COURT OF APPEAL FOR ONTARIO

CITATION: R. v. Mernagh, 2013 ONCA 67
DATE: 20130201
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Doherty, Simmons and LaForme JJ.A.

BETWEEN

Her Majesty the Queen

Appellant

and

Matthew Mernagh

Respondent

Croft Michaelson and Amber Pashuk, for the appellant

Paul Lewin, for the respondent

Ryan Peck and Paul Burstein, for the interveners the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network and the HIV & AIDS Legal Clinic Ontario

Ryan Dalziel, Emily Lapper and Jessica Orkin, for the intervener the British Columbia Civil Liberties Association

Jean-Marc Leclerc and Christi Hunter, for the intervener the Canadian Civil Liberties Association

Heard: May 7 and 8, 2012

On appeal from the order of Justice Donald J. Taliano of the Superior Court of Justice, dated April 11, 2011, with reasons reported at 2011 ONSC 2121, 269 C.C.C. (3d) 297.

Simmons and LaForme JJ.A.:

A. OVERVIEW

[1] This is the third time in just over a decade that this court has dealt with the issue of medical marihuana. In all three cases, the court has been asked to decide whether Parliament's attempts to restrict the use of marihuana for medical purposes are constitutional.

[2] In the first case, *R. v. Parker* (2000), 49 O.R. (3d) 481, this court held that a blanket criminal prohibition on the possession and cultivation of marihuana was unconstitutional because it did not provide an exemption for people who used marihuana for valid medical purposes.

[3] Parliament responded to Parker by introducing the *Marihuana Medical Access Regulations*, SOR/2001-227, as amended ("*MMAR*"). The *MMAR* allow individuals to possess, and in some cases produce, marihuana for medical purposes if they obtain proper medical documentation.

[4] The *MMAR* sparked a second round of constitutional litigation on the grounds that, among other things, the criteria for obtaining a medical exemption to use marihuana were too onerous.

[5] In *Hitzig v. Canada* (2003), 231 D.L.R. (4th) 104, leave to appeal dismissed [2004] S.C.C.A. No. 5, this court struck down some aspects of the *MMAR*, but it refused to declare the scheme unconstitutional in its entirety. In particular, the court upheld the constitutionality of the requirement that physicians act as

"gatekeepers" to determine who should receive an exemption from criminal liability for possessing and/or producing marihuana.

[6] This brings us to the present appeal.

[7] In April 2008, the respondent, Matthew Mernagh, was charged with producing marihuana contrary to s. 7(2)(b) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 ("*CDSA*"). At the outset of his trial, he applied for a declaration that the combined effect of ss. 4 and 7 of the *CDSA* (the offences of possessing and producing marihuana, respectively) and the *MMAR* violates his rights under s. 7 of the *Canadian Charter of Rights and Freedoms*.

[8] According to Mr. Mernagh, he suffers from fibromyalgia, scoliosis, epilepsy and depression. He believes that marihuana alleviates his debilitating pain and helps prevent seizures. He therefore asserts that he has a valid medical need to produce and use marihuana and that he is entitled to a constitutional exemption from the criminal prohibition against those activities. The problem, he says, is that he has been unable to obtain an exemption under the *MMAR* because no physician will sign his medical declaration.

[9] On the *Charter* application, Mr. Mernagh did not argue that the *MMAR* are unconstitutional as they are drafted.[1] Rather, he argued that the *MMAR* are unconstitutional as they are implemented because physicians have decided *en*

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[1] One of the interveners does challenge the constitutionality of the *MMAR* on their face. We will deal with this issue when we address the interveners' arguments.

masse not to participate in the scheme. Relying on *R. v. Morgentaler*, [1988] 1 S.C.R. 30, Mr. Mernagh claims that the protection accorded by the *MMAR* has proven to be illusory, depriving him and others like him of the right to liberty and security of the person in a manner that is contrary to the principles of fundamental justice.

[10] The trial judge agreed with Mr. Mernagh, concluding that the *MMAR* made legal access to medical marihuana "practically unattainable for those who desperately need it". As a result, the trial judge struck down the *MMAR* in their entirety.

[11] Since this declaration of invalidity left no legislative scheme in place for people to obtain exemptions from the prohibitions in ss. 4 and 7 of the *CDSA*, the trial judge also declared those sections to be of no force and effect. He suspended the declarations of invalidity for three months; those suspensions were later extended pending this court's decision on the Crown's appeal. He also granted Mr. Mernagh a personal exemption to both possess and produce marihuana during the period of the suspension. Finally, the trial judge permanently stayed the charges against Mr. Mernagh.

[12] In concluding that the *MMAR* violated s. 7 of the *Charter*, the trial judge made four crucial findings of fact that the Crown challenges on appeal:

- Mr. Mernagh and all of the other "patient witnesses" who provided evidence on the application were entitled to medical exemptions under the *MMAR*;
- many of the physicians who dealt with the patient witnesses had acted in an "arbitrary and biased" manner in rejecting their requests for medical declarations;
- the "vast majority" of people entitled to exemptions under the *MMAR* have been unable to obtain them; and
- Canadian physicians have "massively boycotted" the *MMAR*, "completely undermin[ing]" the effectiveness of the program.

[13] As we will explain, in our view the trial judge erred by: (1) wrongly interpreting *Parker* and *Hitzig* to recognize a constitutional "right" to use medical marihuana; (2) relying on anecdotal evidence and making findings not supported by the record to conclude that Mr. Mernagh and the patient witnesses qualified for exemptions under the *MMAR*; and (3) finding that the *MMAR* operate in such a way as to make medical exemptions practically unavailable, rendering the defence provided by the *MMAR* illusory.

B. BACKGROUND

The Evolution of the *MMAR*

[14] This case cannot properly be considered in isolation. As we have just explained, it is preceded by earlier cases that addressed the constitutionality of access to marihuana for medical purposes, and must be considered against that background. Moreover, as the record in this case reveals, the *MMAR* have been amended since they were first introduced, both as a result of this court's decision in *Hitzig* and as a result of input from interested stakeholders – and it is necessary to consider their evolution.

[15] As a starting point, it is important to recognize that marihuana is both a "drug" as defined in s. 2 of the *Food and Drugs Act*, R.S.C. 1985, c. F-27 ("*FDA*") and a "controlled substance" as defined in s. 2 of the *CDSA*. Currently, marihuana is an unapproved drug that has not undergone the standard processes for assessing the safety, efficacy and quality of new therapeutic products. As such, its sale in Canada for medical purposes is subject not only to the criminal prohibitions in the *CDSA*, but also to the restrictions in the *FDA* aimed at regulating therapeutic products.

[16] The legislative history of the exemption from criminal liability for the medical use of marihuana prior to *Hitzig* is set out in *Hitzig* at paras. 24-73, and will not be repeated here.

[17] In 2003, the *MMAR* were challenged in *Hitzig*. This court held that the scheme's failure to provide a legal supply of marihuana and one of its eligibility requirements were unconstitutional. But the court specifically upheld the constitutionality of the "physician as gatekeeper" requirement, which is at the heart of the present appeal. The court explained, at para. 139:

> Whether marihuana will mitigate the particular symptom of an individual with a particular serious medical condition is fundamentally a medical question. Just as physicians are relied on to determine the need for prescription drugs, it is reasonable for the state to require the medical opinion of physicians here, particularly given that this drug is untested.

[18] The court went on to acknowledge that some physicians' organizations had objected to this gatekeeping role. However, it accepted the application judge's finding that a "sufficient number" of physicians were participating in the scheme that it could not be said that exemptions were practically unavailable.

[19] However, the court was careful to limit its conclusion to the evidentiary record in that case, noting, at para. 139: "[I]f in the future physician co-operation drops to the point that the medical exemption scheme becomes ineffective, this conclusion might have to be revisited."

[20] Similarly, at para. 143, the court noted that while it did not offend s. 7 of the *Charter* to require that a specialist (as opposed to a general practitioner) must sign off on declarations for certain types of illnesses, this conclusion could be revisited if it proved over time to be a significant practical impediment.

[21] Following *Hitzig*, Health Canada made several amendments to the *MMAR* both to conform to this court's directions and to address various concerns identified by stakeholders.[2] The overall effect of these amendments was to make it easier for people to obtain medical declarations. For example:

- Patients suffering from symptoms listed in the former "category 2"[3] could obtain declarations from general practitioners, provided that the patient's case had been assessed by a specialist who concurred that conventional treatments were ineffective or medically inappropriate, and who was aware that marihuana was being considered as an alternative treatment;
- The new "category 2" was redefined to capture any debilitating symptom associated with a medical condition, or its treatment, that did not fall within "category 1"; and
- For either category, the declarant physician was no longer required to recommend a daily dosage, but only to indicate the amount of marihuana that the patient proposed to use. Also, the physician was no longer required to indicate that the benefits of marihuana use outweighed the risks, or that marihuana would mitigate the symptoms of the applicant patient.

