

➤ Science, Diplomacy and Cannabis: The Evidence Base and the International Drugs Regulatory System, 1924-1961¹

James H. Mills

No government should take unilateral measures without considering the impact of its actions and ultimately the consequences for an entire system that took governments almost a century to establish.

In 2003 David Blunkett, then Home Secretary, sought to reclassify cannabis, thus ensuring that those caught in possession of it in the UK could not be arrested. His action was immediately condemned by Philip Emafo, who used the quote above to criticise it. At the time Emafo was President of the International Narcotics Control Board (INCB) of the United Nations, and the most senior drugs official in the world. At the heart of Emafo's rebuke to Blunkett was history.

This paper begins to answer the question raised by Emafo's response, namely, was he right to be confident that history supported his case? In other words, was it safe to assume that the century of regulatory action on cannabis had been one of sensible decisions made for sound reasons that had resulted in a coherent and well thought-out approach to controlling the drug, a history that no wise government could contemplate improving upon? Discussion here will focus on one aspect of the evidence-base – the scientific data that was deployed at key moments in the integration of cannabis into the international drugs regulatory system – in order to understand what sort of information lay behind the expansion of the range of drugs incorporated into it throughout the twentieth-century.

THE SECOND GENEVA OPIUM CONFERENCE AND CANNABIS

Cannabis made its entry into the international drugs regulatory system in 1925, in the Geneva Opium Convention of that year. The full context for this is explored elsewhere,² but in summary the Egyptian delegation took the initiative to include cannabis into the agenda that had initially been designed simply to deal with opium, opiates and cocaine. Few other delegations had much information to hand about cannabis, and some impressively forceful rhetoric on the part of the Egyptian representatives seems to have been enough to convince most of the case against the drug. The dramatic announcements on the mental health implications of cannabis use in Egypt had a considerable impact, as the country's chief delegate, Mohammed El Guindy, was able to support these with statistics. In his opening speech on the subject he claimed that 'illicit use of hashish is the principal cause of most of the cases of insanity occurring in Egypt... generally speaking, the proportion of cases of insanity caused by the use of hashish varies from 30 to 60 percent of the total number occurring in Egypt'. Similar evidence was included

¹ This paper draws on research funded by the ESRC (RES-000-27-0018), and the Wellcome Trust (WT085432/Z).

² James H. Mills, *Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928* (Oxford University Press, 2003), 152-87.

in the official 'Memorandum with reference to hashish as it concerns Egypt' that was submitted by the delegation in support of El Guindy's speeches. However, this time the figure was even more alarming, claiming that 'about 70 percent of insane people in lunatic asylums in Egypt are hashish eaters or smokers.'³

Throughout the Egyptian campaign, this was the only material produced that might be considered 'medical' or 'scientific' evidence. It could be argued that, if the figures were reliable, this was all the evidence necessary. However, this also raises the question of where the statistics came from and how compelling they were. Their origins lie in the Egyptian Lunacy Department. This had been the personal fiefdom of an Englishman for over a quarter of a century. John Warnock was appointed by the Public Health Department in Cairo in 1895, at a time when Egypt was an established part of the British Empire. He had been working in the British asylum system for almost a decade by this time, and was seen as the ideal man to reform the Abbasiya Asylum. He remained at the task until 1923, during which time he expanded the existing institution, built a new hospital, drafted laws on mental illness in Egypt, and created a whole new Department dedicated to Lunacy within the colonial Ministry of the Interior. By the time he retired, almost two and a half thousand Egyptians were being treated at any one time within the units of the Lunacy Department.

Warnock seems to have developed little attachment to the place that was to be his home for such a large part of his life. He admitted that he did not study written Arabic and that he found it 'impossible to learn all the tongues necessary to converse with all the patients and their friends' and his grasp of the vernacular was such that he could only 'make [his] wants known and give orders'. The country exhausted him, and by 1916 he had to take a long leave from the stress of work in Egypt, which had been exacerbated by the presence of shell-shocked soldiers from the African campaigns of World War I. He contemptuously dismissed Egyptian political ambitions after the war, and noted that 'self-determination was proving to be an infectious mental disorder'.⁴ Yet despite this apparent lack of sympathy with the society around him, he felt sure that he could locate the chief cause of insanity in the Egyptian population. This was the use of cannabis.

