



Marihuana Consultations
Controlled Substances and Tobacco Directorate
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Submission of the British Columbia Civil Liberties Association ("BCCLA") on the Proposed Changes to Health Canada's Marihuana Medical Assess Program ("MMAP")

1. The BCCLA is the oldest and most active civil liberties organization in Canada. We have spent nearly fifty years working to preserve, defend, maintain and extend civil liberties and human rights in Canada. We have extensive experience in drug policy dating back to submissions before the LeDain Commission in the 1970's and longstanding involvement in working to ensure proper balance and respect for patients' rights in the many difficult legal and ethical issues that arise in the provision of health care.

Executive Summary of the BCCLA's Recommendations

Patients should be directly authorized by a health care provider to use medical marihuana.

Given the documented widespread non-participation of physicians in the MMAP, authorization authority cannot be limited to physicians and must include other health care providers.

Health Canada should undertake and support medical marihuana research.

The MMAP must provide appropriate patient identification so that patients can disclose their status as medical marihuana users to officials when needed to prevent wrongful arrest and medication seizures.

Patient and designate production licenses should be retained and an appropriate non-profit or price-regulated production and distribution system should be developed which builds on the proven model of community-based dispensaries (i.e. compassion clubs).

Introduction

2. In mid-June of this year, the Government of Canada announced a public consultation on proposed amendments to the MMAP, citing as some of the key concerns of the current MMAP: the risk of abuse and exploitation by criminal elements; the complexity and length of the application process; the need for more current medical information for physicians, and public health and safety risks associated with the cultivation of marihuana plants in homes.
3. In order to address the concerns that are cited in the consultation documents, Health Canada is proposing to substantially redesign the MMAP. The proposed changes would see individuals ceasing to apply to Health Canada for authorization to use medical marihuana and instead receiving an authorization directly from physicians. After receiving authorization from a physician, an individual could only access a legal supply of marihuana for medical purposes from commercial distributors, as the proposed changes would eliminate personal and designated cultivation.
4. After many years of having Canadian courts repeatedly find the MMAP unconstitutional for failing to provide patients genuine access to medical marihuana, changes to the MMAP are urgently needed. However, in our view, while some of the proposed changes would genuinely improve the program, other aspects of the proposal are likely to make medical marihuana even less accessible to patients than it is currently, thus prolonging the unconscionable discrimination against medical marihuana patients so long documented in a litany of court cases.

The Applicable Legal and Ethical Framework

5. Section 7 of the *Canadian Charter of Rights and Freedoms* (the “*Charter*”) provides that:

“Everyone has the right to life, liberty and security of person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”.

6. In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, Beetz J. (joined by Estey J.) expressly articulated a constitutional right to access to health care without fear of criminal sanction:

“Security of the person” within the meaning of s. 7 of the *Charter* must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.

7. In *R. v. Parker*, 146 C.C.C. (3d) 193, the Ontario Court of Appeal recognized that it is a violation of section 7 of the *Charter* to deprive a person with a serious illness for which marihuana provides relief, of the right to use marihuana to treat her illness. The *Medical Marihuana Access Regulations*, which are the legislative framework allowing qualifying patients to use marihuana for medical purposes, were created in response to the decision in the *Parker* case.
8. While in *Hitzig v. Canada* (2003), 177 C.C.C. (3d) 449 [“*Hitzig*”] the Ontario Court of Appeal did not fault the MMAP for establishing doctors as gatekeepers to determine eligibility for medical marihuana licenses, the Court stated that “if in future physician co-operation drops to the point that the medical exemption scheme becomes ineffective, this conclusion might have to be revisited” (*Hitzig* at para. 139).
9. And indeed, that conclusion has just been revisited in *R. v. Mernagh* 2011 ONSC 2121 [“*Mernagh*”], which found on the evidence that the vast majority of physicians in Canada are refusing to participate in the MMAP. The Court in *Mernagh* found that the ordeal of medical marihuana patients forced to go to extraordinary lengths to find a physician willing to sign their

declarations was “oppressive and unfair” (*Mernagh* at para 204). As a result the Court determined that the defense to criminal charges for cultivation and possession of marihuana purportedly offered by the MMAP was wholly illusory and that the barriers to accessing medical marihuana and the widespread exposure to the risk of criminal prosecution were the direct result of deficiencies in the MMAP.