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[2] Attached as Appendix A to these reasons is a comparison of s. 6 of the *MMAR* as it was at the time of the *Hitzig* appeal and as amended in 2005. Where not otherwise specified, "*MMAR*" in these reasons refers to the current regulations, as amended in 2005.

[3] Attached as Appendix B to these reasons is a list of the categories of illnesses covered by the *MMAR*, both prior to and following the 2005 amendments.

[22] These amendments came into effect in 2005 and were in force at the time Mr. Mernagh was charged under the *CDSA*.

C. THE PRESENT CASE

(1) The *Charter* Application

[23] In his *Charter* application, Mr. Mernagh attempted to show that he needed to use marihuana for medical purposes but that he was unable to get a physician to sign a medical declaration because of a widespread lack of co-operation on the part of Canadian doctors with the *MMAR*.

[24] In support of his application, Mr. Mernagh filed affidavits from 19 people who live in different parts of Canada and who wanted to use marihuana to treat their medical symptoms. Mr. Mernagh, two of the affiants, and one other individual also gave *viva voce* evidence on the application. Mr. Mernagh called two expert witnesses and also filed certain documentary evidence which we will refer to below.

(a) Mr. Mernagh's Evidence

[25] Mr. Mernagh was 37 years old at the time of his application. He testified that he began experiencing severe pain in 1991 when he was 18 years old. After a number of tests, he was diagnosed with fibromyalgia, a rare condition about which little was known at the time. He was prescribed painkillers such as Demerol, and, among other treatments, undertook acupuncture, meditation and

physiotherapy. The Demerol relieved his pain but left him "zombie-like" and unable to do much more than sleep. In later years, Mr. Mernagh experienced problems from scoliosis and developed a seizure disorder. As a result of his pain, Mr. Mernagh also experienced depression.

[26] During his second year of college, Mr. Mernagh tried marihuana. He found that although marihuana did not relieve his pain as effectively as Demerol, it provided good pain relief without the side effects. In his words, marihuana made him "functional".

[27] In 1996, Mr. Mernagh began seeing a physician at a walk-in clinic in Toronto, who, it appears, became his primary physician. She supported his application to the Medical Marihuana Resource Centre, which would later become the Toronto Compassion Centre. Mr. Mernagh obtained marihuana through this centre for some time.

[28] In late 2002 and early 2003, Mr. Mernagh was quite ill. He became concerned about his ability to access medical marihuana and asked the physician he had been seeing for a *MMAR* medical declaration. According to Mr. Mernagh, the physician was supportive of the idea but told him he would have to see a specialist, as was required under the *MMAR* at that time. Mr. Mernagh did not follow up on this recommendation. In his evidence on the application he

explained that, at the time, he let the issue go because he was preoccupied with school and with applying to the Ontario Disability Support Program.

[29] Shortly thereafter, the physician Mr. Mernagh had been seeing closed her practice to start a family. According to Mr. Mernagh, she tried, without success, to find him another physician in his hometown of St. Catharines. Mr. Mernagh also tried to find a physician by calling local hospitals but was told that there were no general practitioners accepting new patients. He says he was advised to use clinics if he needed medical care. It does not appear that Mr. Mernagh asked any of the physicians he saw between 2003-2005 to sign a medical declaration.

[30] In 2006, Mr. Mernagh went to a doctor/patient "meet and greet" in an effort to find a new family physician. After explaining to the physician that he suffered from fibromyalgia and scoliosis and that he treated his symptoms with marihuana, the physician said she would prescribe morphine instead. Mr. Mernagh testified that he was not interested in a prescription for morphine at that point in his life, or, for that matter, in any other prescription painkiller. He therefore decided that he and this prospective physician would not work well together.

[31] In April 2007, Mr. Mernagh consulted another physician described by friends as likely to be receptive to someone who used medical marihuana. This physician did not sign the *MMAR* declaration, but did write a letter addressed "to

whom it may concern" advising that Mr. Mernagh had made a "dramatic improvement" with his medical problems. The letter concluded: "I fully support Mr. Mernagh using cannabis to keep his problems under control."

[32] Although the physician did not explain why he would not sign the medical declaration, Mr. Mernagh believes it was because he (Mr. Mernagh) suffers from depression.[4] Mr. Mernagh did not call this physician as a witness on his *Charter* application to explain why he did not sign a medical declaration.

[33] As we stated at the outset, in April 2008, Mr. Mernagh was charged with producing marihuana contrary to the *CDSA*.

[34] On his application challenging the operation of the *MMAR*, Mr. Mernagh did not lead any medical evidence to establish that he actually met the medical criteria for obtaining an exemption under the *MMAR*.

(b) The Patient Witnesses' Evidence

[35] Mr. Mernagh called other people to testify about the problems they encountered obtaining medical exemptions. In their affidavits and oral evidence, the patient witnesses described their various illnesses and symptoms, the relief they experienced or hoped to experience from taking marihuana, and the efforts they had made to find physicians who would sign the medical declarations

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[4] In contrast to Mr. Mernagh's testimony, in his letter, the physician said Mr. Mernagh advised the doctor that he suffers from "Bipolar disease, Fibromyalgia and Chronic pain syndrome."

required by the *MMAR* in order to apply for a medical exemption. Some of those who had succeeded in having declarations signed described delays while Health Canada considered their applications. Some described hardships suffered by resorting to criminal sources of marihuana. Others told of their relief when they did get declarations signed.

[36] Some of the patient affidavits described their physicians' statements or conduct in refusing to sign the medical declarations. The trial judge ruled these hearsay statements to be admissible for the fact that they were made, but not the truth of their contents. This ruling was not appealed.

[37] Mr. Mernagh did not lead any medical evidence to establish that the patient witnesses who had not succeeded in obtaining medical declarations qualified for exemptions under the *MMAR*.

(c) The Expert Evidence Led by Mr. Mernagh

[38] Dr. Joel Lexchin testified as an expert witness on the influence of the pharmaceutical industry on physicians' prescribing practices and how this might relate to the role of physicians as facilitators of the *MMAR* defence. He testified that the majority of physicians receive visits from pharmaceutical industry representatives, who provide samples of drugs and educate them about their use. Physicians only prescribe those drugs that have been approved pursuant to a process that includes research, clinical trials and government approval.

[39] Dr. David Rosenbloom testified as an expert witness on the effects of prescription drugs, the use and abuse of prescription opioids, and Canada's methadone program and registry. He testified that prescription narcotics, the conventional treatment for chronic pain, can cause a variety of undesirable and dangerous side effects.

(d) Other Evidence Adduced by Mr. Mernagh

[40] Mr. Mernagh also filed certain other documentary and affidavit evidence on consent. This evidence included transcripts from another proceeding in which the regulation of medical marihuana was at issue. Included with the transcripts were two reports co-authored by an HIV/AIDS expert, epidemiologist Lynne Belle-Isle, who testified as an expert witness at the trial. The reports were dated 2006 and 2007, respectively.

[41] In addition, a copy of the *Report of the Senate Special Committee on Illegal Drugs: Cannabis* (Toronto: University of Toronto Press, 2003) ("The Nolin Report"), was filed on consent.[5]

(e) The Evidence Led by the Crown

[42] In reply to Mr. Mernagh's evidence, the Crown filed affidavits from Jeannine Ritchot, Director, Bureau of Medical Cannabis, Office of Controlled Substances

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[5] Given that this report (released by the Senate in September 2002) pre-dates *Hitzig* and the 2003 and 2005 amendments to the *MMAR*, it is of historical interest only.

and Tobacco Directorate, Health Canada, and made her available for cross-examination. In addition, the Crown filed affidavits from Ronald Denault, Manager of the Marihuana Medical Access Division, Office of Controlled Substances, Health Canada.

[43] Among other things, the Crown affidavits set out evidence about physicians' participation in medical marihuana access schemes between 1998 and 2010 and about the number of authorizations to possess ("ATPs") that were issued during this period.

