substance use disorders) is currently rarely justified."

The findings echo the position of the The Royal College of Psychiatrists, who say "recent studies have shown that the benefits of cannabis as a medicine may have been overstated for many conditions".

They added: "While these products have evidence of modest benefit for some addictions, they should not at present be offered for the many mental illnesses for which no benefit has been found." Both say that more high-quality research is needed.

But it also concluded that his "emotional dysregulation" had partly been caused by a psychological dependence on both prescription and illicit cannabis, and that "use of prescription cannabis had acted as an obstacle to him receiving appropriate psychiatric and addictions care", a finding his family and legal team believe is a first in this country.

✚ The value of the employer D&A policy

- An employer policy clarifying whether it is acceptable or not for an employee to be taking “medical cannabis” is crucial
- That same policy should also make it clear what approach will be taken if the employee tests positive for cannabis
- Legal cases in the UK seem to support the employer having a policy recognising that the employer carries ultimate safety risk
- The OH clinician is in a difficult position in the absence of employer policy



✚ Challenges for the OH clinician

- Evidence of clinical benefit will continue to evolve
- There is no certainty on timeframe to cessation of potential impairing side effects
- There is no objective test of impairment
- Not all employers have a D&A policy
- Evidence from Canada suggests patients prescribed cannabis will commonly “top-up” with recreational cannabis the employer carries ultimate safety risk



Final thoughts

- Would you be comfortable letting this person drive you or a family member/friend home?
- Would be happy to see them driving a lorry or bus?
- Would you be happy if they were a doctor or nurse on duty in A&E treating patients?





Your Questions?