CITATION: R. v. Mernagh, 2011 ONSC 2121

COURT FILE NO.: 1640/09

DATE: 2011/04/11

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	)	
HER MAJESTY THE QUEEN	)	Kevin Wilson, for the Respondent
	)	
	)	
Respondent	)	
- and -	)	
	)	
MATTHEW MERNAGH	)	Paul Lewin, for the Applicant
	)	
	)	
Applicant	)	
	)	
	)	**HEARD:** January 17, 18, 19, 20, 24, 26, 31, and February 1, 2011

THE HONOURABLE MR. JUSTICE D.J. TALIANO

Contents

INTRODUCTION

[1] Matthew Mernagh is a seriously ill young man. He suffers from the debilitating effects of fibromyalgia, scoliosis, seizures and depression. He lives with constant pain. Prescription medications have failed to provide adequate relief for his condition, and in many ways, they create additional problems. Marihuana, used medicinally, eases his symptoms and allows him to function. Mr. Mernagh cultivates his own supply.

[2] The Ontario Court of Appeal has recognized that it is a violation of s. 7 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982*(U.K.), 1982, c. 11, to deprive a person with a serious illness for which marihuana provides relief, of the right to use marihuana to treat his illness (*R. v. Parker*, 146 C.C.C. (3d) 193). As a result, the government has created a legislative framework, the *Marihuana Medical Access Regulations*, SOR/2001-227 [*MMAR*], to allow such individuals to legally access, possess, and cultivate marihuana for medicinal purposes by obtaining a licence to do so. A licence is obtained by completing an application which includes the signed declaration of a supporting medical doctor.

[3] However, Mr. Mernagh has been unable to find a doctor to sign his declaration. As a result, he has been unable to obtain a licence to possess or cultivate marihuana under the regulations. Therefore, despite his undisputed and serious illness, and despite the relief he gets from the medicinal use of marihuana, Mr. Mernagh's cultivation of marihuana for his personal, medical use is illegal. He comes before this court because he stands charged with the offence of production of marihuana, contrary

to section s.7(2)(b) of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 [*CDSA*].

[4] As an individual whose liberty is at risk as a result of pursuing his medical treatment of choice Mr. Mernagh contends that this prosecution violates his rights of liberty and security of the person under s. 7 of the *Charter*. He argues that the combined effect of the *MMAR* and the provisions relating to marihuana under the *CDSA* are unconstitutional and he seeks a declaration of invalidity with respect to the offences of possession, cultivation and trafficking in marihuana contained in the *CDSA.*

[5] The Crown submits that the problem that Mr. Mernagh is experiencing in accessing marihuana for medicinal purposes, is not the fault of the legislation, but with the doctors whose decision to sign or not to sign a declaration for a patient is theirs alone and is not subject to government control.

[6] The Crown concedes that as an accused facing trial for an indictable offence there is a threshold violation of Mr. Mernagh's s. 7 rights to liberty. The only question then, is whether that violation is in accordance with fundamental principles of justice. The Crown submits that it is. Mr. Mernagh submits that it is not.

LEGAL BACKGROUND

[7] Before further defining the question before the court, a brief overview of the history that gave birth to the governing legal principles is necessary. The starting point is of course s. 7 of the *Charter* which reads:

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

[8] In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, the celebrated case of the Supreme Court of Canada that dealt with assisted suicide, the Court held that security of the person included the right to make choices concerning one's bodily integrity. Speaking for the majority Justice Sopinka stated the following important principle:

> There is no question then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.

[9] This built on the concept expressed by the court in *R. v. Morgentaler*, [1988] 1 S.C.R. 30 [*Morgentaler*], that:

> 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.

[10] These principles were at the forefront of the Court's decision in *Parker*, rendered July 31, 2000. In *Parker*, the accused suffered from a severe form of epilepsy. Conventional medicine had only been moderately successful in controlling his seizures, and the accused turned to growing and using marihuana to treat his symptoms.

[11] Upon being charged with cultivation of marihuana under the now defunct *Narcotic Control Act*, R.S.C. 1985, c. N-1, and possession of marihuana under its replacement, the *CDSA*, Parker resisted the charges by challenging the constitutionality of the offences. He argued that he

needed to grow and use marihuana as medicine to control his epilepsy, and the statutory prohibitions against doing so forced him to choose between his health and his liberty, thus violating his rights under s. 7 of the *Charter*.

[12] In its analysis of the principles of fundamental justice, the Court acknowledged that the state had an interest in protecting against the harmful effects of marihuana and satisfying Canadian international treaty obligations by controlling the domestic and international trade in illicit drugs. In spite of these valid objectives, the Court held that the blanket prohibition on possession and cultivation, without an exception for medical use, did little or nothing to enhance the state interests.

[13] In arriving at its conclusion, the Court made the following important findings:

> Consumption of marihuana is relatively harmless compared to the so-called hard drugs and including tobacco and alcohol and there is no "hard evidence" that even long-term use of marihuana can lead to irreversible physical or psychological damage. Marihuana use is not criminogenic (i.e. there is no causal relationship between marihuana use and criminality) and it does not make people more aggressive or violent. There have been no recorded deaths from consumption of marihuana. Marihuana does have an intoxicating effect and it would not be prudent to drive while intoxicated. As with tobacco smoking, marihuana smoking can cause bronchial pulmonary damage, especially in heavy users. There may be other side effects from the use of marihuana and its effects are probably not as benign as was thought some years ago. However, these other effects are not acute except in very narrow circumstances, for example, people with schizophrenia (at para. 39).
>
> On the other hand, marihuana, although it has a variety of effects in humans, has no overdose liability. There has never been a proven overdose death caused by marihuana in humans. Unlike the conventional medications,

marihuana has an extremely wide safety margin. There is no reliable evidence that even chronic use of marihuana has an adverse impact on cognition or memory. Marihuana is not known to harm the foetus. Since marihuana and tobacco smoke are similar in character, it can harm the lungs. However, a regular marihuana smoker, even a therapeutic marihuana smoker, smokes much less than a tobacco smoker (three to five marihuana cigarettes a day compared to 30 to 50 tobacco cigarettes) and therefore inhales much less smoke. There is, therefore, reason to believe that the marihuana user will not suffer as much pulmonary harm as tobacco smokers. There are no reports of marihuana-only smokers developing emphysema or lung cancer (at para. 48).

Using a criminal prohibition to bar access to a drug for a person, such as Parker, who requires it to treat a condition that threatens his life and health, is antithetical to our notions of justice. It is inconsistent with the principle of sanctity of life which, according to Sopinka J. in Rodriguez at p. 605, as a general principle "is subject to limited and narrow exceptions in situations in which notions of personal autonomy and dignity must prevail". (Para. 137)

The blanket prohibition on possession and cultivation, without an exception for medical use, does little or nothing to enhance the state interest. To the extent that the state's interest in prohibiting marihuana is to prevent the harms associated with marihuana use including protecting the health of users, it is irrational to deprive a person of the drug when he or she requires it to maintain their health (at para. 144).

…the danger from the use of the drug by a person such as Parker for medical purposes is minimal compared to the benefit to Parker and the danger to Parker's life and health without it (at para. 161).

…one of the purposes of the law is to prevent harm to the health of Canadians and the resulting costs to society. However, the broad nature of the marihuana prohibition has the effect of impairing the health of Parker and others who require it for medical purposes. In this sense, the legislation works in opposition to one of the primary objectives and thus could be described as "arbitrary" or "unfair" (at para. 192).

> There have been no recorded deaths from consumption of marihuana (at para. 39).

[14] The Court ultimately concluded that the prohibition against the possession of marihuana contained in s. 4 of the *CDSA* was unconstitutional and of no force and effect without a constitutionally viable exception allowing for medical use. The declaration of invalidity was suspended for twelve months to allow government time to craft an acceptable solution.

[15] That solution arrived on July 30, 2001, one day before the suspension expired. On that date the *MMAR* came into force, providing a regulatory framework for seriously ill people to possess and in some cases cultivate marihuana for therapeutic purposes pursuant to the exemption in s. 55(1) of the *CDSA*. The regulations established three categories of applications to obtain an authorization to possess marihuana.

[16] Category 1 referred to persons with symptoms associated with a terminal illness and death was expected in twelve months. This category required the declaration of one physician.

[17] Category 2 referred to patients with specific symptoms identified with specified, long term or chronic conditions set out in a schedule to the regulations. The conditions referred to included Cancer and Aids and the category required the declaration of a specialist.

[18] Category 3 was a catch all and included patients with symptoms associated with medical conditions other than those who fell within categories 1 and 2. The declaration required the signature of two specialists.

[19] Section 51 of the regulations permitted the Minister of Health or a designated person to import and possess marihuana seed for the purpose of delivering it to a licensed dealer or the holder of a licence, but the Minister had not yet done so and there were no licensed dealers in existence.

[20] Perceived deficiencies in the newly enacted regulations, led to a further constitutional challenge to the medical marihuana scheme in *Hitzig v. Canada* (2003), 171 C.C.C. (3d) 18 (Ont. Sup. Ct.), where the applicants sought a declaration that the *MMAR* were constitutionally invalid. The application was heard in the Superior Court in September and October of 2002. Judgment was rendered on January 9, 2003 declaring the scheme unconstitutional and suspending the declaration for a period of six months.

[21] Lederman J., the judge of first instance, held that the requirement for approval by one or two specialists did not offend *Charter* rights. However, the lack of a lawful and safe source of medicinal marihuana violated the constitutional right to security of the person. Without a lawful and safe source, seriously ill people were placed in the position of having to deal with the criminal underworld to obtain medicine they had been legally authorized to take.