[44] This evidence indicated that in 1998 (the first year that the Minister of Health issued an exemption permitting possession of marihuana under s. 56 of the *CDSA*), only four physicians signed medical declarations. In 2003, the year that *Hitzig* was decided, 499 physicians signed medical declarations. After the amendments to the *MMAR* were passed in 2005, the number of physicians participating increased each year. This evidence was conveniently summarized in the appellant's factum in chart form, which is reproduced here:

Year	Number of medical practitioners who signed declarations
1998	4
1999	102
2000	368

2001	727
2002	456
2003	499
2004	509
2005	754
2006	1,139
2007	1,345
2008	1,887
2009	2,698
2010 (to Oct. 20)	2,351

[45] The Crown's evidence also indicated that, in 2001, 88 ATPs under the *MMAR* were issued nationwide. By 2009, that number had increased to 4,876, including 2,068 first-time ATPs. From 2001 to October 20, 2010, a total of 20,052 ATPs had been issued. This figure represents 80% of all applications for exemptions submitted to Health Canada within that timeframe. At the very least, the Crown submitted, this indicates that the regime is functional.

D. THE TRIAL JUDGE'S REASONS

[46] It was common ground on the application that the *MMAR* constituted a "threshold" violation of Mr. Mernagh's right to liberty and security of the person

under s. 7 of the *Charter*. The issue to be decided was whether the deprivation of Mr. Mernagh's rights accorded with the principles of fundamental justice.

[47] The trial judge framed the constitutional questions as: Has a lack of physician participation rendered the *MMAR* scheme ineffective and the related defence illusory? If so, is this a result of the legislation?

[48] In answering the first question, the trial judge concluded that there were significant problems in obtaining medical declarations necessary to obtain exemptions under the *MMAR*.

[49] At para. 160 of his reasons, he found that many of the physicians named in the patient witnesses' affidavits were "arbitrary and biased" in rejecting their patients' requests for medical declarations without turning their minds to the criteria in the *MMAR* as the basis for their refusals. He cited the stigma associated with marihuana as a reason for this attitude.

[50] At paras. 205-207, the trial judge found that all of the patient witnesses "ought to qualify for an exemption", yet the majority of them had been unable to find physicians willing to sign medical declarations on their behalf. The 21 patient witnesses were from 7 different provinces. While their evidence was anecdotal in nature, the trial judge found it to be representative of the experiences of similarly situated individuals across the nation and concluded that this access problem was Canada-wide.

[51] Despite the Crown's evidence that the number of medical declarations was increasing annually, the trial judge concluded that the number of approved applications was a "trickle" compared to the demand. At para. 214, he found as a fact that Canadian physicians have "massively boycotted" the *MMAR* and that their refusal "completely undermines the effectiveness of the program." He concluded on this point, at para. 230:

> [L]egal access to medical marihuana is practically unattainable for those who desperately need it. The defence to the possession and cultivation of marihuana purportedly offered by the *MMAR* is illusory and does not accord with principles of fundamental justice.

[52] In answering the second question, the trial judge concluded that the reason the *MMAR* scheme is ineffective is because the regulations blindly delegate the gatekeeping role to physicians, who have chosen not to accept the responsibility that Parliament thrust onto them. He held that this was the case even after the 2005 amendments which were intended to address the profession's concerns.

[53] The trial judge acknowledged that in *Hitzig*, this court upheld the constitutionality of the physician as "gatekeeper" under the *MMAR*. Despite this, the trial judge held, at para. 248, that the "overwhelming problem" with the *MMAR* is that "they require physicians, who have taken an oath to do no harm, to endorse the use of a largely untested and unapproved drug without any safeguards."

[54] Having conferred on physicians the “sole responsibility for the therapeutic distribution of an untested drug”, the trial judge was of the view that it was “incumbent” on Parliament to ensure that they were willing and able to take on the role. He explained, at para. 259:

> The deficiency with the legislation is not that doctors were appointed as gatekeepers, but the fact that there were no steps taken to obtain the support, co-operation and participation of the medical profession as gatekeepers before or after they were so designated.

[55] The trial judge concluded, at para. 262, that the lack of a “viable” exemption to the offence of production of marihuana violated s. 7 of the *Charter*. Not surprisingly, he went on to hold that the *MMAR* could not be saved under s. 1.

[56] In the result, the trial judge struck down the *MMAR* in their entirety, pursuant to s. 52 of the *Constitution Act, 1982*. As we explained at the outset of these reasons, this declaration of invalidity was initially suspended by the trial judge and was later extended by this court pending the outcome of the Crown’s appeal. The criminal charge against Mr. Mernagh was permanently stayed pursuant to s. 24(1) of the *Charter* and he was granted a personal exemption to both possess and produce marihuana during the period of suspension.

E. ISSUES

[57] On appeal, the Crown submits that the trial judge erred in concluding that the *MMAR* are unconstitutional. It submits that the trial judge erred in his factual

findings, relied on inadmissible evidence and had no basis to conclude that physicians in Canada have boycotted the *MMAR*.

[58] Mr. Mernagh and the interveners submit that, on the evidence adduced on the application, it is clear that requiring physicians to act as "gatekeepers" for the use of medical marihuana has created a major impediment to obtaining exemptions under the *MMAR*. Because of this, they argue, the exemption scheme provided by the *MMAR* is illusory and the trial judge was correct in finding that to be the case.

F. ANALYSIS

(1) Sufficiency of the Record

[59] Given that this appeal turns on the sufficiency of the record, it is important to clarify the nature and significance of the evidence required to establish a *Charter* breach in a case like this.

[60] The trial judge stated at para. 2 of his reasons that this court had recognized in *Parker* that it was "a violation of s. 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 his illness". With respect, this is an inaccurate interpretation of *Parker* that, unfortunately, appears to have influenced the trial judge's subsequent legal analysis.

[61] The correct proposition expressed in *Parker* is that, given that marihuana can medically benefit some individuals, a blanket criminal prohibition on its use is unconstitutional. This court did not hold that serious illness gives rise to an automatic "right to use marihuana", and *Parker* did not remove the requirement that the applicant lead evidence that his or her rights were impaired.

[62] As we have said, Mr. Mernagh did not argue that the limitation on his rights created by the *MMAR* as they are drafted renders the scheme unconstitutional. Rather, he argued that the medical exemption provided by the *MMAR* was practically unavailable to him and others like him who require marihuana to relieve their symptoms. Logically, then, to establish a breach of s. 7 of the *Charter*, Mr. Mernagh was first required to establish that he (or at least one of the patient witnesses who were unable to obtain medical declarations) was entitled to a medical exemption under the *MMAR*. Further, to establish that he was entitled to a medical exemption under the *MMAR*, Mr. Mernagh had to do more than report that he has a serious illness and assert that his symptoms are relieved by the use of marihuana. Rather, as we will explain more fully below, he had to lead evidence from a physician who could confirm that Mr. Mernagh met the medical criteria for an exemption.

(a) The Limited Scope for Anecdotal Evidence

[63] Mr. Mernagh, both on the application and on this appeal, fundamentally misconceived the nature of the evidentiary foundation required in a case of this kind. He relies on the passage at para. 9 of *Hitzig*, which states: "[T]he courts, relying on evidence of individuals' personal experiences and anecdotal evidence have determined that some seriously ill persons derive substantial medical benefit from the use of marihuana." He wrongly takes this to mean that anecdotal evidence of serious illness, and the relief of symptoms through marihuana use, is sufficient to establish a person's own medical need to use marihuana. This interpretation misunderstands the scope for anecdotal evidence in *Charter* analysis and over-reads the passage in *Hitzig*.

[64] The reference to anecdotal evidence in *Hitzig* recognizes nothing more than that for the purposes of judicial fact-finding, anecdotal evidence has been used to establish the general proposition that marihuana can have some medical benefit for some people. Anecdotal evidence, in a sense, compensates for scientific evidence that might otherwise have been used for that purpose. In the absence of more and better studies about the therapeutic value of marihuana, anecdotal evidence may be a reasonable substitute.

[65] Mr. Mernagh's lay evidence was sufficient to show that he was not a recreational user and that his s. 7 right to security of the person was engaged.[6] However, it was not sufficient to show that he fit the medical criteria in the *MMAR*, and was therefore entitled to a physician's declaration in support of an application for an exemption.

(b) The Requirement for Evidence Sufficient to Establish a *Charter* Breach in a Given Case

[66] The parties addressed the evidentiary requirements on a *Charter* application of this kind in their submissions on appeal. Mr. Mernagh argues that requiring every litigant to produce a record as detailed as that in *Parker* in every case would be too onerous a burden. In *Parker*, the court accepted that marihuana has medical uses on the basis of a considerable body of scientific evidence, legislative reports, clinical studies, research reports and *viva voce* medical opinion evidence. We agree that a *Parker*-style record is not always required, but as discussed above, only as it pertains to the general proposition that marihuana has some medical benefit.

