CANADA'S *MARIJUANA MEDICAL ACCESS REGULATIONS*: UP IN SMOKE

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INTRODUCTION

Researchers have discovered that chocolate produces some of the same reactions in the brain as marijuana. The researchers also discovered other similarities between the two but can't remember what they are. – Matt Lauer[1]

The subject matter of this issue of the Albany Government Law Review is topical and timely. Years of trying to enforce drug prohibition through the criminal law has demonstrably failed to reduce the supply or demand of prohibited substances, particularly cannabis.[2] Around the world, different countries have experimented with legalizing and decriminalizing drugs.[3] In the United States, voters in Colorado and Washington State have recently taken the initiative to legalize cannabis.[4] Canada has a unique political and legal landscape. The criminal law is in the exclusive jurisdiction of the federal government.[5] There are no voter initiatives to amend the criminal law.[6]

While public attention on the issue of cannabis law reform has gained some momentum in recent years, the issue of cannabis use is not new. The cannabis plant has been utilized by civilizations worldwide for millennia.[7] Throughout history, many societies have cultivated the plant for medicine, fuel, food, clothing, and as an intoxicant.[8] The anecdotal and observational reports of its medical and non-medical use date back thousands of years B.C., appearing in the Bible, and continuing ever since.[9] However, the

[1] *Marijuana Quotes*, FINESTQUOTES.COM, http://www.finestquotes.com/select_quote-category-Marijuana-page-0.htm (last visited Feb. 3, 2013).

[2] *Legalizing Marijuana: An Exit Strategy from the War on Drugs*, BECKLEY FOUND. (Apr. 4, 2011), http://www.beckleyfoundation.org/2011/04/20/legalizing-marijuana-an-exit-strategy-from-the-war-on-drugs/.

[3] *See* Alexei Barrionuevo, *Latin America Weighs Less Punitive Path to Curb Drug Use*, N.Y. TIMES, Aug. 27, 2009, at A8.

[4] Dan Frosch, *In Colorado, Getting Down to Business of Marijuana,* N.Y. TIMES, Dec. 18, 2012, at A18.

[5] Constitution Act, 1867, 30 & 31 Vict., c. 3, § 91 (27) (U.K.).

[6] *See id.*

[7] LEAH SPICER, SENATE SPECIAL COMM. ON ILLEGAL DRUGS, HISTORICAL AND CULTURAL USES OF CANNABIS AND THE CANADIAN "MARIJUANA CLASH", pt. I(A)(1) (2002), http://www.parl.gc.ca/Content/SEN/Committee/371/ille/library/Spicer-e.htm.

[8] *Id.*

[9] *Id.* at pt. I(A)(3). The historical accounts of cannabis are fascinating and detailed but beyond the scope of this paper. For a comprehensive account of marijuana's ancient history, *see generally* Chris Bennett, *Early/Ancient History, in* THE POT BOOK: A COMPLETE GUIDE TO CANNABIS 17 (Julie Holland ed., 2010).

case for reform has never been clearer. Modern scientific research has significantly changed the way we understand the effects of cannabis use. The commonly reported effects, including memory issues referenced in the joke above, have been partially explained by the location of cannabinoid receptors in the mammalian brain.[10] In-depth studies into the physical and psychological effects of the plant have found that while there are acute and chronic risks associated with its use, marijuana (the dried bud of the female plant) is relatively harmless when used in moderation by healthy adults, and can be tremendously beneficial for some individuals suffering from illness and disease.[11]

The following is a critical examination of Canada's medical cannabis laws, divided into three main parts. Part One provides a brief overview of the legal framework of Canada's cannabis prohibition. Part Two outlines some evidence of the risks and medicinal benefits of cannabis, to form the factual underpinning for a constitutional analysis under section 7 of the Canadian *Charter of Rights and Freedoms*. In Part Three, I apply the research literature to the *Charter*. I suggest a minimum system of medical access, and an ideal system that accounts for broader societal goals. Although there has been a great deal of progress in understanding some individuals' legitimate medical need for cannabis, there is still a long way to go before those individuals can use cannabis without the fear of criminal sanction.

I. THE LEGAL FRAMEWORK

So what are the laws that govern cannabis in Canada? In this part, I examine the laws that provide a backdrop to the issue of

[10] Roni Caryn Rabin, *Legalizing of Marijuana Raises Health Concerns*, N.Y. TIMES WELL BLOGS (Jan. 7, 2013, 5:08 PM), http://well.blogs.nytimes.com/2013/01/07/legalizing-of-marijuana-raises-health-concerns/.

[11] *See* CAN. GOV'T COMM'N OF INQUIRY, LE DAIN CANNABIS REPORT 86 (1972) [hereinafter LE DAIN], http://www.druglibrary.eu/library/reports/ledaincan.pdf; MAYOR'S COMM. ON MARIJUANA, THE LA GUARDIA COMMITTEE REPORT, THE MARIJUANA PROBLEM IN THE CITY OF NEW YORK 67–68 (1944), http://files.meetup.com/4391172/laguardia.pdf; MARIJUANA: REPORT OF THE INDIAN HEMP DRUGS COMMISSION 1893–1894, at 223 (1969); GABRIEL G. NAHAS & ALBERT GREENWOOD, THE FIRST REPORT OF THE NATIONAL COMMISSION ON MARIHUANA: A SIGNAL OF MISUNDERSTANDING OR EXERCISE IN AMBIGUITY 63 (1972), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1749335/pdf/bullnyacadmed00168-0058.pdf; REPORT OF THE SENATE SPECIAL COMM. ON ILLEGAL DRUGS, CANNABIS: OUR POSITION FOR A CANADIAN PUBLIC POLICY, vol. 1, at 137 (2002), [hereinafter CANNABIS: OUR POSITION], http://www.parl.gc.ca/Content/SEN/Committee/371/ille/rep/repfinalvol1-e.pdf.

medical cannabis in Canada. First, I provide an overview of the criminal prohibition. Second, I outline section 7 of the Charter, which has been the focus of the litigation in this area. Third, I consider the medical exception to the criminal prohibition. I discuss the enactment and subsequent revision of the Marijuana Medical Access Regulations currently in force, and the proposed Marijuana for Medical Purposes Regulations, expected to be enacted in the spring of 2013.

A. The Criminal Prohibition

I begin by looking at the roots of the prohibition of cannabis in Canada. In this subsection, I provide a brief history of cannabis prohibition. Although the concern over cannabis was not widespread in the early days of prohibition, the subsequent fervor, and the infamous "war on drugs" seems to have firmly rooted cannabis prohibition in the Canadian legal landscape. In 1922, Emily Murphy, a police magistrate and judge of the Juvenile Court in Edmonton, wrote a chapter called "Marahuana—A New Menace" in *The Black Candle,* Canada's first book on drug abuse.[12] Seemingly the first Canadian to publicly voice concern about cannabis, Murphy quoted the police chief of Los Angeles:

> Persons using this narcotic[] smoke the dried leaves of the plant, which has the effect of driving them completely insane. The addict loses all sense of moral responsibility. Addicts to this drug, while under its influence, are immune to pain, and could be severely injured without having any realization of their condition. While in this condition they become raving maniacs and are liable to kill or indulge in any form of violence to other persons, using the most savage methods of cruelty without . . . any sense of moral responsibility.
>
> When coming from under the influence of this narcotic, these victims present the most horrible condition imaginable. They are dispossessed of their natural and normal will power, and their mentality is that of idiots. If this drug is indulged to any great extent, it ends in the untimely death of its addict.[13]

It is not clear if this description had any effect on Parliament's

[12] EMILY F. MURPHY, THE BLACK CANDLE 332–33 (1922); *see also* R. Solomon et al., *Legal Considerations in Canadian Cannabis Policy*, 4 CAN. PUB. POL'Y 419, 420 (1983).

[13] MURPHY, *supra* note 12, at 332–33.

decision to prohibit cannabis possession and distribution. Only brief mention was made of cannabis in the Parliamentary debates, and there was no discussion of the drug's health effects or the rationale for its inclusion.[14] However, in 1923, Parliament amended *The Opium and Narcotic Drug Act* to make cannabis a federally prohibited substance, albeit incorrectly classified as a narcotic.[15] Until the early 1960s, the negative characterization of cannabis was unchallenged since most of the public had no contact with cannabis use or users, and there were no alternative sources of information.[16] Solomon *et al* have argued that:

> [a]s long as cannabis use was perceived to be a moral evil which led to ruin, insanity and violent crime, its elimination at any cost was an inherently desirable goal. [However, t]he sudden and sustained increases in the rates of cannabis use which began in the mid-1960s rendered such an extreme view of the drug's [negative] effects untenable. In the course of a few years, large numbers of middle and upper class young people were subjected to the ordeal of drug investigations and the adverse consequences of arrest, conviction and a criminal record.[17]

Currently in force is the *Controlled Drugs and Substances Act* (CDSA),[18] which replaced the *Narcotic Control Act* (NCA) in 1996. Pursuant to the CDSA, it is a federal offense for any person to possess, traffic, import/export, or produce any of the scheduled substances. Schedule II prohibits:

> Cannabis, its preparations, derivatives and similar synthetic preparations, including
>
> (1) Cannabis resin
> (2) Cannabis (marihuana)
> (3) Cannabidiol (2–[3–methyl–6–(1–methylethenyl)–2–cyclohex en–1–yl]–5–pentyl–1,3–benzenediol)
> (4) Cannabinol (3–n–amyl–6,6,9–trimethyl–6–dibenzopyran–1–ol)
> (5) Nabilone ((±)–trans–3–(1,1–dimethylheptyl)–6,6a, 7,8,10,10a –hexahydro–1–hydroxy–6,6–dimethyl–9H– dibenzo[b,d]pyran–9–one)
> (6) Pyrahexyl (3–n–hexyl–6,6,9–trimethyl–7,8,9,10–tetrahydro–6–dibenzopyran–1–ol)
> (7) Tetrahydrocannabinol (tetrahydro–6,6,9–trimethyl–3–penty

[14] LE DAIN, *supra* note 11, at 166.

[15] The Opium and Narcotic Drug Act, S.C. 1923, c. 22 (Can.); s*ee* CANNABIS: OUR POSITION, *supra* note 11, at 256.

[16] LE DAIN, *supra* note 11, at 166.

[17] Solomon et al, *supra* note 12, at 421.