His first year at the asylum was a particularly trying period. He arrived in February 1895 and noted the following difficulties:

*Besides the almost complete lack of funds, my total ignorance of Arabic, and the total ignorance of patients and staff of any language but Arabic, prevented my doing anything for some time. I was unable even to tell the servant to shut the door or to ask a patient his name. I had no interpreter. However, after some time I found a patient who could write English and for a while he was employed in translating Arabic letters etc. until it was discovered that he interpolated numerous mis-statements founded on his delusions. In those days an English or French-speaking clerk was not available. For a time I could only look on and guess at what was going on in most matters.*⁵

Yet despite the range of difficulties in gathering accurate details about patients, which included problems of translation, deliberate mis-information, communicating with staff, and a reliance on guess work, Warnock claimed that he was able to produce an authoritative account of the causes of mental illness in the asylum within ten months of his arrival. This was reported as 'The Cairo Asylum: Dr Warnock on Hasheesh Insanity by TS Clouston MD Edinburgh', published in the *Journal of Mental Science* in 1896. This was a summary of Warnock's observations of the asylum statistics that his hospital had generated in the period from his arrival at the hospital in February to the end of 1895. Warnock's statistics were central to Clouston's argument and after noting such numbers as 'in 41 percent of all his male patients hashish alone or combined with alcohol caused the disease' he concluded that 'I have no doubt that in quite a number of cases there hashish

3 Egyptian Proposal for Inclusion of Hashish, 12th December 1924, PRO HO 144/6073.

4 John Warnock, 'Twenty-Eight Years' Lunacy Experience in Egypt (1895-1923),' *Journal of Mental Science*, 70 (1924): 233-61.

5 Thomas S. Clouston, 'The Cairo Asylum: Dr. Warnock on Hasheesh Insanity,' *Journal of Mental Science*, 42 (1896): 793-4.

is the chief if not the only cause of the mental disease'. He went on to note the clinical features of this 'Hasheesh Insanity' that included 'an elated, reckless state, in which optical hallucinations and delusions that devils possess the subject frequently exist' or even 'terrifying hallucinations, fear of neighbours, outrageous conduct, continual restlessness and talking, sleeplessness, exhaustion, marked incoherence and complete absorption in insane ideas'. The statistics, and the exotic location, seem to have been enough to convince TS Clouston, who exclaimed 'such are the latest words in regard to hashish and its insanity.'⁶

Despite Warnock's frank admissions that he had very little idea of what was going on upon his arrival in Egypt – and indeed had no reliable means of remedying this situation beyond hazarding a few guesses of his own and trying to interpret the lunatic translations of his delusional clerk – it seems that he was happy to jump to conclusions about the cause of illness among a large proportion of his patients within twelve months of his taking up the post. He may well have read an earlier report on Egyptian mental illness, which he had certainly seen by the end of his career and mentioned in his 1924 article, which argued that 'with the men the attack of insanity was attributed in nearly all cases to one of three causes, the use of hashish, some disappointment or grief, and religious excitement. Of these, the first is by far the most frequent.'⁷ Whatever was the case, these were conclusions that he stuck to. In 1903 he published a lengthy account of his observations at the asylum. Again, he relied on numerical evidence to make his point: 'in Egypt, statistics are available since the year 1895. During the six years 1896-1901 out of 2564 male cases of insanity admitted to the Egyptian Asylum at Cairo, 689 were attributed to the abuse of hashish, i.e. nearly 27 percent'. He quoted statistics from India to make the comparison: 'between 1882 and 1892 Indian hemp caused 25 to 35 percent of the insanity in Bengal asylums' even though the reliability of these numbers had been challenged by the Indian Hemp Drugs Commission itself. He was at pains to refute the conclusions of the IHDC and emphasised that 'my experience does not confirm the Indian Commission's belief that cannabis indica only sometimes causes insanity. In Egypt it frequently causes insanity'. He was keen to stress that his statistics were entirely dependable. He did this by claiming that each patient counted as a sufferer of hashish insanity was correctly diagnosed. He did not believe police reports of hashish use nor did he give much credence to relatives of the patient. Indeed, he did not believe the patients themselves noting that 'excited protests and denials of the habit are known by experience to indicate a hardened hashish smoker'. Instead he relied on his own intuition and repeated questioning of the patients until a confession was obtained.

Quite how reliable this method was of establishing that a case was one of cannabis use is worth considering. In 1895 he stated that he thought that one of the key symptoms of weak mindedness caused by hashish insanity was that 'they deny the use of hashish'. He made it clear in 1903 that 'as the mental state of the patient improves he is again questioned about hashish and before discharge he is invited to give full details of his habit'. It seems then that procedures in Warnock's hospital encouraged inmates to confess to use of cannabis preparations, as the final hurdle before release was another interrogation on the subject of cannabis use by a doctor who admitted that he could consider a denial of the habit as a symptom of problems of mental illness.