[67] Each litigant seeking to exempt himself or herself from criminal liability by arguing a medical need to use marihuana must, nevertheless, establish that individual need on a case-by-case basis.

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[6] Depending on the facts of each case, medical evidence might be required to show that the applicant's security of the person interests are engaged, for example where the Crown contests that the applicant's illness is of sufficient gravity.

[68] In contrast to Mr. Mernagh, in Mr. Parker's case he did not simply present anecdotal evidence that he was seriously ill and that marihuana alleviated his symptoms. Mr. Parker's evidence about his individual condition established that: he had lived with his epilepsy for many years; he had treated it through highly invasive surgery; and he continued to take conventional medication notwithstanding the side effects. His evidence included the opinions of his physicians on the severe side effects of his own prescription medications, and that it was medically necessary for him to use marihuana for optimal control of his life-threatening seizures.

[69] Mr. Parker also offered as evidence the results of a research study in which he was a participant to support a reasonable explanation for why the prescription drug Marinol – a synthetic version of a marihuana constituent – was not an effective form of treatment for him. In short, this court found that there was ample evidence from which the trial judge in Mr. Parker's case could conclude that he was not asserting a mere preference for an illegal treatment over a legal one.

[70] In *Hitzig* there was no analysis of what evidence was sufficient to establish a medical need for marihuana. Unlike this case, *Hitzig* was a civil case in which the applicants sought a declaration of invalidity under s. 52 of the Constitution. None of the applicants was facing criminal charges. In that context, the Crown

conceded that the *Hitzig* applicants – four of whom already had licences to possess marihuana – included persons with such a need.

[71] The trial judge in this case appears to be under the impression that the trial Crown made a concession similar to the concession made in *Hitzig*. With respect, however, our reading of the record and the transcript of the application does not disclose such a concession, nor was such a concession made in this court.

[72] Unfortunately, after holding that a "threshold violation" was conceded, the trial judge overlooked a crucial portion of the analysis: that is, whether Mr. Mernagh had established on a balance of probabilities that either he, or at least one of the patient witnesses who had not obtained a medical declaration, was entitled to an exemption under the *MMAR*. If he could not establish this, he could not establish the practical ineffectiveness of the *MMAR* scheme. It follows that he could not establish that the defence provided by the *MMAR* is illusory.

[73] In contrast to Mr. Parker, in this case, Mr. Mernagh did not lead expert medical evidence to support his application. In particular, he did not lead medical evidence that he qualifies for a medical exemption under the *MMAR*. The record relating to the patient witnesses who had been unable to obtain medical declaration suffers from the same deficiency.

[74] In our view, in the absence of such evidence, it was not open to the trial judge to hold that Mr. Mernagh and the patient witnesses who had not obtained medical declarations were entitled to exemptions under the *MMAR*. The question of their eligibility was fundamentally a medical one. In the absence of expert medical evidence to establish that Mr. Mernagh or other patient witnesses without medical declarations qualified for an exemption under the *MMAR*, it was simply not open to the trial judge to conclude that they did.

[75] Further, in our view, the record in this case did not establish that Mr. Mernagh and the patient witnesses failed to obtain medical declarations because of bias or arbitrariness on the part of the physicians they consulted. Nor did it establish a widespread lack of co-operation with the *MMAR* on the part of the Canadian medical profession. Thus, the record does not support the trial judge's inference that they failed to obtain medical declarations only because Canadian physicians are boycotting the *MMAR*.

[76] In Mr. Mernagh's case, he did not consult a specialist when advised to do so in late 2002 or early 2003. There is no evidence on the record that he attempted to seek a medical declaration between 2003 and 2005, though he did make informal inquiries of a prospective family physician in 2006. Moreover, the physician he consulted in 2007 could hardly be described as "biased and arbitrary" or as boycotting the *MMAR* given that he specifically wrote a letter supporting Mr. Mernagh's use of marihuana for pain relief.

[77] The record discloses that Mr. Mernagh made some efforts to obtain a medical declaration after he was charged in this case. In August 2010, a year after he was diagnosed with a seizure disorder, he raised the medical marihuana program with his neurologist. The neurologist claimed not to know about the program and advised him to return to the hospital that had diagnosed his seizure disorder. In November 2010, Mr. Mernagh asked his family physician for either a medical declaration or a prescription for Tylenol 3 and a referral to a pain specialist. His physician agreed to the latter.

[78] Similarly, while there is no dispute that the patient witnesses who had not obtained medical declarations all had very serious health problems, their evidence also fell short of showing they failed to obtain medical declarations because of a widespread lack of co-operation on the part of the medical profession with the *MMAR*. One had not even asked a physician to sign a declaration after the 2005 amendments to the *MMAR* and five others had only asked one physician to sign during that time period. Respectfully, these efforts fail to demonstrate a profession-wide “boycott” of the *MMAR*. We also note that five of the patients had illnesses for which marihuana may be contra-indicated, meaning that the physicians who were consulted may well have had valid medical reasons for refusing to sign the declarations.

[79] These errors in the trial judge's findings alone require that the appeal be allowed. We now turn to an analysis of the trial judge's other findings in the light of the evidentiary record available.

(2) The Trial judge Made Factual Findings That Were Not Supported by the Evidence

[80] The Crown submits that there was no evidentiary basis for the trial judge's finding that the defence provided by the *MMAR* is illusory. More specifically, the Crown submits that there was no evidentiary foundation for the crucial findings of fact made by the trial judge that formed the foundation for his decision:

- The patient witnesses were all entitled to obtain authorizations to possess marihuana (at para. 205);
- Many of the physicians who dealt with the patient witnesses acted in an arbitrary and biased manner (at para. 160);
- The medical community in Canada had "massively boycotted" the *MMAR* (at para. 214); and
- The "vast majority" of persons who needed to use marihuana to treat serious illnesses had been unable to obtain medical declarations (at para. 269).

[81] We agree that the evidence before the trial judge did not support these factual conclusions. The finding that the patient witnesses were entitled to obtain

authorizations to possess marihuana is effectively answered by our discussion in the previous section and does not need to be addressed again.

[82] The remaining three findings challenged by the appellant are related and can be taken together. Respectfully, and as we explain, all three findings were made in error and are not supported by the record. We say this for several reasons.

[83] First, the documentary evidence relied on by the trial judge was insufficient to establish a boycott. In concluding that physicians were boycotting the *MMAR*, the trial judge referred to some correspondence of medical associations expressing their concerns with the "physician as gatekeeper" system that was written during the early years of the *MMAR*. He did not, however, refer to other correspondence in the record indicating that some of those concerns had in fact been allayed by the 2005 amendments to the regulations.[7] In addition, Mr. Mernagh did not adduce any evidence as to the current or recent position of the medical profession on this issue.

[84] Second, the trial judge failed to follow his own hearsay ruling on the admissibility of the patient witnesses' evidence. The findings that many of the doctors who dealt with the patient witnesses acted in an arbitrary and biased manner and that the medical community in Canada had "massively boycotted"

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[7] This included letters from the Canadian Medical Association to the federal government in 2004 regarding, among other things, the proposed wording of the declaration.

the *MMAR* were based in large part on the patient witnesses' evidence about negative reactions from some physicians to their requests for a medical declaration. With respect, there was no admissible evidence as to why the patients' requests were refused.

[85] The physicians' statements about their reasons for not signing medical declarations, as set out in the patient affidavits, were ruled admissible only for the fact that they were made and not for the truth of their contents. The trial judge appears to have overlooked this ruling when he prepared his reasons.

[86] For example, in his review of the evidence the trial judge noted:

- D.D., a British Columbia resident, had been told by many physicians in Vancouver that it was the policy of the Vancouver Coastal Health Authority to prohibit doctors from signing medical declaration forms (para. 98);
- F.F., another British Columbia resident, was told by his general practitioner that the physician's medical clinic, the College of Physicians and Surgeons of British Columbia and his insurer would not approve of his signing (para. 105);
- T.C., an Alberta resident, was informed by his physician that the College of Physicians and Surgeons of Alberta did not permit him to sign the form (para. 121); and

- M.C., a Quebec resident, was told by his physician that he refused to sign a declaration and "that the Canadian Medical Protect[ive] Association discourages the practice in Quebec and treats a waiver of liability as ineffective" (para. 129).