[22] The decision was subsequently appealed to the Court of Appeal and the matter was heard in July 2003, with judgment released on October 7 of the same year (*Hitzig v. Canada* (2003), 177 C.C.C. (3d) 449 (Ont. C.A.). For the most part, the Court agreed with Lederman J. and held that the *MMAR* constituted a scheme of medical exemption which deprived those who needed to take marihuana for medical purposes of the rights to liberty and security of the person. That was a threshold violation of s. 7 of the *Charter*.

[23] The Court further agreed with the trial court that the deprivation was not in accordance with the principles of fundamental justice because the *MMAR* placed the government in an alliance with the black market.

[24] Seriously ill patients, who had an acknowledged need for marihuana and were legally entitled to possess it, were forced to consort with criminals to fulfill that medical need. As the court had observed in *Parker*, and *R. v. Krieger* (2000), 225 D.L.R. (4th) 164, affirmed (2003), 225 D.L.R. (4th) 183 (C.A.), it is an absurdity to permit the possession of something which is not legally obtainable.

[25] However, contrary to Lederman J.'s holding, the Court found the requirement for a second specialist for category three applicants did not accord with the principles of fundamental justice. The requirement added little to no value to the assessment of medical need and was an arbitrary barrier to the granting of an exemption for category three applicants.

[26] None of the violations identified by the Court were saved by s. 1, and the Court made an immediate declaration that the specific provisions of the *MMAR* which created the violations were of no force and effect.

[27] While the Court had no difficulty finding the above mentioned features created a constitutional defect within the *MMAR*, it was unable to say the same about the placement of doctors as gatekeepers to determine eligibility for access to the drug. The Court upheld the doctor as gatekeeper requirement, stating:

> 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 (*Hitzig*, *supra* at para. 139).

[28] In answer to the argument of the Hitzig appellants that the concerns of the medical profession and its governing bodies regarding the role of doctors as gatekeepers would prevent doctors from signing the requisite forms and thereby prevent worthy individuals from obtaining a licence, the Court found that on the record before it the argument was:

> ...answered by Lederman J.'s findings that despite the concerns of central medical bodies, a sufficient number of individual physicians were authorizing the therapeutic use of marihuana that the medical exemption could not be said to be practically unavailable (*Hitzig*, *supra* at para. 139).

[29] Yet, importantly, the Court noted that:

> This ***finding of fact is entirely reasonable on the record in this case*** and we would not interfere with it. ***Of course, 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*, *supra* at para. 139). [Emphasis added.]

[30] The Court left open the possibility that on a different evidentiary record, the result might also be different.

[31] The Court's comments with respect to the requirement for specialist involvement for certain medical conditions were similar in nature. On this point, the Court had this to say:

> Moreover, ***on this record***, the Hitzig applicants simply have not shown that the specialist requirement is a significant impediment to obtaining a medical exemption. [...] Here as well, Lederman J.'s finding of fact, at paras. 154-156, that the specialist requirement does not make the medical exemption practically unavailable, is entirely reasonable and not open to interference by

> this court. ***However, as with the concern over physician co-operation, should the passage of time reveal that access to specialists is a significant practical impediment a different conclusion might be reached.*** Thus, ***on this record*** we conclude that the specialist requirement does not constitute an undue constraint on the individual's ability to get a medical exemption and represents a fair balance between the interests of the individual and the state (*Hitzig*, *supra* at para. 143). [Emphasis added.]

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

THE REGULATIONS

[33] As a result of the Court's decision in *Hitzig*, the second specialist provision for category three applicants was removed from the *MMAR* in July of 2003. In 2005, the gatekeeper provisions were relaxed, the effect being that the physician was no longer required to recommend the daily dosage of marihuana, but rather to simply indicate the amount of marihuana the patient proposed to use. In addition, the physician or specialist was no longer required to indicate that the benefits of the marihuana use outweighed the risks. Finally, where a specialist was required, it was no longer necessary for the specialist to provide the declaration that s/he had reviewed the case and concurred that conventional treatments were ineffective or medically inappropriate and was aware that marihuana was being considered as an alternative treatment.

[34] The current version of the *MMAR*, that is, the *MMAR* in their post-Hitzig form, which govern for the purposes of this application, are

set out at Tab 17 of Volume 2 of the Respondent's Book of Authorities. Section 1 contains the definition of category 1 and category 2 symptoms as follows:

> 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.
>
> 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.

[35] Section 4 provides that a person seeking an authorization to possess dried marihuana for a medical purpose shall submit an application to the Minister containing a declaration of the applicant, a medical declaration made by the medical practitioner treating the applicant and two copies of a current photograph. The requirements of the medical declaration are set out in s. 6 of the regulations which provide:

> 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 symptoms have been tried or considered and have been found to be ineffective or medically inappropriate for the treatment of the applicant; and

(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.

[36] The schedule referred to in the definition section provides:

Category 1 Symptoms

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

[37] It should be noted that a specialist is not required for Category 1 symptoms, although in most cases a specialist would have been consulted. This category includes symptoms treated within the context of providing compassionate end-of-life care or symptoms associated with the specified medical condition listed in the Schedule.

[38] Category 2 includes any debilitating symptom of a medical condition other than those in Category 1. However, the application requires that a specialist concur that conventional treatments are inappropriate or ineffective. Although a specialist must assess the case, a medical practitioner can sign the declaration.

THE ISSUES

[39] In broad terms, the issue before the court is whether the violation of Mr. Mernagh's s. 7 right to life, liberty and security of the person brought about by s. 7(2)(b) of the *CDSA* is contrary to principles of fundamental justice. More specifically, do the *MMAR* provide a constitutionally sound exemption to this provision in accordance with *Parker*? This question having been addressed somewhat in *Hitzig*, the issue can be further distilled to whether a lack of physician participation has rendered the medical exemption scheme ineffective and the appurtenant defence illusory? And if so, is this a result of the legislation?

THE EVIDENCE

[40] The hearing of this matter took place over three weeks at the end of January. In addition to the *viva voce* testimony of some seven witnesses, a large volume of documentary and affidavit evidence was filed.

[41] Counsel for Mr. Mernagh called six witnesses;

- Mr. Mernagh;
- Three individuals suffering from serious medical conditions who use marihuana medicinally ("patient witnesses");
- Dr. Joel Lexchin, an expert on the pharmaceutical industry and its impact on doctors and healthcare; and
- Dr. David Rosenbloom, an expert on the effects of various pharmaceuticals commonly prescribed to the patient witnesses, the use and abuse of prescription opioids, and the methadone program/registry.

[42] On consent of counsel, the *viva voce* evidence was supplemented by numerous affidavits from other patient witnesses who live in different

parts of Canada. In addition, transcripts from the proceedings in *R. v. Matthew David Berens and Michael Andrew Swallow* (2009), 192 C.R.R. (2d) 79 (B.C. S.C.) were also tendered into evidence. The transcripts contain the report of Ms. Lynne Belle-Isle, an expert on the subject of AIDS and HIV, which report was filed as Exhibit 23 in this proceeding. In addition, counsel agreed to the filing of a copy of *The Report of the Senate Special Committee on Illegal Drugs* (otherwise known as the Nolin Report), dated September, 2002.

[43] In reply, the Crown filed the affidavit of Jeannine Ritchot, Director, Bureau of Medical Cannabis, Office of Controlled Substances, and Tobacco Directorate, Health Canada at Health Canada and made her available for cross-examination. The Crown also relied on the affidavits of Ronald Denault, Manager of the Marihuana Medical Access Division, Office of Controlled Substances, Health Canada.

[44] It was argued by the applicant that the body of evidence I am about to review suggests a country-wide failure of the *MMAR* to provide access to medicinal marihuana to those who are constitutionally entitled to it.

[45] The Crown maintained that it is not the legislation that has created the difficulties complained of. The government's only obligation is to permit access to the drug, not to market it, nor to educate the doctors. Doctors have been designated by the *MMAR* to assess the medical needs of a patient and to decide whether or not to support that patient's declaration. It is not the fault of the *MMAR* if the doctor declines to support the patient's application.

THE PATIENT WITNESSES

[46] Mr. Mernagh's application was supported by the evidence of him, and a number of other patient witnesses who testified as to their medical issues, their marihuana use and their experiences with Health Canada's medical marihuana program. The affidavits of the patient witnesses were bound in a book marked accordingly. In view of the sensitivity of the contents of their affidavits, and at the urging of counsel for the applicant and with no objection from counsel for the Crown, I have ordered the book of affidavits to be sealed. In the course of this judgment, with the exception of Mr. Mernagh, I will only identify the patient witnesses by their initials to preserve their privacy.

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

[48] Of the patients who testified either by affidavit or in the court room:

- Ten come from Ontario (St. Catharines, Holland Landing, London, Toronto, Peterborough, Niagara Falls, Hamilton, Hersall);
- Three reside in British Columbia (Cranbrook, Prince George, Vancouver);
- Three reside in Alberta (Cochrane, Lethbridge, Taber);
- One resides in Saskatchewan (Regina);
- Two reside in Nova Scotia (Halifax, Jordan Falls);
- One resides in Prince Edward Island (Charlottetown); and
- One resides in Quebec (Montreal).

[49] I will now highlight portions of the patient affidavits.

THE APPLICANT – MATTHEW MERNAGH

[50] The applicant, Mr. Mernagh, is thirty-seven years of age and lives in St. Catharines, Ontario. He is a frail young man with a fragile yet genuine demeanour. He moves with difficulty, his body clearly showing the ravages of illness. Educated and articulate, he is using what little strength he has to focus attention on the unnecessary difficulties faced by himself and others like him, in attempting to access medicinal marihuana to cope with their debilitating illnesses.