In fact, his conclusions themselves were more wide-ranging than they had a right to be. Based on his experience of cases at the asylum that he believed to be caused by cannabis use, he made sweeping observations such as 'the use of cannabis indica in Egypt seems to have graver mental and social results than in India and is responsible for a large amount of insanity and crime in this country'. However, he also admitted that 'as to whether excessive use of hemp drugs is commoner here than in India I can give no opinion, but many thousands use it daily here' and indeed went further in noting that while 'many thousands smoke hashish only a comparatively few suffer from grave toxic symptoms'.⁸ In other words, he made broad generalisations

6 Ibid.

7 A. R. Urquhart and William S. Tuke, 'Two Visits to the Cairo Asylum, 1877 and 1878,' *Journal of Mental Science* 25 (1879-80): 43-53.

8 John Warnock, 'Insanity from Hasheesh,' *Journal of Medical Science* 49 (1903): 96-110.

about cannabis use and cannabis users that were meant to apply to all users, in all of Egypt, despite the fact that he saw only a small proportion of them at the hospitals. The issue of whether this was a representative proportion of the cannabis users in the country never seems to have troubled him, and he broadened his conclusions drawn from the troubled individuals at the asylum to apply to thousands of ordinary Egyptians that took hashish and yet never became subjects of his scrutiny. In short, his method of establishing that an individual at his hospital was a cannabis user was suspect, and the conclusions that he drew about cannabis use in general were based simply on the small sample of all of Egypt's many users that had ended up in his hospital. Much as in India in the nineteenth century, the habits indulged in by much of the local population were condemned by colonial doctors who had no idea what was going on outside of the walls of the hospital, and to whom it never occurred that a small band of lunatics could in no way be considered a representative sample on which to base observations about wider society.⁹ It was in these circumstances that the scientific evidence was generated that secured the passage of cannabis into the international drugs regulatory system for the first time.

THE WHO AND THE SINGLE CONVENTION ON NARCOTIC DRUGS, 1961

Cannabis remained an uneasy presence in the international drugs regulatory system for the next three decades. Often ignored in deliberations at the League of Nations and later the United Nations, when it did figure in discussions it divided opinions and caused confusion to those unfamiliar with it. As such, it came as some relief to the Secretariat of the United Nations Commission on Narcotic Drugs when in 1952 the World Health Organization's Expert Committee on Habit Forming Drugs issued a clear statement on the issue of whether substances made from the plant served any useful purpose. The Committee was of the opinion that cannabis preparations were practically obsolete, and that, so far as it was concerned, there was no justification for the medical use of cannabis preparations.¹⁰

With a stroke of the pen a range of substances that had featured in the medical systems of societies in Africa, Asia and elsewhere for centuries, together with the allopathic preparations of the plant that had been developed since the nineteenth century, were declared useless. The United Nations Secretariat readily adopted the statement, which was to eventually find itself enshrined in the 1961 Single Convention on Narcotic Drugs, the centrepiece of the international drugs regulatory system of the period.

The evidence for the WHO position can be found in its statement on 'The Physical and Mental Effects of Cannabis', which was presented to the Commission on Narcotic Drugs in 1955. It was authored by Pablo Osvaldo Wolff, who had served as Secretary of the Expert Committee on Addiction Producing Drugs of the WHO. It was damning in its revelations and in its tone, and drew on over fifty publications and scientific papers to support its argument. Among these publications were those by John Warnock discussed above. Many of the papers had been considered by the League of Nations Sub-Committee on Cannabis, which had patiently collected data on the plant and preparations of it for five years between 1935 and 1940 only to fail to reach any clear or definitive conclusions because of its growing awareness of the complexity of the issues.

Wolff made it clear that he had succeeded in reaching clear conclusions where predecessors had failed because he had no time for those who would 'minimise the importance of smoking marihuana'. The report scarcely dwelt on physical effects: 'among cannabis smokers diseases of the respiratory tract are frequent, bilharsiasis and circulatory as well as alimentary diseases become refractory etc.' It was with its mental effects that the author was most concerned. Wolff ranged widely across the work of others and lifted their observations on

⁹ James H. Mills, *Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928* (Oxford University Press, 2003), 93-123.

¹⁰ World Health Organization, *Third session of the World Health Organization Expert Committee on Drugs Liable to Produce Addiction* (Geneva, 1952), http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1952-01-01-01_3_page008.html.

varied conditions such as 'transitory intoxication', 'mania from hashish', 'acute psychosis associated with the withdrawal of cannabis indica from addicts' or 'a certain link between chronic cannabis consumption and the atypical schizophrenic picture'.