[18] Controlled Drugs and Substances Act, S.C. 1996, c. 19 (Can.).

l–6H–dibenzo[b,d]pyran–1–ol)
(7.1)3-(1,2-dimethylheptyl)-7,8,9,10-tetrahydro-6,6,9-trimethyl-6H-dibenzo[b,d]pyran-1-ol (DMHP)

but not including

(8) Non-viable Cannabis seed, with the exception of its derivatives
(9) Mature Cannabis stalks that do not include leaves, flowers, seeds or branches; and fiber derived from such stalks[19]

The penalties for possessing, trafficking, importing/exporting, or producing cannabis cover a broad range. Simple possession of cannabis marijuana under thirty grams, or cannabis resin under one gram is a summary offense carrying a maximum penalty of a $1,000 fine, six months imprisonment, or both.[20] In contrast, trafficking in cannabis is an indictable offense, and carries a potential penalty of imprisonment for life.[21] There is a mandatory minimum sentence of one year in prison if the offender was associated with a criminal organization, threatened or used violence, carried a weapon or imitation weapon, or if he or she has been "convicted of a designated substance offense" within the previous ten years.[22] There is a mandatory two year prison sentence if the offense was committed near a school or public place usually frequented by young people; if the offense was committed in prison; or if a person under eighteen was used in committing the offense.[23] Trafficking is a "designated substance offense," which is proven once a person is found to have given or delivered a drug to another.[24] It is not necessary for the Crown to prove that the person acted to promote the distribution of the drug.[25] Profit is not an element of the offense.[26] The offense of trafficking can be established for behavior as minor as passing a joint or giving a small amount to someone else for safekeeping.[27]

In some circumstances, Parliament recognizes that there are legitimate purposes to possess, traffic, import/export, or produce controlled substances such that the disapprobation of society is

[19] *Id.* at sched. II.
[20] *Id.* § 4(5).
[21] *Id.* § 5(3).
[22] *Id.* § 5(3)(a)(i). A "designated substance offense" is defined in the CDSA to include any of the drug offenses except simple possession, including conspiracy to commit or being an accessory after the fact to any of those offenses. *Id.* § 2.
[23] *Id.* § 5(3)(a)(ii).
[24] R. v. Larson (1972), 6 C.C.C. 2d 145 (Can. B.C. C.A.).
[25] *Id.*
[26] *See* R. v. Drysdelle (1978), 22 N.B.R. 2d 86 (Can. N.B. Sup. Ct. App. Div.).
[27] *See* R. v. Lauze (1980), 17 C.R. 3d 90 (Can. Que.).

unwarranted. Some of these legitimate purposes include: research, law enforcement, or medical purposes. Section fifty-five of the CDSA empowers the Governor in Council to make regulations exempting persons or classes of persons from the application of the CDSA or *Regulations*.[28] It is by this authority that Parliament has enacted regulations that provide an exemption for some individuals to engage in cannabis-related activities that would otherwise be illegal. Some individuals may possess and cultivate cannabis if they meet the conditions established by regulation.[29]

Notwithstanding the "stigmatization of the accused, loss of privacy, stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, uncertainty as to the outcome and sanction" during the process of criminal litigation, the negative consequences for individuals upon conviction are very serious and cannot be understated.[30] Although a range of sentences gives judges some flexibility in imposing a fit sentence, any criminal record can affect present employment as well as the individual's personal life. For medical users, in addition to the deprivation of their liberty at the time of the arrest, the Ontario Court of Appeal noted that if a jail sentence is imposed upon conviction, the "collateral consequence" for someone with a medical need for cannabis is that he is deprived of his medicine while incarcerated, rendering this penalty "particularly severe," such that it may affect security of the person—a person's physical and psychological integrity.[31]

Considering the evidence and constitutional principles, courts in Canada have held that a blanket criminal prohibition against cannabis is unconstitutional without a medical exemption.[32] The result is that if Canada wants to maintain a general criminal prohibition on cannabis, there must be an exemption for medical use.[33] Without a constitutional medical exemption, the criminal prohibition will be of no force and effect. There is a growing body of anecdotal and scientific evidence that suggests cannabis

[28] Controlled Drugs and Substances Act. S.C. 1996, c. 19 § 55 (Can.); *see* R. v. Long (2007), 88 O.R. 3d 143, ¶ 2, 3 (Can. Ont. Sup. Ct. J.).

[29] Marihuana Medical Access Regulations (Controlled Drugs and Substances Act), SOR/2001-227 (Can.).

[30] Mills v. The Queen, [1986] 1 S.C.R. 863**,** 920 (Can.).

[31] R. v. Parker, [2000] 49 O.R. 3d 481 (Can. Ont. C.A.).

[32] *See* Long, 88 O.R. 3d, ¶ 9.

[33] *Id.*

(marijuana) provides a unique medicinal benefit that, for some individuals, offers a great deal of relief for a range of unpleasant physical and psychological symptoms.[34] The medical evidence is often conflicting, and it seems that the only consensus is that more research needs to be done.[35] However, some of the main effects are relatively well understood.

Despite the best efforts of law enforcement, it has proved very difficult to control production and distribution. Canadians are increasingly saying "No" to "Just Say No." A recent national survey conducted by Forum Research indicates that sixty-five percent of the Canadian public supports legalizing marijuana.[36] Cannabis use in Canada is approximately four times the world average.[37] In spite of the criminal prohibition, many individuals use marijuana and derive benefit from that use.[38] For some individuals, the medicinal benefit is so great that courts have found those individuals have a right to be free from government interference with their cannabis use.[39] In this respect, the *Charter* has been pivotal in the development of a legal medical exemption for cannabis in Canada. In the next section I provide an overview and give an introduction to the basic principles of section 7 of the *Charter*, before considering the medical evidence in Part Two.

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[34] *See Medical Use of Cannabis (marijuana)*, HERE TO HELP, http://heretohelp.bc.ca/factsheet/medical-use-of-cannabis (last visited Jan. 22, 2013); *see also Cannabis and Cannabinoid Research*, MULTIPLE SCLEROSIS RESOURCE CENTRE, http://www.msrc.co.uk/index.cfm/fuseaction/show/pageid/18 15 (last visited Jan. 21, 2013).

[35] *See* Glenn Blain, *Medical Marijuana Proponents in New York Renew Push for Legalization*, N.Y. DAILY NEWS (Nov. 25, 2012), http://www.nydailynews.com/new-york/medical-marijuana-proponents-ny-renew-push-legalization-article-1.1207862; *see also* Lauren Cox, *Medical Marijuana: Benefits vs. Risks*, LIVE SCI. (Nov. 5, 2012, 4:26 PM), http://www.livescience.com/24554-medical-marijuana.html.

[36] Press Release, Forum Research Inc., Two Thirds Support Legalization or Decriminalization of Pot (Nov. 20, 2012) (*available at* https://www.forumresearch.com/forms/News%20Archives/News%20Releases/49974_Canada-wide_-_Marijuana_Poll_(Forum_Research)_(20121119).pdf).

[37] U.N. OFFICE ON DRUGS & CRIME, WORLD DRUG REPORT 2011, at 176, 218 (2011); *see also Canadian Pot Use Four Times Global Rate*, CANADA.COM (July 10, 2007), http://www.canada.com/nationalpost/news/story.html?id=67996149-9dee-4a3a-a86e-f7a022274658&k=75899.

[38] *Medical Use of Cannabis (marijuana)*, *supra* note 34.

[39] *Id.*

B. The Charter

The *Charter* is the supreme law of Canada. Any laws that are inconsistent with it are of no force and effect.[40] To the extent of any inconsistency with the *Charter*, courts are required to strike down, read in, or read down legislation to make it *Charter*-compliant.[41] Section 7 of the Canadian *Charter of Rights and Freedoms* guarantees that, "[e]veryone has 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."[42] In this section I consider the legal constructs of security of the person and the principles of fundamental justice found in section 7.

Section 7 provides three independent legal rights: life, liberty, and security of the person, subject to the principles of fundamental justice.[43] The legal rights described in section 7 of the *Charter* apply to every natural person in Canada.[44] These rights are independent but overlapping.[45] Presently, no comprehensive definition exists for these three interests, and constitutional challenges are decided on the basis of the evidence presented in each case.[46] 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.[47] The courts determine whether the government has infringed these rights using a "purposive" analysis, which seeks to understand the values underlying the individual rights and the state interests.[48] Rights violations that conform to the principles of fundamental justice will not violate the *Charter*. For a successful claim under section

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

[41] *See id.*

[42] *Id.*

[43] *Id.*

[44] *See* Singh v. Minister of Emp't & Immigration, [1985] 1 S.C.R. 177, 204 (Can.).

[45] *See id.* (stating that violations of life and liberty often violate security of the person).

[46] ROBERT J. SHARPE & KENT ROACH, THE CHARTER OF RIGHTS AND FREEDOMS 201 (3d ed. 2005); *see* Carter v. Canada (Att'y Gen.), 2012 B.C.S.C. 886, ¶ 1306 (Can. B.C.).

[47] United States v. Burns, [2001] 1 S.C.R. 283, ¶ 4 (Can.).

[48] R. v. Morgentaler, [1988] 1 S.C.R. 30, 52 (Can.).

7, the legal burden is on the person claiming a *Charter* violation.[49] He must show, on a balance of probabilities, that the government action has violated his right to life, liberty, or security of the person, and identify a principle of fundamental justice that was breached.[50]

Although there has not been a need to argue a violation of life, this dimension of section 7 may also be engaged where the deprivation of marijuana increases a risk of death.[51] 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, which is fundamental to their security of the person.[52] This is where the debate has focused in the medical context.

1. Security of the Person

Security of the person encompasses both the physical and psychological integrity of the individual.[53] In *Morgentaler*, Chief Justice Dickson 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."[54] It is well established in Canada's legal history that the human body should be legally protected from physical interference.[55] For example, the common law recognizes that any medical procedure carried out on a person without his consent constitutes an assault.[56]

In addition to encompassing a person's physical integrity, the Supreme Court has held that security of the person also

[49] R. v. White, [1999] 2 S.C.R. 417, ¶ 113 (Can.).

[50] Canadian Charter of Rights Decisions Digest § 7, CANADIAN LEGAL INFORMATION INSTITUTE, http://www.canlii.org/en/ca/charter_digest/s-7.html (last visited Jan. 22, 2013).

[51] *See* Canada (Att'y Gen.) v. PHS Cmty. Servs. Soc'y, [2011] 3 S.C.R. 134, 138 (Can.); Chaoulli v. Québec (Att'y Gen.), [2005] 1 S.C.R. 791, 795 (Can.); R. v. Parker, [2000] 49 O.R. 3d 481, ¶¶ 7, 10 (Can. Ont. C.A.); Rodriguez v. British Columbia (Att'y Gen.), [1993] 3 S.C.R. 519, 587–88 (Can.); *Morgentaler*, 1 S.C.R. at 32.

[52] *See PHS Cmty. Servs. Soc'y (Att'y Gen.)*, 3 S.C.R. at 138; *Chaoulli*, 1 S.C.R. at 795; *Parker*, 49 O.R. 3d, ¶¶ 7, 10; *Rodriguez*, 3 S.C.R. at 587–88; *Morgentaler*, 1 S.C.R. at 32.

[53] *Morgentaler*, 1 S.C.R. at 32.

[54] *Id.* at 53.