[51] For Mr. Mernagh, the onset of his illness occurred when he was eighteen years of age. He was admitted to hospital experiencing sharp pain on the left side of his body. It was noted at the time that his bladder was swollen but tests failed to indicate the reason for his condition.

[52] In due course, he was diagnosed with Fibromyalgia. His doctors told him that they knew little about the condition or its origins, other than it was a rare disorder. He was prescribed anti depressants and pain medication. Over time, he pursued other treatment modalities, such as

diet, meditation, and physiotherapy but nothing seemed to help. He was tired all of the time and was in constant pain which continued to worsen. The prescription pain medications were also getting stronger.

[53] While enrolled in his second year of college, someone introduced him to marihuana. He tried it and found it made a huge difference in his symptoms. Suddenly, he could function, his pain was reduced and he could actually sit and read a book or work at his computer. In 1997, after returning to Toronto, he filled out the necessary forms to be able to procure marihuana at the Compassion Centre in that City.[1]

[54] By the time he returned to St. Catharines in 2002, his disease had worsened to the point that he was too sick to work. Unfortunately, his family doctor had closed her practice to start a family. Mr. Mernagh desperately needed a doctor, and hopefully one who would support his marihuana use. However, his first problem was that at the time family doctors in St. Catharines were not accepting new patients because of the chronic shortage of doctors in this, and many other Canadian cities.

[55] Mr. Mernagh went to a walk-in-clinic and spoke to a doctor who agreed to try to find him a general practitioner. Unfortunately, she was unable to do so. In 2006, he finally found a doctor who was accepting new patients. However, when Mr. Mernagh pointed out that he wished assistance in obtaining marihuana for medical purposes, the doctor declined and suggested morphine for his pain. Mr. Mernagh declined and advised that he didn't believe they would work well together.

[56] He subsequently learned of a doctor in Bradford who might assist him (in particular by signing his Health Canada declaration for medical

[1] A Compassion Centre is an illegal centre which distributes medicinal marihuana to persons in ill health. The Centre is staffed by persons with compassion for those suffering from illnesses who would not otherwise be able to access marihuana for their illnesses.

marihuana) and he made an appointment to see him. However, after a two hour journey, the doctor was only prepared to sign a letter attesting that marihuana was helping Mr. Mernagh with his symptoms (See Exhibit 7). He declined to sign the necessary Health Canada declaration that Mr. Mernagh required to obtain a licence to legally possess and cultivate marihuana.

[57] Since then, Mr. Mernagh has developed other problems, some related to his initial condition, some perhaps not; he now suffers from epilepsy which has resulted in fractures of his shoulder; he has been diagnosed with scoliosis, and a brain lesion.

[58] The many doctors he has seen have all prescribed various drugs for pain, epilepsy, and depression, but not one has been willing to sign the Health Canada declaration necessary to authorize him to use medicinal marihuana. This is the situation despite their knowledge of Mr. Mernagh's serious medical conditions, and despite being told by Mr. Mernagh that marihuana lessens the severity of his symptoms without the undesirable side effects he experiences from prescription narcotics.

[59] Mr. Mernagh's possession and cultivation of marihuana is an attempt by him to get relief from the constant pain he endures every day. Pain which is not properly managed by the narcotics that the various medical doctors he has consulted are only too willing to prescribe. Mr. Mernagh desperately seeks relief from his suffering without the stigma, stress and fear of a criminal conviction. He hopes that in bringing this application that relief will soon come.

OTHER ONTARIO WITNESSES:

WW

[60] WW lives in London, Ontario and has had Lyme Disease for over ten years. He was one of three patient witnesses to provide *viva voce* testimony on this application. WW's pain was evident as he walked into the court room with considerable difficulty. He required time to marshal his strength to respond to questioning and needed a break to rest during his testimony, which was not lengthy.

[61] WW is a man in his sixties who labours just to breathe and walk, but he endures his illness with grace and dignity. His illness is painful permanent and disabling. He described his pain as being "severe and extremely severe." His condition affects his speech, sleep, and mobility.

[62] Before he started using marihuana to treat his condition, WW was constantly fatigued, needing eighteen to twenty hours of sleep per day. He was often unable to function and sometimes even to move. In addition, he worried about addiction to the prescription pain medication he was taking. Side effects of constipation and cloudiness of thought, were additional concerns.

[63] Once he started taking marihuana, he found that he was able function. In his words, marihuana worked like a "miracle." It reduced his pain, his mobility improved, his sleep improved and it didn't adversely affect his thinking like the prescription pain medications did. Marihuana permitted him to function.

[64] WW has a good relationship with his doctor and his doctor has observed firsthand how marihuana has improved WW's life. However, his doctor refuses to sign WW's declaration and won't explain why. WW does not wish to "rock the boat" by persisting to bring up the

matter as he fears losing his doctor. If his doctor fired him as a patient, he feels that he would not be able to find another doctor to treat him. For WW, being without a doctor would be a serious set-back for his health as he requires amoxicillin, a prescription antibiotic, just to keep his condition stable.

[65] He is forced to resort to the dangerous and illegal practice of buying the marihuana he requires to treat his pain from illicit sources. The stress and fear associated with obtaining his medicine further aggravates his medical condition and the expense involved prohibits him from purchasing the ideal quantities that his condition calls for. WW is not a criminal but he is forced to engage in criminal activity to survive.

ML

[66] ML lives in Niagara Falls. She is fifty-five years of age and suffers from MS. Her pain on a scale of one to ten (with ten being the most severe), is usually a nine. Her legs constantly twitch and shake and stress and anxiety make things worse.

[67] She has been prescribed pain killers, anti-spasm medication, anti-anxiety medication, medication for constipation, and bladder pills. Collectively, these medications have enlarged her liver, caused weight gain, dry mouth, aching teeth, constipation and fatigue. Marihuana however, gives her instant relief without the side effects. She states that everything improves when she takes marihuana.

[68] She has asked two neurologists to support her marihuana use by signing the Health Canada declaration. Both have refused. One of these doctors told her he did not sign for anyone; the other held her hands over her ears and sang “la, la, la, la, I can’t hear you” as a response to her request.

[69] In 2008, she finally found a doctor in Hamilton who filled out her Health Canada declaration, which she submitted in March, 2010. She called Health Canada regularly to ascertain the status of her application but no one would return her calls. On October 5, 2010, after months of calls to Health Canada, she learned that her application was missing a page and could not be approved. No one at Health Canada had previously advised her of this problem.

[70] ML has to be secretive about her marihuana use. Despite her knowledge that it is illegal and risky, to control her symptoms, ML must smoke when she is out in public simply to do normal day-to-day things like shopping for groceries. When she is out in her wheelchair, and needs to have relief, she will seek privacy behind a dumpster in the alley behind the plaza where she shops.

CE

[71] CE is fifty-five years of age. She resides in Holland Landing, Ontario and travelled to St. Catharines to give *viva voce* testimony at the hearing of this application. In 1979, she was struck by a drunk driver. The collision caused debilitating injuries to her spine which are permanent and painful. As a result of these injuries, she suffers from intense muscle spasms, nausea and dizziness.

[72] For years she was prescribed and took a number of prescription narcotics. These caused side effects, including migraine headaches, severe fatigue and drowsiness, which ultimately became unbearable.

[73] CE finally turned to marihuana in 2003. Although her specialist (rheumatologist) saw improvement in her symptoms, he would only give her a letter which helped her to access marihuana through a compassion centre. He was not willing to sign the Health Canada paperwork.

[74] Her symptoms continued to show dramatic improvement and her doctor was supportive of her marihuana use for some three years. At the end of that three year period, x-rays were taken. They showed that no further deterioration had occurred and CE's doctor was so amazed he told her whatever she was doing to keep it up. It was at that point that CE decided it was a good time to try once more to obtain her doctor's signature on her Health Canada declaration.

[75] As soon as she asked the question, the doctor's attitude, which had previously been friendly and supportive, became hostile. He ushered her out of his office and advised her he was no longer her physician. This event caused CE extreme stress. She had been relying on this doctor to complete her Ontario Disability Support Program paperwork (which he ultimately did).

[76] CE returned to her family doctor. After parting ways with her rheumatologist, she needed a referral to a neurologist. She also wanted to ask her family doctor about the Health Canada form for medicinal marihuana. She went armed with research, the forms and a waiver. The visit began cordially enough but took a turn for the worse as soon as she mentioned the Health Canada form.

[77] After refusing to sign and commenting how he was not licensed to prescribe marihuana and did not want to put his family at risk, the doctor left the room. When he eventually returned and found CE still there, he escorted her out into the lobby. A few days later when CE called the doctor's office to inquire after her referral for the neurologist, she was informed that she (and her autistic son) were no longer patients.

[78] CE did not seek a doctor for herself again until April 2009, when she developed psoriasis. It was around this time that she learned of a pain specialist who was willing to sign Health Canada declarations. She

booked an appointment but needed to obtain a referral from a general practitioner prior to the appointment.

[79] There was a doctor shortage in her area at this time, so this was not going to be easy. In the course of trying to find a family doctor and get treatment for her yet undiagnosed psoriasis, CE went through three more doctors. Finally, she did find a family doctor who was willing to accept her as a patient. However, as soon as CE related her need for assistance to access marihuana to treat her symptoms, things changed. The doctor indicated that she knew nothing about marihuana, and would not assist her to get access to the drug. She then advised CE that she would be reporting her use of marihuana to the Ministry of Transportation.

[80] CE protested that if that was the case, she did not want the doctor to be her physician and there would be no obligation to report her to the Ministry. Her plea did not prevail and within a few days, the Ministry suspended CE's licence. It would be forty-seven days before she would get it back. Since she lived in a rural area and had her son to look after, this was a great and unnecessary hardship for this woman.

