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Canada's Marihuana Medical Access Regulations: Up In Smoke

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CANADA'S MARIHUANA MEDICAL ACCESS REGULATIONS: UP IN SMOKE

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ABSTRACT & KEYWORDS

The Supreme Court of Canada has interpreted the constitutional principles entrenched in the *Canadian Charter of Rights and Freedoms* to mean that everyone in Canada has a constitutional right to access necessary medical treatment without fear of criminal sanction. The latest research suggests cannabis (marihuana) provides a unique medicinal benefit that, for some individuals, is necessary. The federal criminal prohibition of cannabis deprives many individuals of a potentially beneficial medicine and stigmatizes them with a criminal record.

Without a valid medical cannabis access system, the criminal prohibition is invalid. The current *Marihuana Medical Access Regulations* were recently struck down. Parliament is considering substantive changes and will propose new *Regulations* in late 2012.

There *are* a range of regulations that would meet the requirements of the *Charter*. Based on the best available medical evidence and constitutional analysis, I recommend a regulatory system that will maximize legitimate access and minimize attendant harm.

Keywords:

Constitutional law, *Canadian Charter of Rights and Freedoms*, *Controlled Drugs and Substances Act*, *Marihuana Medical Access Regulations*, medical marihuana, marihuana, cannabis, cannabinoids.

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This project would not have been possible without the enduring and patient support of my supervisor, Robert Solomon. His infinite wisdom helped guide me through the challenges of research and writing to bring my vision into focus.

To my amazing family and friends, I could not have done it without you. Thank you for understanding the late nights, early mornings and everything in between. I am truly blessed.

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Researchers have discovered that chocolate produces some of the same reactions in the brain as marihuana. The researchers also discovered other similarities between the two but can't remember what they are.

- Matt Lauer[1]

INTRODUCTION

Although cannabis has been used as a medicine around the world for millennia, in the early 20th century a policy of broad drug prohibition took root in North America.[2] In Canada, the *Controlled Drugs and Substances Act* (*CDSA*) currently prohibits the possession, trafficking, importing/exporting and production of cannabis.[3] The *Canadian Charter of Rights and Freedoms* has had a significant impact on the development of the criminal law in this area.[4]

Prior to the first successful *Charter* challenge in 2000 and the resulting enactment of the initial *Marihuana Medical Access Regulations* (*MMAR*) in 2001,[5] individuals suffering from serious medical conditions defended criminal charges of possession and production of marihuana using the common law defence of necessity.[6] The purpose of the 2001 *MMAR* was to "establish a framework to allow access to marihuana by individuals suffering from grave or debilitating illnesses, where conventional treatments are

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[1] Matt Lauer, *Finest Quotes: Marihuana Quotes - Matt Lauer*, online: <http://www.finestquotes.com/select_quote-category-Marihuana-page-0.htm#ixzz1y9j1g5FL>.

[2] The historical accounts of cannabis are fascinating and detailed but beyond the scope of this paper. For a comprehensive account of marihuana's ancient history see Chris Bennett, "Early/Ancient History" 17 at 17 [Bennett] in Julie Holland, ed, *The Pot Book: A Complete Guide to Cannabis* (Toronto: Park Street Press, 2010) [Holland]. In Canada, cannabis (marihuana or marihuana) was declared illegal in 1923 pursuant to *The Opium and Narcotic Drug Act*, *1923*, SC 1923, c 22.

[3] *Controlled Drugs and Substances Act*, SC 1996, c 19 at ss 4-7 and Schedule II [*CDSA*].

[4] *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

[5] *Marihuana Medical Access Regulations*, SOR/2001-227 [*MMAR*].

[6] See *R v Parker*, [2000] OJ No 2787 at 26 [*Parker*]. The decision was based on the common law defence of necessity found in *Perka v The Queen* (1994), 14 CCC (3d) 385.

inappropriate or are not providing adequate relief."[7] After the *MMAR* were enacted, problems gaining access to the program and an inadequate legal supply of marihuana led to a series of constitutional challenges and regulatory amendments. In 2011, the Ontario Superior Court struck down the *MMAR* for being unconstitutional.[8]

Currently, Parliament is considering substantive changes to bring the *MMAR* in line with the *Charter*. Public consultations occurred between June and November 2011 and the results have now been published.[9] Based on this information, Parliament will publish new *MMAR* in the Canada Gazette in late 2012 for further input.[10]

In this paper, I take up the challenge of developing constitutionally permissible regulations governing medical access to marihuana. The term marihuana is derived from Mexican slang and refers to the dried flowers (buds) of the plant genus *cannabis*.[11] Although cannabis plants may be cultivated for food, fiber, fuel, medicine and shelter, the dominant purpose for cannabis cultivation in North America is for its psychoactive properties.[12]

The remainder of the paper is divided into three major parts. Part One summarizes the available research on cannabis to provide a sufficient evidentiary basis. Part Two reviews the development of the relevant constitutional principles and traces the chronology of challenges and the ensuing amendments to the *MMAR*. Part Three applies the medical evidence and *Charter* analysis to the *MMAR*. Canada is uniquely positioned to lead the world in providing an evidence-based medical marihuana access program. Based on my

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[7] Health Canada, "Drugs and Health Products: Fact Sheet – Medical Access to Marihuana" (08 February 2008), online: <http://www.hc-sc.gc.ca/dhp-mps/marihuana/law-loi/fact_sheet-infofiche-eng.php> [*Medical Access*].
[8] *R v Mernagh*, 2011 ONSC 2121 [*Mernagh*].
[9] Health Canada, "Drugs and Health Products, *Medical Marihuana Regulatory Reform 2011: Consultations Results*" (30 May 2012), online: Health Canada <http://www.hc-sc.gc.ca/dhp-mps/consultation/marihuana/_2011/program/consult_reform-eng.php> [Consultation Results].
[10] *Ibid*.
[11] Lyle E Craker & Zoe Gardner, "The Botany of Cannabis" 35 at 35 in Bennett, *supra* note 2.
[12] *Ibid*.

research and analysis, I suggest an optimal medical marihuana access program that balances individual rights with those of broader society.

The primary sources of data for this project include: scientific monographs and articles, Canadian and international news articles, legislation, jurisprudence, and publicly available official literature.

PART ONE: THE PLANT-BRAIN CONNECTION

Part One is divided into four major subsections. The first subsection deals with the evidence on the risks and medicinal benefits of cannabis.[13] The second subsection deals with cannabis and chemistry, to explain how and why cannabis exerts its effects. In the third and fourth subsections I review the scientific literature on the risks and medicinal benefits of cannabis. I discuss areas for future development before drawing conclusions on the medical evidence.

I: The Evidentiary Basis

There are various sources of evidence on the risks and benefits of marihuana use. The primary sources of information are the human experience and empirical studies, where controlled variables are scientifically manipulated to produce replicable results.

The available anecdotal evidence suggests that many people using marihuana experience significant relief from serious symptoms, with little report of adverse physical, mental or moral consequences in adult users.[14] An anecdotal account of marihuana's effects recently appeared in the New York Times.[15]

Gustin Reichbach is a sitting judge of the State Supreme Court in Brooklyn. He uses marihuana (illegally) to treat Stage 3 pancreatic cancer. In an op-ed piece, he shared the pain of enduring "months of chemotherapy, radiation hell and brutal surgery." After a relapse, his treatment got worse:

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[13] Cannabis is the scientific name for the plant and a more accurate term in the medical context. I use the term and spelling of marihuana in many parts of the paper to mirror Canada's legislative provisions.

[14] *The Indian Hemp Drugs Report* (1893-1894), reprint (Maryland: Jefferson Press, 1969), online: <http://digital.nls.uk/indiapapers/browse/pageturner.cfm?id=74908458 >.

[15] Gustin Reichbach, "A Judge's Plea for Pot", *The New York Times* (17 May 2012) A27, online: NY Times <http://www.nytimes.com/2012/05/17/opinion/a-judges-plea-for-medical-marihuana.html> [Reichbach].

> Every other week, after receiving an IV booster of chemotherapy drugs that takes three hours, I wear a pump that slowly injects more of the drugs over the next 48 hours.
>
> Nausea and pain are constant companions. One struggles to eat enough to stave off the dramatic weight loss that is part of this disease. Eating, one of the great pleasures of life, has now become a daily battle, with each forkful a small victory. Every drug prescribed to treat one problem leads to one or two more drugs to offset its side effects. Pain medication leads to loss of appetite and constipation. Anti-nausea medication raises glucose levels, a serious problem for me with my pancreas so compromised. Sleep, which might bring respite from the miseries of the day, becomes increasingly elusive.
>
> Inhaled marihuana is the only medicine that gives me some relief from nausea, stimulates my appetite, and makes it easier to fall asleep. The oral synthetic substitute, Marinol, prescribed by my doctors, was useless. Rather than watch the agony of my suffering, friends have chosen, at some personal risk, to provide the substance. I find a few puffs of marihuana before dinner gives me ammunition in the battle to eat. A few more puffs at bedtime permits desperately needed sleep.

Canadian courts have accepted and relied on this type of anecdotal evidence when adjudicating *Charter* challenges to the prohibition on marihuana contained in the *CDSA*.

> …[T]he courts, relying on evidence of individuals' personal experiences and anecdotal evidence have determined that some seriously ill persons derive substantial medical benefit from the use of marihuana. The pronouncements in these cases reflect the normal process of judicial fact-finding made in the context of an adjudicative process based on the evidence and arguments led by the parties in a given case. These factual findings have in turn provided the basis for the legal conclusion that s. 7 of the *Charter* requires that a medical exemption be carved out of any criminal prohibition against the possession of marihuana.[16]

Although the human experience is essential to understanding some of the effects of marihuana, unscientific studies make it difficult to control potential bias, confounding factors or interactions with tobacco, alcohol or other drugs. Although there are also methodological limitations of empirical evidence,[17] it is more reliable.[18] Double-blind

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[16] *Hitzig v Canada*, [2003] OJ No 3873 at 9 [*Hitzig ONCA*].

[17] Lester Grinspoon & James Bakalar, *Marihuana: The Forbidden Medicine* (United States: Yale University, 1997) at 226 [Grinspoon & Bakalar]. Previous cannabis

randomized control trials (RCTs) are the most reliable way of determining predictable effects that can be generalized.[19] However, these studies are expensive and it can be difficult to gain legal access to cannabis even for research purposes.[20]

Although scientists understand the biological mechanism that precipitates marihuana's effects, the research evidence leaves much to be desired. To date, no prospective epidemiological studies examining the long-term effects of marihuana consumption have been undertaken.[21] This lack of empirical evidence can neither support nor refute the use of cannabis for medicinal use. Additionally, research on marihuana's effects for recreational use is limited in its application to medical users.

> The conclusions must be treated with caution because it is not clear whether the use of medical cannabis has similar safety concerns as recreational use. The quality and amounts used are different. The existence of co-morbidities is different in the two populations. Moreover, medical cannabis users have entirely different expectations regarding the adverse events from those of recreational users, meaning that one must use caution when assuming that adverse effects of recreational cannabis will be relevant for medical use.[22]

When developing policy and law, one must look to both the individual experience and empirical evidence. These two sources are complementary. Anecdotal evidence suggests areas of research based on individual experience and scientific inquiry attempts to provide an explanation for that experience by systematically manipulating dependent and independent variables to determine a causal or correlational link between them.

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exposure, potential confounding factors and the choice of control groups make it more difficult to parse the effects attributable to cannabis.

[18] Tongtong Wang, *Methodological issues in the assessment of the safety of medical cannabis* (DPhil Thesis, McGill University Faculty of Medicine, 2009) [unpublished] at 4 [Wang].

[19] *Ibid*.

[20] See generally Sharon Kirkey, "Doctors refuse to authorize pot use, leaving patients in pain", *Postmedia News* (30 October 2011) online: <http://www.canada.com/health/Doctors+refuse+authorize+leaving+patients+pain/5630488/story.html>.

[21] *Wang, supra* note 18 at 4.

[22] *Ibid* at 64.

This paper emphasizes "evidence-based medicine derived from knowledge and experience informed by rigorous scientific analysis, as opposed to belief-based medicine, which is derived from judgment, intuition, and beliefs untested by rigorous science."[23] It is necessary to first understand how and why cannabis has its effects before considering the law. The empirical evidence will provide a foundation for understanding the risks and medicinal benefits of marihuana and in what circumstances a criminal prohibition on this plant-drug will violate the *Charter*.

II: Cannabis & Chemistry

Our understanding of how cannabis affects the brain is relatively new and premised on an ever-increasing understanding of neurology. A basic knowledge of how marihuana works is important to understand its therapeutic potential and to ascertain whether it can be considered a necessary medicine for the purposes of section 7 of the *Charter*, which guarantees all Canadians the right not to be deprived of their life, liberty or security of the person except in accordance with the principles of fundamental justice. Security of the person has been violated when the government imposes significant barriers to access a necessary medicine. The analysis depends on the facts of each case. The duration and intensity of the *Charter* violation also factor into the analysis. The principles of fundamental justice are rapidly evolving, with legal analysis becoming increasingly evidence-based. Whether the violation accords with the principles of fundamental justice is a legal question. Whether cannabis has therapeutic properties is a scientific one. The answer begins in the brain.

Within the central nervous system there are more than 100 billion neurons.[24] Each of these neurons contains receptors responsible for sending and receiving information, resulting in physical and sometimes psychological change in the individual whose brain

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[23] Janet Joy, Stanley Watson Jr and John Benson Jr, eds, *Marihuana and Medicine: Assessing the Science Base* (Washington, DC: National Academy Press, 1999) at 12 [Joy, Watson & Benson].

[24] Arthur C Guyton & John E Hall, *Textbook of Medical Physiology*, 11th ed (Philadelphia, PA: Elsevier Inc, 2006) at 555 [Guyton & Hall].

is affected.[25] "Neurons in the brain are activated when a chemical binds to its receptor. Employing the most common analogy used by neurologists to explain neurological functioning, consider the chemical as a 'key' and the receptor as a 'lock.'"[26]

Neurons send and receive electrical signals in a networked fashion.[27] Neurons are living, growing cells but unlike electrical circuits they are not fixed. Almost every neuron is constantly changing its function by adapting to bodily demands, sensations and environmental influences.[28] Neurons act as regulators, releasing or inhibiting the production of neurotransmitters that cause various experienced effects. Receptor cells form part of a neuronal network. When a cell in a network is activated by its chemical key, it responds by doing a variety of things: sending a chemical signal to other cells, switching a gene on or off, or becoming more or less active.[29] Different neurons contain different numbers of connections to other neurons; some have as few as one hundred connections, whereas others contain upwards of 200,000 incoming connections.[30]

One principle of neurology is that if a synthetic drug stimulates brain receptors, then the brain likely produces a similar chemical that stimulates the same receptors by producing similar effects.[31] In the lock and key analogy, cannabinoid receptors are the lock and cannabinoids are the key.

Although two cannabinoids, cannabinol (CBN) and cannabidiol (CBD) were isolated and identified in 1895 and 1934 respectively, it was not until 1964 when the primary psychoactive ingredient, delta-9-tetrahydrocannabinol (Δ^9-THC or THC) was isolated

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[25] *Ibid*.
[26] Matt Stolick, *Otherwise Law-Abiding Citizens: A Moral and Scientific Assessment of Cannabis Use* (Toronto: Lexington Books, 2009) at 8 [Stolick].
[27] Paul Gahlinger, *Illegal Drugs: A Complete Guide to Their History, Chemistry, Use, and Abuse* (New York: Plume, 2004) at 134 [Gahlinger].
[28] *Ibid* at 137.
[29] Glen Hanson, Peter J Venturelli & Annette Fleckenstein, *Drugs and Society*, 7th ed (Boston: Jones and Bartlett Pub, 2002) at 118 [Hanson].
[30] Guyton & Hall, *supra* note 37 at 555.
[31] Stolick, *supra* note 39 at 8.

and synthesized.[32] Mapping the chemical structure of THC led to the discovery of the endogenous mammalian cannabinoid receptor system in the late 1980s and early 1990s, when Allan Howlett discovered two receptors for THC, named CB_1 and CB_2.

> The cannabinoid receptors Howlett found showed up in vast numbers all over the brain (as well as in the immune and reproductive systems)… They were clustered in regions responsible for the mental processes that marihuana is known to alter: the cerebral cortex (the locus of higher-order thought), the hippocampus (memory), the basal ganglia (movement), and the amygdala (emotions). Curiously, the one neurological place where cannabinoid receptors didn't show up was in the brain stem, which regulates involuntary functions such as circulation and respiration. This might explain the remarkably low toxicity of cannabis and the fact that no one is known to have ever died from an overdose.[33]

The CB receptors are activated by the brain's naturally occurring cannabinoids.[34] Cannabinoids produced by the body are called endogenous cannabinoids or "endocannabinoids." Sometimes referred to as the "brain's own marihuana,"[35] researchers have discovered two endocannabinoids, named arachidonyl glycerol (2-AG) and anadamide.[36] The word "anadamide" comes from the Sanskrit word meaning "bliss."[37] For 500 million years, all vertebrate species have been utilizing endocannabinoids using a complex signaling system in various regions of the brain.[38]

The endocannabinoid system appears to have a large role in pain modulation, appetite and movement control.[39] The endogenous cannabinoid system also "appears to help

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[32] See P Robson, "Therapeutic Aspects of Cannabis and Cannabinoids" (2001) 178 British Journal of Psychiatry 107.
[33] Michael Pollen, *The Botany of Desire: A Plant's-Eye View of the World* (New York: Random House, 2001) at 153.
[34] Wang, *supra* note 18 at 9.
[35] Roger Nicoll & Bradley Alger, "The Brain's Own Marihuana", *Scientific Am* (22 November 2004) at 68, 73 [Nicoll & Alger]. See generally Ruth Stern & Herbie DiFonzo, "The End of the Red Queen's Race: Medical Marihuana in the New Century" (2009) 27(4) Quinnipiac L Rev 673 at 695 [Stern & DiFonzo].
[36] *Ibid*.
[37] *Ibid*.
[38] *Ibid*.
[39] Joy, Watson & Benson, *supra* note 23 at 28-34.

maintain homeostasis within the central nervous system."[40] Scientists have hypothesized that the release of endocannabinoids might constitute a protective response during injury to neurons.[41] Endocannabinoid levels increase in response to skeletal muscle spasm, spasticity, and in response to inflammatory pain.[42] The release of endocannabinoids apparently eases these symptoms.[43] Endocannabinoids may also help to moderate phobias and post-traumatic stress disorder (PTSD) by "extinguishing the bad feelings and pain triggered by reminders of past experiences."[44]

In contrast to endocannabinoids, which are produced by the body, exogenous cannabinoids come from outside the body, either from the cannabis plant or from synthetic derivatives. When introduced into the body, exogenous cannabinoids bind to the receptors in the brain and mimic the properties and activities of the brain's endocannabinoids.[45]

Cannabinoid receptors are among the most ubiquitous neurotransmitter elements in the mammalian brain.[46] They are present in almost every region and exist in many different types of neurons.[47] Neurons are the fundamental functional units of nerve tissue. The diverse effects of marihuana are explained by the wide distribution of CB_1 and CB_2 receptors in the body, with dense concentrations of cannabinoid receptors in certain areas of the brain.

The CB_1 receptors are found primarily in the cerebral cortex (psychoactive effects), the hippocampus (memory formation), the hypothalamus (appetite), the amygdala (emotional

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[40] RG Pertwee, "Ligands that target cannabinoid receptors in the brain: from THC to anadamide and beyond" (2008) 13(2) Addict Biol 147, online: <www.ncbi.nlm.nih.gov/pubmed/18482430> [Pertwee].
[41] Diego Centonze et al, *The Endocannabinoid System in Targeting Inflammatory Neurodegenerative Diseases*, (2007) 28 Trends Pharmacological Sci 180 at 182.
[42] Pertwee, *supra* note 40 at 14.
[43] *Ibid*.
[44] Stern and DiFonzo, *supra* note 35 at 696.
[45] *Ibid* at 695.
[46] Allyn C Howlett et al, *Cannabinoid Physiology and Pharmacology: 30 Years of Progress*, 47 Neuropharmacology 345 at 350 [Howlett].
[47] *Ibid*.

responses), and the basal ganglia (movement control centres).[48] The CB_2 receptors have been found in the pancreas, thymus, tonsils, bone marrow, and spleen, which are the major tissues of immune cell production and regulation.[49] Additional receptor sites are located in the spinal cord, digestive, reproductive, ocular and cardiovascular systems.[50] The mild euphoria, sleepiness, cognitive dysfunction, short-term memory loss, changes in perception and time measurement, motor incoordination, and food cravings are associated with areas of the brain that have high densities of CB receptors.[51]

Cannabinoids are the precursors to chemical action in the brain.[52] Different neurotransmitters and neurological reactions are apparent by looking at the effects these chemicals have on the brain.[53] About 60 of the 483 chemical compounds in the cannabis plant are cannabinoids.[54] The cannabinoid receptors in the brain mediate the effects of cannabis.[55] THC is the only cannabinoid that produces any significant psychoactive effects.[56]

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[48] Nicoll & Alger, *supra* note 35 at 71-72.

[49] Howlett et al, *supra* note 46 at 349. See also Croxford, J Ludovic and Takashi Yamamura, "Cannabinoids and the Immune System: Potential for the Treatment of Inflammatory Disease?" (September 2005) 166 J Neuroimmunology 3 at 5.

[50] M Llanos Cassanova et al, "Inhibition of Skin Tumor Growth and Angiogenesis in vivo by Activation of Cannabinoid Receptors" (2003) 111 J Clinical Investigation 43 at 43.

[51] Stern & DiFonzo, *supra* note 35 at 695.

[52] Joy, Watson & Benson, *supra* note 23 at 25.

[53] *Ibid*.

[54] Mahmoud A ElSohly, "Chemical Constituents of Cannabis" [*ElSohly*] at 28. In *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential*, Franjo Grotenhermen and Ethan Russo (eds), (New York: The Haworth Integrative Healing Press, 2002).

[55] John McPartland & Ethan Russo, "Cannabis & Cannabis Extracts: Greater than the Sum of their Parts" (2002) 1 *Journal of Cannabis Therapeutics* 103 at 107 [*McPartland & Russo*].

[56] *Ibid*.

The effects of cannabis are qualitatively similar regardless of whether it is inhaled or taken orally, but there are some differences in the onset and offset of the effects.[57]

> Because the lungs have a large surface area and many blood vessels leading directly to the brain, the onset of psychoactive effects produced are rapid, occurring within seconds. Due to this rapid onset, experienced smokers can easily titrate their dose to achieve the desired subjective effects… Typically, the effects following smoked administration are relatively short-lived, lasting no longer than one to two hours. By contrast, marijuana (or delta-9-THC) taken by mouth produces a slower onset of effects. After oral ingestion, the drug must move from the stomach to the small intestine, where it is absorbed into the bloodstream. Before reaching the bloodstream, however, some of the drug is metabolized (or broken down) by the liver. Once in the bloodstream, the drug moves to the heart and then to the brain. Because the drug does not travel directly to the brain following oral ingestion, the onset of psychoactive effects is delayed. Peak psychoactive effects (or subjective effects) following oral administration usually occur one-and-a-half hours after ingestion.[58]

Current scientific understanding of cannabis has come a long way. Scientists are now able to assess the potential impact of cannabis use on various regions of the brain and body. It is clear from observational and anecdotal evidence that cannabis does have predictable effects. Identifying and locating the CB receptors allows researchers to understand how cannabis affects certain areas of the brain.

Considering the relatively recent discovery of the CB receptors, and the difficulties gaining legal access to a controlled supply of marihuana, some researchers have published a considerable amount of scientific research on many aspects of cannabis, particularly THC. There is much less research on the other chemical compounds in the plant.

There is a threshold that must be met in order to qualify for constitutional protection. Not all therapeutic benefits will be constitutionally protected. For instance, a person's right to security of the person will not be violated if the prohibited treatment is only somewhat beneficial and there are better options available. Thus, in order to constitute an acceptable

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[57] Matthew G Kirkpatrick & Carl L Hart, "The Subjective Effects of Cannabis" 9 in Holland, supra note 2 at 13 [Kirkpatrick & Hart].
[58] *Ibid* at 12-13.

medical treatment, marihuana's potential benefits as a medicine must outweigh its potential harms and it must provide a level of relief for a serious ailment that meets the standards for *Charter* protection.

A neurological understanding of marihuana's effects provides a solid foundation for scientific research that produces generalizable results. Below, I look at the research evidence of the risks and harms. Significant harms caused by a medical treatment undermine its therapeutic benefits.

III: Harms

This subsection examines the scientific evidence on the harms associated with the medicinal use of cannabis. Acute physiological and psychological harms are considered first, followed by the evidence of chronic harms. I review the evidence on tolerance, dependence and addiction before moving on to address cannabis use by specific vulnerable groups. The available research is often conflicting, reflecting the deep divisions in attitudes toward this plant-drug.

One author remarked, "after being expelled from pharmacopoeiae, ignored by science and industry, and scapegoated by government and the establishment for so long, cannabis' smooth re-entry into medical practice has proven impossible."[59] Others have claimed that, "The most contentious aspect of the medical marihuana debate is not whether marihuana can alleviate particular symptoms but rather the degree of harm associated with its use."[60] Physicians abide by the rule *Primum Non Nocere*, which means first, do no harm.

The relative harms and benefits are particularly relevant in the *Charter* context. Laws limiting access to medical treatments that provide significant benefits and moderate risks are more likely to violate the *Charter*. Government-imposed barriers to accessing a medicine with significant benefits is a more severe infringement of security of the person,

[59] Robin Steen, *Marihuana as Scapegoat, Cannabis as Medicine: A Cognitive-Rhetorical Analysis of a Canadian Drug-Policy Problem* (MA Thesis, University of British Columbia, 2010) [unpublished] at 4 [Steen].
[60] Joy, Watson & Benson, *supra* note 23 at 56.

which encompasses an individual's physical and psychological integrity. There must be a very close connection between the measures and the objectives.[61] In contrast, greater harm will justify more restrictive government limits on accessing this medicine. I turn first to consider the potential acute harms.

IV: Acute Harms

The term "acute harms" refers to the negative consequences of short-term use. The acute physiological and psychological harms are dealt with below.

Physiological

THC has effects on the cardiovascular system, which includes the heart (cardiac system) and the blood vessels (vascular system). When people use cannabis it causes an elevation in their blood pressure and can cause orthostatic hypotension (head rush or dizziness) when standing up.[62] This can have effects on many organs in the body including the heart, brain and kidney.[63] In humans, cannabis causes enlarged-blood vessels (vasodilation) and an increase in heart rate related to the amount of THC consumed.[64] The risks of smoking are elevated for individuals with high blood pressure, heart disease, or those who have hardening of the arteries.[65]

The acute toxicity of THC is low. Death due to cannabis toxicity has not been observed. In a rat study involving high doses of THC, the overall survival rate in the THC group was 70% compared to 45% in the untreated controls.[66] The decreased mortality in the THC group was attributed to the lower incidence of cancer.[67]

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[61] *Chaoulli v Québec (AG)*, 2005 SCC 35 at 40 [*Chaoulli*].
[62] William Holubek, "Medical Risks and Toxicology" 141 at 146 in Holland, *supra* note 2 [Holubek].
[63] *Ibid*.
[64] Hanson et al, *supra* note 29 at 385.
[65] M Herkenham et al, "The cannabinoid receptor: biochemical, anatomical and behavioural characterization" (1990) 13 Trends Neurosci 420.
[66] PC Chan et al, "Toxicity and carcinogenicity of delta 9-tetracannabinol in Fischer rats and B6C3F1 mice. (1996) 30(1) Fundamental and Applied Toxicology 109 at 109-117.
[67] *Ibid*.