[55] *Id.*

[56] *Id.*

encompasses protection of psychological integrity, which can be negatively affected by "overlong subjection to the vexations and vicissitudes of a pending criminal accusation."[57] As noted previously, a criminal accusation can cause 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; all of which may lead to stress, anxiety, and the compromise of an individual's psychological integrity. Psychological effects must be sufficiently serious to reach a level that will engage the section 7 right to security of the person. Ordinary stress or anxiety does not fall within the ambit of protection, but serious psychological effects "need not rise to the level of nervous shock or psychiatric illness."[58]

The right to security of the person has not generally been interpreted to create a positive obligation on the state,[59] nor has it been extended to include economic rights or any rights wholly unconnected with the administration of justice.[60] There are circumstances in which 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."[61] It is clear that imposing a criminal sanction for accessing a necessary medicine affects an individual's right to be free from government interference and this affects his security of the person.[62] The serious threats to the rights protected by section 7 require a clear connection between valid objectives and the measures adopted by Parliament to achieve those objectives.[63] The law prohibiting cannabis must be in place for good reason, and the measures used must be tailored to that reason. However, violations of security of the person are justified if they are in accordance with the principles of fundamental justice.[64]

[57] Mills v. The Queen, [1986] 1 S.C.R. 863**,** 919–20 (Can.).

[58] *Chaoulli*, 1 S.C.R. ¶ 116 (quoting New Brunswick (Minister of Health & Cmty. Servs. v. G. (J.), [1999] 3 S.C.R. 46, ¶ 60 (Can.)).

[59] Gosselin v. Quebec (Att'y Gen.), [2002] 4 S.C.R. 429, 491 (Can.).

[60] PETER W. HOGG, CONSTITUTIONAL LAW OF CANADA 47–15 (2010).

[61] R. v. Morgentaler, [1988] 1 S.C.R. 30, 54 (Can.).

[62] Chaoulli v. Quebec, [2005] 1 S.C.R. 791, 820 (Can.).

[63] Canadian Charter of Rights Decisions Digest, Section 1, Updated April 2005, *available at* http://canlii.org/en/ca/charter_digest/s-1.html.

[64] Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c. 7 (U.K.).

2. 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.[65] Violations that are consistent with these principles are justified in law.[66] 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.[67] Early on in the *Charter* jurisprudence, the SCC set a high standard by requiring that government action meet principles of fundamental justice in both procedure and substance.[68]

The SCC has said the principles of fundamental justice are "the basic tenets" of the legal system,[69] a balance of individual rights and state interests,[70] and principles that "have general acceptance among reasonable people."[71] Laws that are arbitrary, vague, or overbroad will violate the principles of fundamental justice.[72] More specifically, these principles require that serious criminal offenses have a minimum *mens rea* requirement,[73] a right to make full answer and defense,[74] and a right to silence.[75] It would violate the principles of fundamental justice if youths were treated the same way as adults in sentencing,[76] or if a punishment would shock the conscience of the public.[77]

Two years after the *Charter* was enacted, the SCC attempted to infuse the term with precise legal meaning:

> [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

[65] Canadian Charter of Rights Decisions Digest, Section 7, Updated July 2004, *available at* http://www.canlii.org/en/ca/charter_digest/s-7.html at 10.

[66] *Id.*

[67] HOGG, *supra* note 60, at 47–19.

[68] Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486, 487 (Can.).

[69] *Id.*

[70] Cunningham v. Canada, [1993] 2 S.C.R. 143, 144 (Can.).

[71] Rodriguez v. British Columbia (Att'y Gen.), [1993] 3 S.C.R. 519, 607 (Can.).

[72] *Id.* at 619, 621 (McLachlin, J., dissenting with the agreement of L'Heureux-Dubé, J. and Cory, J.).

[73] *See* Re B.C. Motor Vehicle Act, 2 S.C.R. at 487; *see also* R v. Vaillancourt, [1987] 2 S.C.R. 636, 638 (Can.).

[74] R. v. Stinchcombe, [1991] 3 S.C.R. 326, 326–27 (Can.).

[75] R. v. Hebert, [1990] 2 S.C.R. 151, 152 (Can.).

[76] R. v. D.B., [2008] 2 S.C.R. 3, 15 (Can.).

[77] Canada v. Schmidt, [1987] 1 S.C.R. 500, 522 (Can.).

> simply one in which . . . future growth will be based on historical roots.[78]

In 2003, the Supreme Court released a decision in the case of *R. v. Malmo-Levine*. David Malmo-Levine was charged with possession of marijuana, and argued that the criminal prohibition violated his right to liberty and was contrary to the principles of fundamental justice because the impugned conduct did not cause harm to most individuals.[79] 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.[80]

In that case, the harm principle was rejected as a principle of fundamental justice.[81] The majority found that there were some criminal laws that do not necessarily cause harm, but which, nevertheless, are valid exercises of Parliament's power.[82] Even still, the majority found there was some apprehension of harm for some vulnerable groups, and the decision to criminalize marijuana fell within Parliament's discretion.[83]

In other jurisprudence, courts have held that for those who qualify, or ought to qualify for a legal exemption, legislation that has the effect of forcing people to the black market to access something they are legally entitled to possess will violate the rule of law, one of the fundamental principles of justice.[84] Vague, arbitrary, overbroad, or grossly disproportionate laws will also violate the principles of fundamental justice.[85] The *Charter* defines the borders of state action, drawn in relation to valid

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[78] Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486, 512–13 (Can.) (quoting Luc Tremblay, *Section 7 of the Charter: Substantive Due Process?*, 18 U. B.C. L. REV. 201, 254 (1984)).

[79] This argument hearkens to the essential points elaborated upon by John Stuart Mill in his famous treatise, *On Liberty*. JOHN STUART MILL, ON LIBERTY & UTILITARIANISM 96–121 (2008).

[80] R. v. Malmo-Levine, [2003] 3 S.C.R. 571, 574 (Can.).

[81] *Id.* at 575.

[82] *Id.* Cannibalism, bestiality, cruelty to animals, and consensual adult incest were some examples provided by the court. *Id.* at 635.

[83] *Id.*

[84] Hitzig v. The Queen, [2003] 171 C.C.C.3d 18, ¶ 118 (Can. Ont. C.A.)

[85] Canadian Charter of Rights Decisions Digest, *supra* note 65, at 25.

objectives.[86] More recently in the section 7 analysis, courts have focused on arbitrariness, over-breadth, and gross disproportionality.[87]

The constitutional analysis begins with a consideration of the objectives of the impugned legislation. Only once the objectives are clear can the courts assess whether the measures adopted by Parliament violate life, liberty, or security of the person contrary to the principles of fundamental justice.[88] Although it sounds simple, it is unclear whether the analysis suggested for these concepts can be applied clearly. The objective of the enabling legislation, the CDSA, is the protection of health and public safety.[89] The objective of the current *MMAR* is 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."[90] The objective of the proposed MMPR is to reduce the risks to public health, security, and safety of Canadians, while significantly improving the way in which individuals access marihuana for medical purposes.[91]

The capricious whims of a tyrannical ruler have no place in a free and democratic society. The proposition that laws should not be arbitrary has been accepted as a principle of fundamental justice. The jurisprudence on arbitrariness is not entirely settled. In *Chaoulli*, three justices[92] preferred an approach that asked whether a limit was "necessary" to further the state objective.[93] Conversely, three other justices, 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[.]"[94]

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[86] *Id.* at 26.

[87] *Id.*

[88] *Id.* at 1.

[89] R. v. Malmo-Levine, [2003] 3 S.C.R. 571, ¶ 65 (Can.).

[90] *Fact Sheet-Medical Access to Marihuana,* HEALTH CANADA, http://cannatherapyhealing.com/images/Fact_Sheet_-_Medical_Access_To_marihuana.pdf (last updated Feb. 8, 2008).

[91] *Marihuana for Medical Purposes Regulations: Regulatory Impact Analysis Statement*, CAN. GAZETTE (Dec. 15, 2012), http://gazette.gc.ca/rp-pr/p1/2012/2012-12-15/html/reg4-eng.html.

[92] Chaoulli v. Quebec, [2005] 1 S.C.R. 791, 852 (Can.) (per McLachlin, C.J. and Major, J.).

[93] *Id.* at 852 ¶¶ 131–32.

[94] *Id.* at 894 ¶ 232 (per Binnie and LeBel, J.J.).

When given the opportunity to clarify the approach that should prevail, the unanimous SCC in *Insite* found it "unnecessary" because the government action at issue in that case qualified as arbitrary under any definition.[95] At present, there appear to be three different tests for arbitrariness: (1) whether the impugned law is necessary to achieve the objectives, (2) whether the deprivation life, liberty or security of the person bears any relationship to the objective, or (3) whether it is inconsistent with the state interest that lies behind it.[96] In *Bedford,* the ONCA adopted "the more conservative test for arbitrariness . . . that requires proof of inconsistency, and not merely a lack of necessity[, u]ntil a clear majority of the Supreme Court holds otherwise. . . ."[97]

A measure is overbroad if it goes beyond what is necessary to achieve the state objectives, and catches conduct that does not contribute to the social harm Parliament seeks to curtail.[98] Measures that are grossly disproportionate will also violate the *Charter*.[99] In *Suresh*, the SCC considered whether deportation to torture would violate section 7.[100] The Court confirmed that the means taken to achieve an objective can be so disproportionate to the desired end so as to offend the principles of fundamental justice.[101] "Thus we must ask whether the government's proposed response is reasonable in relation to the threat."[102]

This was reiterated in *Malmo-Levine* where the majority found that the federal criminal prohibition of cannabis was not *grossly* disproportionate to the legislation's objectives.[103] The majority said that the law did not violate the principles of fundamental justice, partly because there was some apprehension of harm and there was no minimum sentence for simple possession.[104] The Criminal Code dictates that a criminal sanction must be proportional "to the gravity of the offence and the degree of

[95] Canada (Att'y Gen.) v. PHS Cmty. Servs. Soc'y, [2011] 3 S.C.R. 134, 187 (Can.).

[96] R. v. Morgentaler, [1988] 1 S.C.R. 30, 74 (Can.).

[97] Ontario (Att'y Gen.) v. Bedford [2012], 2012 O.N.C.A. 186, ¶ 147 (Can. Ont. C.A.).

[98] *Id.* ¶ 201.

[99] *Id.* ¶ 256.

[100] Suresh v. Minister of Citizenship and Immigration, [2002] 1 S.C.R. 3, 32 (Can.).

[101] *Id.*

[102] *Id.*

[103] R. v. Malmo-Levine, [2003] 3 R.C.S. 571, 577 (Can.).