[87] To the extent that the trial judge used hearsay to prove the truth of what the physicians told the patients – i.e. that physicians had been instructed not to co-operate with the *MMAR* – he violated his own hearsay ruling. Further, the individual examples he cited do not support his generalized conclusion of arbitrariness and bias in the medical profession, nor do they support a finding of a boycott.

[88] In any event, evidence that a physician refused to sign a medical declaration for a patient who reported that marihuana relieved his or her symptoms is not, on its face, evidence of arbitrariness or bias. Physicians have been fixed with the responsibility of being gatekeepers, but they remain bound by their own ethics and codes of conduct.

[89] According to the patients' evidence, there were also instances where they were treated rudely or unreasonably. This was understandably upsetting to the patients and we should not be taken as condoning such conduct. However, the evidence fell short of demonstrating a *systemic* failure of the *MMAR* regime to operate in accordance with the *Charter*.

[90] Third, the trial judge misapprehended documentary evidence about physicians' views about marihuana. As we explained earlier, the trial judge found that many physicians hold a stigmatized view of marihuana. In addition to relying on the patient evidence, he found evidence of stigma in an exploratory study submitted to Health Canada in 2007, which was attached as an exhibit to the affidavit of one of the two Crown witnesses.

[91] The qualitative study he referred to, *Views of Physicians Regarding The Use of Marihuana for Medical Purposes* (Montreal: Les Études de Marché Créatec, 2007), involved telephone interviews with 30 physicians who were already involved in the *MMAR* process and treating at least one patient using medical marihuana. The study was expressly stated to be exploratory qualitative research that could not be extrapolated to any population or audience without further validation. While some of the physicians interviewed did raise the concern that being singled out as a marihuana-prescribing physician might contribute to increased risk of liability and social stigma, this risk was perceived as "low" and concerns tended to disappear over time.

[92] On the evidence before him, a finding that many physicians hold a stigmatized view of marihuana was not open to the trial judge and could not support his conclusion that physicians were boycotting the *MMAR*.

[93] A fourth reason that the trial judge's findings are in error is that he drew incorrect conclusions from the statistical evidence. The trial judge's conclusion, at para. 212, that the number of approved applications is a "trickle" compared to the demand was based on counting the number of physicians who had signed declarations each year and dividing it by the estimated number of doctors in Canada to arrive at a percentage.[8] However, there was simply no evidence in the record about the number of physicians who were asked to sign declarations, or about whether the requesting patients met the medical criteria. As a matter of simple logic, there is no correlation between the number of approved applications and the number of physicians in Canada. Many physicians may have areas of expertise that would never bring them into contact with this type of patient.

[94] In contrast, at paras. 226 and 227, the trial judge described the Crown's statistical evidence to show that physician participation in the program has steadily increased since its inception as having a "superficial appeal", but that it lacked an appropriate point of reference. He held that, in the absence of showing how many physicians were practicing in Canada and how many physicians were signing or refusing to sign declarations, the statistics could not

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[8] In this regard, we note that the application judge made various arithmetic errors in his calculations. For example, he calculated that .012% of doctors practicing in Canada in 2001 had signed medical declarations, when the correct figure was actually 1.2%. Further, he stated that assuming there were approximately 60,000 physicians in practice in each year between 1998 and 2010, "the number of physicians who signed declarations for patients in any one of those years is less than one half of one percent" (0.50%), when the correct figure in each of those years was below 4.5%, as seen in the chart at para. 44 above.

establish the actual effectiveness of the program. The reality is that the same evidentiary deficiency the trial judge described here also exists in his finding that the number of approved applications is a "trickle".

[95] Similarly, the trial judge found that the "vast majority" of those who needed medical marihuana were unable to get physicians to sign declarations. Again, however, there was no direct evidence as to either the number of people in Canada who were potentially eligible for medical marihuana exemptions, or who had attempted to have declarations signed. Rather, the trial judge's conclusion appears to have been based on a footnote in a paper by an epidemiologist that was filed as an exhibit in *R. v. Beren and Swallow*, 2009 BCSC 429, 192 C.R.R. (2d) 79, leave to appeal dismissed [2009] S.C.C.A. No. 272, at para. 38.

[96] The passage relied on by the trial judge states the following, L. Belle-Isle, *Cannabis as Therapy for People Living with HIV/AIDS, "Our Right, Our Choice"*, (Ottawa: Canadian AIDS Society, 2006) at p. 63, footnote 22:

> An estimate of 400,000 medical users in Canada is often cited. This estimate is based on one study conducted in Ontario that found that 1.9% of the population aged 18 years and over reported that they use marijuana for medical purposes. This is most likely an underestimate. In British Columbia alone, it is estimated that about 7%, or 290,000 people, use cannabis for therapeutic purposes. [Citations omitted.]

[97] There are several reasons why this footnote could not support the trial judge's finding.

[98] First, the position paper was only filed as an “adjunct” to Ms. Belle-Isle's evidence at the *Beren and Swallow* trial. At that trial, Ms. Belle-Isle was not qualified to give expert evidence concerning the number of persons in Canada who were entitled to obtain medical exemptions to use marihuana.

[99] Second, the estimates came from sources other than Ms. Belle-Isle and were therefore hearsay, not admissible to prove the truth of the estimates.

[100] Third, and perhaps most importantly, the estimate of 400,000 medical users was apparently based on a telephone survey of 2,508 adults age 18 or over in Ontario in which 49 people reported using marihuana for a “medical” reason, primarily pain or nausea. However, the fact that 49 people said they had used marihuana for some reason they considered “medical” was not capable of supporting a finding that any of them qualified for an exemption under the *MMAR*.

[101] In the final analysis, we agree with the appellant that the evidentiary record does not support the trial judge’s findings of fact. It follows that the record is wholly unable to support the conclusion that the *MMAR* scheme is illusory because of insufficient participation by physicians. At its highest, the evidence shows that some patients, for some reason, were having difficulties finding a physician to support their applications. There is no evidence as to what, if any,

proportion of physicians who were asked to, but did not, sign a declaration should have done so, and no evidence as to why they did not.

[102] Without such evidence there was no way for the trial judge to reasonably assess the efficacy of the regime and determine that there had been a boycott. Indeed, with much of the same evidence before her, the trial judge in *Beren and Swallow* found that as of 2009 there was no factual foundation to find that physician co-operation had declined; in fact it appeared inferentially that it had increased.

[103] As a result, we conclude that Mr. Mernagh and the interveners have failed to prove that access to the medical exemption scheme pursuant to the *MMAR* applies to them, or is illusory. Further, the evidence in this case fails to prove that the vast majority of physicians in Canada refuse to participate in the *MMAR* scheme. Finally, there is no basis on which to distinguish the holding of this court in *Hitzig* that the gatekeeping role given to physicians in the *MMAR* remains constitutionally sound.

[104] We agree with the appellant on the factual issues and would give effect to these grounds of appeal. We now turn our attention to the submissions advanced by the interveners.

(3) Additional Issues Raised by the Interveners

[105] Three organizations were granted leave to intervene in this case. They were required to take the record as they found it and not seek to enhance it with additional facts. Their arguments were, therefore, constrained by the lack of evidence on certain key aspects of the application.

[106] The Canadian Civil Liberties Association ("CCLA") argues that the requirement that physicians attest that conventional treatments have been tried or considered, and found to be ineffective or medically inappropriate, effectively makes marihuana a medication of "last resort". The CCLA submits that this requirement does nothing to enhance the state's interest, is not a clear legal standard and sets up unnecessary barriers that violate the principles of fundamental justice.

[107] The trial judge dealt with this requirement in the regulations in his s. 1 analysis. He found, at para. 286, that the requirement in the *MMAR* for the physician to declare that conventional treatments have been tried or considered, and found ineffective or medically inappropriate, is an additional barrier that is not minimally impairing. However, there was no evidence before the trial judge from which to conclude that this requirement should not form part of the medical declaration. The trial judge substituted his own lay opinion on this point and drew an improper inference from a lack of evidence.

[108] Further, the trial judge erred in law on this point. This issue was decided in *Hitzig* where this court stated, at para. 142:

> The declaration must say that all conventional treatments for the symptom have been tried or considered and why each is medically inappropriate. *The requirement for a declaration in this form serves substantial and compelling state interests.* First, it serves the state interest in protecting the health and safety of its citizens in relation to an untested drug. Second, it serves the state interest in complying with international conventions aimed at restricting the use of drugs such as marihuana save for legitimate medical and scientific purposes. [Emphasis added.]