Psychological

Some individuals report acute adverse effects on their mood including panic attacks or waves of paranoia. [68] These changes in mood are generally short-lived and most individuals can be talked through the experience.[69] Of greater concern is the negative effect on cognitive performance in a variety of domains, including psychomotor control, attention and executive function.[70] Memory performance is consistently found to be compromised following cannabis consumption.[71] Impairment may continue even after discontinuing use for 24 hours.[72] These findings are most evident in infrequent smokers and typically more limited in frequent users, perhaps due to developed tolerance and compensatory behaviour.[73]

The physiological and psychological harms from short-term cannabis use are generally mild and appear to relate mostly to altered cognition and perception from the psychoactive chemical, THC. THC impairs perception, psychomotor performance, and cognitive and affective functions, which may contribute to a driver's increased risk of causing a traffic accident or fatality.[74] The consequences when individuals decide to

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[68] Oakley Ray & Charles Ksir, *Drugs, Society, & Human Behavior*, 7th ed (Toronto: Mosby, 1995) at 417 [Ray & Ksir]. See also Franjo Grotenhermen, "The Toxicology of Cannabis and Cannabis Prohibition" (2007) 4 Chem Biodiv 1744 at 1746 [Grotenhermen "Toxicology"].

[69] Ray & Ksir, *supra* note 68 at 417.

[70] See e.g. Caroline Marvin & Carl Hart, "Cannabis and Cognition" in Holland, *supra* note 2 at 161.

[71] See generally EL Abel, "Retrieval of Information after Use of Marihuana" (1971) 231 Nature 58.

[72] Hanson et al, *supra* note 29 at 378.

[73] *Ibid*.

[74] Grotenherman "Toxicology", *supra* note 68 at 1750 (It is estimated that acute cannabis use doubles the risk of causing an accident, while regular users who are not acutely intoxicated seem to have no increased risk, the combined use of cannabis and alcohol or other drugs may increase accident risk considerably. However, chronic cannabis use (in the absence of acute administration) did not *per se* potentiate the effects of alcohol. In fact, regular cannabis users showed lower scores for dizziness and a superior tracking accuracy compared to infrequent users after alcohol.)

undertake divided attention tasks such as driving can be very serious. Impaired driving appears to be the biggest acute risk.

In a 2003 report commissioned by Transport Canada entitled, "Impacts of Cannabis on Driving: An Analysis of Current Evidence With an Emphasis on Canadian Data" the authors conclude that:

> First, it appears clear that, in a laboratory situation, cannabis impairs the skills thought to be necessary for safe driving. This impairment is not restricted to high levels of the drug, and occurs at the dosage levels that result from typical use of the drug. Tolerance may occur with continued use, but even individuals who have acquired tolerance to some of the effects of cannabis may demonstrate impairment on task performance. Combining alcohol with cannabis will result in an increase in the effects of cannabis, and the interaction could be multiplicative.[75]
>
> After alcohol, cannabis is the drug most often found in dead and injured drivers. In Canadian samples, cannabis has been found in 10.9% to 19.5% of dead drivers, and one study found that 13.9% of crashed drivers admitted to a trauma unit were positive for cannabis. However, this evidence does not necessarily mean that cannabis was a causative factor in those collisions. For example, a general population sample may reveal similar proportions testing positive for cannabis.[76]

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[75] Robert E Mann et al, "Impacts of cannabis on driving: An analysis of current evidence with an emphasis on Canadian data" (May 2003) Road Safety and Motor Vehicle Regulation Directorate Transport Canada at 61 [Mann et al].

[76] *Ibid*. Epidemiological studies employing control groups are necessary to identify more precisely the contribution of the drug to collision causation. Case-control studies, in which samples of injured or killed drivers are compared to control samples, do not yet provide conclusive evidence that cannabis contributes to collision risk. This is primarily because of the difficulties involved in obtaining an appropriate control group for these studies. While the small numbers of existing studies provide some indications of increased risk, methodological concerns preclude firm conclusions. Studies employing clinical samples provide an additional means for assessing collision risk among cannabis users, and some indications of increase in risk are appearing in these studies as well. Again, though, increased collision risk in these studies may be due to factors other than the effects of cannabis.

The number of Canadians who admitted to past year cannabis use in 2004 was 14.1%.[77] In 2010, it was 10.7%.[78] The general consensus is that cannabis-impaired driving can cause serious negative consequences not only to the individual but unnecessarily puts others at risk.[79]

The acute effects of cannabis can be unpleasant or disconcerting for some but are generally short-lived. Combining cannabis with alcohol, other drugs and driving elevates the risks. While the acute effects are an area of some concern, the effects of chronic use are a far greater health issue in Canada and worldwide.

V: Chronic Harms

The term "chronic harms" refers to the negative physiological and psychological effects of long-term cannabis use. Below is a summary of the evidence on the chronic harms of cannabis use.

This evidence is pertinent in both the medical and legal context. Significant risks associated with long-term use would undermine marihuana's value as a medicine and impact the court's assessment of the appropriateness of restrictive laws. However, these long-term risks are not relevant to individuals with terminal illnesses or to individuals who are suffering from life-threatening seizures or similar conditions.

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[77] Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey: Summary of Results for 2010" (18 July 2011), online: <http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2010/summary-sommaire-eng.php> [CADUMS].

[78] *Ibid*.

[79] See Mann et al, supra note 75. Contradictory evidence based on US data concluded, "legalization [of cannabis] is associated with a nearly 9% decrease in traffic fatalities, most likely to due to its impact on alcohol consumption." D Mark Anderson & Daniel I Rees, "Medical Marihuana Laws, Traffic Fatalities, and Alcohol Consumption" Montana State University, University of Colorado Denver and IZA. Discussion Paper No 6112 November 2011.

Cardiovascular Harms

The composition of the combustion products in cannabis is at least qualitatively similar to that of tobacco smoke or that of the smoke generated from other dried plant material.[80] It would make sense to expect similar damage from cannabis smoke as that of tobacco. Indeed, signs of airway inflammation were found in bronchial biopsies of cannabis smokers.[81] Regular cannabis smoking in young adults was associated with wheezing, shortness of breath during exercise, and the production of mucus, known as sputum.[82] Another group found that heavy cannabis smokers had a significantly higher prevalence of chronic cough, chronic sputum production, wheeze and episodes of acute bronchitis compared to those who did not smoke.[83] The prevalence of symptoms of chronic and acute bronchitis was not significantly different between cannabis and tobacco smokers.[84]

There is a significant amount of tar in cannabis smoke, up to 50% more than an equal weight of tobacco.[85] Smoking unfiltered cannabis cigarettes ("joints") and holding the smoke in the lungs for longer periods of time increases the accumulation of tar.[86] The carcinogen Benzopyrene is 70% more abundant in marihuana smoke than in tobacco smoke.[87] Chronic cannabis users have a higher incidence of respiratory problems such as laryngitis, pharyngitis, bronchitis, asthma-like conditions, cough, hoarseness, and dry throat compared to non-smokers.[88]

Biopsies from cannabis smokers have also yielded a higher rate of precancerous pathological changes compared to non-smokers, which is suggestive of an increased cancer risk of the respiratory tract and other cancers.[89] It may take longer to see an effect

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[80] Grotenhermen "Toxicology", *supra* note 68 at 1753.
[81] *Ibid*.
[82] *Ibid*.
[83] *Ibid*.
[84] *Ibid*.
[85] Hanson et al, *supra* note 29 at 385.
[86] *Ibid*.
[87] *Ibid*.
[88] *Ibid*.
[89] *Ibid*.

because heavy cannabis smokers do not smoke as much as heavy tobacco smokers. It is difficult to ascertain the number of individuals who consume cannabis and the amount they smoke because many people are reluctant to disclose their use of an illegal substance.

So far, the epidemiological data is inconclusive. A review of two cohort studies and 14 case-control studies by the International Agency for Research on Cancer did not find a clear association between cannabis use and cancer.[90] Authors noted that sufficient studies are not available to adequately evaluate the impact of cannabis smoking on cancer risk, and available studies often have limitations including too few heavy cannabis users in the study samples. The causal relationship that has been demonstrated between cigarette smoking and cancer has not been reliably demonstrated for individuals who smoke cannabis only, though it may be due to a lack of data.[91]

The largest epidemiological study conducted so far, with 1,212 cancer cases and 1,040 cancer-free controls did not find a positive association between cannabis smoking and the investigated cancer types (mouth, larynx, lung, pharynx).[92] There was no dose–effect relationship, and even heavy use was not associated with an increased risk.[93] As time goes on, the long-term consequences will become evident. The cannabis smoking lifestyle only became popular in the 1960s.[94] An individual who started smoking at age 15 in the year 1960 would be 67 now. One would expect more conclusive evidence about the long-term effects of smoked cannabis to emerge shortly as more heavy cannabis users age.

Smoked marihuana is "a crude cannabinoid delivery system."[95] Smoking delivers therapeutic cannabinoids to the body but also harmful by-products. Although cannabis

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[90] *Ibid*.
[91] *Ibid*.
[92] M Hashibe, H Morgenstern, Y Cui et al, "Marijuana Use and the Risk of Lung and Upper Aerodigestive Tract Cancers: Results of a Population Based Case-Control Study" (2006) 15 *Cancer Epidemiol Biomarkers Prev* 1829.
[93] *Ibid*.
[94] Ray & Ksir, *supra* note 68 at 417.
[95] Joy, Watson & Benson, *supra* note 23 at 4.

can be consumed using a broad range of non-smoked methods, it would be wise to conduct clinical trials to continue developing rapid-onset, reliable, and safe cannabinoid delivery systems.[96]

Currently, there is virtually no data on the long-term health consequences of providing marihuana for medicinal purposes.

Cognitive Harm

Cognitive damage is cause for concern in chronic users. The hippocampus is one area of the brain thought to be responsible for learning, memory and stress.[97] CB receptors are densely concentrated in this area and it is no surprise that cannabinoid activity modulates a broad range of behaviours relevant to cognition. Despite intense research attention, there is limited consensus regarding cannabis' effects on cognition.[98]

The results of long-term cannabis use on cognition are nuanced and often inconsistent. In general, prolonged daily or near-daily use of cannabis places individuals at the greatest risk for adverse physiological and psychological consequences.[99] The most consistent effects relate to impairments in learning, memory, attention and executive function, as well as increased risk of psychiatric symptoms.[100] However, there is no evidence from human studies of any structural brain damage following prolonged exposure to cannabinoids.[101]

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[96] *Ibid.*
[97] Caroline B. Marvin & Carl L. Hart, "Cannabis and Cognition" 161 at 161 in Holland, supra note 2 [Marvin & Hart].
[98] *Ibid*.
[99] W Hall et al, "The health and psychological consequences of cannabis use," National Drug Strategy Monograph Series No 25 (Canberra: Australian Government Publishing Service, 1994).
[100] Solowij & Grenyer at 306. See also Marvin & Hart, *supra* note 97 at 165, 167. IQ may be a moderating factor. Individuals with a higher IQ show fewer decrements and perhaps even better performance on multiple tasks after consuming marihuana.
[101] Nadia Solowij & Brin Grenyer, "Long-Term Effects of Cannabis on Psyche and Cognition" 299 at 301 [Solowij & Grenyer] in Franjo Grotenhermen and Ethan Russo, eds, *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential* (New York: The Haworth Integrative Healing Press, 2002) [Grotenhermen & Russo].

Tolerance, Dependence & Abuse

Tolerance to marihuana's effects, dependence on its use, and abuse of this drug are cause for concern.

Tolerance refers to the phenomenon where, following repeated exposures to a drug over time, larger doses of the drug are required to achieve a desired effect, or the same amount of a drug has less of an effect than it once had. The term "substance abuse" is defined as "a maladaptive pattern of repeated substance use manifested by recurrent and significant adverse consequences."[102] Substance abuse and dependence are both diagnoses of pathological substance use.[103] Dependence is the more serious diagnosis because it implies compulsive drug use that is difficult to stop despite significant substance-related problems.[104] If users have to consume larger amounts of cannabis to get the desired effect or are unable to discontinue use, the inherent harms will increase over time.

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[102] "Substance dependence" refers to use of a substance that causes the user significant impairment or distress and is associated with at least three of the following effects within the same twelve-month period:

1. Tolerance develops (a need to use more of the drug to get the desired effect, or the same amount of drug has less of an effect than it use to).
2. Withdrawal symptoms occur when use of the drug is stopped and/or the drug or other drugs are used to avoid withdrawal symptoms.
3. Larger amounts of the drug are used or use persists for a longer period of time than was intended.
4. The user reports a persistent desire to reduce use of the drug or is unsuccessful in attempts to cut down or quit using the drug.
5. A great deal of time is spent in activities surrounding obtaining, using, and recovering from the effects of the drug.
6. Use of the drug interferes with engagement in important social, recreational, or work-related activities.
7. Use of the drug is continued despite knowledge that the drug is likely causing or worsening a health problem.

American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 4th ed (Washington, DC: American Psychiatric Association, 2000) [*DSM-IV*].

[103] *Ibid*.

[104] Joy, Watson & Benson, *supra* note 23 at 57.

Controlled experiments have reliably shown that tolerance to the behavioural, subjective and physiological effects of both marihuana and isolated THC develops following repeated exposure.[105] Research suggests that tolerance to different effects of cannabinoids develops at different rates.[106]

Research on cannabis withdrawal in the 1970s showed mixed results but more recent research has demonstrated a valid and reliable withdrawal syndrome for some people when regular cannabis use is abruptly stopped.[107] Frequent high doses of THC can produce mild physical dependence.[108] The intensity of withdrawal symptoms is compared to caffeine, with a psychological dependence similar to the hallucinogens.[109]

In one study, healthy subjects who smoked several joints a day (or were given comparable amounts of THC orally) and abruptly discontinued use reported experiencing irritability, sleep disturbances, loss of appetite, weight loss, sweating, and gastrointestinal upsets.[110] Most cannabis withdrawal symptoms occur within the first twenty-four hours of quitting, are most severe two to four days later, and last approximately one to two weeks.[111]

A large national Australian study concluded that approximately 30% of current marihuana users reported experiencing withdrawal symptoms when they stop using.[112] Among daily users and those who sought treatment, a majority experienced withdrawal.[113] Most reported that the experience of withdrawal directly resulted in at

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[105] Ryan Vandrey & Margaret Haney, "How Real is the Risk of Addiction?" 187 at 189 in Holland, *supra* note 2 [Vandrey & Haney].
[106] Joy, Watson & Benson, *supra* note 23 at 35.
[107] *Ibid*.
[108] Hanson et al, *supra* note 29.
[109] Harold Doweiko, *Concepts of Chemical Dependency*, 3rd ed (Pacific Grove, CA: Brooks/Cole, 1996) at 123 [Doweiko].
[110] Vandrey & Haney, *supra* note 105 at 190.
[111] *Ibid*.
[112] Hall et al, *supra* note 99.
[113] *Ibid*.

least one failed attempt to quit.[114] Existing data suggests that approximately one out of eleven people (9%) who try cannabis will meet the criteria for addiction at some point in their lives. This is lower than tobacco (32%), heroin (23%), cocaine (17%) and alcohol (15%), but it is not insignificant.[115]

Although some studies have identified an "amotivational" syndrome, others have found the evidence is unconvincing.[116] Research suggests that the "constellation of behaviours" including apathy, poor short-term memory, difficulty in concentration, and a lingering disinterest in maintaining personal appearance or pursuing goals may be the result of chronic cannabis intoxication.[117] De-intoxication appears to resolve these symptoms.[118]

There has been some concern expressed that marihuana use leads to the use of more harmful drugs. As one author noted, "There are strikingly regular patterns in the progression of drug use from adolescence to adulthood."[119] Unsurprisingly, most people who use "hard" drugs like cocaine and heroin have also used tobacco, alcohol and cannabis.[120] The "stepping stone theory" has largely been abandoned in the scientific literature in favour of the theory that suggests cannabis is a "gateway" to the world of

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[114] *Ibid*.
[115] Vandrey & Haney, *supra* note 105 at 193.
[116] Joy, Watson & Benson, *supra* note 23 at 72.
[117] A Johns, "Psychiatric effects of cannabis" (2001) Br J Psychiatry 178 at 116-122. See also DJ Castle and N Solowij, "Acute and subacute psychomimetic effects of cannabis in humans" in D Castle & R Murray, eds, *Marihuana and madness* (Cambridge: Cambridge University Press, 2004) 127-141.
[118] *Ibid*.
[119] Joy, Watson & Benson, *supra* note 23 at 65. The "stepping stone" hypothesis, as it is called, is based on the idea that progression from marihuana to other drugs arises from pharmacological properties of marihuana itself.
[120] See DB Kandel & K Yamaguchi, "From beer to crack: developmental patterns of drug involvement" (1993) 83 American Journal of Public Health at 851-855. See also DB Kandel, K Yamaguchi & K Chen, "Stages of progression in drug involvement from adolescence to adulthood: Further evidence for the gateway theory" (1992) 53 Journal of Studies in Alcohol at 447-457. See also E Labouvie, ME Bates & RJ Pandina, "Age of first use: Its reliability and predictive utility" (1997) 58 Journal of Studies on Alcohol at 638-643.

illegal drugs.[121] There is some limited support in the research that individuals using cannabis, particularly youths, have greater opportunity to access other drugs.[122]

There is a social concern that increased medical use may translate to increased use in the general population. Given the current and likely restrictions on accessing medical marihuana and the abundance of supply in the illicit market, the likelihood of significant diversion is limited. Moreover, "there is no evidence that the medical marihuana debate alters the perceived risks associated with marihuana use among adolescents."[123]

Some groups are more susceptible to the risks of cannabis than others. We now turn to a consideration of the special risks that attend cannabis use by some individuals. The vulnerable groups considered in the next subsection include special consideration of the increased apprehension of risks for men and women wishing to have children, individuals with a predisposition to psychosis, and young people.

VI: Vulnerable Groups

Certain groups of individuals are particularly susceptible to the harms of cannabis and should avoid it if safer alternatives exist. The evidence of potential risks for these individuals puts the overall net value into question. Without compelling evidence of a significant medical benefit to the individual it is highly unlikely that cannabis use for the following groups would be constitutionally protected.

Reproductive Function

In both men and women, the primary target of cannabinoid action is the brain where administered cannabinoids bind with cannabinoid receptors and affect the hormonal system. Cannabis use impacts the hormonal system before pregnancy, alters the course of

[121] Joy, Watson & Benson, *supra* note 23 at 65.
[122] *Ibid*.
[123] *Ibid* at 67.

pregnancy, and has effects on neonatal growth, infant behaviour and on executive functioning after infancy.[124]

Before a baby is conceived, marihuana use lowers testosterone levels in men.[125] Heavy use can decrease a man's sperm count.[126] The results of well-controlled studies indicate that the stage of a woman's menstrual cycle dictates her hormonal response to marihuana smoking.[127] Short-term use of THC may cause "transient decreases" in hormonal levels, which could lead to shortened menstrual cycle length and an increased incidence of anovulatory (irregular) menstrual cycles for "drug-naïve" females.[128]

Pregnant women especially should avoid using cannabis since THC crosses the placenta and enters the circulation of the developing fetus, reaching concentrations of about 10 - 30% of maternal concentration.[129] Most, though not all, studies suggest prenatal cannabis use is associated with a decrease in fetal weight, length and head circumference.[130] Some research has reported an increased incidence of preterm labor with marihuana use, while others fail to show this association.[131]

Since 1978, the Ottawa Prenatal Prospective Study (OPPS) has been monitoring the effects of marihuana and cigarettes inhaled during pregnancy.[132] In this prospective, longitudinal study, researchers interviewed 682 women in the Ottawa area once during each trimester of pregnancy. The results showed a statistically significant reduction of about one week in the gestational age of infants born to mothers who used marihuana six

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[124] Laura Murphy, "Hormonal System and Reproduction" 289 at 289-290 in Grotenhermen and Russo, *supra* note 99.
[125] GG Nahas, "Toxicology and pharmacology" in GG Nahas, ed, *Marihuana in Science and Medicine* (New York: Raven Press, 1984) 109 [Nahas 1984].
[126] See Murphy, *supra* note 124.
[127] *Ibid* at 291.
[128] *Ibid* at 292.
[129] Hollubek, *supra* note 62 at 149.
[130] Ray & Ksir, *supra* note 68 at 420.
[131] *Ibid*.
[132] PA Fried, "The Ottawa Prenatal Prospective Study (OPPS): methodological issues and findings--it's easy to throw the baby out with the bath water." (1995) 56(23-24) Life Sci 2159-68, online: <http://www.ncbi.nlm.nih.gov/pubmed/7539879>.

or more times per week.[133] Fried et al. followed the development of approximately 180 of these offspring by subjecting them to a battery of age-appropriate tests in the years beyond the neonatal period. There appeared to be some evidence for cognitive and behavioural abnormalities in the offspring of those mothers who "abused" marihuana.[134]

Prenatal marihuana exposure was negatively associated with the executive function tasks that required impulse control and visual analysis/hypothesis testing.[135] This appears to parallel some of the evidence on the risks of tobacco smoking. However, in contrast to children exposed to cigarette smoking, prenatal marihuana exposure was not associated with decreases in global intelligence.[136]

Considering that cannabis is the most commonly used drug of women of childbearing age, more research needs to be done.[137] Nevertheless, the precautionary principle should apply. Those who are planning a family should abstain from using marihuana, even for medical purposes, unless there are no safer alternatives. Non-smoked methods and non-psychoactive cannabinoids should be substituted for smoked marihuana whenever possible.

Psychiatric Illness

There is some evidence that links cannabis and psychiatric disorders such as depression, anxiety or psychosis though, like many of the studies on cannabis, this evidence is far from conclusive. In the 20th Century, studies showed that controlled administration of cannabis could lead not only to paranoia but to delusions and hallucinations as well.[138] Parts of the brain, including the limbic and prefrontal cortices, as well as the striatum

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[133] PA Fried et al, "Marihuana use during pregnancy and decreased length of gestation" (1984) 150(1) Am J Obstetrics and Gynecology 23-27 [Fried].
[134] *Ibid*.
[135] *Ibid*.
[136] Peter Fried, "Pregnancy" 269 at 273 in Franjo Grotenhermen and Ethan Russo, eds, *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential* (New York: The Haworth Integrative Healing Press, 2002) [Fried "Pregnancy"].
[137] *Ibid* at 269.
[138] Cheryl Corcoran, "Mental Health Risks Associated with Cannabis Use" 179 at 179 in Holland, *supra* note 2 [Corcoran].

have a high density of CB receptors, co-localized with dopamine receptors. These parts of the brain, and the chemical dopamine, are known to be dysfunctional in people with schizophrenia.[139] Indeed, many antipsychotics exert some of their beneficial effect by blocking dopamine receptors in these areas of the brain.[140] The medical journal, *Lancet* published a systematic review in 2007 reporting a causal link between cannabis use and the risk of psychotic outcomes.[141] This study found a causal link between early cannabis use and later onset of psychosis by comparing control groups in the military.[142]

Critics have claimed that it is unclear which way the association goes. Individuals with disrupted thought patterns may be more likely to try cannabis. The properties of THC may lead to the earlier onset of a disease that was inevitable.[143] Many research studies have found that the psychosis-producing effects of cannabis are restricted to a subset of individuals who are vulnerable, in terms of psychosis proneness or genetic vulnerability.[144] Biological data has been marshaled against the theory that cannabis use leads to psychosis. As Weiser and colleagues point out, there may be similar factors leading to cannabis use and schizophrenia. Independent of cannabis use, there are more receptors for cannabinoids in the brains of patients with schizophrenia than in normal individuals.[145] Since genes for these receptors are associated with schizophrenia risk, the authors suggest it is possible that abnormalities in the cannabinoid system in the brain could lead independently to both cannabis use and schizophrenia.[146]

Although cannabis and specifically THC has been implicated in the development of psychosis, there are promising leads in using the cannabinoid CBD as an anti-psychotic medication. Unlike THC, CBD is a noneuphoriant, anti-inflammatory analgesic that does

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[139] *Ibid* at 183.
[140] Julie Holland, "Cannabinoids and Psychiatry" 282 at 287 in Holland, *supra* note 2 [Holland "Psychiatry"].
[141] Corcoran, *supra* note 138 at 178.
[142] *Ibid*.
[143] *Ibid* at 185.
[144] *Ibid*.
[145] *Ibid* at 184.
[146] *Ibid*.

not bind well to the CB receptors.[147] Zuardi et al have proposed that the ratio of THC to CBD is crucial in determining the effects of cannabis on psychosis.[148] In a review of 23 studies of schizophrenics using cannabis, fourteen studies reported that cannabis users had better cognitive performance than nonusers. Eight reported no difference, and one study reported better cognitive performance in the schizophrenics who did not use cannabis.[149]

Individuals with a genetic history of psychotic episodes should be cautioned about using cannabis as a medicine, especially cannabis with higher THC levels and lower CBD levels. If cannabis does speed up a psychosis prognosis, delaying its onset may allow time to consolidate and improve social and vocational functioning before becoming ill, benefitting the patient over the long-term.[150] Since marihuana use is a choice, unlike genetics, it may be wiser to avoid the risk or at least minimize the risk by choosing a product lower in THC and higher in CBD.

Young People

The demographics of cannabis use indicate that recreational use of cannabis typically begins around age 15, whereas individuals who use it medicinally are typically older. Nevertheless, there are young people with serious and severe illnesses that may respond well to cannabinoid-based therapies. Extra caution must be exercised in this group because the brains of young people are still developing.

The prefrontal cortex is a region of the brain that weighs outcomes, forms judgments, and controls impulses and emotions. Teenagers experience a wealth of growth in synapses during adolescence when the brain starts pruning away the unnecessary synapses to make the remaining ones more efficient. The pruning process appears to start in the back of the brain and move forward, so that the prefrontal cortex is the last to be trimmed. As the

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[147] *Ibid* at 286.
[148] *Ibid*.
[149] *Ibid* at 287. The authors say this meta-analysis "confirmed their own experiences with cannabis-using patients."
[150] *Ibid*.

connections are trimmed, an insulating substance called myelin coats the synapses to protect them.[151]

As a result, the prefrontal cortex is immature in teenagers as compared to adults and may not fully develop until the mid-20s. Cannabis use at this time modifies the functioning of this area of the brain, altering its natural development.[152] Teenaged cannabis use has been specifically linked to an adult diagnosis of schizophreniform disorder, but not depression.[153] Except in severe cases, cannabis use by those under 25 should be avoided while the brain is maturing. Smoking should be avoided and non-psychoactive cannabinoid preparations should be used.

Further Research

Marihuana has some effect on immune system but the relationship is unclear.[154] The CB_2 receptors are found primarily in the tissues of the immune system. Two studies of HIV infection in homosexual men showed no clear association between marihuana use and increased progression to AIDS[155] but more research needs to be undertaken to fully understand this relationship.[156]

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[151] Ronald Kotulak, "Teens Driven to Distraction" *Chicago Tribune* (24 March 2006), online: How Stuff Works <http://health.howstuffworks.com/human-body/systems/nervous-system/teenage-brain1.htm>.
[152] Corcoran, *supra* note 138 at 183.
[153] *Ibid*.
[154] AE Munson & KO Fehr, "Immunological effects of cannabis" in AE Munson & KO Fehr, eds, *Cannabis and Health Hazards* (Toronto: Addiction Research Foundation, 1983) at 253. See also LE Hollister, "Marihuana and Immunity" (1992) 24 J Psychoactive Drugs 159.
[155] RA Coates et al, "Cofactors of progression to acquired immunodeficiency syndrome in a cohort of male sexual contacts of men with human immunodeficiency virus disease" (1990) 132 Am J Epidemiol 717. See also RA Kaslow et al, "No evidence for a role of alcohol or other psychoactive drugs in accelerating immunodeficiency in HIV-1 positive individuals. A report from the Multicenter AIDS Cohort Study" (1989) 261(23) JAMA 3424.
[156] Ray & Ksir, *supra* note 68 at 420.

VII: Conclusions On The Harms

Numerous studies suggest that marihuana smoke is an important risk factor in the development of respiratory disease.[157] It is clear that the potential harms from using cannabis are not trivial, but using non-smoked methods and avoiding divided attention tasks like driving can mitigate the most serious harms.

The presence of harms indicates that where the benefits are unclear, other proven treatments may be preferred. Only some individuals will have a constitutional claim to marihuana for medical purposes. The constitutional claim is strongest where the evidence of a medical benefit is clear. In the next section, I review the evidence on the medical benefits.

