Ketamine and international control

There are others here who are better qualified than I to speak of the therapeutic properties of ketamine. For now, I will briefly introduce ketamine before moving on to the issue of its control.

Ketamine is an anaesthetic used in both veterinary and human surgical procedures, such use being of central importance across large areas of the developing world, where it is often the sole anaesthetic agent available. Ketamine is easy to use, especially in undeveloped and emergency settings where controlled clinical conditions are unavailable; it has been authoritatively described as, 'for sedation of both children and adults…perhaps the most widely used agent in the world'.[1]

In some parts of the world it is also consumed recreationally as a hallucinogen, a form of consumption that has grown over recent decades, prompting moves to control the substance under international law. However, this trend should, I will argue, be resisted.

Ketamine has been critically reviewed in 2006,2012 and 2014. On each of these occasions, the ECDD (which is appropriately mandated under the international drug control conventions to assess substances for international control) has recommended to the CND not to control ketamine.

Prior to last year's CND, China sent out a notification to the SG, the first step in placing a substance under international control. Initially, China called for ketamine's control under Schedule 1 of the 1971 Psychotropics Convention, which is reserved for drugs that have 'very limited medical purposes by duly authorised persons, in medical or scientific establishments, which are directly under the control of their Government or specifically approved by them...' This type of situation is very remote from the characteristics of ketamine and the contexts in which it is used for medical purposes.

Owing to ketamine's therapeutic profile, China's was a controversial proposal, and was quickly and powerfully opposed by much of civil society, professional and representative bodies of clinicians, and governments. The controversy was soon picked up by the mass media, and in due course China changed its proposal, seeking instead to control ketamine under Schedule iv; this classification applies to substances having some risk of abuse, and a therapeutic utility that can be enormous. In theory, it is a level of control flexible enough to suppress illicit use while allowing the drugs extensive medical purposes to be met.

In practice, however, even the more flexible controls represented by Schedule iv can be almost equivalent to a prohibition in the poor rural zones of Africa and Asia. We can see the

same problem in the example of Phenobarbital. This is a first line treatment for epilepsy, and is classified under Schedule iv of the 1971 Treaty, as is proposed for ketamine.

However, in low income countries, some 80 per cent of sufferers do not receive this treatment.

So, why does a supposedly flexible set of controls have such a detrimental effect? Briefly, it's because the processes involved in meeting the requirement of international drug control are expensive and complex, and poor rural states do not have the economic, technical and human resources to facilitate the process. It is much simpler, cheaper and less onerous to simply ban the substances. This is what happens in practice, in all likelihood, what would happen to ketamine. Not in Vienna or London, New York or Geneva, but in impoverished Africa.

There is one further matter to mention. With a proliferating group of New Psychoactive Substances requiring review, and with CND Member States experimenting with provisional scheduling, it is becoming more important than ever that the ECDD is sufficiently funded and adequately robust to maintain the principles underpinning the review process: namely, that drugs cannot be banned for arbitrary and political reasons, but must be subject to independent and scientifically informed scrutiny. The global drug control regime has openly declared its intention to become more health- and human-rights oriented; if this is to be more than a rhetorical objective, the public health-driven process of review must be defended, and the ECDD's recommendations followed apart from in the most exceptional circumstances.

Finally, another of these scattered points must be raised: this is the difference between the Expert Committee's assessment of a substance, on which it bases its judgement, and the equivalent process followed by the CND. The ECDD has a transparent process of review, in which the criteria are clearly structured and made public; the reasons why the ECDD makes a given recommendation are open to scrutiny. The CND, by contrast, introduces factors such as social, economic, administrative and others; these are of course important and valid fields of consideration. But the manner in which they are invoked as justifications for scheduling a substance, particularly where this runs counter to the ECDD's recommendation, are often obscure, opaque and outside public scrutiny. If the CND is to reject health-driven recommendations on the grounds of social or economic considerations, the rationalities underlying its position must be made explicit and open to scrutiny. Socio-economic and cultural conclusions are based in evidence just as much as medical and scientific, even if that evidence differs in form and mode of collection.

[1] Letter from the World Society of Intra Venous Anaesthesia to the ECDD, 8th May 2014. Available at 'Letters of Support'
http://www.who.int/medicines/areas/quality_safety/36thecddmeet/en/index5.html