Wolff referred to the evidence of his own research in seeking to convince delegates at the UN that these medical conditions were not simply risks for individual consumers but rather were threats to society at large, and it is this which catches the eye. He turned to 'clippings from newspapers from South American countries which suffer particularly from the consequences of marihuana abuse, and which the writer has been collecting for years'. Clearly conscious of how tenuous this looked, he was forced to admit that these were 'somewhat sensational' in character, but he made a point of insisting that the recurrence of such stories, as well as the police statements referred to within them 'show that there must be much truth in them'. Having done this, he selected the most startling of the stories; 'Four youths, the youngest 16 years old, robbed and murdered a filling station attendant. The defence admitted that they were so strongly under the influence of marihuana that they did not know what they were doing. The jury refused to accept this as a defence and found them all guilty of murder in the first degree'. Despite acknowledging the weakness of such evidence he left colleagues in no doubt about the 'criminogenic influence of the cannabis resin' and he concluded that 'cannabis constitutes a dangerous drug from every point of view, whether physical, mental, social or criminological'.¹¹

Mr Yates of the Secretariat commended Wolff's report to the Commission as he felt that it 'embodied not only a statement of the facts, but also a number of critical evaluations'.¹² The Chair of the Commission, the French representative Charles Vaillie, and Harry Anslinger were careful to publicly record their appreciation of Wolff's efforts. Interestingly, an earlier book by Wolff that had used the same material was used as evidence in a British murder trial in 1952 where it was dismissed by a British doctor who concluded, after being read passages from it, that 'I have a personal lack of confidence in some of the material produced on the other side of the Atlantic'. There were no such qualms at the Commission on Narcotic Drugs, where it was agreed that his account should be forwarded to its parent body, the UN's Economic and Social Council.¹³

CONCLUSION

The intention behind this paper is not to argue that the science behind the incorporation of cannabis into the international drugs regulatory system was flawed and therefore the current position of preparations of the plant in the world's list of banned drugs is wrong. Cannabis is a complex substance that pharmacologists and medical scientists are continuing to grapple with and which promises to defy easy generalisations for the purposes of policy for some time to come. Rather, it has sought to understand the place of knowledge and evidence in the evolution of the international drugs regulatory system, particularly as it expanded beyond opium from the 1920s onwards. This article has further suggested that at important moments of this history related to cannabis the evidence that was presented, and indeed accepted as justifying action, was questionable in origin and readily endorsed with little scrutiny.

What does this mean for those contemplating the wider history of the evolution of the international drugs regulatory system and considering its possible futures? The episodes recounted above draw attention back to the evidence base that has been deployed in the past for all key decisions regarding not just cannabis but the wider schedule of drugs. If the material gathered in support of including preparations of cannabis into the international drugs regulatory system was so slight, it raises the question of how far it was the case that

11 The Physical and Mental Effects of Cannabis, Additional Study, 17th March 1955, BL, WHO/APD/56, p. 32.

12 Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Sixth Meeting 20th April 1955, BL, UN, E/CN.7/SR 266, p. 14.

13 Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Seventh Meeting 21st April 1955, BL, UN, E/CN.7/SR 267, p. 4.

controls were imposed on other drugs on similarly flimsy evidence. Historians such as Frank Dikotter and Yangwen Zheng have begun to answer this question with their re-examination of the assumptions made about the Chinese market for opium in the nineteenth-century that lay behind the origins of the international drugs regulatory system. They have argued that these assumptions were based on misrepresentations and misunderstandings of the cultures of consumption and political agendas in China in that period.¹⁴ It remains to be seen just how far the evidence behind other aspects of the establishment and development of the international drugs regulatory system stands up to scrutiny.

If nothing else, this weak evidence base should act as a brake on politicians and officials like Philip Emafo, who seek to use the longevity of the system in order to defend it, on the assumption that its history is a rational and well-founded one. If the system is not founded upon a sound evidence base and a rational assessment of it then what has driven it? Others, like William McAllister and David Courtwright, are better placed to give a full answer, but it is certainly the case, regarding cannabis at least, that political and diplomatic ambiguities, personal and moral prejudices, and bureaucratic forces have been important factors. For those thinking about the future of the system it is important to acknowledge this, and also to realise that most of those political agendas, moral positions and bureaucratic drivers are now long gone, distant memories from an age of European imperialism, World War, racial hierarchies and discredited values.

If those addressing contemporary problems want to tackle drugs and their consumption in a fresh way then the lesson from the past is to reject it. Put aside the status quo as something that is tainted by the confusion and connivance of previous generations rather than formed by their wisdom, and start with a blank sheet of paper and an honest declaration of interests. Even if what emerges from such a process resembles what is in place today, at least it will have been arrived at through a fully-informed and transparent process, rather than warped by the flows of world history. ■

¹⁴ Zheng Yangwen, *The Social Life of Opium in China* (Cambridge University Press, 2005); Frank Dikotter, *Narcotic Culture: A History of Drugs in China* (University of Chicago Press, 2004).