VIII: Medical Benefits

> Among those who used cannabis, 17.7% (representing about 420,000 Canadians or 1.6% of the Canadian population aged 15 years and older) reported doing so for medical purposes. Prevalence of use for medical purposes was similar between male and female cannabis users (17.3% versus 18.4%, respectively), while more than one in five (21.8%) cannabis users aged 25 years and older reported using it for medical purposes, representing 1.5% of all adults in this age group. The percentage of youth who used cannabis for medical purposes is not reportable.
>
> Half (49.7%) of those who used cannabis for medical purposes did so mainly for chronic pain caused by conditions such as arthritis, back pain and migraines, while the remaining 50.3% used cannabis primarily for one of a variety of conditions that included insomnia, depression and anxiety. These numbers do not in any way measure or reflect enrolment in the federal Medical Marihuana Access Program.[158]

This section assesses the various therapeutic effects of cannabis. Clinical indications are noted within the sections. I have focused on some of the more common applications: anorexia (loss of appetite) and cachexia (wasting), nausea and vomiting, movement disorders, pain relief, and glaucoma (progressive loss of vision). The research shows that cannabis can reliably relieve some symptoms but it comes with risks. The relative risk-benefit profile is relevant to the *Charter* analysis. Withholding medical treatment that has

[157] Joy, Watson & Benson, *supra* note 23 at 5, 6.
[158] CADUMS, *supra* note 77.

strong evidence of a significant benefit is more difficult to justify. More severe infringements require a very clear connection between the purpose of the legislation and the means chosen to effect that purpose.[159] After assessing some of the commonly reported therapeutic benefits of cannabis, I consider whether synthetic cannabinoids currently offer an acceptable alternative.

Appetite

The desire to consume food is one of the fundamental physiological processes necessary for survival.[160] The appetite is regulated by a highly complex integration of hormonal and neuronal systems to maintain homeostasis.[161] Disruptions of these homeostatic mechanisms are often a result of disease and can result in food deprivation or excess eating.[162]

Reference to cannabis' appetite-stimulating properties was recorded as early as AD 300.[163] The presence of many CB receptors in the hypothalamus is a strong indication that the endocannabinoid system is involved in the normal physiological regulation of appetite.[164] Cannabis stimulates appetite and enhances enjoyment of food, which helps people with involuntary weight loss.

Cannabis has been reliably shown to relieve symptoms of cachexia, which refers to the dramatic weight loss that is characteristic of several diseases, including malabsorption, congestive heart failure, major trauma, severe sepsis, AIDS, and cancer.[165] Weight loss known as cachexia is characterized by the loss of lean body mass through increased

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[159] *Chaoulli*, *supra* note 61 at 131.
[160] Billy Martin, "The Endocannabinoid System and the Therapeutic Potential of Cannabinoids" 125 at 128 [Martin] in ElSohly, supra note 54.
[161] *Ibid*.
[162] *Ibid*.
[163] *Ibid* at 147.
[164] Tim Kirkham, "Cannabinoids and Medicine: Eating Disorders, Nausea and Emesis" [Kirkham] in Vincenzo Di Marzo, ed, *Cannabinoids* (Texas: Klewer Academic, 2004) at 148 [DiMarzo].
[165] Martin Schnelle & Florian Strasser, "Anorexia and Cachexia" 153 at 153 [Schnelle & Strasser] in Grotenhermen & Russo, *supra* note 101.

protein degradation and reduced protein synthesis. This is unlike simple starvation where muscle mass is conserved and body fat is converted to energy. Cachexia also involves abnormalities in lipid and glucose metabolism, which, together with an increased resting metabolic rate, result in a negative energy imbalance.[166] Unlike most starving people, cachexia sufferers do not have an increase in motivation to eat.[167] Traditional treatments for cachexia involves steroids combined with enternal nutrition delivered through a feeding tube but these interventions are costly and can require very high doses.[168] Cachexia is associated with other health issues including anorexia, chronic nausea, early satiety, constipation, asthenia, decreased motor and mental skills, decline in attention span and concentration abilities, and change in body image.[169] These symptoms negatively impact an individual's quality of life and hasten the onset of death.[170]

In a long-term study of 94 AIDS patients, the appetite-stimulating effect of THC continued for months.[171] THC doubled appetite on a visual analogue scale in comparison to placebo. Patients tended to retain a stable body weight over the course of seven months.[172]

Cannabis-based treatments can be a useful tool in attempting to maintain proper nutrition in patients with anorexia. *Anorexia*, manifesting as the simple loss of appetite, occurs frequently in cancer patients.

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[166] Kirkham, *supra* note 164 at 152.
[167] See A Calignano et al, "Control of pain initiation by endogenous cannabinoids," (1998) 394 Nature 277.
[168] Kirkham, *supra* note 164 at 154.
[169] See generally Kirkham, *supra* note 155 at 152, 155. See SD Gauldie et al, "Anadamide activates peripheral nociceptors in normal and arthritic rat knee joints" (2001) 132 Br J Pharmacol 617. See also L Facci et al, "Mast cells express a peripheral cannabinoid receptor with differential sensitivity to anadamide and palmitoylethanolamide" (1995) 92 Proc Natl Acad Sci USA 3376.
[170] Kirkham, *supra* note 164 at 155.
[171] M Haney et al, "Dronabinol and marihuana in HIV-positive marihuana smokers. Caloric intake, mood, and sleep." (2007) 45(5) J Acquir Immune Defic Syndr 545-54. This confirmed the results of a shorter six-week study.
[172] *Ibid*.

Woolridge et al. evaluated the effects of cannabis on symptom control at a large HIV clinic, measuring the patterns and prevalence of cannabis use. Of their 523 patients, 27% (n. 143) used cannabis to treat symptoms associated with HIV. Of the 143 cannabis-using patients, 71% smoked marihuana (n. 101) and 27% ate or drank it (n. 39). Two percent (3 patients) ingested the cannabis in another way.[173] The most frequently reported symptom, loss of appetite, was improved in 97%. Half of the patients reported feeling pain and 94% of those individuals reported a benefit from cannabis.[174] The collective results demonstrated statistically significant improvement in at least half of patients with nausea, anxiety, nerve pain, depression, tingling, numbness, weight loss, headaches, tremor, constipation, and tiredness.[175] Symptoms that were not improved included weakness and slurred speech. Almost half of the respondents (47%) were found to have statistically significant memory deterioration.[176]

More complicated cases of *anorexia nervosa* involve the deliberate withholding of food to control one's weight. Both the British Medical Association and the Institute of Medicine advise that cannabis is unlikely to be effective in the patients with *anorexia nervosa* since the underlying psychopathology is very complex, involving issues with control over consumption rather than loss of appetite.[177] Indeed, "in patients diagnosed with primary anorexia nervosa there was no measurable cannabinoid effect, presumably because the underlying pathological mechanism is not loss of appetite."[178]

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[173] Emily Woolridge et al, "Cannabis Use in HIV for pain and other medical symptoms" (2005) 29 Journal of Pain and Symptom Management 358 at 360. See generally Stolick, *supra* note 26 at 65.
[174] *Ibid*.
[175] *Ibid*.
[176] *Ibid*.
[177] Kirkham, *supra* note 164 at 154. See generally Health Canada, "Drugs and Health Products: Information for Health Care Professionals" (September 2010), online: Health Canada <http://www.hc-sc.gc.ca/dhp-mps/marihuana/how-comment/medpract/infoprof/index-eng.php#tphp> [Information for Health Care Professionals].
[178] Franjo Grotenhermen, "Review of Therapeutic Effects" 123 at 129 [*Grotenhermen* "Review"] in Grotenhermen & Russo, *supra* note 101.

This evidence suggests that the benefit to individuals suffering from an involuntary loss of appetite and wasting are significant. The empirical evidence supports the anecdotal and observational evidence that marihuana stimulates the appetite.[179]

Nausea & Vomiting

Emesis is the medical term for throwing up, the forceful ejection of one's stomach contents through the mouth and/or nose. Keeping food down is a significant and problematic side effect of chemotherapy and radiation in cancer patients. Nausea and vomiting can substantially contribute to the progressive deterioration of a patient's physical condition and psychological well-being.[180]

Nausea and vomiting may be the most common and troublesome side effect of cancer drugs, causing some patients to discontinue treatment:

> Retching (dry heaves) may last for hours or even days after each treatment, followed by days and even weeks of nausea. Patients may break bones or rupture the esophagus while vomiting. The sense of loss of control can be emotionally devastating. Furthermore, many patients eat almost nothing because they cannot stand the sight or smell of food. As they lose weight and strength, they find it more and more difficult to sustain the will to live.[181]

In cancer chemotherapy patients, simple behavioural interventions including distraction and relaxation can help to reduce nausea but most conventional treatments are pharmacological.[182] After repeated treatments, people develop conditioned reactions, causing them to feel ill before chemotherapy begins. Patients who vomit frequently have difficulty getting proper nutrition, often with severe consequences.[183]

Some research has evaluated the anti-emetic efficacy of cannabinoids in cancer patients receiving chemotherapy using a systematic review of literature in electronic databases. A

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[179] See e.g. Reichbach, *supra* note 15.
[180] Kirkham, *supra* note 164 at 155.
[181] Grinspoon & Bakalar, *supra* note 17 at 24.
[182] Mitchell Earleywine, *Understanding Marihuana: A New Look at the Scientific Evidence* (Cary, NC: Oxford University Press, 2002) at 180 [Earleywine].
[183] *Ibid*.

meta-analysis found that the anti-emetic efficacy of cannabis was "superior as compared to conventional drugs and placebo."[184]

Several studies have demonstrated that oral dronabinol or nabilone (synthetic cannabinoids) were superior, or of equal effectiveness, to other drugs such as prochloperazine and metoclopramide.[185] Cannabinoids have also been shown to be effective in patients whose nausea is refractory to other drugs.[186] Non-psychoactive cannabinoid therapies could also prove useful for children who experience nausea or vomiting as a result of chemotherapy. Unlike Delta-9-THC, Delta-8-THC is not psychoactive and was shown to prevent vomiting during chemotherapy for children with a minimum of side effects.[187] Patients often report a preference for a cannabinoid treatment to other regimens.[188] Studies pooling the data of 768 patients reported that oral THC provided 76-88% relief of nausea and vomiting, while smoked cannabis figures supported 70-100% relief in the various surveys.[189]

Newer anti-emetics may be more effective than cannabinoids in reducing the frequency of nausea and vomiting. However, after taking the appetite-stimulating, mood-elevating and analgesic properties into account, there may be a good rationale for considering cannabinoid use to help control emesis.[190] These studies provide strong support for the anecdotal evidence that suggests cannabis provides significant relief from nausea and vomiting.

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[184] Machado Rocha et al, "Therapeutic use of *Cannabis sativa* on chemotherapy-induced nausea and vomiting among cancer patients: systematic review and meta-analysis" (2008) 17 Eur J Cancer Care 431.
[185] *Ibid*.
[186] *Ibid*.
[187] Earleywine, *supra* note 182 at 180.
[188] *Ibid*.
[189] Stolick, *supra* note 26 at 59.
[190] Kirkham, *supra* note 164 at 155.

Movement Disorders, Spasticity & Seizures

The basal ganglia is a subcortical brain network responsible for the selection and execution of motor routines and learning habitual memories. Riding a bike or learning an instrument involve this area of the brain, which is also implicated in unwanted movements and behavioural tics. The locations of endocannabinoid receptors are in the primary brain centers for involuntary and fine-tuning of motor functions like posture and muscle tone.[191]

Involuntary movements, spasms and seizures are significant health issues for individuals with MS, epilepsy, Tourette's Syndrome, and Parkinson's Disease, to name just a few. CBD in doses between 100 and 600 milligrams per day produced improvements of 20-50% in five patients with dystonia, a neurological disorder characterized by involuntary muscle contractions that cause slow repetitive movements or abnormal postures.[192]

Research has shown that cannabis can reduce physical tics and spasticity.[193] It may also be beneficial for treating obsessive-compulsive behaviour, but more evidence is needed to determine whether cannabis is a safe and effective medicine for these conditions.[194] The clinical use of marihuana for patients with multiple sclerosis (MS) to help control muscle spasms and spasticity is well established.[195]

> MS is a disorder in which patches of myelin (the protective covering of nerve fibers) in the brain and spinal cord are destroyed and the normal functioning of the nerve fibers themselves is interrupted. It seems to be an autoimmune response in which the body's defense system treats the myelin

[191] Hanson et al, *supra* note 29 at 123.
[192] Grotenhermen "Review of Therapeutic Effects," *supra* note 178 at 125.
[193] In small clinical trials of THC, nabilone, and cannabis, a beneficial effect on spasticity caused by MS or spinal cord injury has been observed. Among other positively influenced symptoms were pain, paraesthesia, tremor, and ataxia. Some anecdotal evidence of cannabis' benefits in spasticity due to central lesions also exists. See Grotenhermen "Review of Therapeutic Effects," *supra* note 178 at 125. See also Stolick, *supra* note 26 at 67.
[194] A Curtis, CE Clarke & HE Rickards, "Cannabinoids for Tourette's Syndrome (Review)" (2009) 4 *The Cochrane Library,* online: <www.thecochranelibrary.com>
[195] Grotenhermen "Review of Therapeutic Effects," *supra* note 178 at 125.

> as a foreign invader. The symptoms usually appear in early adulthood, then come and go unpredictably for years. Attacks last weeks to months, and remission is often incomplete, with gradual deterioration and eventual severe disability. Injury, infection, or stress may cause a relapse. The average survival time is thirty years, but some patients deteriorate much faster, and others stabilize after a few attacks.[196]

In one study of cannabis use for MS, a majority of patients reported diminished pain and spasticity.[197] Cannabis also helps with bladder control, which is a serious quality of life concern for those living with MS.[198] Some individuals may experience an improvement in their psychological symptoms. One study reported that 57% of individuals with MS were using marihuana because it provided relief of their psychological symptoms in addition to reducing pain and spasticity.[199]

In addition to improving the symptoms of MS, some individuals with epilepsy experience a reduction in seizure frequency and severity after cannabis use. However, this is not fully confirmed and more research needs to be done.[200]

Pain Relief

"Patients seek medical assistance for pain more often than any other symptom."[201] Chronic pain involves persistent, long-term pain, which may include diffuse, throbbing pressures, or sharp, specific aches. An estimated 10% of patients with chronic pain use cannabis to treat their symptoms.[202]

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[196] Grinspoon & Bakalar, *supra* note 17 at 80.
[197] Dean Wingerchuk, "Cannabis for Medical Purposes: Cultivating Science, Weeding out the Fiction" (2004) 364 *Lancet* 315 at 315 [*Wingerchuk*].
[198] Grinspoon & Bakalar, *supra* note 17 at 91.
[199] Wingerchuk, *supra* note 197 at 315.
[200] Elisabeth Gordon & Orrin Devinsky, "Marihuana: Effects on Neuronal Excitability and Seizure Threshold" 619 at 625-626 in Nahas et al, ed, *Marihuana and Medicine* (New Jersey: Humana Press, 1999) [Nahas].
[201] Earleywine, *supra* note 182 at 173.
[202] MA Ware et al, "Cannabis use for chronic non-cancer pain" (2003) 102(1-2) *Pain* 211. See Wang, *supra* note 18 at 4.

Treatments for pain can be quite simple and cause few side effects. A placebo can minimize pain in 16% of surgery patients.[203] Pain varies with tension and mood so behavioural interventions can decrease symptoms. Alternative treatments like acupuncture can alleviate symptoms for some people.[204] For individuals with severe, chronic pain, the treatment is usually opioid narcotics and various synthetic analgesics. These drugs have many negative effects. Withdrawal from the more potent opioid painkillers includes extremely aversive flue-like symptoms and spastic muscle twitches.[205]

> Opioids are addictive and tolerance develops. The most commonly used synthetic analgesics - aspirin, acetaminophen (Tylenol), and nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen - are not addictive, but they are often insufficiently powerful. Furthermore, they have serious toxic side effects, including gastric bleeding or ulcer, and in the long run, a risk of liver or kidney disease. Stomach bleeding and ulcers induced by aspirin and other NSAIDs are the most common serious adverse drug reactions reported in the United States... These drugs may be responsible for as many as 76,000 hospitalizations and more than 7,600 deaths annually.[206]

The spinal cord contains numerous CB receptors, which helps to improve the peripheral sensation of pain.[207] THC may inhibit the production of the enzyme *adenylate cyclase*, which is involved in the transmission of pain messages.[208] Although cannabis has been shown to have a level of analgesia comparable to that of codeine, the doses required induce unwanted behavioural effects.[209]

Evidence suggests cannabinoids and opioids have synergistic analgesic effects, meaning they work together to produce greater pain relief.[210] The combination of opioids and

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[203] Earleywine, *supra* note 182 at 173.
[204] *Ibid*.
[205] *Ibid* at 174.
[206] Grinspoon & Bakalar, *supra* note 17 at 107.
[207] Chris Vaughn & MacDonald Christie, "Mechanisms of Cannabinoid Analgesia" 89 at 89 [Vaughn & Christie] in Grotenhermen & Russo, *supra* note 101.
[208] Doweiko, *supra* note 109 at 121.
[209] Martin, *supra* note 160 at 130-131.
[210] Vaughn & Christie, *supra* note 207 at 90.

cannabinoids may allow individuals to reduce the doses of both opioids and cannabinoids necessary to achieve desirable levels of analgesia.

Considering Canada's aging population, pain management may be one of the most important future uses for medical cannabis. For individuals suffering from chronic pain, the risks associated with traditional pharmacological treatments may be more undesirable than those associated with cannabis use. Although cannabis is not as powerful as the opioids, it has fewer serious side effects and the risk of dependence is slim. It may complement pharmaceutical treatments by allowing patients to reduce their doses of opioid pain medication.

Glaucoma

CB receptors are found in the eye and have proven invaluable for some individuals with glaucoma. The first patient in the United States to obtain a federal exemption for cannabis had glaucoma. Robert Randall's prognosis was blindness within three to five years. With medically supervised cannabis use, Randall maintained his sight for nearly thirty years and reportedly retained some distance vision when he died in 2001.[211]

> Glaucoma is a disorder that results from an imbalance of pressure within the eye. The eyeball must be almost perfectly spherical to focus light accurately on the retina. Its shape is maintained by the pressure of an internal fluid, the aqueous humor. If the eye produces too much of this fluid or the channels through which it flows out are blocked, the increasing pressure may damage the optic nerve, which carries impulses from the eye to the brain. Glaucoma afflicts 1.5 percent of the population at age fifty and about 5 percent at age seventy. Almost one million Americans suffer from the disorder, and every year 80,000 are blinded by it…
>
> Today, glaucoma is treated chiefly with eye drops containing betablockers such as timolol (Timoptic), which inhibit the activity of epinephrine (adrenaline). They are highly effective but may have serious side effects; they may induce depression, aggravate asthma, slow the heart rate, and increase the risk of heart failure.[212]

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[211] *Ibid*.

[212] Grinspoon & Bakalar, *supra* note 17 at 45-46.

The discovery that marihuana reduces the pressure inside the eye occurred accidentally during an experiment at the University of California, Los Angeles (UCLA). The experiment was designed to determine whether cannabis dilated the pupils. Researchers photographed the eyes of student volunteers as they smoked marihuana. They observed the pupils slightly constrict rather than dilate.[213] An ophthalmological examination showed that cannabis also reduced tearing and intraocular pressure. Further experiments with glaucoma patients showed a reduction in intraocular pressure for an average of four to five hours, with "no indications of any deleterious effects…on visual function or ocular structure."[214]

In a number of studies, cannabis decreased intraocular pressure by an average of 25 – 30% and occasionally up to 50%, with effects lasting four to six hours. Some non-psychotropic cannabinoids (CBD, CBG, CBN), and to a lesser extent, some non-cannabinoid constituents of the cannabis plant have also been shown to decrease intraocular pressure.[215]

Neither the American Glaucoma Society nor the Canadian Ophthalmological Society currently recommend cannabis use for glaucoma due to the availability of other therapeutic options and the inability to separate the desirable from undesirable effects.[216]

Other Benefits

The evidence is mixed on the therapeutic benefit of cannabis in treating other diseases although there is anecdotal evidence to support its application in many areas. There is somewhat of a confirmed therapeutic effect for treating allergies, inflammation, infection, depression, bipolar disorders, anxiety disorders, dependency and withdrawal from other

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[213] *Ibid* at 46-47.
[214] *Ibid*.
[215] Grotenhermen "Review of Therapeutic Effects," *supra* note 178 at 129.
[216] See H Jampel, "American glaucoma society position statement: marihuana and the treatment of glaucoma" (2010) 19 J Glaucoma 75. See also: YM Buys and PE Rafuse, "Canadian Ophthalmological Society policy statement on the medical use of marihuana for glaucoma" (2010) 45 Can J Ophthalmol 324.

drugs.[217] More research still needs to be done to confirm the effects on autoimmune diseases, cancer, neuroprotection, fever and blood pressure disorders.[218]

Lester Grinspoon, professor emeritus at Harvard, provides a comprehensive account of many diseases that may be improved by cannabis. Although derived from anecdotal sources, Grinspoon spent his career devoted to the scientific study of cannabis.[219] He provides accounts and evidence for some less common medical uses, including insomnia, adult attention deficit disorder, tinnitus, phantom limb pain and addiction.[220]

As will be discussed, there is a threshold level of state interference with physical or psychological integrity that must be met before security of the person will be breached. Although a person may receive some medicinal benefit from cannabis use, in many cases, it may not be serious enough to warrant granting constitutional protection for that use.

Synthetic Alternatives

With the potential for synthetic cannabinoid derivatives that are less susceptible to abuse, is there a constitutional requirement for marihuana?

Although THC is the primary active compound, other compounds play a role in marihuana's effects. Evidence suggests that whole plant cannabis is more effective than THC alone or currently available synthetic derivatives.

In their article, "Cannabis and Cannabis Extracts: Greater Than the Sum of Their Parts?" McPartland and Russo discuss therapeutic effects of chemical compounds other than THC and illustrate the synergy among them. [221] The authors present information about six other cannabinoids, over twelve terpenoids, three flavonoids, and one phytosterol.[222] They conclude that because of the various chemicals working together, whole plant

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[217] Grotenhermen "Review of the Therapeutic Effects," *supra* note 178 at 124-125.
[218] *Ibid*.
[219] Grinspoon & Bakalar, *supra* note 17 at 45-138.
[220] *Ibid* at 163-222.
[221] McPartland & Russo, *supra* note 55 103.
[222] *Ibid*.

cannabis is therapeutically superior to synthetic THC. For instance, although there are carcinogenic elements of cannabis smoke, there is a lack of evidence showing lung cancer in cannabis-only smokers. CBD may counteract the potentially negative effects of smoking by offering a protective effect to the lungs.[223]

> [CBD] provides sedative properties, reduces anxiety, provides antipsychotic benefits, increases dopamine activity, inhibits serotonin uptake, enhances norepinephrine activity, protects neurons from glutamate toxicity, acts as an antioxidant, reduces hippocampal Ach release (which correlates with loss of short-term memory), and is an anti-convulsant on par with phenytoin (a standard antiepileptic drug).[224]

The CBD in cannabis smoke could explain why inhaling it causes less airway irritation and inflammation than inhaling pure THC.[225] Cannabis has been shown to be helpful for asthma because the CBD blocks lipoxygenase, the enzyme that produces asthma-provoking leukotrienes.[226] Cannabinoids are odourless, but other chemical compounds of the cannabis plant, known as terpenes are quite aromatic and also appear to have a therapeutic benefit.[227] In addition to cannabinoids and terpenes, many other chemical messengers may contribute to marihuana's experienced effects.

In fact, for many patients, synthetic alternatives containing only THC or CBD are not adequate.[228]

Russo provides five reasons why cannabis-based medicine extracts (CBME) offer a distinct advantage over THC alone:

1. Potentiation – which involves an "entourage effect" - having other compounds along with THC makes for better THC binding and effectiveness;
2. Antagonism – certain compounds of cannabis (e.g. CBD) may offset negative side effects of THC;

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[223] *Ibid* at 104.
[224] *McPartland & Russo*, *supra* note 55 at 106.
[225] *Ibid*.
[226] *Ibid* at 107. See also Stolick, *supra* note 26 at 49.
[227] Robert C Clarke & David P Watson, "Cannabis and Natural Cannabis Medicines" 1 at 7 in ElSohly, *supra* note 54.
[228] E.g. Reichbach, *supra* note 15. See also *Parker*, supra note 6 at 34.

3. Summation – a number of cannabis components may contribute to a certain therapeutic effect of THC;
4. Pharmacokinetic – exemplified by one compound (e.g. CBD) which may alter the metabolism of THC; and
5. Metabolism – due to the co-evolution over the millennia, humans are better able to metabolize herbal preparations (i.e. cannabis) as opposed to synthetic pharmaceuticals (i.e. synthetic cannabinoids).[229]

This evidence explains why the currently available synthetic alternatives do not provide the same benefit as marihuana. The costs associated with producing and consuming pharmaceutical drugs is also very high, relative to cannabis.

IX: Future Research & Development

Scientists are able to manipulate the endocannabinoid system by introducing cannabinoids into the body or by blocking the CB receptors, preventing cannabinoids from binding with receptors. Research into manipulating cannabinoids may produce promising therapies that affect only the targeted receptor sites or do not have psychoactive effects.

> One possible improvement is to use cannabinoids that do not act on either of the two known cannabinoid receptors and therefore are devoid of the psychoactivity that is usually unwelcomed by patients who have not previously used cannabis for non-medical purposes.[230]

According to the *Maariv Daily*, Israeli researchers have developed a plant that "looks, smells and even tastes the same [as marihuana], but does not induce any of the feelings normally associated with smoking marihuana that are brought on by the substance THC."[231] Tzahi Klein, head of development at Tikkun Olam, the firm that developed the

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[229] See McPartland & Russo, *supra* note 55. See also Ethan Russo "Cannabis: From Pariah to Prescription" (2003) 3 Journal of Cannabis Therapeutics 1 at 4 [Russo].

[230] Harold Kalant & Amy Porath-Waller, "Clearing the Smoke on Cannabis: Medical Use of Cannabis and Cannabinoids" (2012) Canadian Centre on Substance Abuse, online: <www.ccsa.ca> [Kalant & Porath-Waller].

[231] Agence France-Presse, "Israel researchers develop marihuana plant without the high," *National Post* (30 May 2012) online: National Post <http://life.nationalpost.com/2012/05/30/israel-researchers-develop-marihuana-plant-without-the-high/>.

species said they wanted "to neutralise the effect of the THC and to increase the effect of another substance called CBD."[232]

The Institute of Medicine recommends, "clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems."[233]

Of the approximately 400,000 – 1 million Canadians who report using marihuana for medicinal purposes,[234] just over 12,000 people are currently authorized to possess marihuana under the *MMAR*.[235] There are methodological limitations in this accuracy of type of self-reported survey data. Furthermore, the data does not reflect how many of these individuals are in a situation where depriving them of cannabis would meet the threshold level for constitutional protection, there is a large discrepancy between the number of individuals reporting medical use of marihuana and those legally authorized to do so. The problems with the current framework are evident in the number of successful constitutional challenges. Future research and development depends largely on the

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[232] *Ibid*.

[233] Joy, Watson & Benson, *supra* note 23 at 4.

[234] *R v Beren and Swallow*, 2009 BCSC 429 at 38 [*Beren*]. "The Canadian Addiction Survey, described by Dr. Kalant as the most detailed and comprehensive survey of its kind, reported in 2004 that 5% of Canadians over 15 years of age used cannabis for its self-reported medical use, putting the number of medical users at approximately one million persons. Senator Nolin testified that the Senate Special Committee on Illicit Drugs heard evidence in 2001 and 2002 from several witnesses that referenced 400,000 as the working estimate of the total number of medical users. Ms. Belle-Isle, who was accepted to give expert opinion evidence in this trial, is a researcher in the area of epidemiology. She concluded that between 17 - 37% of the estimated 58,000 persons living with HIV/AIDS in Canada use cannabis to relieve their symptoms, which puts the range of users within this category at between 9,860 and 21,460. The two primary societies in British Columbia for which membership numbers are in evidence, the VICC and the British Columbia Compassion Club Society (the "BCCCS"), both have membership criteria that are more restrictive than other such organizations, and together they serve in excess of 4,700 persons. All estimates of users of medical marihuana should be viewed with caution."

[235] Kalant & Porath-Waller, *supra* note 230 at 4.

demand for alternatives. Hopefully, easing barriers to legal access will lead to a greater demand for safer alternatives to smoked marihuana.