[109] In our view, this passage from *Hitzig* is a complete answer to the CCLA's argument.

[110] The British Columbia Civil Liberties Association ("BCCLA"), like Mr. Mernagh, argues that this court should uphold the trial judge's finding that the *MMAR* defence is inaccessible to the point of being illusory. The fundamental problem, the BCCLA submits, is that the *MMAR* operate erratically. It challenges the appellant's position on the basis that it takes an inappropriately global or systemic focus of what is required to render the *MMAR* unconstitutional. In fact, it argues that far less than a "boycott" is required to establish that a defence is illusory for constitutional purposes.

[111] The BCCLA finds support for its position in *Morgentaler* and *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96, as well as the Supreme Court of Canada's recent decision in *Canada (Attorney General) v. PHS Community*

Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134 ("*Insite*"), which was released subsequent to the trial judge's decision in this case.

[112] In *Insite*, the Supreme Court of Canada held that the Minister of Health's failure to grant *Insite* an exemption from the *CDSA* violated the s. 7 rights of intravenous drug users because it denied them access to a safe injection site that all but eliminated the risk of accidental overdose. It follows, the BCCLA argues, that a legislative regime needs to work for every individual that comes within its embrace in order to withstand *Charter* scrutiny. Accordingly, given that Mr. Mernagh and the patient witnesses showed that the *MMAR* regime does not work for them, the provisions should be struck down.

[113] We disagree. The position of the BCCLA depends on the existence of an evidentiary foundation that was simply not present in this case. The court in *Insite* had the benefit of a detailed factual record; in this case, there was no basis for concluding that the regime was not working for Mr. Mernagh or the patient witnesses. In the absence of admissible evidence as to whether they qualified for exemptions and the reasons for which their requests for declarations were rejected, this court cannot accept that the difficulties faced by these individuals render the entire *MMAR* regime unconstitutional. We note as well that in its recent decision in *R. v. St-Onge Lamoureux*, 2012 SCC 57, 351 D.L.R. (4th) 381, the Supreme Court of Canada noted, at para. 74, 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.

[114] The final set of interveners go even further. Appearing jointly, the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network and the HIV & AIDS Legal Clinic Ontario argue that requiring patients to go to great lengths to get a physician to sign a medical declaration is arbitrary, unprincipled and not in accordance with the patients' rights to procedural fairness. Physicians, they submit, are acting as agents of the state under the *MMAR* and as such should be unbiased, give full consideration of the issue and provide written reasons. They should not be able to avoid making a decision and their decisions should be subject to review.

[115] We do not accept this submission. In our view, the *MMAR* require physicians to act as medical professionals and not quasi-judicial officials.

G. CONCLUSION

[116] For the reasons given above, the appeal is allowed, the trial judge's orders are quashed and a new trial is ordered.

[117] In light of our decision, unfortunately no *Charter* remedy is available for Mr. Mernagh. We trust, however, that in exercising its discretion as to whether to reinstate the charge against him, the appellant will take into account that this was a test case and a Crown appeal – and that, if the appellant proposes to proceed

with the charge that it will first afford Mr. Mernagh a reasonable opportunity to obtain a medical declaration and an ATP.

J.A.

J.A.

Doherty J.A. (concurring):

[118] I have read the reasons of my colleagues. I also would allow the appeal and uphold the constitutionality of the current provisions of the *Marihuana Medical Access Regulations*, SOR/2001-227, as amended ("*MMAR*").

I

[119] Unlike the claimants in *Hitzig v. Canada* (2003), 231 D.L.R. (4th) 104 (Ont. C.A.), Mr. Mernagh does not challenge the facial constitutionality of the *MMAR*.[9] Consistent with this court's analysis in *Hitzig*, Mr. Mernagh accepts that Parliament can constitutionally limit access to marihuana for medical purposes using a scheme that requires a doctor to provide a declaration in support of the request. Mr. Mernagh also does not challenge any of the requirements of the declaration as set out in s. 6 of the *MMAR*. He does not suggest that those requirements are arbitrary, unrelated to the purpose of the *MMAR*, or otherwise constitutionally infirm.

[120] Mr. Mernagh does argue, however, that the scheme created by the *MMAR* is unconstitutional because it operates in a manner that does not afford realistic access to medical marihuana for persons who are entitled to the medical exemption under the terms of the *MMAR*. Mr. Mernagh contends that the

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[9] Some of the interveners do challenge the facial constitutionality of some of the *MMAR*. I would reject those arguments for the reasons in *Hitzig*, as well as the reasons given by my colleagues.

medical exemption in the *MMAR* to the criminal prohibitions against the cultivation and possession of marihuana is illusory because the medical profession, which under the terms of the *MMAR* effectively controls access to medical marihuana, has "massively boycotted" the *MMAR* leaving "the vast majority" of persons who are entitled to use medical marihuana unable to obtain the necessary exemption. Mr. Mernagh's argument focuses on what he describes as the practical reality of the operation of the *MMAR* rather than the statutory language used in the *MMAR*. In his submission, the constitutional failing lies not in the words of the *MMAR*, but in the way it works.

[121] This argument was advanced and failed in *Hitzig* and *R. v. Beren*, 2009 BCSC 429, 192 C.R.R. (2d) 79. Those cases, while helpful, are not determinative as the argument is essentially a fact-driven one. Mr. Mernagh argues that, on this record, he has shown what the claimants failed to show in *Hitzig* and *Beren*, that is, that in its actual operation, the *MMAR* fails to deliver a constitutionally viable defence based on medical need to the charges of possession and cultivation of marihuana.

[122] I agree that the constitutional claim made by Mr. Mernagh is fact-driven. I also agree with my colleagues that on a reasonable reading of the evidence, there is no support for the findings that doctors have "massively boycotted" the *MMAR*, or that "the vast majority" of persons seeking to and entitled to receive medical exemptions under the *MMAR* are unable to obtain those exemptions.

Not only does the trial record fail to show that the statutory defence to the cultivation and possession of marihuana provided by the *MMAR* is unavailable on a systemic level, Mr. Mernagh's evidence about his own efforts to obtain the necessary exemption prior to being charged in April 2008 come nowhere near demonstrating that a medical exemption under the *MMAR* was, for all practical purposes, unavailable to him.

[123] In my view, the trial judge's appreciation of the evidentiary record was skewed by his misconception of the applicable law. He wrongly took this court's jurisprudence as holding that persons who were seriously ill had a constitutional right to use marihuana to treat their illness. In fact, this court has held that there must be a constitutionally viable medical exemption to the prohibition against the possession and cultivation of marihuana. That exemption does not, however, depend exclusively on the individual's desire to use marihuana, but also requires medical oversight of that decision.

[124] Moreover, the trial judge's analysis of the record is further undermined by his assumption that any refusal by a physician to provide the necessary declaration to persons who were seriously ill and received some relief from their symptoms by using marihuana could not possibly be medically or professionally justified. That assumption, essentially a medical opinion, is not one the trial judge was entitled to make.

[125] I think my colleagues' reasons amply demonstrate the two errors I have described above. I write separately to set out my understanding of the approach that must be taken when a party argues that a defence to a criminal prohibition, constitutionally valid on its face, is illusory in its effect, thereby rendering the related criminal prohibition contrary to the principles of fundamental justice and an unconstitutional limit on the right to liberty and security of the person guaranteed by s. 7 of the *Charter*.

II

[126] A legislative scheme that is constitutionally unobjectionable on its face may be rendered unconstitutional in its effect. As Chief Justice Dickson explained in *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at pp. 62-63:

> Even if the purpose of legislation is unobjectionable, the administrative procedures created by law to bring that purpose into operation may produce unconstitutional effects, and the legislation should then be struck down.... In the present case, the appellants are complaining of the general effects of s. 251. If section 251 of the *Criminal Code* does indeed breach s. 7 of the *Charter* through its general effects, that can be sufficient to invalidate the legislation under s. 52. [Emphasis omitted.]

[127] The "general effects" of legislation refers to the way in which the legislation actually operates. One looks beyond the bald terms of the legislation to related administrative requirements, procedural rules and governmental policies traceable to the legislation which together shape the manner in which the

challenged legislation actually operates. For example, when considering the constitutionality of the *Criminal Code* provisions creating the crime of abortion and the statutory defence to that crime, the court in *Morgentaler* looked beyond the terms of the *Criminal Code* to related provincial health regulations made relevant by definitions in the *Criminal Code* which had the effect of significantly limiting the availability of abortions. The "general effects" of the abortion provisions in the *Criminal Code* could not be properly assessed by simply reading the legislation. Evidence of the way the legislation actually worked was central to the claim that the legislation was unconstitutional in its "general effects".