[81] Still without a doctor and with her psoriasis still spreading and still undiagnosed, CE resorted to the Emergency Room at a hospital in Newmarket. It was then that she finally obtained the referral she needed to a dermatologist, as well as to the pain specialist with whom she had an appointment.

[82] CE described her appointment with the pain specialist as "wonderful." He understood her concerns and knew about medicinal marihuana. After some six years and three doctors, she was finally able to get her paperwork signed. She left the specialist's office and cried with joy and relief.

AH

[83] AH resides in Peterborough, Ontario. She has twenty-seven chronic diseases, including lupus and a seizure disorder. They cause her "terrible, terrible pain." In the course of treatment, she became addicted to the "hard drugs" she had been prescribed. When she stopped taking them, it led to "the worst three days of her life." As a result, AH turned to marihuana. This significantly reduced her pain and stress, and managed her seizures.

[84] Twice, she asked her rheumatologist of fifteen years to sign her Health Canada declaration and/or compassion club application. He refused and told her not to bring it up again. This led to an argument in which she told him the opioids were horrible, addictive and were changing her personality, which discussion led to the end of the doctor-patient relationship.

[85] AH also asked her family doctor to sign the forms. He also refused her and on or about the third time she asked he fired her as a patient.

[86] Finally in 2009, AH found a doctor who agreed to sign the Health Canada declaration. After waiting twelve weeks for her licence to arrive, AH called Health Canada. She was told that if they looked into the status of her file, her application would be put on the bottom of the approval list. Accordingly, she had her lawyer call on her behalf and he was told the same thing.

[87] AH's medicinal use of marihuana was led to embarrassment, mistreatment and the risk of criminal prosecution. Ambulance personnel and medical staff are habitually rude and make inappropriate remarks when they detect the smell of marihuana.

SS

[88] SS resides in Toronto, Ontario. He has HIV and says that marihuana is widely recognized for its effectiveness in treating symptoms related to HIV and the side effects of conventional treatment for HIV. However, his doctor, who is both a general practitioner and HIV specialist, has refused to sign his Health Canada declaration. The doctor cited the government's "fluid position" on the political, criminal and medical implications of medicinal marihuana and the potential risk of legal repercussions on his licence to practice as the reason for his refusal.

[89] Without a licence, SS must attempt to secure his medicinal marihuana from costly and unreliable sources. He fears criminal sanction and feels guilty and ashamed.

[90] There are other Ontario witnesses whose evidence I have not reviewed. Their evidence is similar and need not be repeated.

PATIENT WITNESSES FROM BRITISH COLUMBIA

DD

[91] DD is 50 years old and lives in Vancouver. He is disabled and lives on a fixed income. He accidentally swallowed bleach as a three year old child and has lived with the horrific consequences ever since. Having barely survived the toxicity, DD now lives with chronic pain, nausea, cramping, gas and food digestion difficulties.

[92] His pain ranges from mild to severe and is ever present. Because of a very restricted diet, he cannot go to a restaurant, and cannot eat processed foods such as wheat, pastas, and sugars, food from cans or spices. Everything must be very plain. Vomiting sometimes lasts for days and weight loss is a constant concern.

[93] DD's health issues have led to many hospitalizations and since nausea is a constant companion, he cannot be outside of his house for any length of time. Cramping, nausea and seizures through the night cause him to wake up exhausted. Seizures leave him vulnerable and defenceless, and he has been robbed several times when he was having a seizure. Prescription medications no longer work for DD. In addition, the side effects became unacceptable.

[94] DD started using marihuana in 2005 after being very sick for weeks due to his prescription medications. With marihuana he gets relief from the pain, cramping and nausea. Vaporizing is his preferred method of ingestion as it gives him instant relief. DD's health has improved since he started using marihuana. There have been fewer hospitalizations and his symptoms are reduced.

[95] When he doesn't take marihuana he feels terrible, particularly in the mornings. DD lives in an assisted care facility. Although the building manager permits him to have a small four plant medical marihuana grow, the yield is not nearly enough to meet his needs.

[96] DD's interaction with the Vancouver Police has been positive. Although he has been reported by Emergency Medical Services Personnel who saw his plants when attending to his care after a seizure, the police have never charged him. Staff of the assisted care facility where he lives have tried for seven months to find him a doctor who will sign his Health Canada declaration without success.

[97] DD has personally called or visited thirty-seven doctors in downtown Vancouver in an attempt to find one who will sign his declaration. Eighteen requests were by telephone and nineteen doctors were asked face to face. Although many were sympathetic, not one of

the thirty-seven doctors was prepared to sign. The names of those doctors are set out in his affidavit.

[98] DD attests that the majority of doctors in downtown Vancouver are employed by Vancouver Coastal Health (VCH), the local health authority. Some of the doctors he spoke to indicated that VCH has told doctors not to sign the declarations. Others have said their lawyers have advised them not to sign. Some said they are not specialists in medical marihuana and claimed that he needed a specialist. At another clinic, he was told that they would not support any drug that promoted an addiction. Still others claimed that they were part of a group practice in which the group had agreed not to get involved with medical marihuana. One clinic claimed that there is no evidence that marihuana helps anything. They refused to sign DD's declaration and urged him to try another prescription medication – Ondansetron, a heavy drug used in chemotherapy. Ondansetron has serious adverse side effects worse than those of another drug DD previously used which affected him badly.

[99] When DD has enough marihuana he is free from pain, nausea and cramping. He worries about being arrested and the cost of black market marihuana is difficult to manage. In addition, using marihuana is a housing barrier. He feels like he is living like a criminal and never knows when the next seizure might attract an officer who won't be sympathetic and he will be arrested. It has happened before and he spent hours in custody vomiting while the police checked his story.

FF

[100] FF is fifty-seven years of age and lives in Cranbook, British Columbia. He was diagnosed with Multiple Sclerosis in 1988 and has been disabled by the disease since 1989. Once the owner of his own business, FF now lives on a disability pension.

[101] FF has diligently pursued all available conventional treatments available to him, all to no avail. In 1994, he began to use marihuana as a food product and found it gave him significant relief from his symptoms. However, it was very difficult to obtain.

[102] FF's condition grew significantly worse over the years. By 2000, his pain was so severe, he seriously considered the surgical severing of his spine to alleviate it. Hospitalizations in 2002 and 2003 led to the introduction of five new prescription drugs. By 2003, he needed a walker to get around and a wheelchair for longer journeys. He was so weak he spent most of his time in bed.

[103] Eventually, he learned that the prescription drugs he had been taking had burned a hole in his stomach and caused Diverticulosis. Marihuana, on the other hand, offered him more relief than any of the prescription drugs without the side effects. It was the only medication that reduced his muscle spasms and anxiety. It has also improved his sleep, his mood and he is now able to walk without a walker and move more freely which has greatly improved his quality of life. Since 2004, FF has eliminated prescription medications from his life and relies on medicinal marihuana and other natural substances to successfully control his condition.

[104] FF was able to obtain a licence to possess and cultivate marihuana for medicinal purposes in 2002. After his neurologist refused to sign the Health Canada declaration, he was fortunate to have another neurologist sign the form. The licence was renewed annually until the end of 2006. At that time, his care had to be transferred to other doctors who have since refused to sign the forms. As a result, FF has been without a licence since January of 2007.

[105] His current neurologist and family doctor have refused to sign his Health Canada declaration. His neurologist wishes to prescribe pharmaceuticals which FF does not want to use, and FF has the sense that he would prefer that he not be his patient at all. The neurologist refused to sign the form on the stated basis that "there is grossly insignificant medical evidence that marihuana has a significant role in treatment of this condition." FF's family doctor refused to sign, stating that the clinic, the College of Physicians and Surgeons, and his insurers would not approve of his signing.

JB

[106] JB lives in the town of Prince George, British Columbia. He suffered a fractured skull in a work related injury and is now on CPP. In 1990, he began to experience pain in his back and shoulders which has gradually gotten worse. He has been prescribed various pain killers but in 1994 came to realize that marihuana gave him more relief from his symptoms without the side effects. With the right strain and potency, his symptoms are greatly reduced and he is able to sleep and function.

[107] JB has been unable to find a doctor to sign his Health Canada declaration and it is difficult to obtain marihuana in Prince George. JB must therefore travel 950 kilometres to a Compassion Club in Vancouver to obtain his medicine, or go without.

[108] Both JB's specialist and his general practitioner have refused to sign his declaration. JB is unable to go searching for a more receptive doctor because in Prince George there are no doctors or chronic pain specialists accepting new patients.

PATIENT WITNESSES FROM ALBERTA

KG

[109] KG is fifty-nine years of age and lives in Lethbridge, Alberta. She travelled to St. Catharines in great discomfort to testify in this matter. KG walked with noticeable difficulty assisted by a cane. Her appearance was that of a woman in obvious pain and with serious health issues.

[110] Ten years ago, she was diagnosed with chronic vertigo. Attacks last anywhere from one-half day to three days. During a bad attack the room is spinning and she must lie down in a dark room, close her eyes and hope that it will soon be over. Any movement brings on waves of nausea; a bad attack usually results in diarrhea and depression. She has sustained many injuries during these attacks which have resulted in fractures to her shoulders and knees. She also suffers from inflammatory arthritis.

[111] No less than twenty-nine drugs have been prescribed by her medical doctors and they are listed in her "will say" found at Tab 5 of Book 7, Applicant's Draft Affidavits. The names and quantity of the drugs are not as important as her evidence that they did not work for her. The side effects of many of these drugs were found to be unacceptable, leaving her feeling like a "drug zombie." Marihuana, on the other hand, allows her to function during a bad attack and makes the lesser attacks tolerable without the health-threatening side effects. It also helps with her nausea by settling her stomach and allowing her to eat. Marihuana also makes the pain from her injuries and arthritis more tolerable. Marihuana helps her to deal with her medical condition and provides respite from the disabling effects of her health issues.