[104] *Id.* at 653.

responsibility of the offender."[105] In some cases, prison may "constitute a fit sentence."[106]

Interestingly, 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.[107] 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.[108]

Although the concepts involved are almost identical, the legal burden is different. In section 7, the burden is on the claimant to show his rights have been violated in a manner inconsistent with the principles of fundamental justice.[109] If he 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.[110] 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.[111] Any state justification will likely be insufficient unless exceptional circumstances, such as war or natural disaster, justify overriding the fundamental principles of justice.[112]

Based on section 7 of the *Charter*, the Supreme Court of Canada has said that everyone in Canada has a constitutional right to access necessary medical treatment without fear of criminal sanction.[113] One of the fundamental cases contemplating section 7 of the *Charter* in this context was *R. v. Morgentaler*.[114] In that case, Parliament carved out a legal exemption to the general provision prohibiting women from procuring an abortion unless the continuation of the pregnancy would endanger the life

[105] Canada Criminal Code, R.S.C. 1985, c. C-46, P.826 (Can.).
[106] Malmo-Levine, 3 R.C.S. at 653.
[107] *Id.* at 711.
[108] *Id.* at 641.
[109] R. v. Malmo-Levine, [2003] 3 R.C.S. 571, 627 (Can.).
[110] *Id.* at 659.
[111] *Id.* at 719.
[112] See R. v. Heywood, [1994] 3 R.C.S. 761, 765 (Can.); Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486, 488 (Can.).
[113] Rodriguez v. B.C. (Att'y Gen.), [1993] 3 R.C.S. 519, 586 (Can.).
[114] R. v. Morgentaler, [1988] 1 S.C.R. 30, 32 (Can.).

or health of the mother.[115] Where certain conditions were met, women were permitted to obtain a "therapeutic abortion."[116] As it turned out, the conditions that were established in law meant that women who would prima facie qualify for the defense were nevertheless unable to obtain an abortion, largely as a result of the conditions established by the legislation.[117]

The legislation made it optional for hospitals to establish an abortion panel.[118] The required composition of the panel precluded its establishment in many hospitals.[119] The statutory standard of endangering the woman's life or health was vague and inconsistently applied.[120] Many women had to travel a great distance to appear before the abortion panel.[121] This legal system caused delays in getting approval for an abortion, which led to many undesired consequences, including greater health risks for those women.[122] In that case, Chief Justice Dickson of SCC said:

> 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.[123]

As we will see, the *Marihuana Medical Access Regulations*, first enacted in 2001, had many of the same problems with a legal defence that is difficult to access. Even before the MMAR were enacted, the SCC's precedential findings and conclusions in *Morgentaler* and other jurisprudence set the stage for medical marijuana users to challenge the broad criminal prohibition of marijuana under section 7 of the *Charter*.[124] However, simply that a defense is difficult to access will not make it illusory for

[115] *Id.* at 34.
[116] *Id.* at 33.
[117] *Id.* at 34.
[118] *Id.* at 33.
[119] *Id.*
[120] *Id.*
[121] *Id.* at 33–34.
[122] *Id.* at 35.
[123] *Id.* at 33, 70.
[124] *Id.* at 33.

the *Charter*. In its decision in *R. v. St-Onge Lamoureux*, the SCC noted that a defence created by Parliament will not be illusory, in the sense of practically unavailable, simply because accused persons will rarely be successful in raising it.[125]

The decision to establish a medical exemption system was as a result of criminal litigation against medical cannabis users, not Parliamentary initiative. The evidence presented before the criminal courts caused judges to conclude that the law which allowed the violation of some individuals' right to security of the person was arbitrary, and therefore contrary to the principles of fundamental justice.[126] Prior to an established regulatory system for medical exemption, individuals with a medical condition could get an exemption from the criminal prohibition using the discretionary exemption under section 56 of the CDSA, 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.[127]

The data, albeit limited, suggests that relatively few individuals were successful in obtaining exemptions.[128] Terrance 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.[129] Conventional medications and even two brain surgeries were not helpful in

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[125] R. v. St-Onge Lamoureux, [2012] S.C.C. 57, 74 (Can.), cited in R. v. Mernagh, [2011] O.J. No. 1669, ¶ 113 (Can. Ont. Super. Ct.).

[126] R. v. Parker, [2000] 49 O.R. 3d 481, ¶ 5 (Can. Ont. C.A.).

[127] Controlled Drugs and Substances Act, S.C. 1996, c. 19 § 56 (Can.).

[128] *See, e.g.*, Hitzig v. The Queen, [2003] 171 C.C.C. 3d 18, ¶ 36 (Can. Ont. C.A.). In *Hitzig*, the court stated that:

> [i]n 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.

Id.

[129] *Parker*, [2000] 49 O.R. 3d ¶ 3.

controlling his violent and life-threatening seizures.[130] He started using marijuana and documented his symptoms and use patterns in a journal.[131] He noted that his seizures were less frequent and less severe, that he had reduced his medication, and that he could even prevent oncoming seizures.[132] Parker's doctor wrote in September 1987 that:

> 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 marijuana in conjunction with his other anti-convulsant medications.[133]

Parker grew his own supply of marijuana to avoid the black market. On July 18, 1996, police officers executed a warrant to search his house and seized seventy-one marijuana plants.[134] He was charged with trafficking and cultivation under the NCA.[135] On September 18, 1997, the police again attended at Parker's home and seized three growing marijuana plants. By this time, the NCA had been repealed, and Parker was charged with possession of marijuana contrary to the CDSA.[136]

After he was arrested and charged, Parker challenged the legislative provisions under section 7 of the *Charter*.[137] Since the NCA had already been repealed, the cultivation and trafficking charges were moot.[138] The remaining charge was for possession of cannabis under the CDSA.[139] The Ontario Court of Appeal heard the evidence of Parker's symptoms and the relief obtained from his use of marijuana. It confirmed that, "[w]here an illness or the effects of an injury cannot be cured, then efforts are directed towards preventing deterioration or relieving pain and suffering."[140] The Court found that the state-imposed criminal prohibition on cannabis possession violated Parker's security of

130 *Id.*
131 *Id.* ¶ 24.
132 *Id.*
133 *Id.* ¶ 25.
134 *Id.* ¶ 13.
135 *Id.*; Narcotic Control Act, R.S.C. 1985, c. N-1, §§ 6(1), 4(2) (Can.).
136 Controlled Drugs and Substances Act, S.C. 1996, c. 19 § 4(1) (Can.).
137 *Parker*, [2000] 49 O.R. 3d ¶ 5.
138 *Id.* at 3.
139 *Id.*
140 Airedale N.H.S. Trust v. Bland, (1993) A.C. 789 (H.L) 857.

the person because he was forced to choose between his liberty and his health.[141] As in *Morgentaler*, Parker was being denied a "generally safe medical treatment that might be of clear benefit to him."[142] 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.[143]

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

> (i) 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[;]
>
> (ii) 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[;]
>
> (iii) The absence of a clear legal standard may contribute to a violation of fundamental justice[;]
>
> (iv) 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]
>
> (v) 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.[144]

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 criminal prohibition that prevents access to necessary medicine is not consistent with fundamental justice."[145]

In *R. v. Parker*, the Court held that a blanket prohibition on

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[141] R. v. Parker, [2000] 49 O.R. 3d 481, ¶ 110 (Can. Ont. C.A.).
[142] *Id.* ¶ 109.
[143] *Id.* ¶ 192.
[144] *Id.* ¶ 117.
[145] *Id.* ¶ 139.

cannabis violated Parker's *Charter* rights guaranteed in section 7.[146] Without a medical exemption system that addresses the medical use of marijuana 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."[147] 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.[148] In a landmark decision, the Ontario Court of Appeal ruled that the possession offense created by section 4(1) of the CDSA was unconstitutional without a medical exemption.[149] 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.[150]

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.[151] 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*.[152]

In the next section, I discuss the legislated medical exemption contained in the MMAR since they were first enacted in 2001. I review several constitutional challenges and Parliamentary amendments that shaped the development of the exemption, culminating in the newly announced *Marihuana for Medical Purposes Regulations* (MMPR).

C. The Medical Exemption

In this section, I provide a summary of the current MMAR and some of the challenges to them before considering the new MMPR. The MMPR are expected to come into force in Spring 2013, and run concurrently with the MMAR until April 1, 2014,

[146] *Id.* ¶ 153.
[147] *Id.* ¶ 137.
[148] *Id.* ¶ 184, 188–89.
[149] *Id.* ¶ 210.
[150] *Id.* ¶ 207.
[151] Marihuana Medical Access Regulations, SOR/2001-227, § 73 (Can.).
[152] Controlled Drugs and Substances Act, S.C. 1996, c. 19 § 55 (Can.); *see also* R. v. Long, [2007] 88 O.R. 3d 143, ¶ 11–13 (Can. Ont. Sup. Ct. J.).

at which point the MMAR will become defunct.[153]

1. The MMAR

In this section I provide an overview of the current MMAR and a brief history of some of the most significant legal challenges that have shaped them. The legal challenges to the MMAR have given life to the concepts of security of the person and the principles of fundamental justice enshrined in the *Charter*. Research evidence and statistics can never account for the richness of an individual's personal experience. The cases discussed herein demonstrate how Canadian courts have applied the research evidence to the *Charter* to date. The improvement in the quality of life for some medical cannabis users is quite clear from the facts. The anecdotal experiences of some individuals who receive significant medical benefit from painful or humiliating symptoms cannot be ignored. Courts must give weight to this evidence in the constitutional analysis.

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 conventional treatments are inappropriate or are not providing adequate relief."[154] Although the MMAR provides a framework for individuals to access cannabis for medical purposes, the procedural requirements and practical realities make the defense difficult to obtain.[155]

Under the current system, individuals are categorized by symptom and disease, which affects the type of medical support required.[156] 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.[157] Category 1 applicants require the medical declaration of one physician.[158]

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[153] *Backgrounder—Proposed Marihuana for Medical Purposes Regulations—Transitioning to a New System,* HEALTH CAN., http://www.hc- sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-193bka-eng.php (last updated Dec. 16, 2012).

[154] *Fact Sheet-Medical Access to Marihuana,* HEALTH CAN., http://cannatherapyhealing.com/images/Fact_Sheet_-_Medical_Access_To_Marihuana.pdf (last updated Feb. 8, 2008).

[155] Marihuana Medical Access Regulations, SOR/2001-227 § 4(1) (Can.).

[156] *Id.* § 1(1).

[157] *Id.* § 1, Sched. § 1.

[158] *Id.* § 4(1), (2).

Symptom	Associated Medical Conditions
Severe nausea	Cancer, AIDS/HIV infection
Cachexia, anorexia, weight loss	Cancer, AIDS/HIV infection
Persistent muscle spasms	Multiple sclerosis, spinal cord injury or disease
Seizures	Epilepsy
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 [C]ategory 1 symptom."[159] Glaucoma is one example of a Category 2 medical condition. Category 2 applicants require the support of a specialist in addition to a medical declaration from a physician.[160] Once an individual has the required medical declarations, he must apply to Health Canada to obtain an Authorization to Possess (ATP).[161]

Under the current system, there are three legal ways to obtain cannabis. ATP holders may grow their own cannabis if they are granted a Personal-Use Production Licence (PPL).[162] Alternatively, a person with a Designated-Person Production Licence (DPPL) may grow for a maximum of two ATP holders.[163] Designated growers may not form a group of more than four.[164] The Government of Canada has a contract with Prairie Plant Services (PPS) to provide another source of marijuana to ATP holders.[165] PPS only offers one strain of cannabis, reportedly of inferior quality.[166] Illegal compassion clubs operate as a tolerated

[159] *Id.* § 1(1).
[160] *Id.* §§ 4(1), (2), 6(2).
[161] Marihuana Medical Access Regulations, SOR/2001-227 § 4 (Can.).
[162] *Id.* § 24.
[163] *Id.* §§ 34(1), 41.
[164] *Id.* §§ 32(d), 41.
[165] Sfetkopoulos v. Canada (Att'y Gen.), [2008] F.C. 33, 6 (Can. Ont.).
[166] *Id.* at 30.

illegality to fill a gap in the market.[167] This system of supply and distribution was not established when the Marijuana Medical Access Program began. It was developed through constitutional challenges to the MMAR and incremental Parliamentary response.[168]