X: Conclusions On The Medical Evidence

The greatest benefits of cannabis use appear to arise in the most serious diseases for which concern about the long-term consequences is the least significant. The acute harms resulting from cannabis impaired driving and chronic harms associated with smoking cannabis are not trivial. Even still, with the exception of the harms associated with smoking, the known risks are within the range of other currently available drugs.[236]

The available evidence indicates an established therapeutic effect for treating nausea and vomiting, simple anorexia and weight loss. There is a relatively well-confirmed therapeutic effect for treating spasticity, movement disorders, asthma, glaucoma and providing pain relief.

The role for cannabis in modern medicine is not to replace effective pharmaceutical drugs but to offer unique benefits that can reduce the harms of conventional treatments. Until scientists develop cannabinoid treatments that can selectively target certain regions and minimize undesired behavioural effects, whole plant herbal cannabis appears to be therapeutically superior to synthetic derivatives. Where the use of cannabis is expected to be long-term, the patient must fully understand the potential for chronic harms. Doctors must be able to educate their patients about the known risks and benefits.

Assessing whether an individual patient is constitutionally entitled to possess and use cannabis requires doctors to compare the medical evidence with the individual account. These types of questions are part medical, part legal. In some cases, the medical use of marihuana will not be controversial. In other cases, it may be necessary to critically examine both the empirical evidence and the individual's account of the impact of marihuana use.

[236] Joy, Watson & Benson, *supra* note 23 at 6.

In the next chapter we look at judicial treatment of the constitutional claim to access marihuana for medical reasons.

PART TWO: CANNABIS AND THE *CHARTER*

I: Introduction

Enacted in 1982, the *Charter* is part of Canada's entrenched constitution. It is the supreme law of Canada and laws that are inconsistent with its provisions are of no force and effect.[237]

In this section, I provide an overview of section 7 of the *Charter*, providing descriptions of the rights to life, liberty and security of the person, as well as the principles of fundamental justice. I provide a chronological summary of the cases applying section 7 and examine how these have been applied to the medical use of marihuana. I detail the circumstances that led to the enactment of the *MMAR* and the cases that influenced subsequent regulatory amendments. I analyze the evidence to determine a threshold for when there will be a violation of security of the person and what the principles of fundamental justice require. In the next part, I apply the *Charter* analysis to the current *MMAR*.

II: Section Seven of the *Charter*

Section 7 guarantees everyone in Canada "the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

Section 7 provides three independent legal rights: life, liberty and security of the person, subject to the principles of fundamental justice. The legal rights described in section 7 of the *Charter* apply to everyone in Canada. These rights are independent but overlapping.[238] Presently, no comprehensive definition exists for these three interests.[239]

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[237] *Charter*, *supra* note 4, s 52(1).

[238] See *Singh v Minister of Employment and Immigration*, [1985] 1 SCR 177 at 204, Wilson J [*Singh*]. Violations of life and liberty often violate security of the person.

The *Charter* applies only to government action but *Charter* rights can be violated by the conduct of a non-government body if the violation is a reasonably foreseeable consequence of government action.[240] The courts determine whether the government has infringed these rights on a case-by-case basis using a "purposive" analysis, which seeks to understand the values underlying the individual rights and the state interests.[241] Rights violations that conform to the principles of fundamental justice will not violate the *Charter*.

For a successful claim under section 7, the legal burden is on the person claiming a *Charter* violation. They must show on a balance of probabilities that government action has violated their right to life, liberty or security of the person and identify a principle of fundamental justice that was breached.

The leading cases under section 7 of the *Charter* have dealt with contentious social issues. The Supreme Court of Canada (SCC) has said, "The issue for this Court to determine is not whether Parliament has weighed those pressures and interests wisely, but rather whether the limit they have imposed on a *Charter* right or freedom is reasonable and justified."[242]

The criminal prohibition of marihuana can violate the rights to life and liberty for some medical users. However, the debate in the medical context has largely focused on security of the person. The Supreme Court has established that a government-imposed prohibition on something that provides significant medical benefit will violate security of the person.[243] Courts have also found that unnecessary government-imposed barriers to access needed medical treatment violate an individual's security of the person. The facts and evidence presented in each case will determine whether the medical treatment is

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[239] Robert Sharpe & Kent Roach, *The Cha\rter of Rights and Freedoms,* 4th ed (Toronto: Irwin Law, 2009) at 224 [Sharpe & Roach]. For a recent statement on this see *Carter v Canada (Attorney General)*, 2012 BCSC 886 at 1306 [*Carter*].
[240] *United States of America v Burns,* [2001] 1 SCR 283 [*Burns*].
[241] *R v Morgentaler*, [1988] 1 SCR 30 [*Morgentaler*] at 12.
[242] *Rodriguez v British Columbia*, [1993] 3 SCR 519 at 86 (Per Lamer (dissenting) "Parliament must be afforded a measure of flexibility in its policy choices") [*Rodriguez*].
[243] *Morgentaler*, *supra* note 241.

necessary and whether the barrier or prohibition is justified. This involves considering the individuals involved, the intensity of their symptoms, and the degree of relief offered by the treatment. In what follows, I will briefly discuss the rights to life and liberty before moving to a comprehensive discussion of security of the person.

Life

Section 7 entrenches the right to life, recognizing the inherent value of human life. Though not applicable in Canada, the death penalty is the clearest example of government action that would violate the right to life.

The right to life was carefully considered in *Rodriguez*, where a majority of the SCC stated that Canadian society is "based upon the intrinsic value of human life and on the inherent dignity of every human being."[244] However, in that case, a narrow majority of the Court found that the right to life did not include the right to have someone aid or assist in ending one's life.

In their analysis of the right to life, Sharpe and Roach suggest that, "given the interest at stake, a *risk* to life may itself violate the right to life in section 7 of the *Charter*."[245] The risk to life has been considered in the context of a potential extradition to face the death penalty.[246] The possibility of a risk to life was also considered in *Chaoulli* and *Insite*. In *Chaoulli*, Deschamps J. said the right to life *was* affected by long delays in surgical procedures caused by the province's prohibition on private insurance.[247] In *Insite*, the right to life was affected by the potential denial of medical care for injection drug users.[248]

The courts have not yet found that the prohibition on cannabis violates the right to life, although the evidence indicates that for some individuals, depriving them of cannabis

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[244] See *Rodriguez*, *supra* note 242 at 585.
[245] Sharpe & Roach, *supra* note 239 at 224 [emphasis added].
[246] *Burns*, supra note 240.
[247] *Chaoulli*, *supra* note 61 at 40.
[248] See Canada (*Attorney General)* v *PHS Community Services Society*, 2011 SCC 44 at headnote [*Insite*].

may hasten death. In *Parker*, the Court of Appeal acknowledged that Mr. Parker's seizures were life-threatening because without cannabis, the frequency and severity of his seizures increased. However, the Court found that only the rights to liberty and security of the person were engaged, not the right to life.[249] There may be a case where the deprivation of cannabis violates the right to life, but that case has not been fully argued yet. Violations of liberty and security of the person are far more common.

Liberty

Philosophers have written extensively on the independence of the human spirit. Liberty encompasses the idea that people are autonomous, self-determining agents and should be able to pursue their idea of the good life, within reason.[250]

In the context of the Canadian *Charter*, liberty encompasses two facets, the narrower right to be free from physical restraint including detention, arrest or imprisonment, as well as the broader right to make decisions of fundamental personal importance. Violations of either must accord with the principles of fundamental justice.

Wilson J. describes the broader understanding of liberty in *Morgentaler*:

> The right to "liberty" contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life. Liberty in a free and democratic society does not require the state to approve such decisions but it does require the state to respect them.[251]

As applied to the facts of medicinal cannabis use, the liberty interest is engaged on both definitions. Decisions about medical treatment are of fundamental personal importance. The criminal sanction attached to marihuana possession for those who are not legally exempted can lead to detention, arrest and imprisonment.[252]

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[249] *Parker, supra* note 6 at headnote.
[250] See generally John Stuart Mill, *On Liberty* (London: Longman, Roberts & Green, 1869).
[251] See *Morgentaler*, *supra* note 241 at headnote, Wilson J.
[252] *CDSA*, *supra* note 3, s 4.

The liberty right is clearly engaged and there are potential cases involving the right to life. However, in what follows, I thoroughly consider the right to security of the person, which is most commonly argued in the medical context.

Security of the Person

Security of the person encompasses both physical and psychological integrity. In *Morgentaler*, the SCC recognized that although the *Charter* elevated security of the person to the status of a constitutional norm, "it is not a value alien to our legal landscape."[253] That the human body should be legally protected from physical interference is well-established in Canada's legal history. The common law recognizes that any medical procedure carried out on a person without their consent constitutes an assault.[254]

In addition to encompassing a person's physical integrity, the SCC held that security of the person also encompasses protection of psychological integrity, which can be negatively affected by "overlong subjection to the vexations and vicissitudes of a pending criminal accusation."[255] Psychological integrity may be compromised by the stress and anxiety arising from disruptions to relationships within the family, social and work contexts, negative stigma, loss of privacy, legal costs, and uncertainty as to the outcome and sanction.[256] Psychological effects may be serious enough to reach a level that will engage the section 7 right to security of the person. These psychological effects "need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety."[257]

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[253] *Morgentaler*, supra note 241 at 12.
[254] *Ibid*.
[255] *Mills v The Queen*, [1986] 1 SCR 863 Lamer J, at 919-20 [*Mills*].
[256] *Ibid*.
[257] *Chaoulli*, *supra* note 61 at 116 citing *New Brunswick (Minister of Health and Community Services) v G (J)*, [1999] 3 SCR 46, at 60.

The right to security of the person has not generally been interpreted to create a positive obligation on the state,[258] nor has it been extended to include economic rights or any rights wholly unconnected with the administration of justice.[259]

There are circumstances where infringing the right to security of the person is justified. However, "if the state does interfere with security of the person, the *Charter* requires such interference to conform with the principles of fundamental justice."[260]

Principles of Fundamental Justice

Violations of security of the person are justified if they are in accordance with the principles of fundamental justice. The principles of fundamental justice represent the collective interests that justify violations of the individual rights to life, liberty and security of the person. Violations that are consistent with these principles are justified in law. Early on in the *Charter* jurisprudence, the SCC set a high standard for the government by requiring that legislation meet both procedural and substantive principles of fundamental justice.

The Court has said the principles of fundamental justice are "the basic tenets of the legal system,"[261] a balance of individual rights and state interests,[262] and "principles that have general acceptance among reasonable people."[263] Laws that are arbitrary, vague, or overbroad will violate the principles of fundamental justice.[264] More specifically, these principles require that serious criminal offences have a minimum *mens rea*

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[258] *Gosselin v Québec,* [2002] 4 SCR 429 at 77-80 [*Gosselin*].
[259] Peter Hogg, *Constitutional Law of Canada* (Toronto: Carswell, 2010) at 47-15 [*Hogg Student Ed*].
[260] *Ibid*.
[261] *Re BC Motor Vehicle Act*, *ibid* at 503.
[262] *Cunningham v Canada*, [1993] 2 SCR 143 [*Cunningham*] at 152.
[263] *Rodriguez*, supra note 242 at 607.
[264] *Ibid* at 619, 621 (in the dissenting opinion written by McLachlin J with the agreement of L'Heureux-Dube J and the "substantial" agreement of Cory J).

requirement,[265] a right to make full answer and defence[266] and a right to silence.[267] It would violate the principles of fundamental justice if youths were treated the same way as adults in sentencing[268] or if a punishment would shock the conscience of the public.[269]

The term "principles of fundamental justice" had no legal definition prior to the enactment of the *Charter* but the concept has rapidly evolved as new fact scenarios test the limits of section 7. [270] Two years after the *Charter* was enacted, the SCC attempted to infuse the term with precise legal meaning, per Lamer J.:

> …[T]he principles of fundamental justice are to be found in the basic tenets and principles, not only of our judicial process, but also of the other components of our legal system.
>
> ...[T]he proper approach to the determination of the principles of fundamental justice is quite simply one in which …"future growth will be based on historical roots"...[271]

In the 2003 case of *Malmo-Levine*, the majority summarized the minimum conditions for a principle to qualify as a principle of fundamental justice:

> [I]t must be a legal principle about which there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate, and it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty or security of the person. [272]

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[265] See *Re BC Motor Vehicle Act*, supra note 271. See also *R v Vaillancourt*, 1987 SCC 78.

[266] *R v Stinchcombe*, [1991] 3 SCR 326.

[267] *R v Hebert,* [1990] 2 SCR 151.

[268] *R v DB*, 2008 SCC 25 [*R v DB*].

[269] *Canada v Schmidt*, [1987] 1 SCR 500 [*Schmidt*].

[270] Peter Hogg, *Constitutional Law of Canada*, 5th Ed, vol 2 (Toronto: Thomson Reuters, 2007) at 47-19 [*Hogg*].

[271] *Reference Re Section 94(2) of the Motor Vehicle Act (BC)*, [1985] 2 SCR 486 [*Re: BC Motor Vehicle Act*] at 512-13, Lamer J (as he then was), aff'md in *Rodriguez*, *supra* note 242 at 141.

[272] *R v Malmo-Levine,* [2003] SCR 571 at 113 [*Malmo-Levine*].

Many principles of fundamental justice have been advanced and rejected. The harm principle,[273] the best interests of the child standard[274] and respect for human dignity[275] were not found to be principles of fundamental justice.

Various Canadian courts have acknowledged the medical benefit of cannabis and have struck down sections of the *Controlled Drugs and Substances Act* (*CDSA*) and the *Marihuana Medical Access Regulations* (*MMAR*) on the basis of the guarantees contained in the *Charter*. These decisions prompted the federal government to establish a legal supply,[276] permit exemptions for caregivers who provide assistance to medical marihuana users,[277] simplify the categories of applicants, and reduce the number of requisite medical declarations.[278] Most recently, the courts have mandated a minimum level of physician education[279] and struck down restrictions on the form that cannabis must be in.[280]

In what follows, I provide a chronology of the jurisprudence and regulatory amendments that have shaped the current legal landscape. I apply the medical evidence to determine the minimum threshold for security of the person violations and reach a conclusion on what the principles of fundamental justice require.

III: Post-*Charter* Chronology

The post-*Charter* chronology is divided into three subsections based on the major legal and regulatory developments. The first subsection examines legal developments before the *MMAR* were enacted in 2001. The second subsection deals with *Charter* challenges to the initial *MMAR* and resulting regulatory amendments in 2003. The third subsection considers changes to the law made from 2003 to the present day.

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[273] *Ibid.*
[274] *Canadian Foundation for Children, Youth and the Law v Canada (Attorney General)*, 2004 SCC 4.
[275] See *Rodriguez*, supra note 242.
[276] See *Hitzig ONCA*, *supra* note 16.
[277] *Wakeford v Canada*, [2002] OJ No 85 [*Wakeford*].
[278] *Ibid*. See also *R v Krieger*, 2006 SCC 47 [*Krieger*].
[279] See *Mernagh, supra* note 8.
[280] *R v Smith*, 2012 BCSC 544 [*Smith*].

Early Legal Developments, 1988 – 2001

In 1988, the United Nations adopted the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. A party to the Convention is, *inter alia*, required to adopt measures "subject to its constitutional principles and the basic concepts of its legal system" to prohibit the possession of cannabis and the cultivation of cannabis for personal use.[281]

R v Morgentaler is one of the seminal cases where the SCC discussed section 7 of the *Charter*.[282] At the time, it was an indictable criminal offence to procure or perform an abortion.[283] Women could obtain legal "therapeutic" abortions if they followed the procedure required in the *Criminal Code*.[284] The procedure required women to appear before a panel of "qualified medical practitioners" who would determine whether "the continuation of the pregnancy of such female person would or would be likely to endanger her life or health."[285]

It was optional for hospitals to establish an abortion panel.[286] The required composition of the panel precluded its establishment in many hospitals.[287] The statutory standard of endangering the woman's life or health was vague and inconsistently applied.[288] Many women had to travel a great distance to appear before the abortion panel.[289] These legal requirements caused delays in getting approval for an abortion, which led to many undesired consequences including greater health risks for those women.[290]

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[281] United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 19 December 1988, online: <http://www.unhcr.org/refworld/docid/49997af90.html > [1988 Convention].
[282] See *Morgentaler, supra* note 241.
[283] *Ibid* at 5.
[284] *Ibid*.
[285] *Ibid*.
[286] *Ibid* at 42.
[287] *Ibid*.
[288] *Ibid* at headnote, Dickson CJ & Lamer J.
[289] *Ibid* at 52.
[290] *Ibid* at 70.

A minority of the SCC found that this to be a matter for Parliamentary discretion. They said that it is not up to the courts to solve or even attempt to solve the abortion issue.[291]

The majority found that these laws violated a woman's right to security of the person. There were three concurring opinions. Dickson C.J. and Lamer J. concluded that "state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of security of the person."[292] Beetz and Estey JJ. put it another way: "security of the person, within the meaning of s. 7 of the *Charter* must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction."[293] Wilson J. found a clear violation of security of the person because the law denied women control over their reproductive health. Women were rendered passive recipients of a decision made by others as to whether their bodies would be used to nurture a new life.[294] In accordance with the language of section 7, any violation of security of the person must conform to the principles of fundamental justice.

Considering the principles of fundamental justice, the majority found that the legally mandated administrative procedure was responsible for increasing the delay, and consequently, for the ensuing health risks to women who sought abortions. Furthermore, the impugned provisions set out a defence to a criminal prohibition that was practically unavailable to many women.

> One of the basic tenets of our system of criminal justice is that when Parliament creates a defence to a criminal charge, the defence should not be

[291] *Ibid* at 189, McIntyre & LaForest JJ.
[292] *Ibid* at 22, 24, Lamer CJ. "Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress. Section 251 clearly interferes with a woman's bodily integrity in both a physical and emotional sense. Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person. Section 251, therefore, is required by the Charter to comport with the principles of fundamental justice."
[293] *Ibid* at 70, 155, Beetz J.
[294] *Ibid* at 245, Wilson J.

> illusory or so difficult to attain as to be practically illusory. The criminal law is a very special form of governmental regulation, for it seeks to express our society's collective disapprobation of certain acts and omissions. When a defence is provided, especially a specifically-tailored defence to a particular charge, it is because the legislator has determined that the disapprobation of society is not warranted when the conditions of the defence are met.[295]

In this case, the evidence showed that the defence was unavailable to many women. For the women who were able to adhere to the required procedure, the ensuing delay put their health at risk. The majority concluded this was a violation of security of the person that was inconsistent with the procedural principles of fundamental justice and the law was struck down.

A short time later, security of the person was again at issue in the case of Sue Rodriguez, a 42–year-old mother and wife who had amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), a neurological disorder where motor neurons progressively deteriorate. Her condition was rapidly worsening and her life expectancy was between 2 and 14 months. In the coming months she would lose her ability to swallow, speak, walk, or move her body. Shortly after, she would lose the capacity to breathe or eat without mechanical assistance and would be confined to a bed.[296] Sue wanted to enjoy life for as long as possible and avoid the loss of personal control that would inevitably come as a result of her disease. She knew the time would come when she no longer desired to live but by then, her ability to take her own life would have passed.[297] She wanted to be able to administer a deadly cocktail of drugs under medical supervision at the time of her choosing. There is no criminal prohibition against suicide. However, section 241 of the *Criminal Code* makes it an indictable offence to counsel, aid or abet a person to commit suicide.[298] The Supreme Court of Canada split 5 – 4.

The majority held that although there was a violation of Rodriguez's security of the person, it was in accordance with the principles of fundamental justice. Respect for human dignity, although a fundamental value of Canadian society, was not found to be a

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[295] *Ibid* at 48, Dickson CJ.
[296] *Rodriguez, supra* note 242 at 1, Dickson CJ.
[297] *Ibid* at 2.
[298] *Criminal Code of Canada*, RSC, 1985, c C-46 [*Criminal Code*].

legal principle and therefore, not a principle of fundamental justice.[299] Therefore, section 7 of the *Charter* was not violated.

All the judges who considered section 7 agreed there was a violation of security of the person. They were divided on whether this was in accordance with the principles of fundamental justice. The SCC will likely revisit this issue as a consequence of the decision in *Carter v Canada* where the Supreme Court of British Columbia reconsidered the issues based on the current understanding of the principles of fundamental justice and found that section 241 of the *Criminal Code* does violate section 7.[300] The SCC's findings and conclusions in *Morgentaler* and *Rodriguez* set the stage for medical marihuana users to challenge the broad criminal prohibition of marihuana under section 7 of the *Charter*.

On July 18, 1996, police officers executed a warrant and seized 71 marihuana plants from the home of Terrance Parker. He was charged with trafficking and cultivation under the *Narcotic Control Act* (*NCA*).[301] On September 18, 1997, the police again attended at Parker's home and seized three growing marihuana plants. By this time, the *NCA* had

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[299] *Rodriguez*, *supra* note 242 at 145. The dissenting judges split three ways. LHeureux-Dubé and McLachlin found that the impugned provision violated Rodriguez's right to security of the person because it limited her right to deal with her body as she chose. They found that the limit was arbitrary because it did not bear a relation to the objective (at 212). Cory J. substantially agreed with the section 7 analysis on security of the person and the principles of fundamental justice, but added that the right to life should also protect the right to die with dignity (at 228, 229). Lamer C.J. found that the provision created an inequality solely based on a physical disability and would have struck down the provision based on section 15 of the *Charter*, which guarantees equality rights. He did not find it necessary to consider section 7 (at 34).

[300] *Carter v Canada (Attorney General),* 2012 BCSC 886. The ban on assisted suicide may soon be struck down based as the empirical evidence suggests the impugned criminal prohibition limits individual rights in a way that cannot be justified having regard to the objective of the scheme and the individuals it affects. The evidence presented in *Carter* led the trial judge to conclude the legislation does not fulfill the objectives of protecting vulnerable lives and may in fact lead many people to take their lives prematurely.

[301] *Narcotic Control Act*, RSC 1985, c. N-1, ss 6(1), 4(2) [*NCA*].

been repealed and Parker was charged with possession of marihuana contrary to the *Controlled Drugs and Substances Act* (*CDSA*).[302]

Unlike the *NCA*, the *CDSA* allows the Minister of Health to exempt individuals from the operation of the general provisions pursuant to section 56, which provides:

> The Minster may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.

The data, albeit limited, suggests that relatively few individuals were successful in obtaining exemptions.[303] Parker was not exempted from the operation of the *CDSA* under section 56, though he would be a likely candidate for approval.

Parker was diagnosed with epilepsy as a child. Conventional medications and even two brain surgeries were not helpful at controlling his violent and life-threatening seizures. He started using marihuana and documented his symptoms and use patterns in a journal. He noted that his seizures were less frequent and less severe. He reduced his medication. He could even prevent oncoming seizures. Parker's doctor wrote in September 1987:

> Mr. Parker has had many side effects over the years due to his anti-convulsant medications, which have prevented their perhaps more efficacious use in higher doses. These side effects are well-recognized in the medical literature. Hence, from a medical and quality-of-life point of view, I am of the opinion that it is medically necessary, in order to obtain optimal seizure control, that Mr. Parker regularly use marihuana in conjunction with his other anti-convulsant medications.[304]

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[302] *CDSA, supra* note 3, 4(1).

[303] See e.g. *Hitzig ONCA*, *supra* note 16 at 36. "In June 1999, the Government issued its first exemption under s. 56 of the CDSA. While the terms of s. 56 were broad enough to permit the Minister to exempt individuals from all provisions of the CDSA, exemptions were granted only with respect to the prohibitions against possession and cultivation of marihuana. Individuals who received a s. 56 exemption could grow the marihuana they needed to meet their medical needs. If they could not do so, they had to continue to use the black market."

[304] *Parker*, *supra* note 6 at 25.

Parker grew his own supply of marihuana to avoid the black market. After he was arrested and charged, he challenged the legislative provisions under section 7 of the *Charter*. Since the *NCA* had already been repealed, the cultivation and trafficking charges were moot. The remaining charge was for possession of cannabis under the *CDSA*.

The Ontario Court of Appeal confirmed that, "Where illness can neither be prevented nor cured, efforts are directed towards preventing deterioration or relieving pain and suffering."[305] The Court found that the state-imposed criminal prohibition on cannabis possession violated Parker's security of the person because he was forced to choose between his liberty and his health.[306] As in *Morgentaler*, Parker was being denied a "generally safe medical treatment" that "might be of clear benefit" to him.[307]

The Court in *Parker* summarized five principles of fundamental justice applicable where the criminal law intersects with medical treatment:

1. The principles of fundamental justice are breached where the deprivation of the right in question does little or nothing to enhance the state's interest;
2. A blanket prohibition will be considered arbitrary or unfair and thus in breach of the principles of fundamental justice if it is unrelated to the state's interest in enacting the prohibition, and if it lacks a foundation in the legal tradition and societal beliefs that are said to be represented by the prohibition;
3. The absence of a clear legal standard may contribute to a violation of fundamental justice;
4. If a statutory defence contains so many potential barriers to its own operation that the defence it creates will in many circumstances be practically unavailable to persons who would prima facie qualify for the defence, it will be found to violate the principles of fundamental justice; and
5. An administrative structure made up of unnecessary rules, which result in an additional risk to the health of the person, is manifestly unfair and does not conform to the principles of fundamental justice.[308]

The Court summarized, "the common-law treatment of informed consent, the sanctity of life and commonly held societal beliefs about medical treatment suggest that a broad

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[305] *Airedale NHS Trust v Bland*, [1993] AC 789 at 857.
[306] *Parker, supra* note 6 at 110.
[307] *Ibid* at 109.
[308] *Ibid* at 117.

criminal prohibition that prevents access to necessary medicine is not consistent with fundamental justice."[309] Although one of the primary objectives of the *CDSA* was to protect health, preventing Parker from accessing cannabis actually caused serious harm to his health. Since the effect of the legislation was diametrically opposed to its objectives, it was found to be arbitrary.[310] The Court held that a blanket prohibition on cannabis violated Parker's *Charter* rights guaranteed in section 7. Without a medical exemption system that addresses the medical use of marihuana for the individuals who require it, the *CDSA* deprived individuals of a beneficial medical treatment and subjected them to criminal sanctions. The Court said this result was "antithetical to our notions of justice."[311]

The Court considered the discretionary exemption contained in section 56 and concluded that the unfettered discretion of the Minister of Health was not consistent with the principles of fundamental justice.[312]

The result in this case was that the possession offence in section 4(1) of the *CDSA* was unconstitutional. On July 31, 2000, the Ontario Court of Appeal struck down the provision, but suspended the declaration of invalidity for one year to allow Parliament to fill the void.[313]

On July 30, 2001, one day before the suspension imposed in *Parker* was to expire, the first *Marihuana Medical Access Regulations* (*MMAR*) came into force. The *MMAR* were enacted pursuant to section 55 of the *CDSA*, which empowers the Governor-in-Council to make regulations exempting persons, or classes of persons, from the application of the *Act* or *Regulations*.[314]

The general objectives of the *MMAR* are "to establish a framework to allow access to marihuana by individuals suffering from grave or debilitating illnesses, where

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[309] *Ibid* at 139.
[310] *Ibid* at 192.
[311] *Ibid* at 137.
[312] *Ibid* at 184, 188, 189.
[313] *Ibid* at 207.
[314] *CDSA*, supra note 3. See also *R v Long*, 88 OR (3d) 146 at 11-13 [*Long*].

conventional treatments are inappropriate or are not providing adequate relief."[315] The *MMAR* create a framework by which seriously ill people can apply for an Authorization To Possess (ATP) marihuana and obtain a Personal Use Production Licence (PUPL) or Designated Person Production Licence (DPPL).