[112] In her search for a doctor to sign her Health Canada declaration to permit her to use marihuana legally, KG has spoken to and been refused by approximately thirty-nine physicians according to her "will say." During her testimony, she named twenty-six doctors[2] who have refused her request for medicinal marihuana in several Alberta communities, including, Lethbridge, Coldale, Raymond, Red Deer. One of the doctors who refused her was her own brother. Despite her serious medical illness, not one of the twenty-six doctors was willing to sign her Health Canada declaration. It is KG's belief that the doctors in Alberta have been advised by the Alberta Medical Association not to sign Health Canada declarations. This belief is based on the responses of some of the doctors who refused to sign the form citing the disapproval of the college.

[113] The impact on KG of not having a licence has been grave. It has estranged her from members of her family who view her as a common drug addict. t has caused difficulties at her church (which were resolved in her favour by the Bishop). It has led to the break-up of her marriage and has resulted in a loss of employment opportunities, including being fired by her own brother when he learned she was a marihuana user.

RH

[114] RH is fifty-seven and lives in Cochrane, Alberta. He suffers from Perthes which is a chronic declining condition for which there is no cure. Perthes causes a reduction of blood flow to the joints and has led to osteoarthritis.

[115] He has osteoarthritic damage in his neck, spine, shoulder, wrist knees and hips. His pelvis is broken horizontally and will not heal due

[2] The 26 doctor figure is the one that has been used to calculate the number of physicians who have rejected the requests of patient witnesses for support of their medicinal marihuana applications to Health Canada.

to the lack of blood. His condition causes intense pain and he is often unable to move. RH has undergone numerous painful surgeries and suffers from foggy vision, loss of appetite, exhaustion, nausea and insomnia. He is confined to a wheel chair and over exertion leaves him bedridden for days.

[116] RH has taken numerous prescription drugs for pain, all of which have had negative side effects. They make him feel like a zombie, have caused ulcers, and he worries about heart issues that are also a side effect of some of the prescription drugs he has taken. In addition to the negative side effects, he only gets partial relief from these pharmaceuticals even at very high doses.

[117] Marihuana has been a “miracle” drug for RH. It reduces his pain, inflammation, and spasms. It also helps with his nausea, increases his appetite and lets him sleep up to four or five hours per night. Even his friends have noticed a huge improvement in his condition resulting from his marihuana use.

[118] RH’s doctor is aware of the success he has had with medicinal marihuana. In fact, it was his doctor who suggested he try it in 2004. Nonetheless, that same doctor has refused to sign the Health Canada declaration. RH does not want to keep asking his doctor to sign because he is afraid of being fired as a patient. There is a shortage of doctors in his area and not having a doctor is not an option. RH does not want to doctor-shop and moreover does not know of any doctors in Calgary who are willing to sign Health Canada declarations.

TC

[119] TC lives in Taber, Alberta. She suffers from Colitis and has been prescribed numerous prescription drugs for her condition. The

prescription drugs cause her stomach and bowel discomfort, make her dizzy and interfere with her sleep.

[120] In 2007, she discovered that marihuana eased the symptoms of her Colitis. It allowed her to eat, lessened her stress and allowed her to think. Marihuana reduces her pain, swelling and cramping, and she uses it every day. It allows her to work and function.

[121] TC was hesitant to approach doctors to sign her Health Canada declaration. She feared being reported to Children's Aid or being viewed as doctor shopping. She was also worried about the responses she would get to her inquiry. In May of 2009, she approached her family doctor to sign the form and was refused. The doctor told her the College of Physicians and Surgeons did not permit him to sign. In June of 2009, she approached her family doctor about signing the form. He was aware of her medicinal use of marihuana. That doctor also refused to sign the form and instead prescribed Codeine.

[122] TC has previously been convicted of possession of marihuana in relation to her medicinal use and fears being charged again due to her public advocacy for the drug.

PATIENT WITNESS FROM SASKATCHEWAN

MS

[123] MS lives in Regina and suffers from chronic migraines. As he has gotten older, they have become more debilitating, more intense and more frequent. The migraines are now beginning to interfere with his ability to work. There is no known cure for migraines, although it is thought that the triggers can be managed.

[124] MS cannot use medication for his migraines because of the danger of addiction and the psychosomatic pain that they create. MH's theory is that the subconscious knows that a bout of pain will make him take an opioid and that triggers the pain.[3] The last thing in the world that a chronic pain sufferer needs, he says, is to suffer non-existent pain caused by addiction.

[125] When MS started taking marihuana in 2002, he noticed almost immediate relief. The importance of medical marihuana to controlling his condition is evidenced by his move from the US to Canada in 2003. Rather than risk being caught using marihuana by American authorities (where drug policy is much stricter), MS opted to move back to Canada and attempt to obtain a licence under the *MMAR*. He has thus far been unable to do so.

[126] MS has spent three years trying to get a doctor to sign his Health Canada declaration without success. The first doctor he asked in 2003 advised that he could not sign a Health Canada declaration because his insurance company and the Canadian Medical Association were telling doctors not to. In 2007, he went to a pain clinic in Saskatoon and was informed that the President of the Saskatchewan Medical Association has advised doctors not to get involved with marihuana declarations. His current physician takes the position that marihuana does not help treat migraines.

PATIENT WITNESS FROM QUEBEC

MC

[127] MC lives in Montreal and has degenerative disc disease which leaves him in constant pain. When he is not taking medicinal marihuana

[3] His views on this subject were supported by the evidence of Dr. Rosenbloom whose evidence I will review in due course.

his pain level is an eight out of ten. With the use of marihuana, it is reduced to a four.

[128] Conventional prescription medications did not reduce his pain and he stopped taking them because of the side effects such as shortness of breath and racing heartbeat. Other drugs made him constipated and groggy to the point he was unable to function. None of the prescription drugs were as effective as marihuana.

[129] MC did find a doctor willing to sign his Health Canada declaration; however, it was no small feat, and after more than six months he still has not received his licence. His family doctor in Quebec refused to sign his declaration saying that the Canadian Medical Protection Association discourages the practice in Quebec and treats a waiver of liability as ineffective.

[130] Through an activist, MC learned of a doctor in Ontario who was willing to sign Health Canada declarations for those who qualified. MC obtained the details and set up an appointment. He had to travel five hours each way to get his declaration signed. He will have to make this trip at least once a year to renew his licence, “if it ever arrives.” It is a burdensome trip in the best of times and in the winter involves the expense and inconvenience of an overnight stay somewhere along the way.

PATIENT WITNESSES FROM NOVA SCOTIA

BD

[131] BD lives in Halifax and has Open Angle Glaucoma which is an ocular disease. Left untreated, the condition leads to blindness. The drugs he has been prescribed have terrible side effects. Travatan, one of the drugs he has been prescribed was the subject of a warning by the

Food and Drug Administration in the United States in 2005 and again in 2010. The warning stated that the manufacturer had overstated the drug's effectiveness and understated its risks and side effects.

[132] BD has heard that Glaucoma is a condition for which marihuana has proven beneficial effects. He wishes to use marihuana medicinally but to date has not done so because it is illegal and he has been unable to obtain a licence under the *MMAR*. He does not want to break the law and fears that if he were charged and found guilty of possession, it would lead to the loss of his job.

[133] BD has spoken to his doctor about signing the Health Canada declaration so that he could legally use to treat his condition. His doctor refused, indicating that the forms require every possible treatment option to be explored and found unsuccessful before marihuana may be used. BD also believes that his doctor is afraid of losing his licence to practice.

[134] In Nova Scotia, the number of doctors practicing general medicine is reducing and specialists are even more scarce. Those who will support medicinal marihuana use are even more scarce. It is BD's opinion that the medical profession in Nova Scotia has a "draconian point of view on marihuana."

[135] With his doctor unwilling to sign the form and a paucity of available doctors, BD must continue to take prescription medications with harsh side effects and limited effectiveness or go blind. Despite his serious medical condition BD is unable to secure his own treatment preferences for fear of going to prison.

LR

[136] LR lives in Jordan Falls, Nova Scotia. She suffers from Crohns Disease, a chronic and progressive inflammatory disease of the intestine.

It causes diarrhea, abdominal pain, nausea, fever, loss of appetite, weight loss, severe cramping, intestinal blockages and excruciating pain.

[137] The prescription medications she has taken have unpleasant and painful side effects, some even cause hair loss. However, marihuana provides significant relief from her symptoms and stimulates her appetite helping her to maintain her weight without the nasty side effects.

[138] LR has been smoking marihuana for thirty years. It greatly relieves her pain, takes her mind off the pain it doesn't relieve, and allows her to focus, be active and comfortable.

[139] LR has consulted two family doctors, both of whom are willing to support her by seeking a specialist to sign the Health Canada declaration for her; however, to date, they have been unable to obtain the agreement of a specialist.

[140] At one time, LR lived in Alberta. She asked her gastroenterologist in Alberta to sign the form and the doctor refused. Since refusing to sign the declaration, the doctor has changed the way she behaves and relates to LR; once friendly and supportive she is now cold and gives LR the impression that she has done something wrong.

PATIENT WITNESS FROM PRINCE EDWARD ISLAND

SB

[141] SB is thirty-two years old and lives in Charlottetown, Prince Edward Island. He suffers from psoriasis, anxiety disorders and testicular cancer. These conditions have made his life unbearable at times.

[142] He has been prescribed numerous drugs, all of which cause unwanted side effects, such as dizziness and nausea. What works for SB is marihuana. It helps him to ignore his illnesses, reduces his symptoms so he can work and does not cause the side effects associated with the prescription drugs.