When the MMAR were first enacted, there was no legal supply.[169] The result was that even after obtaining a legal exemption under the MMAR, individuals had to access the black market to purchase dried marijuana or seeds.[170] In *Krieger*, the Alberta Court of Queen's Bench concluded that it was "absurd" for Parliament to remove the possibility of legal access to a substance that an individual is legally allowed to possess.[171] The Court found 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.[172] Significantly, the Court declared the prohibition on production of cannabis unconstitutional vis-à-vis medical cannabis users, and said individuals with a medical exemption should be able to grow their own cannabis if it was impossible to access a legal supply.[173]

In a civil suit in 2003, the claimants in *R. v. Hitzig* challenged the practical availability of the exemption.[174] They claimed that it was difficult to find medical professionals to sign their medical declaration, and impossible to access a legal supply.[175] At that time, there were three categories.[176] Those in Category 3 needed to obtain the declaration of one physician and two specialists.[177] The Court found that the requirement for a second specialist was arbitrary for Category 3, after which the category was eliminated.[178] While the evidentiary record did not reveal that obtaining a physician's signature was practically impossible, the Ontario Court of Appeal found that the legislative restrictions of the MMAR led to a serious shortfall in the legal supply.[179] The

[167] Hitzig v. Canada, [2003] O.J. No. 3873, ¶ 23(Can. Ont.).
[168] *Sfetkopoulos*, [2008] F.C. at 7–10.
[169] R. v. Krieger, [2000] 307 A.R. 349, ¶ 36 (Can.).
[170] *Id.*
[171] *Id.*
[172] *Id.* ¶¶ 54, 55.
[173] *Id.* ¶ 56.
[174] Hitzig v. Canada, [2003] O.J. No. 3873, ¶ 15 (Can. Ont.).
[175] *Id.* ¶¶ 15, 16.
[176] *Id.* ¶ 46.
[177] *Id.* ¶ 47.
[178] *Id.* ¶ 144.
[179] *Id.* ¶ 145.

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 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.[180]

The Court held that the MMAR, as they were at that time, violated the rights to liberty and security of the person contained in Section 7 of the *Charter* by failing to effectively remove state barriers to a licit source of marijuana for medical users.[181] 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 the 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.[182]

In *Hitzig*, the Court confirmed that by failing to provide a legal source, the regulations had the effect of forcing medical users to

[180] *Id.* ¶ 22.
[181] *Id.* ¶ 105.
[182] *Id.* ¶ 104.

the black market. The government must promote obedience to the law, or its authority is undermined. The rule of law is, perhaps, the most significant principle of fundamental justice. As the court phrased the issue, the government is asking individuals who have been granted legal authorization to "consort with criminals" to access their constitutional rights.[183] "The state's obligation to obey the law is central to the very existence of the rule of law."[184] 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.[185]

The Court of Appeal held that the requirement for one specialist was not arbitrary because it served the state's interest in protecting the health and safety of its citizens in relation to an untested drug.[186] Specialists have more knowledge about the range of possible treatments for specific diseases and can provide details about other options.[187] The evidence presented in *Hitzig* did not reveal a significant barrier to obtaining one specialist's signature.[188] However, the court noted that if physician cooperation dwindled, it might represent a significant practical impediment to access.[189]

Recently, Matthew Mernagh was charged with possession and production of cannabis.[190] This young man treated symptoms of fibromyalgia, scoliosis, seizures, and depression with cannabis.[191] Despite his best efforts, he could not find a doctor to sign the medical declarations required by the MMAR.[192] Mernagh was charged with the offense of production of marijuana, contrary to section s. 7(2)(b) of the CDSA.[193] He launched a constitutional challenge against the MMAR, arguing that the defense purportedly offered remained illusory for many individuals who require marijuana for medical purposes.[194] The evidence from across Canada showed that many people are unable to obtain the

[183] *Id.* ¶ 110.
[184] *Id.* ¶ 113.
[185] *Id.* ¶¶ 117–18.
[186] *Id.* ¶¶ 135–37.
[187] *Id.* ¶ 142.
[188] *Id.* ¶ 143.
[189] *Id.* ¶ 143.
[190] R. v. Mernagh, [2011] O.J. No. 1669, ¶ 3 (Can. Ont. Super. Ct.).
[191] *Id.* ¶ 1.
[192] *Id.*
[193] *Id.* ¶ 3.
[194] *Id.* ¶¶ 4, 39, 276.

medical declaration required by the MMAR.[195]

The *viva voce* and affidavit evidence tendered at trial on behalf of the defense attempted to demonstrate how the state-imposed barriers to obtaining a medical exemption violated the security of the person of individuals who require marijuana for medical purposes. The trial judge in *Mernagh* 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 [sic] source of concern and anxiety for all of the patient witnesses. The stress of which further undermines their health.[196]

The evidence presented in the *Mernagh* trial referred to the extent of the medical profession's ongoing concern with the MMAR, particularly in regard to the lack of meaningful consultation with the profession.[197] The court found that many factors contributed to physician reluctance to authorize the medical use marijuana, including the stigma associated with marijuana[198] and the influence of the pharmaceutical industry.[199] Since doctors were not specifically informed about the therapeutic benefits and risks of marijuana, they lacked information about its clinical effectiveness.[200] The judge found that patients were often educating their doctors on the medicinal benefits of cannabis, rather than the other way around.[201] The court also examined the negative impact of opioid painkillers, which are effective but addictive.[202]

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[195] *Id.* ¶ 163.
[196] *Id.* ¶ 47.
[197] *Id.* ¶¶ 154, 257.
[198] *Id.* ¶¶ 157–59.
[199] *Id.* ¶¶ 174, 179–83.
[200] *Id.* ¶ 152.
[201] *Id.* ¶ 162.
[202] *Id.* ¶ 189.

On February 1, 2013, the Ontario Court of Appeal released its decision in *Mernagh*, granting the Crown appeal, and sending the case back for a new trial.[203] The major issue with the trial judgment was that the judge's conclusions were not supported by the evidence.[204] Ironically, in a case about lack of physician participation, there seemed to be very little evidence from physicians on the decision-making process regarding when to sign a *MMAR* declaration. The most persuasive evidence ought to come from physicians who have patients with a real need for cannabis but the particular form of the *MMAR* inhibits them from authorizing it. Mernagh's re-trial may be moot, as Parliament has already proposed substantial overhauls to the regulations that may address many of the issues raised in *Mernagh*.

2. The MMPR

In this section, I provide an outline of the proposed MMPR, which were announced December 16, 2012. The MMPR contain quite significant changes. To obtain a legal exemption, individuals will no longer be required to apply to Health Canada for authorization.[205] The categories of applicants will be eliminated.[206] Individuals will still have to consult with a medical professional, but rather than submitting an application to Health Canada,[207] doctors and nurse practitioners will provide individuals with a medical document indicating, among other things, the supported daily quantity in grams.

> They could then send the original medical document to a licensed producer of their choice. A medical document would allow an individual to register with a licensed producer for the period of use indicated by the authorized health care practitioner, but for no more than one year. After registering as a client, individuals would be able to order dried marihuana from the licensed producer. However, licensed producers would not be allowed to sell or provide more than 30 times the daily amount in any 30-day

[203] *Id.*
[204] *Id.*
[205] *See Drugs and Health Products: Medical Marihuana Regulatory Reform 2011 Consultations Results*, HEALTH CAN., http://www.hc-sc.gc.ca/dhp-mps/consultation/marihuana/_2011/program/consult_reform-eng.php (last modified Jan. 31, 2013).
[206] *Id.*
[207] *Id.*

> period, taking into consideration the expected length of time for the shipment to reach the registered client, nor would they be able to ship more than 150 g at a time.[208]

Production and distribution will be carried out on a commercial scale by businesses that will be regulated and monitored in a manner similar to other prescription drugs.[209] Producers will be able to grow any strains they choose.[210] The price of marijuana is expected to rise to $8.80 per gram, from the current estimated average price of between $1.80 and $5.00 per gram. The average daily dose has risen from three grams per day to ten.[211]

One area expected to remain the same is the requirement that marijuana be dried. This could be the subject of future constitutional challenge, especially in light of the recent ruling of the Supreme Court of British Columbia in *R. v. Smith* where the court struck down the requirement for the marijuana to be dried.[212] The trial judge concluded that "the restriction to dried marihuana unnecessarily, and therefore to an unreasonable degree, impairs the security right to choose how to ingest the medicinal ingredients in the safest and most effective manner."[213]

The timeline for implementing the new regulations is scheduled to take place over the span of one year.[214] The MMPR will run concurrently with the MMAR from the time the new regulations come into force, until March 31, 2014.[215] During that time, individuals may continue to access marijuana for medical purposes under the current system, or order directly from a licensed producer after they are approved by Health Canada.[216] Health Canada's contract with Prairie Plant Systems will end on

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[208] *Id.; Marihuana for Medical Purposes Regulations: Regulatory Impact Analysis Statement*, CAN. GAZETTE (Dec. 15, 2012), http://gazette.gc.ca/rp-pr/p1/2012/2012-12-15/html/reg4-eng.html.

[209] *See Drugs and Health Products: Medical Marihuana Regulatory Reform 2011 Consultations Results*, *supra* note 205.

[210] *Id.*

[211] *Marihuana for Medical Purposes Regulations: Regulatory Impact Analysis Statement*, *supra* note 208.

[212] R. v. Smith, 2012 B.C.S.C. 544, ¶ 123.

[213] *Id.*

[214] *See Drugs and Health Products: Transitioning to a New System*, HEALTH CAN., http://www.hc-sc.gc.ca/dhp-mps/marihuana/future-avenir/transition-eng.php (last modified Jan. 1, 2013).

[215] *About Health Canada: Backgrounder—Proposed Marihuana for Medical Purposes Regulations—Transitioning to a New System*, HEALTH CAN., http://www/hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-193bka-eng.php (last modified Dec. 16, 2012).

[216] *Id.*

March 31, 2014 after which only the MMPR will remain in force.[217] So what is the medical evidence that supports these legal findings? In the next part, I review some of the strongest evidence of risk and medical benefit that provides the *raison d'être* for the exemption.

II. THE MEDICAL EVIDENCE

Here I outline some of the research evidence about how and why cannabis has its effects. Our understanding of how cannabis affects the brain is relatively new, and premised on an ever-increasing comprehension of neurology. A basic knowledge of how cannabis 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*. This part is divided into three sections. First, I look at the neurological evidence. Second, I look at the evidence of therapeutic benefits. Third, I look at the known medical risks.

A. The Plant-Brain Connection

What's in a brain? Within the central nervous system, there are more than 100 billion neurons.[218] Each of these neurons contains receptors responsible for sending and receiving information, resulting in physical and sometimes psychological change in the individual whose brain is affected.[219] "Neurons in the brain are activated when a compound binds to its receptor."[220] "Employing the most common analogy . . . to explain neurological functioning, consider the chemical as a 'key' and the receptor as a 'lock.'"[221]

Neurons send and receive electrical signals in a networked fashion.[222] "Neurons are living, growing cells," but, unlike electrical circuits, they are not fixed."[223] "Almost every neuron is

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[217] *Id.*

[218] ARTHUR C. GUYTON & JOHN E. HALL, TEXTBOOK OF MEDICAL PHYSIOLOGY 555 (11th ed. 2006).