Initially, there were three categories of applicants. Applicants applying under Category 1 had symptoms associated with a terminal illness where death was expected in twelve months. A medical declaration from one physician was required. Category 2 was defined to include individuals with specific symptoms or diseases listed in the Schedule. This category required the declaration of a specialist. Category 3 was for all other applicants and required the declaration of two specialists. Physicians had to declare that all conventional treatments had been tried or considered, that marihuana would mitigate the symptom, and that the expected benefits outweighed the risks. Physicians would specify a daily dose limit for an individual and marihuana could be delivered to the physician's office to provide to the patient.[316]

Part Two created a framework to allow individuals to apply for a PUPL or a DPPL to fill the supply needs of authorized medical users. Individuals applying for an ATP were required to indicate the proposed source of marihuana, even though there were no licensed dealers or legal source of marihuana or marihuana seeds. Applicants for a DPPL could not be compensated, could grow marihuana for only one authorized person (1:1 ratio) and could not grow marihuana in common with more than two other DPPL holders ("three max").[317]

Even after the *MMAR* were enacted, the medical profession was reluctant to authorize the use of marihuana for their patients given the burdensome paperwork that required doctors to declare things that were beyond their knowledge. Given the absence of long-term empirical evidence, in many cases it was practically impossible for doctors to state

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[315] *Medical Access*, *supra* note 7.
[316] *MMAR, supra* note 5. For additional history of the legal development see *Mernagh*, *supra* note 8 at 20-32.
[317] *Hitzig ONCA*, *supra* note 16 at 61 (for statistics on the operational effects of the first version, see *Hitzig ONCA* at 63-66).

definitively that the benefits of using marihuana outweighed the risks. Medical associations across Canada discouraged their members from signing the required forms.

The Canadian Medical Protective Agency (CMPA) provides legal defence and liability protection to Canadian physicians and provides compensation to patients and their families who have been harmed by negligent clinical care. One letter to physicians from the CMPA was particularly "chilling."[318] This letter said physicians were being asked to declare things that were beyond the scope of their expertise. The letter highlighted that unless a physician could be certain that that the benefits outweighed the risks and that *all* conventional treatments had been tried and were inappropriate, they would be at increased risk of being reported to their College to face professional sanctions for making a false declaration.[319]

Although the initial *MMAR* did provide a framework for those with grave or debilitating illnesses to access marihuana when conventional therapies were ineffective or not providing adequate relief, the procedural requirements made the defence difficult to obtain. Furthermore, there was no legal supply so an individual having obtained an exemption, would still have to access the black market to purchase dried marihuana or seeds.

Legal & Regulatory Developments, 2001 – 2003

In 2001, the major federal agency responsible for funding health research in Canada, the Canadian Institute of Health Research (CIHR) established the Medical Marijuana Research Program (MMRP), which included a 5-year, $7.5 million clinical research grant.[320] Only three clinical research proposals were approved for CIHR funding: a smoked-cannabis and chronic pain study initiated by McGill's Pain Center, an HIV/AIDS and appetite study by the Community Resource Initiative of Toronto (CRIT) at St. Michael's Hospital, and the Cannabis for the Management of Pain: Assessment of Safety

[318] *Mernagh*, *supra* note 8 at 168.
[319] *Ibid* at 165.
[320] Phillipe G Lucas, "Regulating compassion: an overview of Canada's federal medical cannabis policy and practice" (2008) 5 Harm Reduction Journal 5 at 6, online: <http://www.harmreductionjournal.com/content/5/1/5> [Lucas].

Study (COMPASS), which was the first project of the CIHR Marijuana Open Label Safety Initiative.[321]

In 2002, a Special Senate Committee was struck to examine, among other things, Canada's approach to cannabis. Chaired by Pierre Nolin, this Committee considered the use of cannabis for therapeutic purposes after the initial *MMAR* were enacted. The Committee reviewed evidence from a number of sources. Although they recognized that smoked marihuana could have harmful side effects, they concluded that the potential therapeutic uses of marihuana had been sufficiently documented to permit its use for therapeutic purposes and recommended further research.[322]

The Committee considered marihuana in a medical context and observed that:

- The MMAR are not providing a compassionate framework for access to marihuana for therapeutic purposes and are unduly restricting the availability of marihuana to patients who may receive health benefits from its use;
- The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an "illusory" legislative exemption and raises serious *Charter* implications;
- In almost one year, only 255 people have been authorized to possess marihuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern;
- Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis;
- Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials;
- No attempt has been made in Health Canada's current research plan to acknowledge the considerable expertise currently residing in the compassion clubs; and
- The development of a Canadian source of research-grade marihuana has been a failure.[323]

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[321] *Ibid*.
[322] The Senate Special Committee on Illegal Drugs, "Final Report: Cannabis: Our Position For A Canadian Public Policy," Online: <http://www.parl.gc.ca/Content/SEN/Committee/371/ille/rep/repfinalvol1part5-e.htm#Chapter%209> [The Nolin Report].
[323] *Ibid* at 23.

September 2002 was the first month that Health Canada provided online statistics about the operation of the *MMAR*. At that time, almost half of the people who were authorized to possess marihuana for medical purposes (488 of 864) were exempted under section 56 rather than under the *MMAR* framework.[324] The number of section 56 exemptions declined as time went on.[325]

In 2002, Jim Wakeford raised further concerns about the newly-enacted *MMAR*. Wakeford was diagnosed with AIDS in 1989. He had tried other medications including Marinol (oral THC), but found smoked cannabis provided the best relief. He used cannabis under medical supervision.[326]

Wakeford obtained a personal exemption under section 56 of the *CDSA* but the exemption did not apply to his caregivers, who had been charged with trafficking in marihuana as a result of their attempts to assist him. He and his caregivers had to access the black market to obtain an adequate supply. He brought a motion before the Ontario Superior Court that his exemption under section 56 was insufficient. However, since the exemption was based on a decision of the Minister of Health, only the Federal Court had jurisdiction to hear the matter. On the constitutionality of the impugned legislation, the Court said that even if he suffered anxiety about the plight of his caregivers, his anxiety would not likely be sufficient to elevate his claim to a constitutionally protected level. Finally, the Court stated that even if Wakeford's anxiety reached that level, the infringement of his security of the person would accord with the principles of fundamental justice.[327]

Wakeford also argued that the *CDSA* and *MMAR* violated his security of the person contrary to the principles of fundamental justice because the government did not establish

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[324] *Beren*, *supra* note 234 at 54-56.
[325] *Ibid*. In May 2004, 733 people were authorized to possess marihuana for medical purposes and 112 were exempted under section 56.
[326] *Wakeford*, *supra* note 277 at 7.
[327] *Ibid* at 53.

a legal supply. The Court held that since Wakeford had access to a supply, he was not reliant on the government to provide it to him.[328]

The absence of a legal supply continued to be an issue and the provisions of the *MMAR* dealing with supply were addressed again. This time, the challenge was successful. The Alberta Court of Appeal in *Krieger* held that it was absurd to remove the possibility of legal access to a substance that an individual is legally allowed to possess.[329] The Court said that it was unconstitutional for the government to require an individual who is lawfully entitled to possess cannabis to participate in an illegal act in order to purchase it.[330] The Court struck down the prohibition on production of cannabis and said individuals should be able to grow their own cannabis if it was impossible to access a legal supply.[331]

The successful *Charter* challenges in the medical context likely encouraged individuals seeking to challenge the criminal prohibition for non-medical use. In *R v Malmo-Levine* and the companion cases of *R v Caine* and *R v Clay*, the SCC considered the constitutionality of the criminal prohibition on cannabis possession in a non-medical context. David Malmo-Levine argued that Parliament went beyond its legitimate powers by criminalizing a plant that caused little to no harm. The Court considered security of the person, but found that since marihuana was non-addicting, deprivation of it did not cause serious stress to the individual. The judges preferred to rest their analysis on a violation of liberty, which was clearly established by the potential for imprisonment.[332]

Malmo-Levine advanced the harm principle as a principle of fundamental justice. He argued that the criminal law is only justified in prohibiting conduct that causes harm to others. The Court said that there are many things that do not cause harm (e.g. consensual incest) that Parliament is justified in prohibiting.[333] The Court concluded that the harm

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[328] *Ibid* at 10, 71.
[329] *Krieger*, *supra* note 278 at 5.
[330] *Ibid*.
[331] *Ibid*.
[332] *Malmo-Levine, supra* note 272 at 88.
[333] *Ibid* at 118.

principle was not a principle of fundamental justice.[334] The majority considered gross disproportionality under the heading of section 12 of the *Charter,* which protects against cruel and unusual punishment. They found that since there was no minimum penalty for cannabis possession, the punishment was not grossly disproportionate.[335]

The three dissenting judges differed in their analysis but all concluded that the law was unconstitutional.[336] In support of his conclusion, Deschamps J. found:

> When the state prohibits socially neutral conduct, that is, conduct that causes no harm, that is not immoral and upon which there is no societal consensus as to its blameworthiness, it cannot do so without raising a problem of legitimacy and, consequently, losing credibility. Citizens become inclined not to take the criminal justice system seriously and lose confidence in the administration of justice. Judges become reluctant to impose the sanctions attached to such laws.[337]

Charter challenges, like the one in *Malmo-Levine* continued to have an impact on defining the scope of security of the person and the principles of fundamental justice contained in section 7.

In March 2003, the Office of Cannabis Medical Access abruptly cancelled the funding for the Toronto-based CRIT research project, despite having already distributed over $800,000 of a $2 million research grant for the study.[338] Likewise, the $260,000 McGill chronic pain and smoked cannabis clinical study that was approved in 2001 suffered delays due to bureaucratic problems in accessing a suitable supply of research cannabis from Health Canada.[339]

The next constitutional challenge to the *MMAR* resulted in major changes. Warren Hitzig and a number of other seriously ill applicants challenged the constitutionality of the

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[334] *Ibid* at 111.
[335] *Ibid* at 153, 160 (There may be potential *Charter* challenges to the newly enacted mandatory minimum penalties for cannabis offences contained in the *Safe Streets and Communities Act*, SC 2012, c 1, ss 39-41).
[336] *Ibid* at 190, 277, 290.
[337] *Ibid* at 290.
[338] Lucas, *supra* note 320 at 6.
[339] *Ibid*.

MMAR in a civil case. They alleged that the *MMAR* imposed overly restrictive barriers that made eligibility difficult. Some of the applicants were unable to get a specialist's approval to possess or cultivate cannabis and were forced to obtain their medicine from the black market.[340] Even after individuals were authorized, the absence of a legal supply remained a significant issue. The Court looked at two main problems: difficulties meeting the eligibility requirements of the *MMAR* and the absence of a legal supply. Most of the argument in *Hitzig* focused on the absence of a legal supply.

Pending the hearing of the *Hitzig* appeal, on July 8, 2003, Health Canada implemented an interim supply policy (ISP) to provide approved persons with the dried cannabis and cannabis seeds from the government supplier, Prairie Plant Systems (PPS).[341] The objective of the ISP was to provide a legal supply and render the medical exemption constitutional until such a time as the appeal was heard and Parliament could make informed legislative changes.[342]

Before the ISP was established, PPS cannabis was for research purposes only. The options to obtain a legal supply were limited. Individuals could seek out a person who could apply for a DPPL, but they could not be compensated, could not grow for more than one person (1:1 ratio), or combine their production with more than two others ("three max"). The last legal option was to apply for a PUPL. However, for seriously ill individuals this option was fraught with difficulties. The time, labour and skills required to produce an adequate crop of marihuana often exceeded their abilities. These legislative restrictions led to a serious shortfall in the legal supply. The black market was filling the void. As the *Hitzig* Court noted:

> The problems associated with the purchase of medicinal marihuana on the black market are numerous and, in most cases, obvious. As with any black market product, prices are artificially high. High prices cause real difficulty for seriously ill individuals, many of whom live on fixed incomes. Black market supply is also notoriously unpredictable. The supplier of marihuana today may have moved on by tomorrow or may have been closed down by

[340] *Hitzig ONCA*, *supra* note 16 at 18.
[341] *Ibid* at 40.
[342] *Long*, *supra* note 314 at 36.

> the police. In addition to unpredictability, there is no quality control on the black market. Purchasers do not know what they are getting and have no protection against adulterated product. This is particularly problematic for some whose illnesses involve allergies, or stomach ailments that can be aggravated by the consumption of tainted products. Resort to the black market may also require individuals to consort with criminals who are unknown to them. In doing so, they risk being cheated and even subjected to physical violence. Finally, the evidence of the applicants makes it abundantly clear that requiring law-abiding citizens who are seriously ill to go to the black market to fill an acknowledged medical need is a dehumanizing and humiliating experience.[343]

In argument, the Government contended that an adequate, safe supply was met by "unlicensed suppliers" but the Court was unwilling to let the existence of well-run compassion clubs relieve the Government of its duty to promote and maintain the rule of law.[344] The evidence adduced showed that many long-term medical cannabis users go to the black market, including compassion clubs, because they have no choice.[345]

The Ontario Court of Appeal held that the *MMAR* violated the rights to liberty and security of the person contained in the *Charter* by failing to effectively remove state barriers to a licit source of marihuana for medical users. In finding the threshold for section 7 was met, the Court said that:

> Even apart from these criminal sanctions for non-compliance, the *MMAR* constitute significant state interference with human dignity of those who need marihuana for medical purposes. To take the medication they require they must apply for an ATP, comply with the detailed requirements of that process, and then attempt to acquire their medication in the very limited ways contemplated by the *MMAR*. These constraints are imposed by the state as part of the justice system's control of access to marihuana. As such, they are state actions sufficient to constitute a deprivation of the security of the person of those who must take marihuana for medical purposes. They are state actions within the administration of justice that stand between those in medical need and the marihuana they require.[346]

In this case, the Court found the principle of fundamental justice that was breached was the rule of law. As the trial judge phrased the problem, "the government is asking

[343] *Ibid* at 21.
[344] *Ibid* at 23.
[345] *Ibid* at 73.
[346] *Ibid* at 104.

individuals who have been granted legal authorization to consort with criminals to access their constitutional rights."[347] The state's obligation to obey the law is central to the very existence of the rule of law.[348] The inevitable consequence of the absence of a legal source for those who were determined to be in medical need of it was a violation of the fundamental principle that the state must obey and promote compliance with the law.[349]

The Government argued that requiring medical specialists for Categories 2 and 3 helped to prevent abuse because individuals were subject to further scrutiny and medical vetting.[350] The Court of Appeal said that the requirement for one specialist was not arbitrary because it served the state interest in protecting the health and safety of its citizens in relation to an untested drug. Specialists have more knowledge about the range of possible treatments for specific diseases and can provide details about other options. The evidence presented in *Hitzig* did not reveal a significant barrier to obtaining one specialist's signature. However, the Court noted that if physician cooperation dwindled it might represent a significant practical impediment to access.[351] The requirement for medical declarations from two specialists for Category 3 applicants was found to be an unnecessary, arbitrary barrier that violated the principles of fundamental justice.[352] There was no rational connection between the offending aspects of the *MMAR* and the government's objectives of better public health and safety, and effective narcotic control.[353]

The Court found the most direct remedy to cure the constitutional defects and respect the rights of medical cannabis users was to immediately declare invalid the offending provisions, leaving the constitutionally valid remainder. The Court struck down the provisions prohibiting compensation for designated growers, they struck down the ratio of one authorized person to one licensed producer and the "three max" provision. The

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[347] *Hitzig v Canada* (2003), 171 CCC (3d) 18 at 160 [*Hitzig ONSC*].
[348] *Ibid* at 113.
[349] *Ibid* at 118.
[350] *Ibid* at 47.
[351] *Hitzig ONCA, supra* note 16 at 142-143.
[352] *Ibid* at 144-145, 159.
[353] *Ibid* at 149.

Court noted, "It is conceivable that, as events unfold, further serious barriers could emerge either to the eligibility or to reasonable access to a licit source of supply. Should that happen, the issue of the appropriate remedy might have to be revisited in a future case."[354]

After the *Hitzig* appeal, on December 17, 2003, the Government published amendments to the *MMAR* in the Canada Gazette. These amendments offered permanent access to a lawful government supply of cannabis to authorized holders who did not have a PUPL or a designated producer. These measures attempted to resolve the problem with supply.[355]

The Government also initiated stakeholder consultations, including patients, physicians, pharmacists and law enforcement agencies, to discuss the need for potential changes to the *MMAR*.[356]

In these amendments, the Government confirmed its commitment to supplying dried marihuana to persons authorized to possess it for medical purposes, and marihuana seeds to persons authorized to produce it, until such time as an alternate supply satisfied the requirements of the *Food and Drugs Act (FDA)*,[357] the *CDSA* and their respective *Regulations*.[358]

These amendments also addressed physician concerns about cannabis deliveries to doctors' offices by permitting home-delivery of cannabis.[359] The sections of the *MMAR* that required licensed producers to maintain particular records and books, and the requirement to transfer the marihuana directly to the authorized person were repealed.[360]

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[354] *Ibid* at 166.
[355] *Ibid* at 37.
[356] Marihuana Medical Access Regulations – Regulations Amending Controlled Drugs and Substances Act, (17 December 2003) C Gaz II, Vol 137 No 26, online: <http://www.gazette.gc.ca/archives/p2/2003/index-eng.html> [December 2003 Amendments].
[357] *Food and Drugs Act,* RSC, 1985, c F-27 [*FDA*].
[358] December 2003 Amendments, *supra* note 356.
[359] *Ibid*.
[360] *Long*, *supra* note 314 at 40.

Parliament reenacted the ratio of one authorized person to one designated producer that was struck down in *Hitzig*. The Government clarified that the objective in maintaining the 1:1 ratio was to limit the size and scale of growing operations. Although there would be a greater number of people authorized to produce cannabis, the justification was that a surplus would be more difficult to hide. The Government further explained that limits on the production of cannabis are necessary to:

- Maintain control over distribution of an unapproved drug product, which has not yet been demonstrated to comply with the requirements of the *FDA/FDR*;
- Minimize the risk of diversion of marihuana for non-medical use;
- Be consistent with the obligations imposed on Canada as a signatory to the United Nations' *Single Convention on Narcotic Drugs,* 1961 as amended in 1972 (the 1961 Convention), in respect of cultivation and distribution of cannabis; and
- Maintain an approach that is consistent with movement toward a supply model whereby marihuana for medical purposes would be: subject to product standards; produced under regulated conditions; and distributed through pharmacies; on the advice of physicians, to patients with serious illnesses, when conventional therapies are unsuccessful. Such a model would include a program of education and market surveillance.[361]

The amendments after *Hitzig* addressed some of the major problems with supply and eligibility but many problems with the *MMAR* remained.

Legal & Regulatory Developments, 2003 - Present

More recent legal developments in the *Charter* jurisprudence suggest a heavy reliance on empirical evidence to decide the legal questions involved in the legal analysis under section 7. The emphasis on the principles of fundamental justice as a balancing exercise in section 7 has virtually precluded any state justification under section 1 of the *Charter*.

Section 1 provides that "The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[362]

[361] December 2003 Amendments, *supra* note 356.
[362] See *Charter*, *supra* note 4.

The balancing that occurs when considering the principles of fundamental justice is similar to the proportionality test conducted under section 1 for other *Charter* violations. Unlike section 1 where the courts ask whether the pressing and substantial objectives are rationally connected to minimally impairing and proportional measures, the vernacular of section 7 asks whether the rights-infringing measures pursue a valid objective, are arbitrary, overbroad or grossly disproportionate.

Although the concepts involved are almost identical, the legal burden is different. In section 7, the burden is on the claimant to show their rights have been violated in a manner inconsistent with the principles of fundamental justice. If they cannot show a violation that is inconsistent with the principles of fundamental justice on a balance of probabilities, there is no *Charter* violation and no government justification is required. If there is a violation of both security of the person and the principles of fundamental justice, the burden in a section 1 analysis shifts to the Government to show on a balance of probabilities that the measures are justified. Any state justification will be insufficient, unless exceptional circumstances such as war or natural disaster justify overriding the fundamental principles of justice.[363]

While the courts dealt with *Charter* issues, researchers were making efforts to improve the state of research on medical cannabis. However, in June 2004, the CIHR posted a notice indicating that funding for the medical marihuana research program (MMRP) initiated in 2001 was "suspended until further notice."[364] This is unfortunate. In the research literature, a common refrain is that more research needs to be done.

Research and empirical evidence played a significant role in the 2005 case, *Chaoulli v Québec (AG),* where individuals living in the province of Québec experienced long delays in non-urgent wait times in the public healthcare system. In *Chaoulli*, the impugned laws were section 15 of Québec's *Health Insurance Act* ("*HEIA*") and section 11 of the *Hospital Insurance Act* ("*HOIA*"), which prohibited the purchase of private

[363] See *Re BC Motor Vehicle Act*, *supra* note 271 at headnote and *R v Heywood*, [1994] 3 SCR 761 at 69.
[364] Lucas, *supra* note 320 at 6.

health insurance for insured services. The objective of these laws was to preserve the integrity of the public health care system.

The appellants were, Jaques Chaoulli, a physician who wanted to operate a private medical practice, and George Zeliotis, who had experienced difficulties with long wait times for heart surgery and hip replacements. Together they asked for a declaratory judgment that the impugned provisions violated section 7 of the *Canadian Charter* and section 1 of the *Québec Charter*. These applicants contended that the prohibition unnecessarily deprived individuals of access to health care services. The appellants were not arguing for a constitutional right to private insurance, just for a declaration that the current system was unconstitutional.[365]

They claimed, *inter alia*, that the waiting times violated section 7 of the *Canadian Charter of Rights and Freedoms* and section 1 of the *Québec Charter of Human Rights and Freedoms* for individuals who had to wait a long time for non-critical surgery. Section 1 of the *Québec Charter* states that, "every human being has a right to life, and to personal security, inviolability and freedom.[366]

The evidence showed that people waiting for non-critical surgery like knee or hip replacement could be on wait lists for up to two years during which time they would suffer on a daily basis. The issue was whether the ban on private insurance could be justified to preserve the public health system, given that the waiting times affected individuals' physical and psychological integrity. The Court agreed that there was a violation of security of the person, but there was no clear consensus about whether the principles of fundamental justice had been breached.

The seven judges who heard this case were divided. One judge found a violation of the *Québec Charter* and did not go on to consider the *Canadian Charter*.[367] Three judges found that the impugned laws violated section 7 of the *Canadian Charter* and section 1 of

[365] *Chaoulli*, supra note 61 at 2.
[366] *Ibid*.
[367] *Ibid* at 42, Deschamps J.

the *Québec Charter*.[368] Three judges found no violation, reasoning that the laws were within the range of constitutional options and the health care debate was properly an issue for the legislature.[369] Because the Court was evenly split on whether there was a violation of section 7 of the *Canadian Charter*, there was only a majority with respect to the *Québec Charter*. Although the decision is binding only in Québec, the reasoning is persuasive and this decision has had a significant impact on subsequent cases in regard to the threshold for violations of security of the person.

The three judges who found a violation of section 7 first considered whether security of the person was engaged. They noted that, in addition to the obvious negative physical effects on individual health, waiting for medical care may have significant adverse psychological effects. The evidence in *Chaoulli* suggested that 95% of patients waiting for knee replacements wait well over one year and, in many cases, over two years.[370] These judges discussed the evidence relating to whether this violation met the threshold for constitutional protection. They said:

> While a knee replacement may seem trivial compared to the risk of death for wait-listed coronary surgery patients, which increases by 0.5 percent per month, the harm suffered by patients awaiting replacement knees and hips is significant. Even though death may not be an issue for them, these patients "are in pain", "would not go a day without discomfort" and are "limited in their ability to get around", some being confined to wheelchairs or house bound.[371]

This case makes it clear that state-imposed limits that significantly reduce an individual's quality of life will violate security of the person because of the impact on the individual's physical and psychological integrity. Serious psychological effects do not have to rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress

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[368] *Ibid* at 102, McLachlin CJ, Major & Bastarache JJ.
[369] *Ibid* at 161, Binnie, LeBel and Fish JJ. They would found that the health plan established by Québec did not violate the principles of fundamental justice because the means were rationally connected and not arbitrary. Although the inevitable delays in accessing health care meant that some people suffered, the dissent said the evidence was unclear that another system of health care provision would have been better (at 237-240).
[370] *Ibid* at 114.
[371] *Chaoulli*, *supra* note 61 at 123.

or anxiety to violate security of the person.[372] Similarly, serious physical effects do not have to be life-threatening, but must be greater than ordinary pain or discomfort. In this case, an average wait time between one and two years met the threshold level for constitutional protection because of the intensity of the pain and discomfort.[373]

After finding a violation of security of the person, these judges next considered whether the violation was consistent with the principles of fundamental justice. They relied heavily on evidence from other western democracies to illustrate alternative measures that the legislature could have adopted.[374] They said that there was not a real connection on the facts between the measures that interfered with security of the person and the purpose that the interference was intended to serve.[375] Therefore, because the measures were not "necessary," they concluded Québec's legislation was arbitrary.[376]

Notably, this is a different standard for arbitrariness than in *Rodriguez*, where the court asked whether the measure was inconsistent with or bore no relation to its purpose.[377] It is much harder to show that a law bears "no relation" to its purpose than it is to show the measure is not "necessary."

Reflecting on arbitrariness, the majority said:

> In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would

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[372] *Ibid*.
[373] In contrast, a thirty-month delay in processing a human rights complaint about sexual harassment did not violate the *Charter* in *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 [*Blencoe*].
[374] *Chaoulli*, *supra* note 61 at 141-146, 149.
[375] *Ibid* at 140.
[376] *Ibid* at 152.
[377] *Rodriguez*, *supra* note 242 at 147.

> expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.[378]

They found that the impugned legislation unnecessarily created delays in accessing medical care, which contributed to the deterioration of those individuals' health. Therefore they held that the law infringed the claimants' security of the person in a manner that did not accord with the principles of fundamental justice.[379]

In contrast, the three judges who found no violation of section 7 said there was no evidence that other systems were better. They acknowledged that the evidence clearly established that the public health care system has serious and persistent problems but rejected the idea that the courts were suited to address the problems. They said, "The resolution of such a complex fact-laden policy debate does not fit easily within the institutional competence or procedures of courts of law."[380] They did not agree that the legislation was arbitrary, saying: "the prohibition against private health insurance is a rational consequence of Quebec's commitment to the goals and objectives of the *Canada Health Act*."[381]

The tension between the legitimate roles for Parliament and the judiciary are often at odds in section 7 cases. The issue of medical access to marihuana is no different. There seems to be little political will to address the constitutional requirements of a medical marihuana exemption system. Parliament has responded to these decisions with regulatory amendments but the courts have been the driving force for striking down the unconstitutional provisions to improve the functioning of the *MMAR*.