[143] SB does not have a family doctor; he has been on a waiting list to get one since 2004. He uses a medical clinic that has an extensive file on his condition and treatment. In 2008, he asked a doctor at the clinic to sign his Health Canada declaration. The doctor refused and told SB that medical marihuana does not exist in PEI and that he would have to go to Nova Scotia to attempt to find a doctor to sign the form.

OPPOSITION FROM MEDICAL PROFESSION

[144] To understand why these patients have had such difficulty in obtaining access to medicinal marihuana, it is necessary to examine the circumstances that prevailed at the time the *MMAR* were introduced. Although the *MMAR* came into effect in August 2001, prior to then, the medical profession had expressed serious opposition to being appointed gatekeepers.

[145] In a letter dated April 7, 2001 found at Tab 3 of the Supplemental Affidavit of Ronald Denault (Ex. 22(b)), the Canadian Society of Addiction Medicine wrote to the Office of Controlled Substances, Department of Health the following:

> The Canadian Society of Addiction Medicine is an organization of physicians and scientists whose goals include contributing to the professional and public examination and discussion of important issues in the drug and alcohol field. In response to the proposed federal Medical Marihuana Access Regulations published in the Canada Gazette, April 7,

2001, the following statement communicates the grave concerns that The Canadian Society of Addiction Medicine has with the proposed legislation:

> There is more risk than benefit in the use of smoked cannabis products for medical purposes.
>
> More research is urgently required before the cannabinoids can be accepted as recognized medical therapy for diseases other than those where oral marihuana is already indicated and available by prescription legally.
>
> No evidence-based data exists to provide guidelines and direction for the medical use of smoked marihuana.
>
> Regulatory reporting and promotion of the medical use of smoked marihuana is not based on sound medical practice.
>
> The regulations place physicians in a moral ethical quandary.
>
> The physician should not be the gatekeeper to a potentially addicting drug with little proven medical efficacy, known medical risk, and serious legal implications.
>
> A physician prescribing a smoked form of marihuana to anyone except those in category 1 could be considered to be acting unethically, and should be judged as such.
>
> The regulations appear to be an attempt to medicalize a social problem.
>
> The smoked form of marihuana has not been shown to meet the rigorous criteria that should apply to all prescription drugs.
>
> Until these issues are addressed and satisfactorily dealt with, any discussion of smoked marihuana is premature in the extreme.

[146] Other excerpts from this letter are noteworthy. At page 3, it is stated:

> Do the regulations provide support for the physician if the drug is misused or diverted to street use? Is there any protection for the physician if legal

> consequences ensue as a result of prescribing smoked marihuana when there is no medical evidence that the harm benefit ratio is positive?
>
> Physicians are being asked to determine who will be able to legally access the drug. No literature supports the use of smoking cannabis as a method of delivery in the treatment of illness. Yet the regulations require that the physician is the gatekeeper for the supply of marihuana….
>
> Do no harm is the first rule of medicine. Smoking marihuana has the potential to harm even though the harm may not be initially noticed by the user, may be delayed, and may not be initially apparent to the physician. The necessity of further investigation into the use of the active ingredients of marihuana for therapeutic use is of great importance but smoked marihuana cannot be consider appropriate to use except in terminally ill persons…
>
> The promotion by Health Canada of the medical use of smoked marihuana is not based on evidence-based medicine or sound medical practice.
>
> The physician should not be the gatekeeper to a potentially addicting drug with little proven medical efficacy, known medical risk, and serious legal implications.

[147] With the leadership of the medical profession being so adamant in its opposition to its proposed role as gatekeeper, it is little wonder that the profession has not been supportive of the *MMAR* and the patient witness evidence of this lack of support becomes understandable.

[148] The following excerpt from the Belle-Isle Report (Ex. 23) at p. 21 is also noteworthy. It states:

> …on May 7, 2001 the Canadian Medical Association wrote to the Minister of Health and clearly stated that "physicians must not be expected to act as gatekeepers to this therapy, yet that is precisely the role Health Canada had thrust upon them. In general, physicians around the country were cautioned by their professional associations to not lend support to the authorization process due to a perceived lack of scientific evidence supporting the medical

> benefits of cannabis. In particular, the Alberta Medical Association cautioned its doctors against completing the forms necessary to prescribe medical cannabis. In his President's Letter, released on July 27th, 2001, Dr. Clayne A. Steed advised Alberta physicians to "think twice" before completing any forms for the use of cannabis. Similar cautions have been issued by the Quebec and Manitoba Associations, while the Ontario Medical Association has advised their physicians not to complete the forms required for their patients to lawfully obtain medical cannabis.

[149] Notwithstanding this opposition, the *MMAR* came into effect on August 1, 2001.

[150] The Canadian Medical Association had expressed strong feelings on the subject of marihuana to the government even after passage of the *MMAR* as evidenced by a series of letters to the Minister of Health commencing in July 2002. They may be found as Exhibits to the affidavit of Ronald Denault (Exhibit 22(A) commencing at Tab J). In a letter dated July 12, 2002, Henry Haddad, President of the Association stated:

> As a follow-up to our meeting in February as well as our most recent conversation, I am writing to seek clarification of Health Canada's current position with respect to the regulations pertaining to medicinal use of marihuana. At the time of their promulgation, we were assured there would be a review of the impact of these regulations and an assessment to redress our concerns through the review process, in a timely fashion. While there has been some progress, the pace has been much slower that we had hoped.
>
> The Canadian Medical Association recognizes and is sympathetic, to, the needs of those individuals who may gain or hope to gain benefit from the use of marihuana in relieving their symptoms. We support the use of any proven safe and effective therapy manufactured with appropriate diligence. However, as stated previously, the regulations have had the effect of putting our members in the unenviable position of acting as gate-keepers for a

> product that has not gone through the normal protocols of rigorous pre-market testing. In addition, a number of my colleagues have reported that federal government's tacit support for marihuana use has had detrimental impact on physician-patient relationships.
>
> We appreciate your efforts to-date to ensure the CMA has an opportunity to participate with Health Canada's Stakeholder Advisory Committee on Medicinal Marihuana to discuss technical issue. At the same time, in anticipation of our Annual General Meeting in Saint John, New Brunswick, this August, it would be helpful to have an update on your position on these federal regulations.
>
> Thank you in advance for your attention to this matter.

[151] At about this time, the government was apparently considering decriminalizing the personal use of marihuana and its public statement on this issue prompted a letter from the CMA dated May 2, 2003 to the Minister of Justice (Tab J) as follows:

> In light of the Prime Minister's announcement and your recent comments pertaining to the forthcoming legislation to decriminalize the personal use of marihuana, I am writing to once again request a meeting. The Canadian Medical Association (CMA) and our more than 55,000 members are very concerned that the federal government may consider proceeding with the decriminalization of marihuana without first putting in place a comprehensive national drug strategy.
>
> It is critical that changes to the criminal law affecting marihuana do not encourage nor promote the normalization of its use. Decriminalization should only be considered as part of a comprehensive national strategy on the non –medical use of illegal drugs. Only under a multi-dimensional approach would the CMA endorse decriminalization.
>
> I would like to meet with you as soon as possible to discuss the Association's position and investigate ways in which the CMA can work with your government to move this legislation forward. ….

[152] On July 15, 2003, the President of the CMA wrote to the Minister of Justice the following letter (Exhibit 22(A), Tab J):

While Canadian physicians have been supportive of your renewal call for clinical research on the medicinal use of marihuana, we are however, very concerned by your decision to designate physicians as the dispensers of this product. As I stated publicly, while the Canadian Medical Association (CMA) recognizes the legal imperatives that your government was facing, we are nonetheless disappointed with your solution. Physicians are disappointed not only in the new "interim" regulations but also with the total lack of consultation with the medical profession, including your own Stakeholder Advisory Committee on Medical Marihuana, where Dr. Henry Haddad ably sits as our representative.

Since medicinal marihuana regulations were first being contemplated, the CMA has consistently raised concerns about the lack of evidence of its safe and efficacious use. Your own assertion that marihuana is not a proven therapeutic product and that as Minister of Health, your first obligation is to ensure the safety and efficacy of this product, is consistent with the opinion of the vast majority of physicians. Like you, we are not convinced that there is sufficient evidence to demonstrate its clinical effectiveness to counter existing evidence of short and long-term health risks; nor guide physicians in its clinical use, including dosing and frequency.

Our position remains steadfast. ***Physicians should not be the gatekeepers for a substance that has not gone through the established regulatory review process, as required by all other drugs. CMA has strongly recommended that the physicians of Canada not participate in dispensing marihuana under existing regulations, and warns that those who do, do so at their own professional and legal peril.***

However, we remain willing to work with you, your department and your Stakeholder Advisory Committee to resolve this situation. CMA has developed a 10 point plan that provides a solid basis for the development of new evidence-based medical marihuana regulations that put the safety of patients first.

You will find attached a copy of our news release including the plan….

[153] The news release dated July 9, 2003, called upon the federal government to put the health and safety of patients first. The release stated that "the government's interim policy on the provision of marihuana for medical purposes does nothing to address patient safety issues." It goes on to state in part as follows:

> The CMA has developed a 10-point plan to ensure that the inherent trust that physicians will act in the best interests of their patients – so important to the patient/physician relationship- is respected. The CMA's plan provides a solid basis for new evidence-based medical marihuana regulations. Today's announcement fails to meet the criteria.
>
> Since the government has not made the case for the safety of the medical use of marihuana, the CMA strongly recommends that the physicians of Canada not participate in dispensing marihuana under existing regulations, and warns that those who do, do so at their professional and legal peril.