10. The problem at the centre of the *Mernagh* case is that the MMAP requires a physician’s authorization for the use of marihuana for medical purposes, but few doctors are prepared to make such authorizations. From the outset, the leadership of the medical profession has adamantly opposed the profession’s role as gatekeepers of the legislation. Professional medical organizations such as the Canadian Society of Addiction Medicine and the Canadian Medical Association have been vocal critics of the MMAP, and have lobbied government to have the gatekeeper provisions removed.
11. The medical benefits of marihuana include relief of muscle spasticity, appetite stimulation for treating wasting syndrome, control of nausea and vomiting and analgesic effect (Joy 2003). Although these benefits are summarized in the Institute of Medicine, some medical practitioners have argued that there is insufficient research to guide treatment decisions. Although important research has been done to establish the medical benefits of marihuana, this field of research is relatively new and currently under-resourced. More extensive investigations are needed to examine a range of issues, such as assessments of risk/benefits for specific populations.
12. The BCCLA echoes the Canadian Medical Association’s calls for government to fund proper investigations of the safety, efficacy and appropriate dosages of medical marihuana for the treatment of specific conditions. However, it is highly unlikely that the underdevelopment of this field of research is the sole cause of what the Court in *Mernagh* called physicians’ “overwhelming refusal to participate” in the MMAP. Decades of criminalization have obviously created a formidable social stigma to the use of marihuana and the piecemeal and minutely incremental approach to providing a program for patients in Canada who use medical marihuana has resulted in a

ludicrous snakes and ladders scenario of ostensible rights interspersed with barriers to exercising those rights.

13. Some stark examples of this situation include the fact that only a tiny minority of medical marihuana patients have successfully acquired licenses through Health Canada: 8, 460 of the approximately one million Canadians who report using medical marihuana (Health Canada 2010; Canadian Centre on Substance Abuse 2005).
14. Further, even this small fraction of licensed users are not necessarily able to secure a supply of medical marihuana that is sanctioned under the regulations; with an estimated 20, 000 Canadian patients accessing medical marihuana through community-based dispensaries (i.e. compassion clubs) (Canadian Association of Medical Cannabis Dispensaries 2011) and the majority of medical marihuana patients presumed to be accessing medical marihuana through the black market.
15. In addition to criminal jeopardy, patients face a broad array of barriers, frequently struggling to achieve required accommodations to use their medications in hospitals, short-or-long term care facilities and even their own homes.
16. Because marihuana is criminalized outside the narrow context of the MMAP, there are unique challenges in creating an effective health policy regarding medical marihuana use. Patients who use medical marihuana currently face profound risks and prejudice, including threats of criminal prosecution and eviction. As these patients already experience extensive discrimination and stigma, it is imperative that they not face any exacerbation of harms through attempted “improvements” to the MMAP.
17. We submit that in keeping with the primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (s.3), Health Canada must amend its regulatory regime to bring it into *Charter* compliance on the basis of demonstrable evidence and in ways that do not involve undue risk

to patients. We do not believe that all of the proposed amendments meet this test.

Proposed Redesign of the MMAP – Authorization

18. Health Canada proposes a new authorization scheme whereby individuals would consult a physician to obtain direct authorization to use medical marihuana. Under this proposal, the physician would not be required to take into account categories of conditions or symptoms and there would be no requirements for support from specialists. The physician's authorization alone would then be submitted to a licensed commercial marihuana producer. Health Canada proposes to establish an Expert Advisory Committee to improve physician access to information needed to appropriately prescribe medical marihuana.