[128] Legislation that creates crimes will inevitably limit an individual's liberty interest under s. 7. When the scheme that creates the crime also provides a defence to the crime, but that defence is unavailable for all practical purposes, the crime-creating provision which interferes with liberty will be held to be inconsistent with the principles of fundamental justice. Once again, the reasons of Chief Justice Dickson in *Morgentaler*, at p. 70, provide an apt description:

> <u>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.</u> 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 legislature has

> determined that the disapprobation of society is not warranted when the conditions of the defence are met. [Emphasis added.]

[129] The Chief Justice makes it clear in *Morgentaler* that a claim that a defence is illusory must address the effects of the legislation on a systemic rather than individual level. The claimant must demonstrate that the defence is illusory on that systemic level. If the claimant is successful, the legislation will most often be declared invalid under s. 52 of the *Constitution Act, 1982*.[10]

[130] It is also clear that a defence is not illusory because it is narrowly drawn by Parliament. The relevant constitutional inquiry under s. 7 is not directed at the scope of the defence as drafted, but at the practical availability of the defence regardless of its scope: see *R. v. St.-Onge Lamoureux*, 2012 SCC 57, 351 D.L.R. (4th) 381, at para. 79.

[131] Mr. Mernagh's constitutional challenge relies heavily on the reasons of Chief Justice Dickson in *Morgentaler*. Those reasons were in turn relied on heavily by this court in *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.). In *Parker*, decided before the *MMAR* existed, this court held that the criminal prohibition against possession of marihuana was unconstitutional absent a viable medical exemption to that prohibition. The court rejected several Crown arguments that various statutory provisions and regulations provided a constitutionally

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[10] The courts recognize as well that unconstitutional effects in an individual case may give rise to a s. 24 remedy: see *Morgentaler*, at pp. 62-63; *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96.

acceptable defence. In rejecting some of those arguments, this court applied the "illusory defence" principle of fundamental justice described by Chief Justice Dickson in *Morgentaler* and concluded that none of the provisions provided a medical exemption that had any practical value to those seeking the exemption.

[132] For the purposes of Mr. Mernagh's constitutional challenge, I take two important lessons from the reasons of Chief Justice Dickson in *Morgentaler* and this court's analysis in *Parker*. First, one must accept the defence as framed in the legislation when determining whether the defence is illusory. A statutory defence to a criminal prohibition is not rendered illusory, thereby making the criminal prohibition unconstitutional, because that statutory defence does not deliver a defence that by its terms the statute was not intended to deliver.

[133] The *MMAR* is not intended to provide access to medical marihuana to all seriously ill persons who decide that it is in their best interest to use marihuana to alleviate their symptoms. Nor does the Constitution, as interpreted in *Hitzig*, demand a medical exemption framed in those terms. The *MMAR* provides access to medical marihuana to persons who obtain the necessary declaration from a medical doctor. That declaration requires that the physician be satisfied that the applicant meets the criteria set out in s. 6 of the *MMAR*. In my view, by requiring the declaration of a physician, the *MMAR* also recognizes that doctors will exercise their professional judgment in deciding whether to provide a patient with the necessary declaration.

[134] Because the *MMAR* requires that physicians act as gatekeepers to the medical exemption created in the *MMAR*, one cannot demonstrate that the defence is illusory simply by evidence that not all seriously ill persons who want to use marihuana for medical purposes can obtain the requisite exemption. Access based solely on serious illness and a personal decision to use marihuana to mitigate symptoms is not the access contemplated by the *MMAR*. It cannot be said that the failure to provide that kind of access renders the defence in the *MMAR* illusory.

[135] The second lesson I take from *Morgentaler* and *Parker* relates to the nature of the evidence required to show that a statutory defence is illusory. In my view, a party claiming that a statutory defence is practically illusory must connect the facts said to render the defence illusory to some form of governmental action, be it the terms of the legislation creating the scheme or related administrative procedures, procedural rules or government policies. Actions by individuals not attributable to the government in any sense which limit the availability of the defence in practice cannot, in my view, render the defence illusory in the constitutional sense.

[136] The distinction between government-related activity and individual choice is alluded to by Chief Justice Dickson in *Morgentaler*. In considering the operation of the abortion-related provisions in the *Criminal Code*, the Chief Justice considered not only the legislation as outlined in the *Criminal Code*, but

also legislation and regulations, both federal and provincial, that affected the operation of the *Criminal Code* provisions. He concluded that the overall scheme created by the interaction of the various legislation provisions severely limited, and in some places entirely eliminated, the operation of therapeutic abortion committees charged with the responsibility of authorizing abortions.

[137] While the Chief Justice went beyond the terms of the *Criminal Code* in considering whether the scheme provided a real defence to the criminal prohibition against abortion, he also observed, at p. 71, that some factors which had the effect of limiting the defence, such as personal choice and geography, could not be traced to the legislative scheme. I read the Chief Justice as drawing a distinction for the purpose of determining the constitutionality of the provision between limits on the operation of a defence that are the product of the terms of the legislation and governmental processes and policies, and limits on the defence that are the function of individual choice and neutral factors such as geography. Only the former are relevant to a determination of whether the defence is illusory for constitutional purposes.

[138] The second lesson from *Morgentaler* and *Parker* is particularly important here. To the extent that physician non-participation in the *MMAR* can be connected to some form of governmental action, it is properly part of the s. 7 analysis as it relates to the contention that the *MMAR* does not deliver a truly available defence based on medical need. However, once one accepts that

medical oversight is a constitutionally valid component of the defence based on medical need, individual decisions by doctors, be they decisions concerning participation in the scheme as a whole or decisions in respect of individual patients, cannot be said to render the defence illusory. Indeed, the exercise of that individual medical judgment is a component of the defence created by the *MMAR*.

[139] If, contrary to what the record actually shows in this case, the evidence established that the medical profession was refusing en masse to participate in the *MMAR*, that would not necessarily make the defence illusory in the relevant sense. Widespread refusal to participate in the *MMAR* by doctors could, however, generate a different constitutional argument. That argument would challenge the facial validity of a scheme which placed doctors in the gatekeeper role, on the basis that doctors' skills and expertise were irrelevant to the exercise of the judgment made when determining whether to use marihuana to mitigate various symptoms. To succeed, the argument would have to demonstrate that a scheme placing doctors in a gatekeeper role was contrary to some principle of fundamental justice such as arbitrariness. This court crossed that constitutional bridge in *Hitzig*. Mr. Mernagh does not ask us to revisit that decision. Nor does this record suggest we should.

[140] Returning to the present reality, medical oversight is a constitutionally accepted feature of the medical exemption defence crafted in the *MMAR*. I do

not see how a defence based on medical oversight becomes illusory when doctors actually exercise that oversight. *Parker* offers no support for Mr. Mernagh's contention that the defence is illusory.

[141] In *Parker*, the Crown argued that persons who wanted to use marihuana for medical purposes could do so lawfully through various statutory and regulatory routes. Three of the ways the Crown argued could be used to lawfully access medical marihuana are relevant to this appeal. The Crown contended that persons could obtain a prescription for marihuana, seek approval for the use of marihuana by following Health Canada's procedure for the approval of new drugs, or obtain approval for the possession and use of marihuana under the Emergency Drug Release Programme.

[142] My colleague, Justice Rosenberg, after extensive reference to *Morgentaler*, tested each suggested statutory source of the medical exemption to the prohibition against the possession of marihuana against the illusory defence standard described in *Morgentaler*. He observed that while it was theoretically possible to obtain a prescription for marihuana, the uncontroverted evidence indicated that the government would not be favourably disposed to any doctor who wrote a prescription for the drug, and that in any event, there was no lawful source from which a pharmacist could fill a prescription for marihuana. Justice Rosenberg concluded that the possibility of getting a prescription for marihuana under the existing scheme was theoretical only.

[143] Justice Rosenberg next considered the new drug approval procedure. He observed that the many governmental requirements controlling approval of any new drug necessitated the expenditure of hundreds of thousands of dollars by anyone seeking to obtain that approval. People like Mr. Parker, who lived on social assistance, could hardly fund that kind of venture. Access to marihuana through the new drug approval procedure was a practical impossibility.

[144] Justice Rosenberg also rejected the submission that the Emergency Drug Release Programme offered any real hope to those seeking to use marihuana for medical purposes. Under that program, an individual could obtain permission to access an otherwise non-marketable drug. The exemption, however, assumed that somewhere, someone was licensed to make and distribute the drug. No such supply existed for marihuana. Justice Rosenberg concluded that the Emergency Drug Release Programme offered no real assistance to persons seeking to use marihuana for medical purposes.