[219] MATT STOLICK, OTHERWISE LAW-ABIDING CITIZENS: A SCIENTIFIC AND MORAL ASSESSMENT OF CANNABIS USE 6 (2009).

[220] JANET E. JOY ET AL., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 37 (1999).

[221] STOLICK, *supra* note 219, at 8.

[222] *See* PAUL M. GAHLINGER, ILLEGAL DRUGS: A COMPLETE GUIDE TO THEIR HISTORY, CHEMISTRY, USE, AND ABUSE 134 (2004).

[223] *Id.* at 137.

constantly changing its function by adapting to bodily demands, sensations, and environmental influences."[224] Neurons act as regulators, releasing or inhibiting the production of neurotransmitters that cause various experienced effects.[225] "Receptor cells form part of a neuronal network[.]"[226] "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."[227] 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.[228]

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.[229] In the lock and key analogy, cannabinoid receptors are the lock and cannabinoids are the key. Cannabinoids are the precursors to chemical action in the brain.[230] Different neurotransmitters and neurological reactions are apparent when looking at the effects these chemicals have on the brain.[231] About sixty of the 483 chemical compounds in the cannabis plant are cannabinoids.[232] The cannabinoid receptors in the brain mediate the psychological effects of THC (Tetrahydrocannabinol).[233] THC is the only cannabinoid that produces any significant psychoactive effects.[234]

Although two cannabinoids, cannabinol (CBN) and cannabidiol (CBD), were isolated and identified in 1895 and 1934

[224] *Id.*

[225] *Id.*

[226] MICHAEL POLLAN, THE BOTANY OF DESIRE: A PLANT'S-EYE VIEW OF THE WORLD 153 (2001).

[227] *Id.*

[228] GUYTON & HALL, *supra* note 218, at 555.

[229] STOLICK, *supra* note 219, at 8.

[230] JOY ET AL., *supra* note 220, at 24–25.

[231] *Id.* at 48.

[232] Mahmoud A. ElSohly, *Chemical Constituents of Cannabis*, *in* CANNABIS AND CANNABINOIDS: PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 27, 28 (Franjo Grotenhermen & Ethan Russo eds., 2002).

[233] JOY ET AL., *supra* note 220, at 35.

[234] John M. McPartland & Ethan B. Russo, *Cannabis & Cannabis Extracts: Greater Than the Sum of Their Parts?*, 1 J. CANNABIS THERAPEUTICS 103, 104 (2001); Seaton Thedinger, *Prohibition in the United States: International and U.S. Regulation and Control of Industrial Hemp*, 17 COLO. J. INT'L ENVTL. L. & POL'Y 419, 422 (2006).

respectively, it was not until 1964 that the primary psychoactive ingredient, delta-9-tetrahydrocannabinol (Δ^9-THC or THC), was isolated and synthesized.[235] 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.[236]

> The cannabinoid receptors Howlett found showed up in vast numbers all over the brain (as well as in the immune and reproductive systems), though they were clustered in regions responsible for the mental processes that marijuana 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 address 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."[237]

"Cannabinoid receptors are among the most ubiquitous neurotransmitter elements in the mammalian brain, as they are present in almost every brain region and [exist] on many different types of neurons."[238] Neurons are the fundamental functional units of nerve tissue.[239] The diverse effects of marijuana 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.[240] The CB_1 receptors are found primarily in the cerebral cortex (psychoactive effects), the hippocampus (memory formation), the hypothalamus (appetite), the amygdala (emotional responses), and the basal ganglia (movement control centers).[241] 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

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[235] *See* Philip Robson, *Therapeutic Aspects of Cannabis and Cannabinoids*, 178 BRIT. J. PSYCHIATRY 107, 108 (2001).

[236] *See* Roger G. Pertwee, *Cannabinoid Pharmacology: the First 66 Years*, 147 BRIT. J. PHARMACOLOGY 163, 166 (2006); Robson, *supra* note 235, at 108.

[237] POLLAN, *supra* note 226, at 153.

[238] Allyn C. Howlett et al., *Cannabinoid Physiology and Pharmacology: 30 Years of Progress*, 47 NEUROPHARMACOLOGY 345, 350 (2004).

[239] *See* GAHLINGER, *supra* note 222, at 135.

[240] Roger A. Nicoll & Bradley E. Alger, *The Brain's Own Marijuana*, SCI. AM., Dec. 2004, at 71–72.

[241] *Id.*

regulation.[242] Additional receptor sites are located in the spinal cord, digestive, reproductive, ocular, and cardiovascular systems.[243]

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.[244] These effects are very relevant in a therapeutic context for many individuals.[245] The CB receptors are activated by the brain's naturally occurring cannabinoids.[246] Cannabinoids produced by the body are called endogenous cannabinoids or "endocannabinoids."[247] Sometimes referred to as the "brain's own marijuana,"[248] researchers have discovered two endocannabinoids named arachidonyl glycerol (2-AG) and anadamide.[249] The word "anadamide" comes from the Sanskrit word meaning "bliss."[250] For 500 million years, all vertebrate species have been utilizing endocannabinoids using a complex signaling system in various regions of the brain.[251]

The endocannabinoid system appears to have a large role in pain modulation, appetite, and movement control.[252] The endogenous cannabinoid system also, "appears to [help] maintain homeostasis within the central nervous system."[253] Scientists have hypothesized that the release of endocannabinoids might

[242] Howlett, *supra* note 238, at 349; *see also* J. Ludovic Croxford & Takashi Yamamura, *Cannabinoids and the Immune System: Potential for the Treatment of Inflammatory Disease?*, 166 J. NEUROIMMUNOLOGY 3, 5 (2005).

[243] M. Llanos Casanova et al., *Inhibition of Skin Tumor Growth and Angiogenesis in Vivo by Activation of Cannabinoid Receptors*, 111 J. Clinical Investigation 43, 43 (2003).

[244] Ruth C. Stern & J. Herbie DiFonzo, *The End of the Red Queen's Race: Medical Marijuana in the New Century*, 27 QUINNIPIAC L. REV. 673, 695 (2008).

[245] *Id.* at 703.

[246] Tongtong Wang, Methodological Issues in the Assessment of the Safety of Medical Cannabis 1 (Aug. 2009) (unpublished Ph.D thesis, McGill University) (on file with the Faculty of Medicine, McGill University).

[247] Nicoll & Alger, *supra* note 240, at 70.

[248] Stern & DiFonzo, *supra* note 244, at 695; *see also* Nicoll & Alger, *supra* note 240, at 70.

[249] Nicoll & Alger, *supra* note 240, at 73.

[250] *Id.*

[251] *Id.* at 75.

[252] JOY ET AL., *supra* note 220, at 27–29.

[253] Roger G. Pertwee, *Ligands that Target Cannabinoid Receptors in the Brain: From THC to Anandamide and Beyond*, 13 ADDICTION BIOLOGY 147 (2008).

constitute a protective response during injury to neurons.[254] Endocannabinoid levels increase in response to skeletal muscle spasm, spasticity, and in response to inflammatory pain.[255] The release of endocannabinoids apparently eases these symptoms.[256] 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."[257]

In contrast to endocannabinoids, which are produced by the body, exogenous cannabinoids come from outside the body, either herbal from the cannabis plant or from synthetic derivatives.[258] 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.[259] The location of the CB receptors helps explain the therapeutic effect for some symptoms when exogenous cannabinoids are introduced to the brain.

B. Medical Benefits

Cannabis has many purported medical benefits. Not all the claimed benefits have been confirmed by scientific research. Here, I highlight three of several relatively well-confirmed therapeutic benefits: appetite, motor control, and pain relief. The scientific evidence is mixed on the therapeutic benefit of cannabis in several other areas although there is anecdotal evidence to support its application for a number of ailments. There is somewhat of a confirmed therapeutic effect for treating allergies, inflammation, infection, depression, bipolar disorders, anxiety disorders, dependency, and withdrawal from other drugs.[260] More research still needs to be done to confirm the effects on autoimmune diseases, cancer, neuroprotection, fever, and blood

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[254] Diego Centonze et al., *The Endocannabinoid System in Targeting Inflammatory Neurodegenerative Diseases*, 28 TRENDS PHARMACOLOGICAL SCI. 180, 182 (2007).

[255] *See* Pertwee, *supra* note 253, at 147.

[256] *Id.*

[257] Stern & DiFonzo, *supra* note 244, at 696 (citing Roger A. Nicoll & Bradley E. Alger, *The Brain's Own Marijuana,* SCI. AM., Dec. 2004, at 68, 73).

[258] *Id.* at 695.

[259] *Id.*

[260] Franjo Grotenhermen, *Review of Therapeutic Effects*, *in* CANNABIS AND CANNABINOIDS PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 123, 124 (Franjo Grotenham & Ethan Russo eds., 2002) [hereinafter *Review of Therapeutic Effects*].

pressure disorders.[261]

1. Increased Appetite

Many of the effects that have a therapeutic application are commonly experienced effects like "the munchies"—the noticeable and predictable increase in appetite after consuming cannabis. In the therapeutic context, cannabis stimulates the appetite and enhances enjoyment of food, which helps people with involuntary weight loss. Reference to cannabis' appetite-stimulating properties was recorded as early as AD 300.[262] The appetite is regulated by a highly complex integration of hormonal and neuronal systems to maintain homeostasis.[263] Disruptions to these homeostatic mechanisms are often a result of disease and can result in food deprivation or excess eating.[264] 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.[265] "The desire to consume food is one of the fundamental physiological processes necessary for survival."[266] 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."[267]

Traditional treatments for cachexia involve steroids combined with internal nutrition delivered through a feeding tube, but these interventions are costly and can require very high doses.[268] 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

[261] *Id.* at 125.

[262] Tim C. Kirkham, *Cannabinoids and Medicine: Eating Disorders, Nausea and Emesis, in* CANNABINOIDS 147 (Vincenzo Di Marzo ed., 2004).

[263] *Id.* at 149.

[264] *Id.* at 150, 152.

[265] *Id.* at 149.

[266] Billy R. Martin, *The Endocannabinoid System and the Therapeutic Potential of Cannabinoids*, *in* MARIJUANA AND THE CANNABINOIDS 125, 128 (ElSohly ed., 2007).

[267] Martin Schnelle & Florian Strasser, *Anorexia and Cachexia*, *in* CANNABIS AND CANNABINOIDS PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 153, 153 (Grotenherman & Russo eds., 2002).