[154] The CMA's 10 point plan entitled *Backgrounder: CMA's 10 Criteria for the Medical Use of Marihuana* was attached to the news release. It stated:

> Fundamental concerns make the current Medical Marihuana Access Regulations unfeasible. It is only through the resolution of these concerns that physicians may feel comfortable with this experimental therapeutic option and patients will have consistent access to a possibly safe product for compassionate reasons. These concerns can best be addressed through an implementation process that, for example might incorporate features such as the following:
>
> > *Early ongoing and meaningful consultations with physicians by government
> >
> > *Registered Physicians – physicians would "opt in" and apply (to Health Canada) to gain authorization to participate in the process. In doing so, a registry would be created for providers to whom patients could be referred.

*Functions as a Clinical Trial – Authorized physicians would provide access to marihuana in a fashion similar to a clinical trial, supported by treatment protocols and incorporating ongoing monitoring and surveillance of patients.

*Provider Education – Registered providers would be provided with specific education prior to commencing registration and on an ongoing basis as more information is gathered by research and the program regarding the use of marihuana.

*Liability Protection – Registered providers would be provided liability protection by Health Canada.

*Known Access Points – Treatment centers or acceptable alternatives would be established and known to patients and providers.

*Central Supply – Marihuana would be supplied from a centrally regulated and controlled source.

*Post Market Surveillance – Marihuana's impact would be monitored on an ongoing basis.

*Privacy – The registry would be secure and maintained in keeping with privacy.

*Revocation – The Minister may revoke a physician's authority to prescribe marihuana if he/she breaches pre-specified conditions of authorization. Further, the Minister can report physicians to regulatory bodies under explicit predetermined conditions.

[155] As Mr. Wilson correctly points out, the *MMAR* have undergone numerous amendments since they first appeared. For instance, the former three categories of patients have been reduced to two, the second specialist requirement has been eliminated, the doctor is no longer required to make definitive statements regarding benefits outweighing risks, or to make specific recommendations regarding the daily dosage of marihuana to be used by the patient and is no longer required to list

specific conventional therapies that have been tried or considered or to provide their reasons for finding those therapies to be ineffective or inappropriate. Therefore several of the initial objections of the medical community have been addressed. However, many of the criteria set out in their public policy announcement have not been addressed nor incorporated into the amendments.

[156] Although mention was made in *Hitzig* of medical opposition to the *MMAR* at both the trial and appellate levels, no reference was made in the body of either judgment to any of these communications which suggests that these communications may not have been before either court. However, if I am wrong in that observation, nevertheless, the evidentiary record on the subject of physician participation in the *MMAR* before this court is drastically different from what was before the court in *Hitzig*.

STIGMA

[157] Although marihuana has had an extremely long history of therapeutic use, going back many centuries, it was nevertheless criminalized in 1923 and became a prohibited substance. Thereafter, it was regarded as a gateway drug, meaning that it was viewed as an introduction to other more harmful drugs. At one time, it was also considered, to be criminogenic, meaning that its use would lead to criminal and or violent behaviour. Although these and other misconceptions about marihuana have since been dispelled, the drug still carries a stigma due to its status as a prohibited substance.

[158] This stigmatized view of marihuana is shared by many physicians as illustrated by the patient evidence but also as shown by the results of in-depth exploratory interviews conducted in December 2007 of general practitioners and specialists across Canada on their attitudes

and opinions on some aspects of their current practice of recommending or supporting access to the therapeutic use of marihuana/cannabis under the current regulatory status. The full survey may be found at Tab S of Mr. Denault's affidavit.

[159] The doctors who were surveyed felt that if they prescribed marihuana, it might invite an influx of unwanted patients and contribute to increased risk of liability, social stigma, criticism and or loss of credibility or standing among peers in the medical community.

[160] These views would clearly account for some of the more bizarre reactions by physicians described in the patient evidence. Stigma of course is not a proper ground for refusing to approve the drug for a patient under the *MMAR*, but I find as a fact that many of the physicians named in the patient affidavits have been arbitrary and biased in their rejection of their patients' requests for approval of the drug and have not addressed their minds to the criteria in the regulations as a basis for their refusals. I will comment on how widespread this attitude is in due course.

KNOWLEDGE OF THE DRUG

[161] Some physicians told the patient witnesses that they knew nothing about marihuana and therefore would not approve of its use. Others remarked that marihuana was untested and its risks and benefits were unknown. At times, this observation was made by a doctor who knew that his or her patient was benefiting from the use of marihuana and in some cases, had benefited from the use for a long period of time.

[162] This aspect of the patient evidence is supported by the results of the interviews of medical doctors previously referred to. The interviews indicated that physicians lacked, but needed clinical knowledge about

marihuana. Their knowledge had most often come directly from patients and, as a result, the doctors surveyed expressed concern about the blurring of the boundary between patient and doctor, meaning that it was the patient imparting knowledge of the drug's benefits to the doctor and not vice versa.

[163] In addition, the Canadian Medical Protective Association (CMPA), a medical mutual defence organization with over 60,000 active members, representing the vast majority of physicians in Canada, took the position that the risks and benefits of marihuana and what dosage would be appropriate, which were requirements in the first set of regulations, was information that was "simply not available" to physicians, making it nearly impossible for the vast majority of doctors to comply with requirements of the *MMAR*. The CMPA advised its members in the following terms (The full text appears in para.167):

> As you will see from the attached Information Sheet, now in the hands of our members, we have advised those physicians who are not or do not feel qualified to make these assessments to refrain from signing a declaration for a patient. We also advised our members to explain to their patients why they do not have the knowledge about marihuana, and to refer the patient to another physician, if known, with more experience in the medical use of marihuana.

[164] Although these communications from national medical organizations are now several years old, and the regulations have been modified, there is no evidence before the court that the CMPA has changed its position with respect to its fundamental objection, that being that studies have not been done to ascertain the "risks and benefits" of the drug. On the contrary, the evidence indicates that the vast majority of doctors in Canada are still refusing to participate in this program. In addition, funding that had at one time been allocated by the Government

for studies that the doctors had demanded, has now been withdrawn. Even though the doctor is no longer required to express an opinion on the benefits and risks of the drug, doctor are obligated by the ethics of their profession not to do anything to harm their patient, and therefore cannot knowingly approve the use of a product whose benefits and risks have not been verified by clinical studies.

DISAPPROVAL OF CMPA

[165] The Nolin Report at p. 309, further details the opposition of the CMPA to the *MMAR*. Found at Volume 4 of the Applicant's Book of Authorities, it quotes from an information sheet dated October 2001 which was sent to its members. It states in part:

> Section 69 of the regulations allows a medical licensing authority to request from the federal health minister information regarding a specific medical practitioner, which may be provided if the minister has reasonable grounds to believe the medical practitioner has made a false statement under the regulations. This is a significant concern, as physicians may unknowingly make a false statement because they are being asked to attest to matters that may go beyond the scope of their expertise. As a result, the risk that physicians could be reported to their College is increased.
>
> The fact that marihuana is not an approved drug product may lead some to conclude marihuana is an <u>alternative</u> medicine. This raises the important point as to whether the Colleges would consider physicians' involvement in the application for a licence to possess marihuana as requiring them to comply with the policy of that College concerning alternative or complimentary medicines. The CMPA advises physicians to ascertain from their regulatory authority what their position is in this regard.
>
> Given the consequences that may befall physicians with respect to their licensing body, or potential medico-legal liability, physicians will want to be very careful when determining whether to assist a patient in making an application under these regulations.

[166] The original version of section 69 remains in the *MMAR*.

[167] This information sheet was forwarded to the Health Minister in a letter dated November 8, 2001, a copy of which may be found at Tab K to the affidavit of Denault (Exhibit 22(A)). The letter states in part:

> On behalf of the Canadian Medical Protective Association (CMPA) and its 60,000 members – about 95% of the physicians practising in Canada – I wish to express our profound concerns regarding Health Canada's Marihuana Access Regulations.
>
> The CMPA believes the medical declarations required under the Regulations place an unacceptable burden on member physicians to inform themselves as to the effectiveness of medical marihuana in each patient's case, as well as the relative risks and benefits of the drug and what dosage would be appropriate.
>
> This information is simply not available. In medicine, knowledge is typically derived from clinical trials, of which we understand there are very few for marihuana. Given the fact that many physicians would not have the necessary knowledge about the effectiveness, risks or benefits of marihuana, ***we believe it is unreasonable to make physicians the gatekeeper in this process.***
>
> As you will see from the attached Information Sheet, now in the hands of our members, we have advised those physicians who are not or do not feel qualified to make those assessments to refrain from signing a declaration for a patient. We have also advised our members to explain to their patients why they do not have the knowledge about marihuana, and to refer the patient to another physician, if known, with more experience in the medical use of marihuana.
>
> Finally, recognizing that some physicians, out of compassion for their patients, may believe in good faith that their medical condition would benefit from marihuana, we have advised them to complete on Parts 1 and 2

> of the form and to NOT complete Parts 3, 4, and 5, leaving HC to decide whether to process an incomplete application.
>
> As a mutual medical organization with the unique mandate of defending the professional integrity of doctors, we are critically aware of and concerned about the medico-legal difficulties that may face members who choose to follow Health Canada's Marihuana Medical Regulations.
>
> We are also committed to working with the medical community and your ministry to develop a solution that is satisfactory to Canadian patients as well as their physicians.

[168] This strong admonition from the CMPA would have had a chilling impact on physicians and would account for their refusal to involve themselves with the *MMAR*, an attitude which is apparent in the patient evidence and is ongoing.