In 2005, Parliament enacted further amendments to the *MMAR,* published in the *Canada Gazette*, Part II, on June 29. These amendments responded to a number of concerns. Individuals who had to use marihuana for medical purposes complained about the onerous requirements that were an impediment to access. Physicians lamented being gatekeepers to an untested and unapproved drug. Police wanted to ensure they would be

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[378] *Chaoulli*, *supra* note 61 at 131.
[379] *Ibid* at 159.
[380] *Ibid* at 164, Binnie, LeBel and Fish JJ.
[381] *Ibid*.

able to have reliable information about whether an individual was legally authorized to possess cannabis. Parliament addressed these concerns and attempted "to streamline the regulatory requirements and processes associated with applying for an authorization to possess marihuana for medical purposes under the *MMAR*."[382]

The 2005 amendments provided explicit authority for Health Canada to communicate limited information to police under prescribed circumstances. The amendments further provided limited authority for pharmacists to supply marihuana to authorized persons. These amendments also re-defined the categories of applicants. Categories 1 and 2 were merged to include those with terminal illnesses and the symptoms and diseases listed in the Schedule. The new Category 1 required the declaration of one physician. Category 3, which related to debilitating symptoms that were not specifically enumerated, became the new Category 2. These amendments eliminated the requirement that Category 2 would have to obtain a declaration from a specialist. However, a specialist consultation was required. Under the new Category 2, a specialist would have to concur that conventional treatments are ineffective or medically inappropriate and indicate that they are aware marihuana is being considered as an alternative treatment.[383]

The 2005 amendments repealed the requirement that marihuana be delivered directly from the designated producer to the ATP holder, and permitted designated producers to ship cannabis through the postal system in the manner specified in the *MMAR*. The requirement that designated producers keep records of their production activities was also removed in these amendments.[384]

After the 2005 amendments, Grant Krieger was charged with production and trafficking of marihuana. He owned and operated the Krieger Wellness Society, a compassion club that provided marihuana to those with a purported medical need, regardless of whether

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[382] Marihuana Medical Access Regulations – Regulations Amending the Controlled Drugs and Substances Act, (29 June 2005) C Gaz II, online: Government of Canada <http://www.gazette.gc.ca/archives/p2/2005/index-eng.html> [2005 Amendments]. See *MMAR*, *supra* note 5, s 6.
[383] *Ibid*.
[384] *Ibid*.

they were authorized under the *MMAR*. Krieger claimed he was justified in doing so because doctors would not sign the application form for him or his approximately 420 clients.[385] Neither Krieger nor his five employees had medical training.[386]

The Court recognized the state had a valid interest in restricting unlicensed production due to the risks from untested plant material. "Microbial content is a concern… Bacteria, moulds, fungi and viruses present on plant material may present a significant health risk to users, particularly those with compromised immune systems and those already in a weakened physical state."[387] Evidence about Krieger's system of production and distribution was absent and there was no evidence it met minimum levels for safety or quality control.[388] These were valid concerns that justified limits on unlicensed production. Relying on the numerical data supplied by Health Canada and the findings in *Hitzig*, the Court found that a sufficient number of physicians were participating in the program and this requirement was not a significant barrier to access.[389] In this case there was no *Charter* breach and Krieger was convicted of the criminal charges. The Alberta Court of Appeal affirmed the trial judgment.[390]

In September 2006, the ruling Conservative party announced that it was cutting $4 million earmarked for the MMRP, effectively terminating this program and ending all federal financial support for medical cannabis research in Canada. As a result, Health Canada's initial commitment to a five-year, $7.5 million dollar research plan was reduced to a three year, two-study initiative.[391]

The Government's policy to supply individuals with marihuana was insufficient to render the *MMAR* constitutional. In 2006, Clifford Long was a passenger in a car that was stopped by the police for a seatbelt infraction. He was charged under section 4(1) of the

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[385] *Ibid* at 34.
[386] *Ibid* at 38.
[387] *Ibid* at 11.
[388] *Ibid* at 55-56.
[389] *Ibid* at 71-72.
[390] See *R v Krieger*, 2008 ABCA 394.
[391] Lucas, *supra* note 320 at 6.

CDSA for possession of approximately 3.5 grams of marihuana.[392] The earlier case of *R v Parker* had established that without a valid medical exemption, the criminal prohibition was invalid. Long argued that there was not a valid medical exemption in place at the time and therefore section 4(1) was invalid.[393]

His liberty was at stake and he argued that although the government had established a *policy* to supply cannabis, the policy was not a law. The Regulations merely permitted the Government to supply cannabis. They did not require it nor did they entitle authorized persons to anything other than the right to ask the Government for access.[394] There was no obligation on the government to supply marihuana. Long argued that it did not matter whether a particular Minister was well intentioned or happened to exercise his or her discretion reasonably. What mattered was the exemption amounted to unfettered discretion, contrary to the principles of fundamental justice.[395] The Court agreed. They found that the *MMAR* created a "constitutionally unacceptable medical marihuana exemption."[396] The Court reasoned that since the constitutionality of the *Regulations* depended on Parliament providing a legal supply of cannabis, a policy to supply it is insufficient. The Government must take on the legal obligation.[397]

Because Long was able to show there was not a constitutionally valid medical exemption in place, it followed from *Parker* that the criminal prohibition in the *CDSA* was of no force and effect and he was acquitted. The Government subsequently took on the legal obligation to provide marihuana to individuals with a medical need and thus addressed that particular defect.

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[392] *Long*, *supra* note 314 at 1.
[393] *Ibid* at 2.
[394] *Ibid* at 49.
[395] *Ibid* at 16.
[396] *Ibid* at 49.
[397] *Ibid* at 71.

Further amendments in 2007 addressed other concerns about the *MMAR*. It focused on correcting inconsistencies between the English and French versions with minor changes to certain substantive provisions, largely dealing with the production site.[398]

These amendments did not change the 1:1 ratio of authorized person to licensed grower contained in section 41(b.1), which Parliament re-enacted after *Hitzig*. Although the Government made PPS marihuana and seeds available to persons holding an ATP, many individuals felt that the product was of inferior quality.[399] The evidence indicated that less than 20% of authorized persons used this supply.[400]

The number of authorized persons far exceeded the number of individuals who wanted to produce marihuana for medical purposes. The result of the 1:1 ratio was that there were not enough individuals to produce marihuana for authorized persons. In the absence of a quality legal supply, many individuals with an ATP went to the black market because they could not find a grower or grow their own.

In *Sfetkopoulos*, the applicants applied to the Federal Court for judicial review of the Minister of Health's decision to deny a production licence to Carasel Harvest Supply Corporation, a husband and wife business that wanted to produce cannabis for more than one individual each.[401] The issue was whether the 1:1 ratio provided an adequate licit supply to satisfy section 7. The Federal Court, for largely the same reasons in *Hitzig*, found that for those who need to use marihuana for medicinal purposes, the right to security of the person entailed access to medication without undue state interference.[402] The Court considered the Government's justifications for the 1:1 ratio provided in the December 2003 amendments but found they were not substantial or compelling when measured against the violation of security of the person. Among other things, the Court

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[398] SOR/2007-207, (3 October 2007) C Gaz, online: <http://www.gazette.gc.ca/archives/p2/2007/2007-10-03/html/sor-dors207-eng.html>.
[399] *Sfetkopoulos v Canada*, 2008 FC 33 at 19 [*Sfetkopoulos*].
[400] *Ibid*.
[401] *Ibid* at 2.
[402] *Ibid* at 10.

found the 1:1 ratio did not have the effect of maintaining control over distribution of an unapproved drug product:

> Indeed it seems logical that if designated producers were authorized to produce for many customers there would be economies of scale and a level of income that might make possible even better quality control by the producer. At the same time, a host of one-customer designated producers would be made unnecessary and therefore any control and inspection system Health Canada might wish to impose on designated producers would be simpler and cheaper to operate with fewer producers.[403]

The judge found the 1:1 ratio was not rationally connected to the objective of minimizing diversion. He said, "designated producers, no matter how many customers they have, must confine their sales to persons with an ATP. A designated producer, since he is authorized to grow marihuana now, has a present potential for producing more than his one customer needs and diverting the surplus for illicit sale. This would be true whether he grows for one customer or 25."[404] The judge acknowledged that with a larger operation it is easier to hide a larger surplus, but found that was not compelling since fewer authorized producers make it easier to inspect.[405]

Other justifications for the 1:1 ratio were considered and rejected.[406] The Court concluded it was not tenable for the government to force individuals to buy from PPS, grow their own, or be limited to the unnecessarily restrictive system of designated producers. Since the only alternative was to purchase cannabis illegally, this violated the rule of law and was inconsistent with the principles of fundamental justice.[407]

The Federal Court declared the 1:1 ratio contained in section 41(b.1) invalid. The declaration was not suspended. The appeal by the Attorney General was dismissed[408] and leave to appeal to the Supreme Court was denied.[409]

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[403] *Ibid* at 14.
[404] *Ibid* at 15.
[405] *Ibid.*
[406] *Ibid* at 18.
[407] *Ibid* at 19.
[408] *Sfetkopoulos v Canada*, 2008 FCA 328.
[409] *Canada (AG) v Sfetkopoulos*, [2008] SCCA 531. See also *Beren*, *supra* note 234.

In response to *Sfetkopoulos*, the Government amended the *MMAR* in 2009. On May 14, 2009, the Government enacted a new ratio of two authorized persons for each licensed producer.

This response was meant to be an incremental step while the government considered a new licensing regime for larger-scale marihuana production, which would include comprehensive labelling, security, and record-keeping requirements similar to those in place for other controlled substances.[410] At this time, the Government suggested that wider stakeholder consultation and a broader review of the marihuana medical access program would consider the constitutional issues raised by the existing *MMAR*.[411]

In 2009, Matthew Beren was charged with possession, trafficking and production of cannabis in connection with a large growing operation that supplied the Vancouver Island Compassion Club (VICC). Beren made a number of arguments to suggest the *MMAR* remained unconstitutional.[412] Beren's position was that the practical effect is that the exemption created by the *MMAR* is illusory for most Canadians.[413]

Beren argued the *MMAR* were constitutionally defective in two main areas. The first was that the exemption was too difficult to access due to the *MMAR* requirements for a physician declaration. The second was that the legal supply was inadequate.[414] He argued that the *MMAR*, even after the amendments, did not create a constitutionally adequate means for qualified persons to obtain an exemption from the absolute prohibition because:

> a) the MMAR requirement that a physician be the gatekeeper to the legal protections of the programs acts to render the exemptions from the criminal law practically unavailable to the vast majority of persons who could benefit from the use of medical cannabis;

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[410] (2009) C Gaz II, 797.
[411] *Ibid* at 800.
[412] *Beren*, *supra* note 234 at 7.
[413] *Ibid* at 21.
[414] *Ibid* at 29.

b) the MMAR requirement that a specialist in the particular illness or disease be consulted in relation to category 2 applications is an arbitrary restriction on access;

c) the MMAR requirement that a physician and patient declare that all conventional treatments have been tried or considered and rejected is an arbitrary restriction on access;

d) the MMAR restriction on the categories of health care professionals that can act as gatekeepers to the legal protections of the program, limiting the gatekeeper role solely to medical doctors, is arbitrary;

e) the MMAR requirement that authorized persons in category 1 renew their licences on an annual basis is arbitrary; and

f) significant delays in processing applications under the MMAR, as well as renewals and amendments, undercut the existence of the right and, for terminal patients, make the protection practically unavailable.[415]

Beren also argued that the *CDSA*, as modified by the *MMAR* and Health Canada's supply policy did not create a constitutionally adequate method for qualified persons to obtain a legal, adequate and effective supply of cannabis because:

a) the MMAR restriction in s. 41(b.1) that prohibits a producer from growing cannabis for more than one authorized person, otherwise known as the one-to-one ratio restriction, is arbitrary;

b) the MMAR restriction in s. 54.1 that prohibits more than three production licence holders from growing at any one physical location, otherwise known as the "three max" restriction, is arbitrary;

c) the federal government's sale, pursuant to a discretionary policy, of a single strain of non-organic, pre-ground, gamma-radiated dried cannabis to licensed end-users does not rectify the supply problems created by the one-to-one ratio and three max restriction;

d) the federal government's policy decision to cease providing dried cannabis to persons that are unable to afford it acts to prevent access to a legal supply of cannabis and forces some authorized persons to either obtain cannabis from the black market or to go without;

e) the Health Canada policy of contacting physicians regarding daily dosages, levels in excess of five or ten grams per day does not facilitate the purposes of the program and is not conducive to the health and healing

[415] *Ibid* at 33.

> of the end-users and acts to prevent or limit access to an adequate lawful supply of medical cannabis; and
>
> f) the government policy decision to permit only the possession of dried cannabis, which has the effect of not permitting the legal use of cannabis resin or the derivatives made with cannabis resin, such as baked goods, salves and sprays is arbitrary.[416]

The arguments about the 1:1 ratio were moot because Parliament had already amended this ratio to 2:1. Evidence was provided on the total number of Canadians who use marihuana for medical purposes. The estimates are based on survey data and cannot be regarded as entirely reliable. Apparently, the range is somewhere between 400,000 and one million.[417] It is uncertain what number of these would meet the level of constitutional protection.

The Court found Beren's s. 7 rights to liberty and security of the person were engaged by the restrictions imposed on producing marihuana.[418] However, the Court held there was ample justification for the requirement of a physician or specialist's declaration.[419]

On the supply issue, the Court said that even without judging the medical evidence on the efficacy of different strains, it was rational for individuals to prefer suppliers who could offer them different strains, especially when it was accompanied by research to support the claimed effects.[420] The Court also struck the "three max" provision in section 54.1, which limited common production.[421] The Court said it was axiomatic that the arbitrary restrictions were not rationally connected to the objectives. Thus, the section 7 breach was not saved by section 1.[422]

The remedy was to declare the impugned sections unconstitutional and they were severed from the *MMAR*. The declaration of invalidity was suspended for one year to allow the

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[416] *Ibid*.
[417] *Ibid* at 38.
[418] *Ibid* at 86.
[419] *Ibid*.
[420] *Ibid* at 109.
[421] *Ibid* at 127.
[422] *Ibid* at 128.

Government to research alternative methods of distribution that would adequately address the supply issue.[423] Beren was found guilty of producing and trafficking in marihuana outside of the legal framework provided by the constitutionally valid parts of the *MMAR*.[424]

In 2010, the Government amended the *MMAR* primarily to address the vacuum that was created when section 54.1 was struck down.[425] Now, up to four production licences can be issued for a single production site ("four max"). These amendments also allowed individuals with a PUPL to grow for another authorized person, which was overlooked when the ratio was amended for DPPL holders.[426]

In 2011, Matthew Mernagh claimed that the defence purportedly offered by the *MMAR* remained illusory for many individuals who require marihuana for medical purposes. He tendered evidence to show that the vast majority of doctors refuse to sign the medical declaration required by the *MMAR*.

Mernagh was diagnosed with fibromyalgia, scoliosis, seizures and depression. Prescription medications had accompanied unwanted effects and failed to provide adequate relief of his symptoms. For Mernagh, pain was a constant companion.[427] He cultivated his own supply of cannabis. The evidence showed that used medicinally, it eased his symptoms and allowed him to function.[428] Despite his efforts, Mernagh was unable to find a doctor to support his ATP, meaning that his cultivation and possession of cannabis was illegal.[429] He challenged the possession, production and trafficking of cannabis provisions of the *CDSA*. Mernagh contended that the combined effect of an inaccessible medical exemption system and a criminal prohibition for accessing necessary medial treatment violated his liberty and security of the person and was

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[423] *Ibid* at 135.
[424] *Ibid* at 136.
[425] SOR/2010-63, (2010) C Gaz II, online: <http://www.gazette.gc.ca/rp-pr/p2/2010/2010-03-31/html/sor-dors63-eng.html> [2010 Amendments].
[426] *Ibid*.
[427] *Mernagh*, *supra* note 8 at 1.
[428] *Ibid*.
[429] *Ibid* at 3.

contrary to the principles of fundamental justice. The Government argued that the problem with access was not a problem with the *MMAR* and the fault lay with doctors whose medical opinion was not subject to government control or the requirements of the *Charter*.[430]

The *viva voce* and affidavit evidence entered at trial illustrated that the state-imposed barriers to legal access are a clear violation of security of the person for individuals who require marihuana for medical purposes. The Court found:

> A common theme in the evidence of all of the patient witnesses was that they suffer from medical conditions that are serious, debilitating and painful. All of the patient witnesses had been prescribed opioids (narcotics) by their physicians and all of the witnesses had, after a period of time, found that these prescribed medications were either ineffective in managing their symptoms, and/or caused side effects, some of which have led to other serious health issues, including addiction. All of the patient witnesses had asked their physicians to assist them in obtaining a licence to use marihuana under the federal program, but most of the physicians involved had refused to do so. Accordingly, the medical use of marihuana by these individuals constitutes a criminal activity, even though they are not criminally minded people. This in turn has created an additional a source of concern and anxiety for all of the patient witnesses. The stress of which further undermines their health.[431]

The Canadian Medical Association (CMA) said it "recognizes and is sympathetic, to, the needs of those individuals who may gain or hope to gain benefit from the use of marihuana in relieving their symptoms." However, the Association was disappointed with the way the medical exemption system had been implemented because the *MMAR* puts doctors in an "unenviable" position of authorizing a potentially harmful drug that had not been approved.[432]

The evidence presented in *Mernagh* showed the extent of the medical profession's ongoing concern, particularly in regard to the lack of meaningful consultation with the profession before the *MMAR* was enacted.[433] The Court found many factors contributed

[430] *Ibid* at headnote.
[431] *Ibid* at 47.
[432] *Ibid* at 150, 152.
[433] *Ibid* at 144-156.

to physician reluctance to authorize the medical use marihuana, including the stigma associated with marihuana[434] and the influence of the pharmaceutical industry.[435] Since doctors are not specifically informed about the therapeutic benefits and risks of marihuana, they lacked information about its clinical effectiveness.[436] The judge found that patients were often educating their doctors on the medicinal benefits of cannabis, rather than the other way around.[437] The Court also examined the negative impact of opioid painkillers.[438] The trial judge found as a fact that "the medical profession does not intend to accept the responsibility that Parliament has thrust upon them."[439]

A violation of life, liberty and security of the person was not debated in this case. All parties accepted that there was a violation that met the threshold test for seriousness. The legal analysis turned on whether this violation was consistent with the principles of fundamental justice.[440]

The question the judge posed was "whether physician participation in the *MMAR*, or perhaps more accurately, the lack of it, has rendered the exemption (and thereby the defence), illusory?"[441] As per *Morgentaler*, an illusory defence to a criminal charge will violate the principles of fundamental justice.[442]

This case revisited the issue of physician cooperation briefly considered in other cases. In *Hitzig*, the requirement for a physician did not render the defence illusory because a sufficient number of individual physicians and specialists were authorizing the therapeutic use of cannabis. On that evidence, the exemption could not be said to be practically unavailable. However, the *Hitzig* Court noted that if the evidence showed

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[434] *Ibid* at 157-160.
[435] *Ibid* at 174-186.
[436] *Ibid* at 152.
[437] *Ibid* at 162.
[438] *Ibid* at 187-192.
[439] *Ibid* at 216.
[440] *Ibid* at 194.
[441] *Ibid* at 193.
[442] *Morgentaler, supra* note 241 at 51.

physician participation was a barrier to access, the conclusions could be revisited.[443] In *Mernagh*, the Court summarized the law:

> The decisions in both *Parker* and *Hitzig* confirm the existence of a constitutional right to choose cannabis as medicine and the concomitant duty on government to provide a constitutionally viable means to exercise this right. Without an effective medical exemption, the Court held, the government loses the constitutional authority to retain the criminal prohibition against the use of cannabis.[444]

The trial judge described the evidentiary record in the *Mernagh* case as "drastically,"[445] "dramatically"[446] and "vastly"[447] different than the record in *Hitzig*. In 2011, the evidence did not support the Crown's contention that the *Regulations* were working.[448]

"The widespread shortage of doctors in Canada and their broad based refusal to prescribe marihuana is a perfect complement to Health Canada's policy of maintaining a tight, almost miserly, control over the distribution of medicinal marihuana."[449] The Court found that Health Canada's "preference for tight controls as opposed to a prompt, fair and efficient approval process does not conform to the principles of fundamental justice."[450] The trial judge stated:

> In my respectful view, the intent to limit the availability of medicinal marihuana to a "small number of persons" is not in conformity with the legal principles set out in *Parker* and in *Hitzig*. "Small numbers" have nothing to do with respecting the constitutional rights of Canadians. Each citizen is entitled to be treated equally. If the citizen qualifies for admission to the program, it should not and does not matter that the government's expectations regarding the number of patients approved or expected to be approved for medicinal marihuana is exceeded.[451]

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[443] *Hitzig ONCA*, *supra* note 29 at 139.
[444] *Mernagh*, *supra* note 8 at 32.
[445] *Ibid* at 156.
[446] *Ibid* at 198.
[447] *Ibid* at 200.
[448] *Ibid* at 203.
[449] *Ibid* at 218.
[450] *Ibid* at 219-220.
[451] *Ibid*.

In addition to the tight controls imposed by the *MMAR*, the numbers presented in *Mernagh* suggest that less than one half of one percent of physicians signed declarations for their patients between 1998 and 2010.[452] There is likely a much greater need than is currently being served.

Of the estimated 400,000 individuals who report using marihuana for medicinal purposes,[453] it is uncertain how many have a legitimate need, have tried alternative treatments or who are content accessing the black market. Nevertheless, there still appears to be a sufficient number with a legitimate need who want to access the program but are unable to do so. In *Mernagh*, this was found to be a direct result of the *MMAR*, which designated physicians as gatekeepers without taking the necessary steps to secure their cooperation. Based on the evidence presented, the defence purportedly offered by the *MMAR* was found to be illusory and contrary to the principles of fundamental justice.[454] The evidence showed that the refusal of physicians was a direct result of the measures adopted in the *MMAR*.

The judge reasoned that by delegating doctors under the legislative scheme, it was incumbent on Parliament to ensure their preparation for, and acceptance of, the responsibilities that had been imposed on them to ensure the regulatory scheme would serve its intended purpose. "The deficiency with the legislation is not that doctors were appointed as gatekeepers, but the fact that there were no steps taken to obtain the support, co-operation and participation of the medical profession as gatekeepers before or after they were so designated."[455]

The legislation was not justified under section 1.[456] The requirement for a physician was integral to the legislation and could not be severed while leaving the rest intact.[457] The

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[452] *Ibid* at 211.
[453] Kalant & Porath-Waller, *supra* note 230 at 5.
[454] *Mernagh*, *supra* note 8 at 230, 234.
[455] *Ibid* at 259.
[456] *Ibid* (there was no rational connection (at 272), minimal impairment (at 275) and was not proportionate to the objectives of the MMAR (at 298)).
[457] *Ibid* at 330.

remedy in this case was to strike down the entire legislation. The declaration of invalidity was suspended for three months, reflecting the amount of time these issues have been ongoing and the government's failure to take positive steps to address the barriers to legitimate access.[458]

The suspension of invalidity was extended until the Court of Appeal renders its decision. Thus, the *Criminal Code* provisions remain in full force and effect.[459] The appeal was heard May 7 - 8, 2012.[460]

The most recent SCC decision discussing the scope of section 7 concerned a federal exemption for *Insite,* an established supervised injection site in Vancouver's Downtown Eastside (DTES). The site was established in 2003 in response to crisis-level health problems associated with injection drug use concentrated in a small geographical region of downtown Vancouver.[461] Many of the health problems were not a result of the drugs themselves, but of the unsafe practices that were apparently consequences of the criminal prohibition.[462] The evidence presented in that case described addicts sharing needles and using dirty puddle water to dissolve drugs before injection.[463] Cooperation between municipal, provincial and federal jurisdictions resulted in a pilot project aimed at reducing these problems.[464]

Since 2003, Insite had been operating under an exemption contained in section 56 of the *CDSA*. In 2008, the federal government failed to extend Insite's exemption from the operation of criminal laws.[465] This resulted in legal action by the claimants for

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[458] *Ibid* at 335.
[459] Public Prosecution Service of Canada, News Release, "Court Grants Stay Pending Appeal" (22 June 2011) online: <http://www.ppsc-sppc.gc.ca/eng/nws-nvs/comm/2011/22_06_11.html>
[460] Megan O'Toole, "Crown urges Ontario court to overturn medical marijuana ruling", *National Post* (7 May 2012), online: <http://news.nationalpost.com/2012/05/07/crown-urges-ontario-court-to-overturn-medical-marijuana-ruling/>.
[461] *Insite*, *supra* note 248 at 1, 11.
[462] *Ibid* at 93.
[463] *Ibid* at 10.
[464] *Ibid* at 12.
[465] *Ibid* at 2.

declarations that the *CDSA* was unconstitutional as it applied to Insite or, in the alternative, that the Minister of Health, in refusing to grant an extension of the exemption, had violated the claimants' rights.[466]

Although the unanimous Court upheld the *Controlled Drugs and Substances Act,*[467] they found that the Minister of Health's exercise of discretion to deny a continued exemption for medical purposes violated drug addicts' right to security of the person and did not accord with the principles of fundamental justice. Specifically, they found the Minister's decision was arbitrary and disproportionate.

On the issue of the constitutionality of the *CDSA* provisions, the Court found for the offence of possession, the availability of imprisonment as a penalty engaged the liberty interests of the staff because they could be found guilty of this offence by virtue of having knowledge of the presence of drugs, and consenting to their presence in the facility over which they have control.[468] Without an exemption, staff would be unable to legally provide services to their clients, which would deprive them of potentially lifesaving medical care, thus engaging their rights to life and security of the person.[469] The Court said: "To prohibit possession by drug users *anywhere* engages their liberty interests; to prohibit possession at Insite engages their rights to life and to security of the person."[470] However, because neither the activities of the clients nor staff at Insite could be construed as trafficking, they did not have the requisite standing to challenge the trafficking provision.[471]

In considering whether the violations of the liberty and security of the person accorded with the principles of fundamental justice, the Court considered two objectives of the *CDSA*: the protection of public health and the maintenance of public safety.[472]

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[466] *Ibid* at 75, 76.
[467] *CDSA*, *supra* note 3.
[468] *Insite*, *supra* note 248 at 89, 90.
[469] *Ibid* at 91.
[470] *Ibid* at 92.
[471] *Ibid* at 95.
[472] *Ibid* at 110.

> The public safety purpose of the Act is achieved by the prohibition on possession and trafficking in listed substances. The public health purpose of the statute is achieved not only by the prohibitions in ss. 4(1) and 5(1), which seek to avert the use of dangerous substances, but also by the provision of regulations guiding exemptions for and the use of listed substances for medical and scientific purposes in ss. 55 and 56 of the Act.[473]

In *Parker*, the Minister's broad discretionary power contained in section 56 amounted to unfettered discretion.[474] In contrast, the SCC found that this exemption was a "safety valve that prevents the *CDSA* from applying where it would be arbitrary, overbroad or grossly disproportionate in its effects."[475] Therefore, the Minister's discretion is limited by the *Charter* and not unfettered. In this case, they found that the *CDSA* itself was not the problem. Based on the evidence, the Minister's failure to exempt Insite was arbitrary.

Following the same reasoning that was applied to the *CDSA*, the Court found the Minister's decision engaged the claimants' section 7 rights to life and security of the person. The Minister's refusal to grant a further exemption was arbitrary and grossly disproportionate in its effects and therefore did not comport with the principles of fundamental justice.[476]

The SCC provided a framework to guide the arbitrariness analysis. The Court said the first step is to identify the law's objectives.[477] The second step is to identify the relationship between the state interest and the impugned law, or, in this case, the impugned decision of the Minister.[478] The SCC reviewed the jurisprudence on arbitrariness:

> The jurisprudence on arbitrariness is not entirely settled. In *Chaoulli*, three justices (*per* McLachlin C.J. and Major J.) preferred an approach that

[473] *Ibid*.
[474] See *Parker*, *supra* note 6 at 117. The SCC distinguishes the unfettered discretion of the Minister in *Insite* from that in *Parker* because, "No decision of the Minister was at stake in *Parker*, and the Court's conclusion rested on findings of the trial judge that, at that time, 'the availability of the exemption was illusory.'"
[475] *Insite*, *supra* note 248 at 113.
[476] *Ibid* at 127.
[477] *Ibid* at 129.
[478] *Ibid* at 130.

> asked whether a limit was "necessary" to further the state objective (paras. 131-32). Conversely, three other justices (*per* Binnie and LeBel JJ.), preferred to avoid the language of necessity and instead approved of the prior articulation of arbitrariness as where "[a] deprivation of a right . . . bears no relation to, or is inconsistent with, the state interest that lies behind the legislation" (para. 232). It is unnecessary to determine which approach should prevail, because the government action at issue in this case qualifies as arbitrary under both definitions.[479]

There appear to be three different tests for arbitrariness: whether the impugned law is necessary to achieve the objectives, whether the deprivation bears any relationship to the objective, or whether it is inconsistent with the state interest that lies behind it.

In this case, the evidence showed that the operations at Insite actually furthered the objectives of public health and safety by reducing the risk of death and disease without leading to increased crime rates, public injection or relapse rates.[480] The staff intervened in 336 overdoses since 2006 with not a single death.[481] The Court said that the Minister's decision was arbitrary regardless of whether the Court adopted the tests for arbitrariness from *Rodriguez* or *Chaoulli*. It bore "no relation" to the objectives, it was "inconsistent with" its underlying objectives and it was "not necessary" to achieve the legislative aims.[482]

On the issue of gross disproportionality, the Court simply said:

> The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.[483]

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[479] *Ibid* at 132.
[480] *Ibid* at 131.
[481] *Ibid*.
[482] *Ibid* at 132.
[483] *Ibid* at 133.