[268] Kirkham, *supra* note 262, at 152.

concentration abilities, and change in body image.[269] These symptoms negatively impact an individual's quality of life and hasten the onset of death.[270]

2. Decreased Nausea & Vomiting

Another unpleasant experience, nausea and vomiting, may be the most common and most 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.[271]

Nausea and vomiting can substantially contribute to the progressive deterioration of a patient's physical condition and psychological well-being.[272] Some research has evaluated "the anti-emetic efficacy of cannabinoids in cancer patients receiving chemotherapy using a systematic review of literature . . . [in] electronic databases . . . ."[273] A meta-analysis found that the anti-emetic efficacy of cannabis was superior as "compared with conventional drugs and placebo."[274]

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.[275] Cannabinoids have also been shown to be

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[269] *See* S.D. Gauldie et al., *Anandamide Activates Peripheral Nociceptors in Normal and Arthritic Rat Knee Joints*, 132 BRIT. J. PHARMACOLOGY 617–621 (2001); *see also,* L. Facci et al., *Mast Cells Express a Peripheral Cannabinoid Receptor with Differential Sensitivity to Anadamide and Palmitoylethanolamide*, 92 Proc. NAT'L. ACAD. SCI. U.S. 3376; *see generally* Kirkham, *supra* note 262, at 152–55.

[270] *See* Kirkham, *supra* note 262, at 155.

[271] LESTER GRINSPOON & JAMES B. BAKALAR, MARIHUANA: THE FORBIDDEN MEDICINE 24 (Yale Univ. Press rev. & expanded ed. 1997).

[272] Kirkham, *supra* note 262, at 155.

[273] F.C. Machado Rocha et al., *Therapeutic Use of Cannabis Sativa on Chemotherapy-Induced Nausea and Vomiting Among Cancer Patients: Systematic Review and Meta-Analysis*, 17 EUR. J. CANCER CARE 431, 431 (2008).

[274] *Id.*

[275] *Id.* at 438.

effective in patients whose nausea is refractory to other drugs.[276] Non-psychoactive cannabinoid therapies could also prove useful for children who experience nausea or vomiting as a result of chemotherapy.[277] Unlike Delta-9-THC, Delta-8-THC is not psychoactive, and was shown to prevent vomiting for children during chemotherapy, with a minimum of side effects.[278] Patients often report a preference for a cannabinoid treatment to other regimens.[279] Studies pooling the data of 768 patients reported that "'oral THC provided 76–88 percent relief of nausea and vomiting, while smoked cannabis figures supported 70–100 percent relief in the various surveys[.]'"[280]

Newer anti-emetics may be more effective than cannabinoids in reducing the frequency of nausea and vomiting.[281] 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.[282] These studies provide strong support for the anecdotal evidence that suggests cannabis provides significant relief from nausea and vomiting.

3. Movement Disorders, Spasticity & Seizures

Involuntary movements, spasms, and seizures are significant health issues for individuals with Multiple Sclerosis, Tourette's Syndrome, Parkinson's Disease, and epilepsy, to name just a few.[283] There is an abundance of endocannabinoid receptors in the basal ganglia, a subcortical brain network that is one of the primary brain centers for the performance and fine-tuning of involuntary motor functions, including posture and muscle tone.[284] The cannabinoid CBD, taken in doses "between 100 and 600 mg per day[,] produced improvements of 20 to 50 percent in five patients with dystonia[,]" a neurological disorder characterized by involuntary muscle contractions that cause slow

[276] *Id.* at 439–40.
[277] MITCH EARLEYWINE, UNDERSTANDING MARIJUANA: A NEW LOOK AT THE SCIENTIFIC EVIDENCE 180 (2002).
[278] *Id.*
[279] *Id.*
[280] STOLICK, *supra* note 219, at 59.
[281] Kirkham, *supra* note 262, at 155.
[282] *Id.*
[283] GLEN R. HANSON, PETER J. VENTURELLI & ANNETTE E. FLECKENSTEIN, DRUGS AND SOCIETY 381, 432 (7th ed. 2002).
[284] *Id.* at 123.

repetitive movements or abnormal postures.[285] Research has shown that cannabis can reduce physical tics and spasticity,[286] and that clinical use of marijuana for patients with multiple sclerosis (MS) can help control muscle spasms and spasticity is well established.[287]

4. Decreased Pain

"Patients seek medical assistance for pain more often than any other symptom."[288] Chronic pain involves persistent, long-term pain, which may include diffuse, throbbing pressures, or sharp, specific aches.[289] An estimated ten percent of patients with chronic pain use cannabis to treat their symptoms.[290] 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 flu-like symptoms, and spastic muscle twitches.[291]

> 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

[285] *Review of Therapeutic Effects*, *supra* note 260, at 125; Brian Shagan, *Washington v. Harper: Forced Medication and Substantive Due Process*, 25 CONN. L. REV. 265, 268 (1992).

[286] *Review of Therapeutic Effects*, *supra* note 260, at 125.

> In small clinical trials of [THC], nabilone, and cannabis, a beneficial effect on spasticity caused by multiple sclerosis 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.

Id.; *see also* STOLICK, supra note 219, at 67–68.

[287] *Review of Therapeutic Effects*, *supra* note 260, at 125, 135–36.

[288] EARLEYWINE, *supra* note 277, at 177.

[289] *Id.*

[290] *See* Mark A. Ware et al, *Cannabis Use for Chronic Non-Cancer Pain: Results of a Prospective Survey*, 102 PAIN 211 (Oct. 10, 2002), *available at* http://www.medicinalgenomics.com/wp-content/uploads/2011/12/Ware-et-al-2003-12620613.pdf; *see also* Wang, *supra* note 246, at 4.

[291] *See generally* GRINSPOON & BAKALAR, *supra* note 271, at 109.

be responsible for as many as 76,000 hospitalizations and more than 7,600 deaths annually.[292]

The spinal cord contains numerous CB receptors, which helps to improve the peripheral sensation of pain.[293] THC may inhibit the production of the enzyme *adenylate cyclase*, which is involved in the transmission of pain messages.[294] Although cannabis has been shown to have a level of analgesia comparable to that of codeine, the doses required may induce unwanted behavioral effects.[295]

Evidence suggests cannabinoids and opioids have synergistic analgesic effects, meaning they work together to produce greater pain relief.[296] The combination of opioids and cannabinoids may allow individuals to reduce the doses of both opioids and cannabinoids necessary to achieve desirable levels of analgesia with a minimum of unwanted effects.[297] 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 much lower.[298] It may complement pharmaceutical treatments by allowing patients to reduce their doses of opioid pain medication.[299]

C. The Risks

So what are the risks? The acute toxicity of THC is low.[300]

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[292] *Id.*

[293] Chris W. Vaughn & MacDonald J. Christie, *Mechanisms of Cannabinoid Analgesia*, *in* CANNABIS AND CANNABINOIDS: PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 89, 90 (Franjo Grotenhermen & Ethan Russo eds., 2002).

[294] HAROLD E. DOWEIKO, CONCEPTS OF CHEMICAL DEPENDENCY 121 (3d ed. 1996).

[295] *Review of Therapeutic Effects*, *supra* note 260, at 128.

[296] Vaughn & Christie, *supra* note 293, at 90.

[297] *See id.* at 91.

[298] *See* Franjo Grotenhermen, *Review of Unwanted Actions of Cannabis and THC*, *in* CANNABIS AND CANNABINOIDS: PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 233, 237, 243 (Franjo Grotenhermen & Ethan Russo eds., 2002).

[299] Dale Gieringer, *Medical Use of Cannabis: Experience in California*, *in* CANNABIS AND CANNABINOIDS: PHARMACOLOGY, TOXICOLOGY, AND THERAPEUTIC POTENTIAL 143, 150 (Franjo Grotenhermen & Ethan Russo eds., 2002).

[300] *Review of Therapeutic Effects*, *supra* note 260, at 234.

"Death due to cannabis toxicity has not been observed."[301] However, 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, which encompasses an individual's physical and psychological integrity. There must be a very close connection between the measures and the objectives.[302] In contrast, greater harm will justify more restrictive government limits on accessing this medicine. I turn first to consider the potential acute and chronic harms.

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.[303] This can have effects on many organs in the body, including the heart, brain, and kidneys.[304] In humans, cannabis causes enlarged blood vessels (vasodilation), and an increase in heart rate related to the amount of THC consumed.[305] The risks of smoking are elevated for individuals with high blood pressure, heart disease, or those who have hardening of the arteries.[306] Some individuals report acute adverse effects on their mood, including panic attacks or waves of paranoia.[307] These changes in mood are generally short-lived, and most individuals can be talked through the experience.[308] Of greater concern is the negative effect on cognitive performance in a variety of domains, including psychomotor control, attention, and executive function.[309]

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[301] *Id.*

[302] *See* Chaoulli v. Quebec (Att'y Gen.), [2005] 1 S.C.R. 791, 794 (Can.).

[303] William Holubek, *Medical Risks and Toxicology*, *in* THE POT BOOK: A COMPLETE GUIDE TO CANNABIS 141, 146 (Julie Holland ed., 2010).

[304] *Id.*

[305] HANSON ET AL., *supra* note 283, at 385.

[306] *See* Allyn C. Howlett et al., *The Cannabinoid Receptor: Biochemical, Anatomical and Behavioural Characterization*, 13 TINS 420, 423 (1990).

[307] OAKLEY RAY & CHARLES KSIR, DRUGS, SOCIETY, & HUMAN BEHAVIOR 419 (7th ed. 1995); *see also* Franjo Grotenhermen*, The Toxicology of Cannabis and Cannabis Prohibition,* 4 CHEMISTRY & BIODIVERSITY 1744, 1746 (2007).

[308] RAY & KSIR, *supra* note 307, at 417.

[309] *See, e.g.*, Caroline B. Marvin & Carl L. Hart, *Cannabis and Cognition*, *in* THE POT BOOK: A COMPLETE GUIDE TO CANNABIS 161, 162 (Julie Holland ed., 2010).

Memory performance is consistently found to be compromised following cannabis consumption.[310] 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.[311]

"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 . . . ."[312] 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 . . . ."[313] "Regular cannabis smoking in young adults was associated with wheezing, shortness of breath during exercise," and the production of mucus, known as sputum.[314]

"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.[315] "[T]he prevalence of symptoms of chronic and acute bronchitis was not significantly different between cannabis and tobacco smokers."[316]

There is a significant amount of tar in cannabis smoke, up to fifty percent more than an equal weight of tobacco.[317] Smoking unfiltered cannabis cigarettes ("joints"), and holding the smoke in the lungs for longer periods of time increases the accumulation of

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[310] *See* Ernest L. Abel, *Retrieval of Information After Use of Marihuana,* 231 NATURE 58 (1971).

[311] ROBERT E. MANN ET AL., IMPACTS OF CANNABIS ON DRIVING: AN ANALYSIS OF CURRENT EVIDENCE WITH AN EMPHASIS ON CANADIAN DATA 61 (2003).

[312] Grotenhermen, *supra* note 307, at 1753.