19. The BCCLA endorses the proposal by Health Canada to eliminate the needless burden on patients of seeking approval from Health Canada in order to access a therapy prescribed by a physician. However, we submit that the proposal as set out is insufficient in a number of areas.

The Proposal Must Include Appropriate Patient Identification

20. Our Association has received many reports from medical marihuana patients of incidents of harassment by authorities including law enforcement and airport security personnel. Given the on-going criminalization of non-medical marihuana, there must be some clear means for patients to identify themselves to authorities as medical marihuana patients in order to prevent their wrongful detention or arrest and the seizure of their medication. In our view, appropriate patient identification needs to be incorporated into the Health Canada proposal.

Physician "Boycott" Not Effectively Addressed by Information Distribution

21. While patients' access to the MMAP will be much improved by eliminating the great delays that have been reported in Health Canada's application processing, this component of the proposal does little to address the dire problem of physician non-participation which caused the court in *Mernagh*

to strike the MMAR as unconstitutional. Health Canada proposes to address the problem of physician non-participation by improving physicians' access to comprehensive and up-to-date information on medical marihuana in order to facilitate physicians' "informed decision-making".

22. The dissemination of accurate medical information and research findings are obviously welcome, however, we submit that this alone is highly unlikely to have a transformational effect on physicians' country-wide failure to participate in this program. Because of the on-going stigma and lingering effects of decades of marihuana criminalization, improvements to patient access generated solely by a physician information campaign are apt to be extremely modest. Recall that the estimated number of medical marihuana users in Canada at this point is one million patients. In the event that it were possible for a physician education initiative alone to produce the needed number of participating physicians, such an outcome would doubtless take many years, thus perpetuating the unconstitutional deprivation of rights identified in *Mernagh*.

23. In our submission, Health Canada's proposal seriously underestimates the magnitude of the problem of physician-as-gatekeeper and does not constitute an effective remedy to the problem identified in *Mernagh*. We say that there is no reasonable possibility of remedying the current program's failure to generate physician participation merely through timely access to information. Health Canada must take more proactive steps, such as expanding prescribing rights to include other health professionals (i.e. nurse practitioners, pharmacist, naturopaths or others who are licensed to prescribe in their respective province/territory), undertaking and/or sponsoring appropriate clinical trials, and incorporating medical marihuana in to the standard of care for various conditions as appropriate (i.e. for the nausea, vomiting and weight loss caused by chemotherapy).

Proven Models of Effective Access Cannot Be Jettisoned for Dangerous Experiments

24. The MMAP has been ineffective since its inception. But rather than focusing on providing genuine and meaningful access to needed medications, the current proposals take the implicit position that medical

marihuana patients are currently a threat to their communities' safety and security. In this, the proposal would seem to have picked up an unfortunate refrain heard in some municipalities in British Columbia. The BCCLA is aware of a lobbying effort by some BC mayors to see medical cannabis cultivators portrayed as dangers to their community. We have been dismayed to see some elected officials depicting patients with chronic and terminal medical conditions and their families as system abusers in need of rigorous monitoring and special regulation. To our knowledge, these allegations are being leveled without any demonstrable evidence.

25. Our information is that indoor marihuana cultivation is indistinguishable from any other indoor plant system, so that a medical marihuana cultivation system poses no more safety risk than an indoor cucumber growing system. Indeed, if hydroponic equipment is unregulated and unsafe, then this safety issue needs to be addressed for all indoor plant growers, with no need to target medical marihuana patients.
26. We have also been troubled by various officials' attempts to characterize medical marihuana patients as essentially criminogenic – i.e.) if not a risk to community safety themselves, then attracting thieves by having marihuana in their homes. Such a stance is clearly based on stigma and prejudice, as we never see officials making the argument that wealthy people with valuable personal property are a “risk” to their communities by attracting home invasions.
27. In short, Health Canada's rationale for depriving medical marihuana patients of personal and designated producer authorization does not withstand scrutiny. On the basis of stereotyping unsupported by evidence of harm, the proposal seeks to deny patients and designated producers, who may have significant investments and expertise in cultivation systems, the ability to legally cultivate marihuana for a medical purpose. Further, the proposal would deprive patients of what may be their most cost-effective means of providing for their medical needs, while providing them no guarantee of being able to afford the product of licensed producers who will be allowed to set their own prices for needed medications that can be cost-effectively produced by other means.