Although the parties did not make a section 1 argument, the SCC said no justification would succeed.[484]

The Minister's decision was found to be unreasonable based on the empirical evidence about the Insite facility.[485] This case highlights the necessity of empirical evidence to demonstrate that the measures are related to the objective. Policy *simpliciter* is not sufficient to justify infringing *Charter* rights.[486]

The reasoning in *Insite* was recently applied in the case of *Canada v Bedford*, which considered section 7 in the context of prostitution.[487] In Canada, prostitution is legal. However, some incidental activities such as operating bawdy houses, living off its avails and communicating for the purposes of prostitution are illegal. Terri Jean Bedford, Valerie Scott and Amy Lebovitch were and are sex workers: prostitutes.[488] They challenged the constitutionality of Canada's *Criminal Code* sections 210, 212(1)(j) and 213(1)(c) under sections 2 and 7 of the *Canadian Charter of Rights and Freedoms*. I will focus on the Court's analysis of the section 7 right to security of the person and the principles of fundamental justice.

The evidence showed that the legislation prohibiting bawdy houses had the effect of isolating prostitutes, thus making their working conditions more dangerous. They could not hire bodyguards or drivers who could increase their safety due to the prohibition on living off the avails of prostitution. Lastly, for the most vulnerable sex workers on the street, the prohibition against communicating for the purposes of prostitution made it extremely difficult to assess and vet potential customers. As a result, these provisions created an extremely unsafe situation for individuals engaged in a lawful activity.[489]

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[484] *Ibid* at 137.
[485] *Ibid* at 140.
[486] *Ibid* at 128.
[487] *Canada (Attorney General) v Bedford*, 2012 ONCA 186 [*Bedford ONCA*].
[488] The nomenclature of sex work remains controversial. The Court uses the term prostitute to track the language of the *Criminal Code*. *Ibid* at footnote 1.
[489] *Ibid* at 110.

The Ontario Court of Appeal found there was a violation of prostitutes' security of the person. They said: "Properly understood, the respondents' security of the person claim is about self-preservation. The preservation of one's physical safety and well-being is a fundamental component of personal autonomy. Personal autonomy lies at the heart of the right to security of the person."[490]

Although it was their clients who inflicted violence on the prostitutes, the law was found to play a sufficient contributory role by preventing prostitutes from taking steps that could reduce the risk of such violence.[491] To determine whether there is a sufficient causal connection between the impugned legislation and the rights violation, the court must first determine what it is that the legislation prohibits or requires. The next step is to determine how the statutory prohibition or requirement impacts those who claim to have suffered a limitation on their right to security of the person because of the legislation. Finally, it is necessary to examine the actual impact of the legislation and determine whether it limits or otherwise interferes with the physical and psychological integrity protected by security of the person.

Individually and in tandem, the impugned provisions in this case criminalized conduct that would mitigate the risk posed to prostitutes.[492] Therefore, the legislation increased the risk of physical harm. This was found to compromise prostitutes' personal integrity and autonomy, which lies at the core of the right to security of the person.[493]

In considering the principles of fundamental justice, the Court noted that the analysis turns on the relationship between the law and its objective. Each principle of fundamental justice uses a different "filter" to assess the relationship. The Court provided a clear framework to be applied in the arbitrariness, overbreadth and gross disproportionality analysis though it is unclear whether it can be applied consistently.

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[490] *Ibid* at 99.
[491] *Bedford v Canada,* 2010 ONSC 4264 at 421 [*Bedford ONSC*].
[492] *Bedford ONCA, supra* note 487 at 135.
[493] *Ibid* at 107, 111.

The Court identified the objectives of the impugned provisions. The objectives of the bawdyhouse provision were to combat neighbourhood disruption or disorder, and to safeguard public health and safety.[494] The objective of the provision prohibiting living off the avails of prostitution was to prevent pimps from profiting from the exploitation of prostitutes.[495] The objectives of the communication provision were to curtail street solicitation and the social nuisance that it creates.[496] The Court's characterization of the objectives may not reflect Parliament's initial concern with the immorality of prostitution. In my submission, criminalizing activities incidental to prostitution is related to the objective of discouraging prostitution, not just to curtail a social nuisance.

The Court found the bawdyhouse provision was overbroad because it caught conduct that did not contribute to the social harm that Parliament sought to curtail.[497] The Court found the provision grossly disproportionate because the extreme impact on prostitutes' health and safety.[498] The Court found the avails provision was overbroad. They "read in" words so the provision prohibited living off the avails of prostitution only "in exploitive circumstances." This remedy attempted to ensure the provision did not use means that were broader than necessary to accomplish the valid state objective.[499] Despite finding that communication with potential clients is an indispensible screening tool used to enhance safety for the most vulnerable street prostitutes, two of three judges held that the communication provision did not violate the principles of fundamental justice in that it was not arbitrary,[500] overbroad[501] or grossly disproportionate.[502]

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[494] *Ibid* at 29.
[495] *Ibid* at 30.
[496] *Ibid* at 31.
[497] *Ibid* at 204.
[498] *Ibid* at 206.
[499] *Ibid* at 248-249.
[500] *Ibid* at 289.
[501] *Ibid* at 291.
[502] *Ibid* at 322.

Leave to appeal to the SCC was filed May 25, 2012[503] and, if granted, will be another case where the empirical evidence presented in court will inform a controversial decision on socio-legal issues with broad implications across Canada. The analysis in the recent section 7 cases shows that the way the objectives are framed will have a significant impact on the legal analysis.

Building on this foundation of *Charter* challenges, in April 2012, Owen Smith challenged the constitutionality of the *MMAR* requirement for cannabis to be in a dried form. This challenge took place during a *voir dire* on the criminal charges that he was facing. Smith was processing cannabis plants to separate the active ingredients from the plant and infuse them into cookies, oil-filled capsules, and other edible and non-edible products.[504] These were sold at the Cannabis Buyers Club of Canada where Smith was employed.[505]

The Crown argued that:

> The current licensing scheme, which restricts authorized medical users to dried marihuana, or that limits the number of plants a licensed producer may grow, allows police or regulators to easily ascertain whether a medical possessor or producer is exceeding the limits of their respective authorizations, thus limiting the chances that some of the product ostensibly might be diverted into the illegal distribution network.[506]

Both the narrow and broad definitions of the right to liberty were engaged. There was a potential for imprisonment as well as a deprivation of the fundamental personal choice. Security of the person was also engaged. The judge's findings of fact included that:

> Oral ingestion also has the benefit of prolonging the effects of the drug in the system, with the corresponding detriment of taking longer to build a therapeutic level of the drug than would occur with smoking, for example.
>
> Because orally ingested THC or CBD stays in the system longer, it would be better for someone with a chronic condition of pain or glaucoma, where some level of therapeutic dosage would remain while the patient

[503] See *Canada (Attorney General) v Bedford*; [2012] SCCA No 159 (application for leave to appeal filed May 25, 2012).
[504] *Smith*, *supra* note 280 at 6, 18.
[505] *Ibid* at 19, 20.
[506] *Ibid* at 73.

slept.[507]

The judge paraphrased *Parker*, saying that the restriction of cannabis to its dried form constituted "an interposition of the threat of criminal prosecution between them and the form of medication found effective to treat the symptoms of their very serious illnesses."[508]

Turning to consider the principles of fundamental justice, the judge considered that there was some reduced risk in administration of cannabinoid therapies that were non-smoked.[509] Importantly, Johnston J. found, "It is not possible to tell by looking what the contents of a cookie might be, or what concentration of THC a capsule of oil might contain."[510] The same laboratory analysis would have to be undertaken regardless of whether cannabis was in dried form or some other form. Thus, he found the restriction of marihuana to its dried form was arbitrary because it was not rationally connected to the state interests, including preventing diversion and controlling false or misleading claims of medical benefit.[511]

This case considered section 1 in more detail than most of the recent section 7 jurisprudence, but found there was "little rational connection" between restricting cannabis to its dried form and the legitimate objective of preventing diversion of lawful medical marihuana into the illegal market.[512] The restriction of cannabis to its dried form unreasonably impaired the right to choose how to ingest the medicinal ingredients in the safest and most effective manner.[513] These restrictions were not proportionate and therefore violated section 7 of the *Charter* in a manner that was not consistent with section 1.[514]

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[507] *Ibid* at 45.
[508] *Ibid* at 89, citing *Parker*, *supra* note 6 at 111.
[509] *Ibid* at 106.
[510] *Ibid* at 45.
[511] *Ibid* at 114.
[512] *Ibid* at 122.
[513] *Ibid* at 123.
[514] *Ibid* at 124.

IV: Conclusions on Section Seven of the *Charter*

A substantial overhaul of the *MMAR* is needed to render the marihuana medical access program constitutionally sound. Currently, the biggest problems with the *MMAR* relate to the issues of obtaining legal authorization and accessing a legal supply. These are complex policy questions that require a careful balancing of interests. *Charter* values must be used to develop a constitutional medical marihuana access program but they do not provide a roadmap to implementation.

After almost three decades of litigation, the outer limits of "life, liberty and security of the person" as well the "principles of fundamental justice" are still rapidly developing in response to new fact scenarios.[515] The constitutional analysis differs depending on the objectives of the legislative scheme and the specific facts that are said to violate life, liberty and security of the person. Much of the constitutional analysis in recent judgments suggests a heavy reliance on empirical evidence to reach a conclusion on whether the legislation infringes section 7. There is a sufficient body of research to support the medical use of marihuana for some individuals.

Below, I consider the implications of the research evidence applied to the *Charter*. I reach a conclusion on the threshold level for a violation of security of the person. I assess whether the legislative measures of the *MMAR* and their effects are consistent with the principles of fundamental justice using the tests articulated in the jurisprudence. From this, it is possible to develop medical marihuana access regulations that balance the interests of individuals and society. I turn first to what circumstances will violate security of the person.

Security of the Person

A lack of access to medical treatment that interferes with the individual's physical and psychological integrity in a substantial way meets the threshold for violating security of the person. Where these conditions are met, state barriers to accessing the treatment that bear no relation to the objectives will violate the principles of fundamental justice. The

[515] Sharpe & Roach, *supra* note 239 at 221.

case law illustrates that a breach of security of the person will only be violated when there is evidence of significant harm to the individual's physical or psychological integrity that is substantially relieved by the prohibited treatment. However, the level of harm or suffering "need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety."[516]

Individuals are not entitled to unlimited choice in their medical treatment and the Supreme Court has said the state is justified in restricting general access to marihuana based upon a reasonable apprehension of harm.[517] There are some clear cases where the empirical and individual evidence demonstrably shows substantial unique benefits of cannabis. Specifically, it has reliable effects in increasing appetite, decreasing pain, intra-ocular pressure, nausea, vomiting, spasticity, seizures and may relieve the psychological discomfort that accompanies these maladies.[518] Clearly, these symptoms seriously affect a person's quality of life. If using cannabis substantially relieves serious symptoms, depriving individuals of this drug will violate their security of the person.

Other individuals may gain significant relief by using marihuana but the evidence of a benefit over existing therapies is inconclusive. In these cases, it is scientifically uncertain whether the benefits outweigh the risks. Here, it is unclear whether marihuana is a necessary medicine that would meet the threshold for *Charter* protection. Whether these individuals will qualify for constitutional protection to possess and use marihuana depends on the individual circumstances. Security of the person will not be violated unless the physical or psychological stress rises above the ordinary level. However, it "need not rise to the level of nervous shock or psychiatric illness."[519] The only way to determine whether the level of physical and psychological harm rises to a level of constitutional protection is for a medical professional to critically examine the empirical evidence and the individual patient.

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[516] See *Chaoulli*, *supra* note 61.
[517] *Malmo-Levine*, *supra* note 272 at 17.
[518] See VIII: Medical Benefits.
[519] See *Chaoulli*, *supra* note 61.

In the context of the federal criminal prohibitions contained in the *CDSA*, the threat of criminalization and restrictions on choice engage the liberty interest. Criminalizing and depriving individuals who require cannabis for medicinal use affects their physical and psychological integrity, fundamental to their security of the person.[520] Although there has not been a need to argue a violation of life, this dimension of section 7 may also be engaged where deprivation of marihuana increases the risk of death. These serious threats to the rights protected in section 7 require the objectives to be clearly connected to valid objectives.

An inaccessible exemption system coupled with a criminal prohibition manifestly violates some individuals' physical and psychological integrity. It is no answer to say these individuals can suffer through ineffective, unpleasant conventional treatments with significant risks when the evidence shows that for some individuals, cannabis provides relief beyond what is currently available in the pharmacopeia. For these individuals, cannabis is a necessary medical treatment. Parliament has carved out an exemption to the operation of the criminal law. Individuals who obtain an authorization to possess under the *MMAR* are exempt from the operation of the criminal law. State barriers to access for those who require medical marihuana must conform to the principles of fundamental justice.

Principles of Fundamental Justice

I have reviewed the evidence on cannabis and its application in a therapeutic context. After finding the criminal prohibition on marihuana infringes the rights to liberty and security of the person for medical users, the next step in the constitutional analysis is to consider whether these infringements are consistent with the principles of fundamental justice.

For individuals who gain a medical benefit from using marihuana, the criminal prohibition against its possession is arbitrary because it works in opposition to the goal of

[520] *Insite, supra* note 248 at 93; *Morgentaler, supra* note 241 at 59; *Rodriguez*, *supra* note 242 at 549; *Chaoulli, supra* note 61 at 43, 118-119; *Parker*, *supra* note 6.

protecting public health.[521] Without a constitutionally valid exemption system, individuals who have a medical need for marihuana are subject to criminal liability. The *MMAR* provide an exemption to the operation of the criminal law. Parliament has indicated the people who qualify under these *Regulations* are not deserving of social censure because they require marihuana for medical purposes. As the Court said in *Morgentaler*:

> One of the basic tenets of our system of criminal justice is that when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory. The criminal law is a very special form of governmental regulation, for it seeks to express our society's collective disapprobation of certain acts and omissions. When a defence is provided, especially a specifically-tailored defence to a particular charge, it is because the legislator has determined that the disapprobation of society is not warranted when the conditions of the defence are met.[522]

Legislation that has the effect of forcing people to the black market will violate the rule of law, one of the fundamental principles of justice. Vague, arbitrary, overbroad or grossly disproportionate laws will violate the principles of fundamental justice. The *Charter* defines the borders of state action, drawn in relation to valid objectives.

The principles of fundamental justice are the fulcrum of *Charter* violations. In Part Three of this paper, I look at the existing system, considered in light of the minimum *Charter* requirements and contemplate what an ideal system might include.

[521] See *Parker*, supra note 6.
[522] *Morgentaler, supra* note 241 at 48, Dickson CJ.

PART THREE: TOWARDS A CONSTITUTIONAL MODEL

In what follows, I will review the main provisions of the current *MMAR* and consider the *Charter* threshold. I suggest an optimal system to ensure the law is prudent and effective, which goes beyond the minimum requirements of the *Charter*. As the Court of Appeal commented in *Parker*, "Parliament is not bound to legislate to the constitutional minimum. It can adopt the optimal and most progressive legislative scheme that it considers just."[523]

I: The Current *MMAR*

In addition to its objectives, the current *MMAR* has four parts. Part 1 establishes a framework for individuals to apply for an authorization to possess. Part 2 deals with licences to produce marihuana, either for personal use or as a designated producer. Part 3 includes general obligations. Part 4 establishes a supply of marihuana seed and dried marihuana. I will address each of these in turn.

Objectives

MMAR

The objectives of the *MMAR* are "to establish a framework to allow access to marihuana by individuals suffering from grave or debilitating illnesses, where conventional treatments are inappropriate or are not providing adequate relief."[524] The objectives of the *MMAR* are intrinsically entwined with those of its enabling legislation, the *CDSA*. The SCC recently identified the objectives of the *CDSA* as the protection of public health and the maintenance of public safety.[525]

> The public safety purpose of the [*CDSA*] is achieved by the prohibition on possession and trafficking in listed substances. The public health purpose of the statute is achieved not only by the prohibitions in ss. 4(1) and 5(1), which seek to avert the use of dangerous substances, but also by the

[523] *Parker*, *supra* note 6 at 205.
[524] *Medical Access*, *supra* note 7.
[525] *Ibid* at 110.

> provision of regulations guiding exemptions for and the use of listed substances for medical and scientific purposes in ss. 55 and 56 of the Act.[526]

The objectives of these related pieces of legislation attempt to limit marihuana use to those who truly need it so that the inherent risks are minimized. There are two standards set out for eligibility in the *MMAR*. First, the suffering must be "grave or debilitating" and second, conventional treatments have failed. These standards appear to be overbroad. I address each of these below.

The first requirement attempts to limit the use of marihuana to those individuals who are suffering from "grave or debilitating" illnesses. However, this high threshold is not consistent with the jurisprudence that says stress "need not rise to the level of nervous shock or psychiatric illness."[527] In order to reach a minimum level of *Charter* protection, the pain or discomfort must be "greater than ordinary stress or anxiety" and the relief offered by marihuana must be substantial. However, the standard of "grave or debilitating" sets the bar too high. Individuals who are not suffering grave or debilitating illnesses may also qualify for *Charter* protection.

An ideal system would limit the medical use of cannabis to those with serious and significant symptoms that are substantially relieved by marihuana or cannabinoid-based treatments. This more accurately reflects the *Charter* standards for security of the person while still maintaining limits set for medical use. Use of the word cannabis rather than marihuana connotes the whole-plant rather than simply the dried buds.

The second requirement that conventional treatments are inappropriate or failing to provide adequate relief is also aimed at protecting public health and safety. This requirement does not seem to be arbitrary. It is rationally connected to the objective of protecting public heath by limiting access to an unapproved drug that carries some health risks.

Approved drugs have gone through rigorous testing procedures and the risks and benefits are generally known. The Court in *Parker* explained, "One only has to remember the

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[526] *Ibid*.

[527] See *Chaoulli*, *supra* note 61.

tragedy of Thalidomide to understand the need for the regulatory structure."[528] However, unlike newly developed pharmaceutical drugs like Thalidomide, marihuana is a plant-based drug that has co-existed with humans for millennia.[529] While a degree of scientific precision about its risks and benefits is lacking, there is a great deal of experiential knowledge about its effects on humans for some conditions. Additionally, the known risks associated with approved pharmaceutical drugs, such as opioid painkillers, are often greater than the known risks of marihuana.[530] The harms associated with smoking can be mitigated by a variety of non-smoked methods.

Fundamental personal choice and control over one's body are both protected by section 7 yet this does not entail an unlimited choice of medication. Some individuals whose pain rises to the level of constitutional protection clearly benefit from using marihuana. The requirement that conventional treatments are ineffective or medically inappropriate for these individuals is an infringement of their rights to liberty and security of the person. Where the benefits are significant and the risks can be mitigated, it would be overbroad to require all conventional medications are tried first.

In other instances, where the benefits are not as clear, it is prudent to first consider medications that have been approved. In these cases, the requirement for conventional medications to fail does not go beyond what is necessary to achieve the public heath and safety objectives. In cases where the evidence is unclear that cannabis provides a unique benefit, there is a valid state interest to require individuals to consider other options before cannabis.

The Charter Minimum

The *Charter* minimum would entail providing access to those who are suffering from diseases where the level of stress or pain, due to its intensity or duration, seriously affects the individual's quality of life. It need not rise to the level of "grave or debilitating." In

[528] *Parker*, *supra* note 6 at 157. Thalidomide was a sedative drug introduced in the late 1950s to treat morning sickness and aid sleep. Its use by pregnant women was shown to cause birth defects in offspring.
[529] See generally Bennett, *supra* note 2.
[530] See *Mernagh*, *supra* note 8 at 189.

most cases, the range of conventional treatments will be considered before cannabis. However, for those individuals who suffer from symptoms or diseases where the empirical evidence demonstrates a unique benefit, other medications should not have to fail before cannabis can be considered. These individuals should be able to choose the risks they want to accept in the course of medical treatment.

The Ideal

An ideal objective might be "to provide access to cannabis (marihuana) to individuals suffering from serious physical or psychological distress where the benefits outweigh the known risks."

Use of the term cannabis, rather than marihuana is a more scientifically accurate term that contemplates a broader range of therapeutic products than simply the flowering buds of the plant. Increased use of other cannabinoid-based medications can lower the risks associated with smoking. The standards contained in this objective specifically address the *Charter* criteria for a breach of security of the person and balance the state interest by incorporating a standard by which to measure eligibility. It acknowledges that some risks and benefits are known. This is more specific than the previous requirement that the benefits outweigh the risks because in this statement, the risks are limited to the *known* risks. It provides a concrete standard against which doctors can weigh the evidence and establish a medical judgment. This objective is consistent with Canada's international obligations under the 1988 Convention because the provisions of the UN Convention are subject to the "constitutional principles and basic concepts of its legal system."[531]

Authorization to Possess

In this subsection, I look at the requirements of the current *MMAR* as it relates to eligibility for an authorization to possess, for both the individual declaration and the medical declaration. I assess the legislative requirements contained in the *MMAR* according to the minimum requirements of the *Charter*. After ascertaining the *Charter* minimum, I deal with the optimal way of obtaining the requisite medical authorization and an authorization to possess.

[531] 1988 Convention, *supra* note 281 at Art 3.

Individual Declaration

MMAR

The current *MMAR* require individuals to apply under one of two categories according to their symptoms and associated medical conditions. Individuals may be eligible under Category 1 or Category 2.

Category 1 is defined as individuals who are treated within the context of compassionate end-of-life care or have any of the listed symptoms in the Schedule reproduced below.[532]

	Symptom	**Associated Medical Conditions**
1.	Severe nausea	Cancer, AIDS/HIV infection
2.	Cachexia, anorexia, weight loss	Cancer, AIDS/HIV infection
3.	Persistent muscle spasms	Multiple sclerosis, spinal cord injury or disease
4.	Seizures	Epilepsy
5.	Severe pain	Cancer, AIDS/HIV infection, multiple sclerosis, spinal cord injury or disease, severe form of arthritis

Category 2 is defined as "a debilitating symptom that is associated with a medical condition or with the medical treatment of that condition and that is not a Category 1 symptom."[533] Glaucoma is one example of a Category 2 medical condition.

Applicants must apply to the Minister and provide their own declaration, a medical declaration and two copies of a current photograph.[534] In addition to providing personal information, the applicant must declare that they are aware that no notice of compliance has been issued under the *Food and Drug Regulations* (*FDR*) concerning the safety and effectiveness of marihuana as a drug.[535] They must also declare that they have discussed the potential benefits and risks of using marihuana with the medical practitioner providing the medical declaration. Further, the applicant must declare they are aware that

[532] *MMAR*, *supra* note 5 at Schedule.
[533] *Ibid,* s 1(1).
[534] *Ibid,* s 4.
[535] *Food and Drug Regulations*, CRC, c 80 [*FDR*].

the benefits and risks associated with the use of marihuana are not fully understood and that the use of marihuana may involve risks that have not yet been identified and that they accept those risks. If the daily dose is more than five grams, they must declare they are aware of and accept the potential risk of drug dependency as well as the elevated risks to the cardiovascular and pulmonary systems and psychomotor performance associated with long-term use. The applicant must sign, date and declare the information to be correct and complete.

Charter Minimum

The state objectives in requiring an individual declaration are to collect relevant personal information necessary to verify identity and ensure accurate record-keeping, proper medical use and acknowledgment that there are known and unknown risks.

Where the requirements of the legislation are met, the Minister has no discretion to deny the application. The requirements for an individual declaration in the *MMAR* address the goals of protecting public health and safety by collecting data for long-term monitoring, confirming the identity of the person who will receive the marihuana, ensuring they have a medical need and are cognizant of the risks. These measures are rationally connected to the objectives and are not arbitrary.

The required information is not unusual. Most everything government-related requires some level of personal information and detail about the particular application. However, there is a delay between the time of physician approval and the time of legal authorization. The currently reported wait time for processing an application is eight to ten weeks.[536] As the Court said in *Parker*, "an administrative structure made up of unnecessary rules, which result in an additional risk to the health of the person, is manifestly unfair and does not conform to the principles of fundamental justice."[537]

This is an unnecessary delay since the Minister is not judging the validity of the medical assessment. Government involvement in the final approval of what is ultimately a

[536] Health Canada, "Drugs and Health Products: Fact Sheet – Medical Use of Marihuana" (31 May 2012), online: <http://www.hc-sc.gc.ca/dhp-mps/marihuana/index-eng.php>.
[537] *Parker, supra* note 6 at 117.

medical decision is unnecessary and therefore overbroad. The requirement for the Minister to approve the application goes beyond what is necessary to achieve the objectives.

The delay caused by the application process coupled with the difficulty obtaining the requisite medical declaration adds to the delay and denial of medical care for many individuals with a medical need. The required procedure has effects that are grossly disproportionate to the benefit obtained by the state. The objectives of verifying ID, record-keeping and ensuring individuals are aware of the risks could be accomplished by other means that are not as great an infringement of individual rights. The benefit obtained by the state must be weighed against the violations to liberty and security of the person, which continue during the delay between physician approval and legal approval. During this time, individuals are either deprived of a needed medicine or must access the black market. In *Hitzig*, the rule of law was violated where individuals were forced to purchase their medicine from the black market.[538]

By creating a two to three month delay in accessing needed medical treatment that has been approved by a physician, the current *MMAR* have established a legal regime that is overbroad because it goes beyond what is necessary to achieve the valid objectives and violates the rule of law because it forces people to access the illegal market.

The Ideal

The required information could be collected through a mandatory filing requirement before or within a reasonable time of obtaining authorization. The same information that is currently required by the ATP form could be included in a filing requirement. A government-issued photo ID card could be mailed to the individual after the filing requirement has been fulfilled.

A federally issued ID card addresses the concerns of law enforcement and individuals who need to show valid authorization. Enhanced security features should be used to prevent forgery. Restrictions and conditions about the extent of the authorization should

[538] *Hitzig ONCA*, *supra* note 16 at 109.

be clear on the card. A warning on the back of the card should alert individuals that there are unknown risks to using cannabis and should also indicate that breach of the conditions may result in civil and criminal penalties.

A voluntary ID card program appears to be imprudent and ineffective. In California where the state-issued ID card is voluntary, only a small percentage of medical users have applied for the card because dispensaries issue their own.[539] This makes it more difficult to ascertain the number of individuals who are legally authorized to use cannabis and to distinguish between legal and illegal users since authorization cards may be easy to forge.[540] A voluntary system also makes it more difficult to track long-term health outcomes.

A filing requirement and ID card system provides a rationally connected, minimally impairing solution. Mandatory filing is an infringement of liberty but it is in accordance with the principles of fundamental justice. It is a small intrusion, which is not arbitrary, overbroad or grossly disproportionate. It is in the interests of all stakeholders to have a clear, consistent, uniform system of regulation.

In the next section, I consider the medical declaration requirement in the *MMAR,* whether it accords with the *Charter* and what the ideal requirements should be.

Medical Declaration

MMAR

Under the current *MMAR*, a physician must provide a medical declaration. This declaration must include relevant information about the physician and their authority to practice medicine. It must also include the name of the applicant, their medical condition, the symptom that is associated with the condition and whether the symptom is a Category 1 or 2 symptom. The physician must declare that conventional treatments for the

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[539] "NORML Estimates One Million Medical Marihuana Patients in California", *Cannabis Culture Magazine* (31 May 2011), online: <http://www.cannabisculture.com/content/2011/05/31/NORML-Estimates-One-Million-Medical-Marihuana-Patients-California>.

[540] *Ibid*.

symptom have been tried or considered and have been found to be ineffective or medically inappropriate for the treatment of the applicant. The physician must also declare that they are aware that no notice of compliance has been issued under the *FDR*.[541] If the applicant is applying under Category 2, the medical declaration must also confirm that a specialist in a field relevant to the applicant's symptoms has been consulted and agrees that conventional treatments for the symptom are ineffective or medically inappropriate. The specialist must be aware that marihuana is being considered as an alternative treatment.[542]

The photograph on the federal ID card does not have to be a passport photo but must follow a similar format. The medical practitioner who is making the declaration must certify on the reverse side that the photograph is an accurate representation of the applicant.[543]

If these requirements are met, the Minister shall issue an ATP and provide notice of authorization to the medical practitioner. The authorization includes the name, date of birth and gender as well as the person's full address. It also includes an authorization number, the name of the medical practitioner, the maximum quantity of marihuana the person can possess, the date of issue and the date of expiry. The maximum quantity (in grams) is determined by a formula, which multiplies the daily dose (in grams) by 30.[544]

The grounds for refusal are limited. The Minister shall refuse to issue an ATP if the person is not ordinarily resident in Canada or if any information, statement or other item included in the application is false or misleading. If the Minister refuses to issue an ATP, the applicant must be provided with written reasons and be given an opportunity to be heard.[545] An ATP expires 12 months after the date of issue, or sooner if the medical use is

[541] *Ibid*, s 6(1).
[542] *Ibid*, s 6(2).
[543] *Ibid*, s 10.
[544] *Ibid*, s 10(3).
[545] *Ibid, s 12.*

for less than a year.[546] Applicants can renew or amend their ATP by following the requirements set out in the *MMAR*.[547]

Caregivers are permitted to possess marihuana while they are in the presence of the ATP holder to provide assistance in the administration of marihuana.[548]

Charter Minimum

The objectives of requiring a medical declaration are to protect public health and safety. These objectives are met by limiting access to a drug to the subset of individuals who require it to maintain their health. Questions of health and drug prescription fall to medical professionals who are trained to assess symptoms, detect malingerers and prescribe treatments. Parliament's choice of medical professionals as gatekeepers is not arbitrary. The requirement for some individuals to consult a specialist serves the valid purpose of ensuring the patient has knowledge of the entire range of available treatments relevant to their disease. The requirement for a specialist is not arbitrary.