[313] *Id.*

[314] *Id.*

[315] *Id.*

[316] *Id.*

[317] HANSON ET AL., *supra* note 283, at 385.

tar.[318] The carcinogen Benzopyrene is seventy percent more abundant in marihuana smoke than in tobacco smoke.[319] 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.[320]

Biopsies from cannabis smokers have also yielded a higher rate of precancerous pathological changes compared to non-smokers, which is suggestive of an increased risk of cancer in the respiratory tract, and other cancers.[321] It is predictably 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. 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).[322] There was no dose-effect relationship, and even heavy use was not associated with an increased risk.[323]

A chronic cannabis smoking lifestyle became popular in the 1960s.[324] As time goes on, the scientific study of long-term consequences should improve. One would also expect more conclusive evidence about the long-term effects of smoked cannabis to emerge as greater numbers of heavy cannabis users age. It is clear that smoked marijuana is "a crude THC delivery system."[325] Smoking delivers not only therapeutic cannabinoids to the body, but also harmful by-products.[326] Although cannabis can be consumed using a broad range of non-smoked methods, until these are the predominant forms of use, there will be an appreciable risk from smoking.[327] Obviously efforts should be

[318] *Id.*
[319] *Id.*
[320] *Id.*
[321] *Id.*
[322] Mia Hashibe et al., *Marijuana Use and the Risk of Lung and Upper Aerodigestive Tract Cancers: Results of a Population-Based Case-Control Study*, 15 CANCER EPIDEMIOLOGY, BIOMARKERS PREVENTION 1829, 1829 (2006).
[323] *Id.*
[324] Susan Jewell, *Signs of Marijuana Addiction in a Middle-Aged Male*, LIVESTRONG.COM (March 23, 2010), http://www.livestrong.com/article/85116-signs-marijuana-addiction-middleaged-male/.
[325] JOY ET AL., *supra* note 220, at 4.
[326] *Id.* at 177.
[327] *Id.* at 177–78.

directed at developing rapid-onset, reliable, and safe cannabinoid delivery systems and modifications to the chemical structure that create fewer undesirable physical and psychological effects for the particular individual.[328] For those whose symptoms are sporadic or have a rapid onset, vaporizing is the preferred method because the device heats the herb to below combustion point while delivering the active ingredients quickly. The dose is easier to control. In other cases, where symptoms are steady or constant, oral cannabis products may be preferable. Because the ingredients must first pass through the digestive system, there is a slower onset and offset of effects, though the effects are qualitatively similar. This method provides less control over the dose because by the time the effects are felt, the dose has already been taken. Currently, there is virtually no data on the long-term health consequences of providing marijuana for medicinal purposes.

Certain groups of individuals are more likely to experience negative effects as a result of using cannabis. Individuals with a heart or lung condition, young people, pregnant or breastfeeding women, and those predisposed to schizophrenia should avoid it if safer alternatives exist.[329] 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, smoked cannabis is not an advisable treatment.

III. THE APPLICATION

A. The Constitutional Minimum

In this section, based on the *Charter* jurisprudence and the medical evidence, I sketch out minimum conditions for a constitutionally valid medical exemption system. I go on to look at broader societal goals that ought to be considered when developing an ideal system for those with a medical need to access cannabis. Although the principles and evidence guide the analysis, at its heart this issue is about people, human beings whose fates are tied together. Like the neuronal network of the brain, our human networks also send signals of information. Suffering, pain, frustration, fear. Optimism, hope, relief, peace.

[328] *Id.* at 178.
[329] *Id.* at 119, 121, 123, 126.

The anecdotal evidence of marijuana's benefits is overwhelming. The human experience of pain relief for hands with rheumatoid arthritis, an epileptic's control over his seizures, decreased vomiting with chemotherapy treatments, increased appetite for HIV/AIDS. These are the people and results that are driving the push for a legal change. The potential to imprison seriously ill individuals for possessing or cultivating herbal medicine is also a polarizing issue. There is a thin line between patient and criminal for many medical cannabis users.

While it may provide relief to many people, not all will qualify for constitutional protection under the *Charter*. To garner constitutional protection, the pain or discomfort experienced by the individual may be physical or psychological.[330] However, it must be of a sufficient intensity that it is above ordinary in terms of the level of discomfort, or it must be for a sufficient duration that the government interference causes the pain or discomfort to reach a level of constitutional protection.[331] The degree of relief or the benefit offered by the treatment must be enough to outweigh the risks.[332] This is a qualitative assessment of individual circumstances in the context of empirical evidence.[333] This type of analysis can only be done on an individual basis.[334] For example, in *Chaoulli*, Québec laws prohibited the purchase of private health insurance for insured services.[335] The objective of these laws was to preserve the integrity of the public health care system. The claimants argued that the waiting times caused by the legislation violated their right to security of the person.[336]

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.[337] 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. Although the seven Supreme Court judges that heard this case agreed that there was a violation of security of the

[330] Chaoulli v. Quebec, [2005] 1 S.C.R. 791, 819 (Can.).
[331] Quebec (Public Curator) v. Syndicat National des Employés de L'hôpital St-Ferdinand, [1996] 3 S.C.R. 211, 253 (Can.).
[332] *Chaoulli*, 1 S.C.R. at 848–49.
[333] *See id.* at 846.
[334] *Id.*
[335] *Id.* at 805.
[336] *Chaoulli*, 1 S.C.R. at 791, 806.
[337] *Id.* at 846.

person, there was no clear consensus about whether the principles of fundamental justice of the Canadian *Charter* had been breached.

One judge found a violation of the *Québec Charter* and did not go on to consider the *Canadian Charter*.[338] Three judges found that the impugned laws violated section 7 of the *Canadian Charter* and section 1 of the *Québec Charter*.[339] 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.[340] However, despite the mixed result, this case does suggest that state-imposed limits which significantly reduce an individual's quality of life will affect security of the person because of the impact on the individual's physical and psychological integrity. If the waiting time had been less than two years, the pain was less intense, or the surgery only provided partial relief, it is questionable whether the court would have found security of the person was violated.

The government, or a reasonably foreseeable consequence of government action, must be interposed between the treatment and the individual's security.[341] After the right to security of the person is found to be affected as a result of government action, the question becomes whether it is consistent with the principles of fundamental justice.[342] As applied to medical cannabis, the government must not deprive individuals of cannabis in a manner that is arbitrary, overbroad, or grossly disproportionate to the objectives of the medical regulations or the CDSA.[343] Currently, there are problems with the MMAR objective "to establish a framework to allow access to marijuana by individuals suffering from grave or debilitating illnesses where conventional treatments are inappropriate or are not providing adequate relief."[344]

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[338] *Id.* at 821.

[339] *Id.* at 843.

[340] *Id.* at 860–61 (Binnie and LeBell JJ., *dissenting*) (finding 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).

[341] *Id.* at 815.

[342] *Chaoulli*, 1 S.C.R. at 791, 815.

[343] *Id.* at 821 (citing Ford v. Quebec (Att'y Gen.), [1988] 2 S.C.R. 712, ¶ 63 (Can.)).

[344] *About the Marihuana Medical Access Program,* HEALTH CAN., http://www.

The standard of "grave or debilitating" illness sets the bar higher than the constitutional minimum, which does not have to reach this level.[345] At a minimum, individuals who are suffering from serious symptoms that cause pain or reduction in quality of life that is of a sufficient intensity and duration should have reasonable access to cannabis if it provides relief of the physical or psychological symptoms that plague these people. Restrictions on access to the needed medicine must not be arbitrary, overbroad, or grossly disproportionate.[346] The restrictions must be related to the objectives of the regulations and the enabling legislation, the CDSA.[347] It remains to be seen whether the new regulations will violate the substantive or procedural principles of fundamental justice.

B. The Ideal

The ideal medical access to cannabis starts with physician education and a rational cannabis policy. There are no pharmaceutical representatives teaching doctors about cannabis, perhaps for obvious reasons. Doctors must become aware of the research literature so they can understand the potential risks and benefits, and have an honest conversation with their patients. As long as cannabis remains illegal, there will be people with an interest in obtaining or providing medical exemptions in false circumstances. While we, as a society, must place some level of faith in members of the medical profession to follow their ethical code, we must also consider the minimal risks of a malingerer obtaining medical cannabis in amounts consistent with personal use. A bigger concern is when individuals with a legitimate medical need are denied a generally safe medical treatment that could be of substantial benefit to them.

Individuals should not be unduly delayed from receiving their treatment. However, the government has a legitimate interest in monitoring the medical use of cannabis to ensure compliance with minimum standards. In a perfect world, those with contraindications would not have access, and those with a

hc-sc.gc.ca/dhp-mps/marihuana/about-apropos/index-eng.php (last visited Jan. 19, 2013).

[345] *See* Quebec (Public Curator) v. Syndicat National des Employés de L'hôpital St-Ferdinand, [1996] 3 S.C.R. 211, 253 (Can.).

[346] *Chaoulli*, 1 S.C.R. at 822.

[347] *Id.*

medical need would not be criminalized. In an ideal system of medical access, those with a medical need would have access to an adequate supply of products that meet their needs. Unfortunately, we do not live in an ideal world. There will be risks to individuals and abuses of any system of medical access. Minimize these risks, and harms will not come through a consideration of the medical users only. It must come through a consideration of our entire cannabis policy and laws.

CONCLUSIONS

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."[348] Unfortunately, Parliament is in, perhaps, a paradoxical situation. The current Canadian government has maintained that the criminal prohibition is in place to protect public health and safety, yet the medical evidence shows that cannabis can improve the health of some ill people. As the body of medical evidence exploring the risks and benefits of cannabis, the current position of cannabis prohibition becomes harder to maintain. We must ask what would really protect public health and safety *vis-à-vis* cannabis policy for both medical and non-medical use. Seriously ill individuals ought not suffer because Parliament is concerned with risks to specific groups in the general public—risks that can be mitigated.

The 2011 Report of the Global Commission on Drug Policy issued a powerful statement that speaks to the heart of the drug prohibition issue:

> The global war on drugs has failed, with devastating consequences for individuals and societies around the world. Fifty years after the initiation of the UN Single Convention on Narcotic Drugs, and 40 years after President Nixon launched the US government's war on drugs, fundamental reforms in national and global drug control policies are urgently needed.
>
> Vast expenditures on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs have clearly failed to effectively curtail supply or consumption. Apparent victories in eliminating one source or trafficking organization are negated almost instantly by the emergence of other sources and traffickers. Repressive efforts directed at

[348] R. v. Parker, [2000] 49 O.R. 3d 481, ¶ 205 (Can. Ont. C.A.).

> consumers impede public health measures to reduce HIV/AIDS, overdose fatalities and other harmful consequences of drug use. Government expenditures on futile supply reduction strategies and incarceration displace more cost-effective and evidence-based investments in demand and harm reduction.[349]

The focus on the constitutional minimum for medical cannabis requirements is a good start, and addresses an important percentage of cannabis users. An ideal system would not criminalize adults for engaging in cannabis-related activities that do not pose a serious risk of harm to society. Writing a minority decision, Deschamps J. explained the situation:

> 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.[350]

While cannabis use for those who require it for their health is of paramount concern, the deprivation of liberty and security of the person for those who do not is also a serious consideration in a society that accepts that laws should not be arbitrary, overbroad, or grossly disproportionate. Canada must consider the debate in the medical context in the broader picture. What measures would really promote public health and protect public safety? A medical exemption from the broad criminal prohibition is simply the constitutional minimum.

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[349] GLOBAL COMM'N ON DRUG POLICY, WAR ON DRUGS: REPORT OF THE GLOBAL COMMISSION ON DRUG POLICY 2 (June 2011), http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf.

[350] R. v. Malmo-Levine, [2003] 3 S.C.R. 571, 728 (Can.).