[145] In the end, Justice Rosenberg had little difficulty concluding that the possibility of obtaining a prescription, approval for marihuana as a new drug, or access to marihuana through the Emergency Drug Release Programme were all illusory in the sense that they were practically unavailable to those seeking to use marihuana for medical purposes. My colleague's findings rested on an evidentiary foundation that goes well beyond demonstrating difficulties in accessing the supposed defences, or limitations on the defences as framed. The

evidence summarized at length by Justice Rosenberg, much of it uncontested and from governmental sources, established that the supposed defences relied on by the Crown were, for all intents and purposes, unreachable by those who needed them.

[146] In rejecting the Crown's contention that medical marihuana was lawfully available through the procedures described above, Justice Rosenberg looked to the actual operation of the legislation as affected not only by its terms, but by government policies and processes. He did not, however, suggest that unavailability of medical marihuana flowing from decisions made by doctors, pharmacists or other non-governmental actors would suffice to render the purported medical exemptions illusory. For example, in explaining why the Crown's argument that individuals could obtain prescriptions for marihuana was unrealistic, my colleague did not simply suggest that doctors and pharmacists, in the exercise of their judgment, might refuse to write or fill prescriptions. He tied those refusals to governmental policies, at para. 155:

> [T]he evidence from the government witness was that since there is no legal source of mari[h]uana, no pharmacist could fill the prescription and that the government would not look favourably upon a physician who purported to write such a prescription.

[147] Much of the evidence relied on by Mr. Mernagh to support his claim that the defence in the *MMAR* is illusory does not link physician non-participation in the *MMAR* or individual refusals by physicians to provide the necessary

declaration with any kind of governmental action. A doctor who refuses to provide the necessary declaration because he or she is not satisfied that the criteria in the regulations are met, does not feel sufficiently knowledgeable about the effects of marihuana, is unfamiliar with the patient, or views the use of marihuana as medically contraindicated, is certainly limiting the availability of the medical exemption contemplated in the *MMAR*. However, that decision is not attributable to the government or any form of governmental action. Nor, in my view, can the physician, by exercising the gatekeeping role demanded of the physician by the legislation, be said to make the defence created by the legislation illusory. Refusals based on the doctor's exercise of his or her judgment are inherent in the defence created by the *MMAR*.

III

[148] Like my colleagues, I would allow the appeal and order a new trial. I also agree with their comments in para. 117.

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Appendix "A"

SOR/2001-227	As Amended by SOR/2005-177
Medical Declarations	*Medical Declarations*
6. (1) The medical declaration under paragraph 4(2)(b) must indicate, in all cases (a) the medical practitioner's or specialist's name, business address and telephone number, provincial medical licence number and, if applicable, facsimile transmission number and e-mail address; (b) the applicant's medical condition, the symptom that is associated with that condition or its treatment and that is the basis for the application and whether the symptom is a category 1, 2 or 3 symptom; (c) the daily dosage of dried marihuana, in grams, and the form and route of administration, recommended for the applicant; and (d) the period for which the use of marihuana is recommended, if less than 12 months. (2) In the case of a category 1 symptom, the medical declaration must also indicate that (a) the applicant suffers from a terminal illness; (b) all conventional treatments for the symptom have been tried, or have at least been considered;	**6.** (1) The medical declaration under paragraph 4(2)(b) must indicate (a) the medical practitioner's name, business address and telephone number, facsimile transmission number and e-mail address if applicable, the province in which the practitioner is authorized to practise medicine and the number assigned by the province to that authorization; (b) the name of the applicant, the applicant's medical condition, the symptom that is associated with that condition or its treatment and that is the basis for the application and whether the symptom is a category 1 or 2 symptom; (c) for the purpose of determining, under subsection 11(3), the maximum quantity of dried marihuana to be authorized, the daily amount of dried marihuana, in grams, and the form and route of administration that the applicant intends to use; (d) the anticipated period of usage, if less than 12 months; (e) that conventional treatments for the symptom have been tried or considered and have been found to be ineffective or medically inappropriate for the treatment of the applicant; and

(c) the recommended use of marihuana would mitigate the symptom; (d) the benefits from the applicant's recommended use of marihuana would outweigh any risks associated with that use; and (e) the medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marihuana as a drug. (3) In the case of a category 2 symptom, the medical declaration must also indicate that (a) the specialist practices in an area of medicine, to be named by the specialist in the declaration, that is relevant to the treatment of the applicant's medical condition; (b) all conventional treatments for the symptom have been tried, or have at least been considered, and that each of them is medically inappropriate because (i) the treatment was ineffective, (ii) the applicant has experienced an allergic reaction to the drug used as a treatment, or there is a risk that the applicant would experience cross-sensitivity to a drug of that class, (iii) the applicant has experienced an adverse drug reaction to the drug used as a treatment, or there is a risk that the applicant would experience an adverse drug reaction based on a previous adverse drug reaction to a drug of the same class,	(f) that the medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marihuana as a drug. (2) In the case of a category 2 symptom, the medical declaration must also indicate (a) if the medical practitioner making the medical declaration is a specialist, the practitioner's area of specialization and that the area of specialization is relevant to the treatment of the applicant's medical condition; and (b) if the medical practitioner making the medical declaration is not a specialist, (i) that the applicant's case has been assessed by a specialist, (ii) the name of the specialist, (iii) the specialist's area of specialization and that the area of specialization is relevant to the treatment of the applicant's medical condition, (iv) the date of the specialist's assessment of the applicant's case, (v) that the specialist concurs that conventional treatments for the symptom are ineffective or medically inappropriate for the treatment of the applicant, and (vi) that the specialist is aware that marihuana is being considered as an alternative treatment for the applicant. SOR/2005-177, s. 4.

(iv) the drug used as a treatment has resulted in an undesirable interaction with another medication being used by the applicant, or there is a risk that this would occur, (v) the drug used as a treatment is contra-indicated, or (vi) the drug under consideration as a treatment has a similar chemical structure and pharmacological activity to a drug that has been ineffective for the applicant; (c) the recommended use of marihuana would mitigate the symptom; (d) the benefits from the applicant's recommended use of marihuana would outweigh any risks associated with that use, including risks associated with the long-term use of marihuana; and (e) the specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marihuana as a drug. (4) In the case of a category 3 symptom, the medical declaration must also indicate (a) the matters referred to in subsection (3); and (b) all conventional treatments that have been tried or considered for the symptom and the reasons, from among those mentioned in paragraph (3)(b), why the specialist considers that those treatments are medically inappropriate.	

Appendix "B"

<table>
<tr><td>SOR/2001-227

"category 1 symptom" means a symptom that is associated with a terminal illness or its medical treatment.

"category 2 symptom" means a symptom, other than a category 1 symptom, that is set out in column 2 of the schedule and that is associated with a medical condition set out in column 1 or its medical treatment.</td><td>As Amended by SOR/2005-177

"category 1 symptom" means any symptom treated within the context of compassionate end-of-life care or a symptom set out in column 1 of the schedule that is associated with a medical condition set out in column 2 or with the medical treatment of that condition.</td></tr>
<tr><td>
CATEGORY 2 SYMPTOMS
<table>
<tr><th>Column 1

Medical Condition</th><th>Column 2

Symptom</th></tr>
<tr><td>1. Cancer, AIDS/HIV infection</td><td>Severe nausea</td></tr>
<tr><td>2. Cancer, AIDS/HIV infection</td><td>Cachexia, anorexia, weight loss</td></tr>
<tr><td>3. Multiple sclerosis, spinal cord injury or disease</td><td>Persistent muscle spasms</td></tr>
<tr><td>4. Epilepsy</td><td>Seizures</td></tr>
<tr><td>5. Severe pain</td><td>Cancer, AIDS/HIV infection, multiple sclerosis, spinal cord injury or disease, severe form of</td></tr>
</table>
</td><td>
CATEGORY 1 SYMPTOMS
<table>
<tr><th>Column 1

Symptom</th><th>Column 2

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

arthritis	
"category 3 symptom" means a symptom, other than a category 1 or 2 symptom, that is associated with a medical condition or its medical treatment.	*"category 2 symptom"* means a debilitating symptom that is associated with a medical condition or with the medical treatment of that condition and that is not a category 1 symptom. *"category 3 symptom"* [Repealed, SOR/2005-177, s. 1]