28. The proposal to deny the ability to produce medical marihuana to all but licensed commercial producers is deeply flawed and constitutes a genuine threat to patients' ability to address their medical needs. As highlighted in the 2009 Status Report on "The National Pharmaceuticals Strategy: A Prescription Unfilled", "Canadians and their governments pay more for medications than many other Western countries" (Health Council of Canada 2009).

29. The National Pharmaceuticals Strategy Key Developments include the following critically important statements of principle:

"No Canadian should suffer undue financial hardship for needed drug therapy."

- *2003 First Ministers' Accord on Health Care Renewal*

"Affordable access to drugs is fundamental to equitable health outcomes for all our citizens. "

- *10-Year Plan to Strengthen Health Care*

30. Health Canada's proposal to relegate all legal production to licensed commercial producers needlessly imperils the ability of patients to access appropriate and affordable medical marihuana. The proposal is largely untested and the one situation that might stand as the 'pilot' for such a proposal (the government's only currently licensed commercial producer) has proved widely unsatisfactory to patients.

31. Health Canada is seemingly going out of its way to simply ignore what is arguably the truly proven model of access, which is the specialized pharmacy model of community-based dispensaries. These are clearly the entities with a proven track-record of providing genuine access and their model of service provision is urgently needed by Canadian patients.

32. The proposed scheme of mailing or couriering medical marihuana to patients relegates these patients to a sub-standard provision of care. It ignores that many of these patients will be completely uninformed about how to use medical marihuana and will require compassionate expertise to manage both the medication and the on-going social stigma.

33. To put the matter simply, no one at this point reasonably expects family doctors to be able to show patients how to prepare marihuana for smoking or ingestion, so medical marihuana patients who do not access a community-based dispensary are generally left without appropriate instruction and guidance. To suggest that such patients would be adequately provided for by accessing information on the Internet or by means of a brochure is to deny these patients the standard of care (consultation with a professional to receive instruction and ask questions) that is afforded to patients of other prescribed medications.

34. In our submission, a non-discriminatory standard of care and a constitutionally sufficient means of accessing medical marihuana is best provided by retaining the personal and designated producers licenses and developing a program of non-profit or price-regulated cultivation and distribution by building on and expanding existing community-based dispensaries.

35. Building on existing systems guarantees that the supply of needed medication will not be needlessly disrupted. This is particularly important in light of the Supreme Court of Canada's decision in *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, in which Chief Justice McLachlin states at paragraph 118:

The jurisprudence of this Court holds that delays in obtaining medical treatment which affect patients physically and psychologically trigger the protection of s.7 of the Charter.

36. Finally, appropriately restraining the monetary returns of the producers, either through price regulation or non-profit models, will help to ensure that the chronically and terminally ill are not deprived of needed medications, which is the primary aim of the *Canada Health Act*.

37. Thus, the BCCLA makes the following recommendations:

Patients should be directly authorized by a health care provider to use medical marihuana.

Given the documented widespread non-participation of physicians in the MMAP, authorization authority cannot be limited to physicians and must include other health care providers.

Health Canada should undertake and support medical marihuana research.

The MMAP must provide appropriate patient identification so that patients can disclose their status as medical marihuana users to officials when needed to prevent wrongful arrest and medication seizures.

Patient and designate production licenses should be retained and an appropriate non-profit or price-regulated production and distribution system should be developed which builds on the proven model of community-based dispensaries (i.e. compassion clubs).

All of which is respectfully submitted,

A handwritten signature in black ink, appearing to read "M. Vonn", followed by a horizontal line and an arrow pointing to the right.

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Policy Director, BCCLA

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