Requiring a physician to approve the medical use of marihuana is tailored to the objective of ensuring only those with a legitimate medical need are authorized to possess and this barrier to access does not go beyond what is necessary.

A specialist may add some knowledge over and above that of a general practitioner. However, the added benefit of a specialist must be weighed against the additional delay and cost to the individual. Some individuals who would seem to prima facie qualify for the exemption have difficulties finding one physician to sign a medical declaration. In *Hitzig*, the Court noted that if physician cooperation dropped to the point where the defence to the criminal offence was illusory, the principles of fundamental justice could be violated.[549] In *Mernagh* the evidence of the patient witnesses illustrate the extent to which this is a problem across Canada.[550]

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[546] *Ibid*, s 13.
[547] *Ibid*, s 14.
[548] *Ibid*, s 23.
[549] *Hitzig ONCA, supra* note 16 at 142-143.
[550] See *Mernagh*, *supra* note 8.

The requirement for a specialist is not strictly necessary but does serve some purpose in that individuals are subject to further medical scrutiny and are given a full range of conventional treatment options so they can make an informed decision about their medical treatment. In *Bedford*, the prohibition on bawdyhouses was overbroad because it caught conduct that did not contribute to the harm Parliament sought to curtail.[551] Likewise, while the requirement for a specialist does prevent some potential malingerers from obtaining legal authorization, it also prevents some individuals with a legitimate medical need. For individuals who would otherwise qualify for admission to the marihuana medical access program, this requirement is a barrier to access that adds delay and cost.

There is some corresponding benefit to the state by reducing the harms associated with increased use. However, the lack of evidence of serious harms suggests these are minimal. Furthermore, there are ways to reduce the known harms. Although some individuals may improperly gain authorization, Health Canada reports that an average dose is between one to three grams per day. These amounts are not consistent with an intention to traffic. If individuals gain access to the legal medical supply for personal use, the risks to them will be lower if they have access to a safer product. Unlike other drugs of abuse, specifically opioids like oxycodone, the likelihood of cannabis abuse and the risks associated with it are significantly lower. Even if the statutory requirement to see a specialist were eliminated, physicians could refer their patients to one for a second opinion if the circumstances warranted.

In my submission, the requirement for a specialist goes beyond what is necessary. One physician is sufficient to meet the objectives of ensuring the individual has serious and significant symptoms. One physician is sufficient to determine whether the expected benefits of marihuana outweigh the known risks. The Government publishes a large body of empirical evidence on the risks and benefits of cannabis online.[552] The Government, doctors and individuals share the responsibility for ensuring they have the required information necessary to make informed choices. In light of research on the potential

[551] *Bedford ONCA, supra* note 487 at 135.
[552] Information for Health Care Professionals, supra note 177.

benefits for some individuals, the maxim, "first, do no harm" entails prescribing cannabis if a failure to do so would cause harm.

The Ideal

The ideal process for authorization to possess marihuana for medical purposes involves medical vetting and minimal delay. There must also be a process to collect necessary information to provide proof of legal authority, monitor statistics and long-term outcomes.

One option that would meet these objectives would be a physician prescription coupled with a requirement that the patient file necessary information forthwith or within a reasonable time. If a physician determines that the individual has serious and significant symptoms where the expected benefits outweigh the known risks, they could provide a prescription to their patient who could immediately take it to a licensed dealer. The patient would file the relevant information with the Government prior to receiving an ID card or prior to receiving their first dose. There would have to be some checks in place to ensure individuals actually filed. Physicians may have to file some information when they prescribe cannabis or the information may have to be filed before the prescription can be filled. This system would meet the objectives of medical vetting, minimal delay, data collection and proof of legal authority in a way that is not overbroad, arbitrary or grossly disproportionate.

In the next section, I move on to consider the Part 2 of the *MMAR*, dealing with licences to produce marihuana. I detail the current system, what the *Charter* requires and what the ideal system would provide.

Production Licences

MMAR

Currently, under the *MMAR*, individuals applying for an ATP, or current ATP holders may apply for a Personal-Use Production Licence (PUPL) if they are over 18 years of age and have not had a PUPL revoked within 10 years.[553] The applicant must provide

[553] *Ibid*, s 26.

relevant personal information and information about the production site. Outdoor production must not be adjacent to a school, public playground, day care facility or other public place frequented mainly by those under 18 years of age. Dried marihuana must be kept indoors.[554] The application must include a description of the security measures in place.[555] The maximum number of plants is determined by a formula. The amount of plants will vary depending on the daily dose limit and whether the production is indoors or outdoors.[556]

The grounds for refusal are similar to the ATP. A person will be refused a PUPL if they would be the holder of more than two licences to produce or the production site would be host to more than four licences.[557]

A person who holds a Designated-Person Production Licence (DPPL) is authorized to produce marihuana for the ATP holder specified in their licence. The person may produce and store the marihuana at different sites provided the requirements of section 34 are met. If the marihuana will be sent in the mail, section 34(1.1) sets out the requirements.

A person is ineligible for a DPPL if they are under 18, or have been found guilty of trafficking or importing/exporting in Canada or another country.[558] The application must include details about the production site, and personal information about the applicant. Section 41(b) provides that a licence will be denied if the person would become the holder of more than two licences. The holder of a licence may not simultaneously produce marihuana partly indoors and partly outdoors.[559]

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[554] *Ibid*, s 28.
[555] *Ibid*.
[556] *Ibid*, s 30. For example, a person with a daily dose of one gram would be permitted to grow 5 indoor plants and keep 225 grams in storage. For exclusively outdoor growing, a person whose daily dose was 1 gram would be permitted a maximum of 2 plants and 750 grams in storage. For this dose amount and a combination of indoor and outdoor plants would permit a maximum of 4 indoor and 1 outdoor plant with a maximum of 375 grams in storage. See "For Patients" online: MedicalMarihuana.ca <http://medicalmarihuana.ca/for-patients/marihuana-calculator>.
[557] *Ibid*, s 32.
[558] *Ibid,* s 35.
[559] *Ibid*, s. 52.1.

An inspector may, without the consent of the occupant, at any reasonable time, enter any place where the inspector believes on reasonable grounds that marihuana is being produced or kept by the holder of the licence to produce, and may, for that purpose

> (a) open and examine any receptacle or package found there that could contain marihuana;
>
> (b) examine anything found there that is used or may be capable of being used to produce or keep marihuana;
>
> (c) examine any records, electronic data or other documents found there dealing with marihuana, other than records dealing with the medical condition of a person, and make copies or take extracts;
>
> (d) use, or cause to be used, any computer system found there to examine electronic data referred to in paragraph (c);
>
> (e) reproduce, or cause to be reproduced, any document from electronic data referred to in paragraph (c) in the form of a printout or other output;
>
> (f) take any document or output referred to in paragraph (c) or (e) for examination or copying;
>
> (g) examine any substance found there and, for the purpose of analysis, take samples, as reasonably required; and
>
> (h) seize and detain, in accordance with Part IV of the Act, any substance found there, if the inspector believes, on reasonable grounds, that it is necessary.[560]

Charter Minimum

The objectives of the provisions dealing with production licences are to provide a legal source of supply, to restrict production to as few plants as possible, to prevent diversion, and to keep the production out of sight of the public, especially areas where youth are present. The Government has said that the objective of maintaining small-scale medical marihuana production is a temporary measure. Its goal is to move Canada toward a supply model whereby medical-grade marihuana is produced under regulated conditions subject to product standards and distributed through pharmacies.[561]

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[560] *Ibid*, s 51.
[561] December 2003 Amendments, *supra* note 356.

The provisions of the *MMAR* dealing with production that have generated the most controversy are the sections that limit licensed producers to grow marihuana for a small number of authorized individuals[562] and limit the maximum number of producers per production site.[563]

While these provisions may not be effective at limiting diversion, they do bear some relation to the Government's objective of limiting the size and scale of production. In *Malmo-Levine*, the majority of the SCC held that although the criminal prohibition against marihuana was "largely ineffective," it was not arbitrary.[564] The Court said, "The so-called "ineffectiveness" of the prohibition on marihuana possession is simply another way of characterizing a refusal to comply with the law. That refusal cannot be elevated to a constitutional argument against validity based on the invocation of fundamental principles of justice."[565] To the extent the provisions limiting the ratio and maximum number of producers reduce the ability to hide a large surplus of marihuana they are not arbitrary.

These provisions are intrinsically linked to the issue of a legal supply and the fundamental principle of the rule of law. Without an adequate legal supply, individuals who are authorized to possess marihuana are forced to the black market. This violates the principles of fundamental justice. These provisions were amended from the original 1:1 ratio and "three max" after successful constitutional challenges.[566] It is uncertain whether these incremental amendments made a real difference in the availability of a quality legal supply. Presumably, the situation has improved marginally but in all likelihood, these incremental amendments fall short of creating an adequate legal supply.

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[562] *MMAR*, *supra* note 5, s 32(e) for PUPL; 41(b) for DPPL.
[563] *Ibid*, s 32(d) for PUPL; 63.1 for DPPL.
[564] *Malmo-Levine*, *supra* note 272 at 151.
[565] *Ibid* at headnote.
[566] See *Sfetkopoulos, supra* note 399 and *Beren, supra note* 234.

If there is still no quality legal supply, these provisions are overbroad and grossly disproportionate. However, these provisions may be moot in light of the proposed changes to the *MMAR* that are anticipated to phase out home-based production.[567]

The principles of fundamental justice contained in section 7 of the *Charter* do not require the Government to permit home-based cannabis production. Home-based production increases the likelihood of criminal mischief, diversion, fire hazards, and the production of inferior quality marihuana that is unsuitable for medical use. These are all serious public health and safety risks. However, at present they are necessary to establish an adequate legal supply. Without an adequate legal supply, individuals with a need for cannabis must access the black market, violating the principles of fundamental justice.

The *Charter* does require that individuals who require cannabinoid-based medicines have access to a lawful source that meets their medicinal needs.[568] Whether the current *MMAR* provide that is uncertain. There is no recent evidence on how the amendments have affected the supply.

The Ideal

There are challenges and risks involved with home-based or community-based production. Individuals may find it difficult to produce a product that meets their needs. The time and effort are significant. Crops can fail to thrive, or become contaminated with mould, increasing the risks to medical users' health. There are risks associated with electrical fires from the lights and wiring. Criminals may break in to steal the marihuana, jeopardizing public safety. The risk of diversion may be increased if there is less oversight. The state has a valid interest in minimizing these risks. Nevertheless, the potential risks do not apply to everyone. Some individuals enjoy the cultivation process and find it therapeutic to grow their own medicine. Proper safety measures and inspection can reduce the dangers associated with home-based cannabis production. Permitting some individuals to grow their own cannabis respects their autonomy and control over

[567] See "II: The Government's Proposed Changes" below.
[568] See "Supply of Marihuana Seed and Dried Marihuana" below.

their body and the medicine they put in it, which strikes at the core of liberty and security of the person.[569]

The ideal system would eliminate the need for most individuals to cultivate their own supply of marihuana but permit it under regulated conditions for those who so desire. The market for illegal medical cannabis and the current home-based production would shrink as the availability of a quality-controlled product eliminates the need to access the black market. It stands to reason that the related risks of these activities would likewise be reduced. For individuals who require marihuana for medical purposes, the availability of a quality legal supply obviates the need for home or community-based production and eliminates the associated risks. I will address the issue of supply more comprehensively when I analyze Part 4 of the *MMAR* dealing with this issue.

General Obligations

MMAR

Part 3 of the current *MMAR* details general obligations. Under the current *MMAR*, the holder of an ATP or a licence to produce must show proof of their authority to a police officer on demand.[570] A revoked licence must be returned to the Minister within 30 days.[571] In the case of loss or theft, written notice must be provided to police within 24 hours and to the Minister within 72 hours. The notice to the Minister must confirm that the police have been given written notice.[572]

The Minister must revoke any licence if the conditions for eligibility are not met, if the medical practitioner advises that the continued use of marihuana is contraindicated, and, among other things, if false or misleading information was provided.[573] The Minister must also revoke a licence if the producer does not comply with the restrictions imposed

[569] See e.g. *Bedford, supra* note 487 at 107, 111.
[570] *MMAR, supra* note 5, s 58.
[571] *Ibid*, s 60.
[572] *Ibid*, s 61.
[573] *Ibid*, s 62.

upon it. For example if more than four licences to produce are authorized at a particular production site, the Minister must revoke the excess licences.[574]

Section 65 of the *MMAR* addresses circumstances where marihuana must be destroyed but does not specify how it must be destroyed.

An inspector who is notified of a complaint must notify the Minister, who is authorized to communicate this information to the police for the purposes of ensuring the proper administration or enforcement of the *CDSA* or *MMAR*.[575] The Minister may also notify the police about the details of authorized production to assist them in their investigation.[576]

Charter Minimum

These objectives of these provisions are an attempt to ensure the system is not abused. The measures adopted permit law enforcement to ascertain the legal authority of an individual in possession of marihuana, maintain control over documents that support legal authority and set conditions under which authorization can be revoked. These also facilitate communication with the police if there are complaints about a production site or the medical practitioner who signed the declaration.

The measures adopted are, for the most part, rationally connected to the objective of maintaining control over the exemption system. As long as cannabis remains illegal, the possibility of diversion to the non-medical market remains a real issue. While some of the underlying requirements are subject to challenge, revoking licences for non-compliance with the law comports with the fundamental principle of the rule of law. These particular requirements do not, in procedure or substance, infringe the section 7 rights of individuals. The information provided to law enforcement is rationally connected to ascertaining the scope of an authorized person's legal authority. The requirement to notify the authorities if a licence is lost or stolen ensures that unauthorized persons do not have access to the medical supply of marihuana.

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[574] *Ibid*, s 63.1.
[575] *Ibid*, s 68.
[576] *Ibid*, s 68.1.

These measures fall within the constitutional range.

The Ideal

The ideal medical marihuana exemption system is one in which those who are legally authorized can produce and possess marihuana without unnecessary state interference. However, there will be some level of interference necessary to ensure the state interests in the safety and health of its citizens. Communicating information to police, revoking licences that do not comply with the law and requiring individuals to return documents that are no longer necessary are prudent measures.

Supply of Marihuana Seed and Dried Marihuana

MMAR

Part 4 of the current *MMAR* address the supply of marihuana. The provisions in this part are partly governed by the *Narcotic Control Regulations,*[577] which regulate the production and distribution of pharmaceuticals and other narcotics.

Part 4 authorizes the Minister to import and possess viable cannabis seed for the purpose of selling, providing, transporting, sending or delivering the seed to the holder of an ATP or to a licensed dealer.[578] A licensed dealer may provide or send viable cannabis seed to the holder of a licence to produce, or dried marihuana to the holder of an ATP. Furthermore, a licensed dealer, a pharmacist, or a medical practitioner may also provide or send dried marihuana to the holder of an ATP.[579]

Charter Minimum

The objectives of providing a legal supply chain are to ensure quality control for the health of medical users and minimize diversion for the health and safety of the community.

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[577] *Narcotic Control Regulations*, CRC, c 1041.
[578] *MMAR*, *supra* note 5, s 70.
[579] *Ibid*, s 70.2, 70.2, 70.4.

The requirement for the marihuana to be dried was recently struck down in *Smith*.[580] In that case, the Crown argued that the objectives underlying the requirement for the marihuana to be dried was primarily to reduce diversion. The Crown argued it would be easier for individuals to divert products if it was unclear whether it contained marihuana. Furthermore, it would be more difficult to determine whether someone exceeded their lawful limit if the marihuana was in a different form. The rationale for the restriction was also to protect people from potentially unfounded claims about the benefits of cannabis in forms other than dried marihuana where the risks and benefits have not been as well researched. The Crown cited the risks of using solvent-based methods to extract cannabinoids as another reason to justify the limit.[581]

The effects of this provision are that to stay within the limits of the law, individuals must smoke, vaporize[582] or bake the dried plant material rather than separating out the cannabinoids, which are fat-soluble and can be absorbed into butter or oil for oral consumption. If individuals with an ATP convert the dried marihuana to another form, they are operating outside of the law. The medical evidence shows there are different therapeutic effects depending on the mode of administration, particularly related to the onset and duration of the subjective effects.[583]

There is some evidence that the relative levels of THC and CBD in particular strains of marihuana have different therapeutic effects. There are also notable differences between sativa and indica types of the plant. The indica varieties appear to produce more of a relaxant effect on the body and the sativa varieties appear to produce more of a cerebral effect on the mind.[584] This is relevant to the different types of symptoms people experience and the desired effects they hope to obtain from cannabis.

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[580] See *Smith, supra* note 280.
[581] *Ibid* at 68-71.
[582] Vaporizing is a method that heats herbal cannabis to below the combustion point so that no plant material is burned and minimal particulate matter, smoke, tar or carbon monoxide are ingested.
[583] Kirkpatrick & Hart, *supra* note 57 at 12-13.
[584] See generally Holland, *supra* note 2.

The choice of how to take a medicine that one is authorized to possess is a decision of fundamental personal importance falling under the liberty interest in the *Charter*. A criminal restriction on the form of a medicine engages the right to liberty and security of the person.

After violations of liberty and security of the person have been found, it is necessary to ask whether limiting marihuana to its dried form is justified according to the principles of fundamental justice.

It appears that the government does have some valid reasons for restricting marihuana to its dried form and in that sense it cannot be said to be arbitrary.

In the gross disproportionality analysis, the effects of the legislation are compared to the measures. In this case, the effects are grossly disproportionate. Restricting cannabis to the form of dried marihuana removes many treatment options that are tailored to different types of symptoms. Furthermore, it increases the likelihood that individuals will smoke the marihuana, raising health concerns. The corresponding benefit to the state is minimal. Although it may be easier to calculate the quantity if it is dried, a certificate of analysis to prove the contents is still necessary. Presently, individuals are limited to a maximum quantity of dried marihuana. The quantity remains the same regardless of whether it remains in its dried form or is converted.

The current *MMAR* limits the medicinal product to its dried form, precluding other effective forms of administration that may be more effective at treating an individual's particular symptoms. This affects their liberty and security of the person in a grossly disproportionate manner that is not justified under the *Charter*.

In order to respect the rule of law and respect the principles of fundamental justice, those with a constitutional entitlement to medical cannabis must have a legal source. There must be reasonable access to a quality supply in order to ensure state barriers do not unduly restrict the availability of a medical treatment that provides substantial relief of serious and significant symptoms.

The Ideal

The ideal system of supply would offer a variety of quality-controlled cannabis-based medicines distributed through regulated, licensed distributors ("dispensaries") operated by healthcare professionals. Below, I address the ideal systems of supply and distribution.

Supply

The current legal supply options are for authorized individuals to produce their own, have a designate produce it or purchase it from the Government supplier, PPS. The numerous small-scale production sites are difficult to control. In contrast, fewer large-scale productions would be easier to monitor. Eliminating the vast majority of home and community-based production would address many of the state concerns about public heath and safety.

PPS currently holds a contract to produce cannabis for the Canadian government. In April 2007, a report evaluating this contract reported that 351 out of the 1,742 ATP license holders were accessing the Government's supply of cannabis.[585] At that time, the cost of the contract with PPS totaled $10,278,276.[586] Health Canada pays PPS $328.75/kg and charges patients $5000/kg.[587] This works out to $5 per gram, about half the price of one gram on the black market.[588]

Expanding the number of licensed commercial producers could offer more variety. Companies involved in agriculture or pharmaceutical production would be ideally suited to producing large crops of medical-grade cannabis. Commercial production facilities could convert the plant to other forms so that dried marihuana is not the only option. Utilizing economies of scale allows large-scale operations to produce a quality product at a lower price. Labelling and packaging standards should obviously be imposed.

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[585] Rielle Capler, "A Review of the Cannabis Cultivation Contract between Health Canada and Prairie Plant Systems" (October 2007) at 2, online: <*safeaccess.ca/research/pdf/hc_pps_contract_report.pdf*>.
[586] *Ibid*.
[587] *Ibid* at 7.
[588] UNODC, *World Drug Report 2011* (United Nations. Publication, Sales No. E.11.XI.10) at 194, online: <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2011.html>.

The main advantages of such a system would be that economies of scale could be employed to produce a variety of products at a cheaper cost. More comprehensive security measures could be implemented. Inspection and monitoring would be easier in a smaller number of locations. To address Parliament's concern about large-scale medical grow operations being indistinguishable from criminal ones, the prudent course of action is to limit the number of legal producers that can exist in each province. In Connecticut, similar legislation provides that at least three but not more than ten licensed cannabis producers can operate in the state.[589] Canada could implement a similar restriction for each province. This would allow for the production of an adequate supply, create competition in the market and allow for better government control of production. With fewer sites of production, it would be easier to implement necessary security and inspection measures. Law enforcement would become much easier because the legal production sites would be known.

Distribution

While pharmacies do offer some potential, they are not ideally suited to being a primary distribution channel for cannabis and cannabis-based medications. Pharmacies should offer some cannabis-based medicines, but the range of products, accessories and specialized knowledge available at a pharmacy may be limited.

An ideal system of distribution would include cannabis dispensaries where a broader range of products, accessories and resources are available. Pharmacists, or individuals with similar training, who have been specifically educated in the medical properties of cannabis and other drugs should operate these dispensaries. A cannabis-specific focus allows for a more comprehensive consideration of how this unique plant-based drug might affect the individual patient. Aside from specialized knowledge, the environment may offer a level of service to individuals using cannabis medicinally.

Individuals would have access to a broader range of products that suit their particular medical needs. Pricing, a concern for those with low or fixed incomes, could not be so

[589] US, HB 5389, *An Act Concerning The Palliative Use Of Marihuana*, 2012, Reg Sess, Conn, 2012, Sec. 10(b)(A) (enacted).

high as to render the defence to the criminal charge illusory, but otherwise, standard business practices could apply.

II: The Government's Proposed Changes to the *MMAR*

In the proposed changes to the *MMAR*, the Government indicates that Health Canada would no longer be responsible for approving a patient's authorization. In order to streamline the process and avoid lengthy waiting periods, the government proposed that:

> The core of the redesigned Program would be a new, simplified process in which Health Canada no longer receives applications from program participants. A new supply and distribution system for dried marihuana that relies on licensed commercial producers would be established. These licensed commercial producers, who would be inspected and audited by Health Canada so as to ensure that they comply with all applicable regulatory requirements, would be able to cultivate any strain(s) of marihuana they choose. Finally, the production of marihuana for medical purposes by individuals in homes and communities would be phased out.
>
> Individuals wishing to use marihuana for medical purposes would still be required to consult a physician who is licensed to practice medicine in Canada.[590]

The proposed *MMAR* will be published in the Canada Gazette, Part I, in late 2012 for further public input before the new *MMAR* are enacted.[591]

III: Beyond the *Charter* Minimum

To develop a medical cannabis access system takes careful planning and thought directed at all the individuals who will be affected by the legislation. Each provision and the legislation as a whole must be constitutional both in procedure and substance. It must respect both the constitutional rights of individuals who require medical cannabis and the collective good of the country.

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[590] Consultation Results, *supra* note 9.

[591] Health Canada, "Government of Canada Considers Improvements to the Marihuana Medical Access Program to Reduce the Risk of Abuse and Keep our Children and Communities Safe" (17 June 2011), online: <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2011/2011_80-eng.php>.

An important issue that arises is the title of the legislation. In my submission, the program and legislation should be renamed the Cannabis Access Program (CAP) and *Cannabis Access Regulations* (*CAR*). These titles and acronyms are more scientifically accurate and also consonant with the valid objectives of the program, unlike the current Medical Marihuana Access Division (MMAD) and *Marihuana Medical Access Regulations* (*MMAR*).

A clear legal standard should be in place to avoid violating the principles of fundamental justice.[592] The ideal objectives of this program should be "to provide access to cannabis (marihuana) to individuals suffering from serious physical or psychological distress where the expected benefits outweigh the known risks."

Based on this standard, a medical professional can evaluated the individual, the empirical evidence and may conclude that cannabis is appropriate. If a patient is approved to use cannabis for medicinal purposes, they must file the required information and may then take their prescription to a pharmacy or dispensary to be filled. Upon receipt of this information, the Government would issue a photo ID card to demonstrate lawful authority. Some individuals who produce cannabis in accordance with prescribed safety and health standards may still be exempted from the prohibition on production in the *CDSA*, but this is not a requirement of the *Charter*.

These suggested changes appear to be somewhat similar to the Government's proposed changes, which will be published in detail later this year.

[592] *Parker*, *supra* note 6 at 117.

CONCLUSIONS

Since the late 1980s, scientific research has provided an explanation for cannabis' apparently unique therapeutic benefits by providing an understanding of how and why this plant exerts its effects. The medicinal benefits of cannabis appear to relate to the location of the cannabinoid receptors in different areas of the brain associated with cognition, appetite, motor control and other functions. While there is a great deal of information on the general effects of cannabis, much more research is needed to reach a scientific consensus on potential therapeutic applications and contraindications. Future research efforts will likely be focused on methods of administration other than smoking that target the individual's particular condition without undesirable behavioural effects.

The *Charter* requires that individuals not be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice. These principles require a viable exemption from the general criminal prohibition of cannabis for those with a bona fide medical need who obtain, or can expect to obtain, significant relief from serious symptoms. For individuals who need to use marihuana for medical reasons, state barriers to access coupled with a criminal sanction is a violation of their liberty and security of the person that does not accord with the principles of fundamental justice.

In this paper, I have suggested a *Charter*-compliant cannabis access program dealing with aspects of production, distribution and possession. The suggested approach is tailored to the objectives of providing safe access to those who require cannabis as a medicine while minimizing the risks associated with its use. Canada has the opportunity to implement a world-class cannabis access program for those with a legitimate need. We are at a constitutional crossroad. Let us take the path toward compassionate access that rationally balances all interests.

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CURRICULUM VITAE

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Education

2011-2012	LL.M. Candidate, *University of Western Ontario*
2011	Admitted to Ontario Bar, *Law Society of Upper Canada*
2010	Admitted to British Columbia Bar, *Law Society of British Columbia*
2006 – 2009	Juris Doctor, *University of British Columbia*
2002 – 2006	Bachelor of Arts (Honours), *McMaster University* Majors: Philosophy & Communication Studies Minor: Psychology
1996-2002	A.B. Lucas Secondary School (Honours)

Presentations & Publications

Presenter, University of British Columbia 17th Annual Interdisciplinary Legal Studies Graduate Student Conference (May 10-11, 2012).

Rodman, G. & Adler, R. & Sévigny, A. Understanding Human Communication, Canadian Edition, (Toronto: Oxford University Press, 2007).

Career Experience

Barrister & Solicitor, Community Legal Services London, ON	November 1, 2011 – July 31, 2012

- Criminal defence work at Western University's Legal Aid Clinic
- Represented individuals charged with criminal offences ineligible for Legal Aid
- Responsible for file management, interviews, researching law and representing clients at trial

Articled Student, Michaels & Filkow Richmond, BC	August 31, 2009 – May 28, 2010

- Sole articling student at a boutique criminal defense firm, specializing in impaired driving

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- Responsible for file management, client interviews, researching law and appearing in court on behalf of First Nations clients