THE NOLIN REPORT

[169] The Nolin Report dealt comprehensively with the subject of cannabis. At page 309 of the report it states:

> It is clear to everyone that requiring medical practitioners to act as "gatekeepers" in the use of marihuana for therapeutic purposes has created a major impediment to access, or, as Health Canada states, "there is a conundrum". The Canadian Medical Association and many other professional medical organizations have refused to support the new federal application process because of issues of patient safety, dosages, and the legal liability of physicians prescribing cannabis.
>
> Their reluctance should not have come as a surprise to Health Canada. During the consultation process with regard to the proposed regulations, two medical associations and two provincial licensing authorities opposed the use of smoked marihuana for medical purposes.

[170] The authors of the Nolin Report conclude at p. 310:

> Clearly, under these circumstances, patients will have difficulty finding a medical practitioner willing to complete the required declaration forms, and even more difficulty accessing the appropriate specialists. This situation has created an unacceptable barrier to access and one must conclude that physicians should not be the "gatekeepers" under the *MMAR*, a responsibility that they themselves do not desire.

[171] The Report also commented on the role of specialists in the *MMAR* and concluded that their involvement would not only negate timely access, but in addition, the position taken by the medical organizations would make it very difficult to get specialists to make the required declarations. Submissions made to the Committee described the specialist requirement as being "unrealistic and punitive".

[172] The Nolin Committee concluded that the *MMAR* were not providing a compassionate framework for access to marihuana for therapeutic purposes and were unduly restricting the availability of marihuana to patients who may receive health benefits from its use. In addition, the Committee concluded that the refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an illusory legislative exemption and raise serious *Charter* issues. Changes were urgently needed with regard to who was eligible and how they were to gain access to the drug. Research was also needed on the safety and efficacy of cannabis (Nolin Report at p. 322).

[173] The Nolin Committee recommended that the requirement to consult with a specialist and the requirement that all conventional treatments have been tried or at least considered before cannabis may be used, be eliminated in the *MMAR* (Nolin Report at p. 317).

INFLUENCE OF THE PHARMACEUTICAL INDUSTRY

[174] In support of his position that it is practically impossible to obtain the requisite support of a medical doctor for the lawful use of medicinal marihuana under the *MMAR*, the applicant called Dr. Joel Lexchin. Dr. Lexchin is highly qualified, and was qualified to give expert evidence on the pharmaceutical industry and its impact on doctor prescribing habits and health care. His evidence was not challenged.

[175] The bulk of his testimony discussed the findings outlined in his paper entitled *Doctors and Detailers: Therapeutic Education or Pharmaceutical Promotion?* Though the article was written in 1989, Dr. Lexchin explained that the circumstances it describes and conclusions it reaches have not changed, though the figures likely have.

[176] Dr. Lexchin described the role of "detailers," who are simply employees of drug companies who visit doctors to provide details on the companies' products. Today, these individuals would be described as sales representatives.

[177] Through his research, Dr. Lexchin determined that there is a conflict between the interest of drug companies in increased sales and the interests of doctors and patients in having better prescribing information and health. Pharmaceutical companies emphasize the sales aspect of the detailer position over and above the role that sales representatives play in the health of the patient, with the result that sales representatives are not equipped with the knowledge and training to fulfill their role in transmitting information about therapeutics to doctors.

[178] For example:

- The President of the Pharmaceutical Manufacturer's Association of New Zealand was candid enough to admit that while the work of the sales representative was not confined to persuading doctors to prescribe his employer's product, this was an essential part.
- Johnson and Johnson's teaching manual encourages sales representatives to, "Think salesmen and not detailmen." The company expected their sales staff to delete the word "detail" from their vocabulary and think selling and sales.
- A former medical director of Squibb said: "The primary purpose of the detailman is to make a sale, even if it involves irrational prescribing and irrational combinations."

[179] Dr. Lexchin's conclusion was that there is a clear imbalance in the way detailers function in favour of their commercial obligations. Instead of being agents for physicians and patients, detailers are agents for their companies; although, that was not necessarily the image they were expected to create.

[180] He found support for his conclusion that the focus was on sales by examining the drug industry's targeting of high prescribing doctors and hospital in-house staff. Doctors who wrote the largest number of prescriptions, received the most visits from detailers because these doctors are most likely to increase product sales. In addition, to promote their product, detailers were encouraged to use gimmicks, and freebies, rather than relying upon simple factual presentations. He also found that pharmaceutical companies withheld information from detailers or instructed them not to pass on information that might result in a reduction in prescriptions.

[181] Dr. Lexchin concluded that these tactics worked and detailers were highly successful in altering doctors' prescribing habits. His study

showed that detailers were the single most important source influencing physicians to prescribe new drugs. In fact, he concluded that much of the problem of drug over-use and the resultant problem of adverse reactions related to the aggressive marketing tactics of the drug industry.

[182] Given that 75% of physicians practising in Canada entertain visits from drug company representatives, Dr. Lexchin's evidence lends credence to the complaint of the patient witnesses concerning their doctors' determination to treat their conditions with pharmaceutical products.

[183] The fact that the drug companies are not producing marihuana products (allegedly because of difficulties with intellectual property questions attaching to the marihuana plant) and are therefore not promoting medicinal marihuana to physicians, partially explains why physicians are not informed about marihuana and are not accepting the responsibility imposed on them to approve its use.

[184] The extent of physician reliance on the pharmaceutical industry's process in getting drug approvals, also lends credence to the applicant's submission that it is unrealistic to expect a physician to sign a declaration stating conventional treatments for the symptom have been tried or considered and have been found to be "ineffective or medically inappropriate" as s. 6(1)(e) of the *MMAR* requires.

[185] The medical profession is prescribing only those drugs that have been approved and authorized by a process that includes research, clinical trials and eventual government approval. As noted in the Belle-Isle report at page 69:

> Allopathic doctors do not normally deal with herbal medicines. Their training consists mainly of prescribing pharmaceutical products that have gone through the regulatory drug review process. They know and

> understand this system and trust its scientific rigor. Naturopathic doctors, on the other hand, have experience dealing with complementary and alternative remedies, including herbal remedies, and may be in a better position to assist people who use cannabis for medicinal purposes…..

[186] I find that, in the circumstances that surrounded the introduction of the *MMAR*, which continues today, it was and continues to be unrealistic to expect a medical doctor to be willing or able to declare that marihuana, an unproven, untested drug is more appropriate than a prescription drug that has been released only after clinical trials and with the blessings of government agencies established for that purpose.

DR. ROSENBLOOM

[187] Dr. Rosenbloom was qualified as an expert on the effects of pharmaceutical drugs, the use and abuse of drugs and the methadone program in Canada. His evidence further demonstrated some of the adverse consequences of the medical profession's reliance on the pharmaceutical industry.

[188] He testified that conventional treatment of chronic pain frequently involves the use of potent prescription narcotics. These drugs come with a variety of problems that include undesirable physical symptoms, addiction and accidental death.

[189] He identified four papers (Exhibits 12, 13, 14 and 15) discussing the growing problems with the abuse and misuse of prescription opioids. Very briefly they are:

- The Popova Report (Exhibit 12), noted that the majority of street drug users in Canada were non-medical opioid users.[4] The report recommended several strategies to prevent prescription drug abuse

[4] Indicates prescription opioids not used for their medical purpose.

one of which was the development of non-opioid treatment of chronic pain.

- *The Prescription Opioid –Related Issues in Northern Ontario* (Exhibit 13), acknowledged that although prescription opioids were an indispensable clinical tool for addressing pain, they also have the potential for addiction and can be misused, abused and diverted. The misuse of these drugs have already reached such serious proportions, that it was considered to be of urgent importance to find a proper balance between the need and use of prescription opioids for pain management and to minimize the risk of addiction and prevent crimes associated with diversion.
- A CMAJ article dated Oct. 13, 2009 (Exhibit 14), indicated that a committee was being established to address the "rampant misuse of prescription pain killers and lower the number of Ontarians seeking treatment for opioid addiction." The article observed that opioid abuse has become the predominant drug problem for most urban centres.
- A December 8, 2009 CMAJ article (Exhibit 15), addressed the number of deaths caused by a combination of opioid and non-opioid medication concluding that the preeminent risk of death was from the use of multiple prescription drugs. It was also noted that prescription opioids were now involved in more overdose deaths than either heroin or cocaine in North America.

[190] Dr. Rosenbloom's opinion was that by contrast, the potential adverse effects of cannabis are minor. It is no longer considered a gateway drug; nor is it linked to lung cancer, and compared to alcohol, narcotics and cocaine, it is certainly less dangerous. In addition, he observed that recent studies indicate that marihuana does have analgesic

properties. In his opinion, making cannabis more available would likely lower the burden of narcotic abuse and its harmful sequaelae.

[191] As an expert on the methadone program in Canada, which makes use of a doctor registry, Dr. Rosenbloom also opined on the lack of such a registry for doctors willing to prescribe medicinal marihuana. He indicated that asking patients in need of medicinal marihuana to simply look around for doctors who will prescribe it is not a particularly feasible solution in Canada. The vast geography and the potential resulting lack of co-ordination of care make it extremely difficult for patients to succeed in such an endeavour and moreover may in fact lead to more harm.

[192] I find that Dr. Rosenbloom's evidence establishes that there is a real problem with the use and abuse of prescription opioid medication in Ontario, and in Canada as a whole. Therefore, the undesired side effects of prescription medication are not simply those experienced by the patients but by society as a whole. Legal access to medicinal marihuana would alleviate the severity of both these problems by providing an alternative form of therapy in which case it would decrease the amount of opioid medication available to be used, abused or diverted.

ANALYSIS

[193] The key question is whether physician participation in the *MMAR*, or perhaps more accurately, the lack of it, has rendered the exemption (and thereby the defence), illusory? If so, is the violation of s. 7 rights, contrary to the principles of fundamental justice?

[194] It is common ground that the *MMAR* constitute a threshold violation of Mr. Mernagh's right to liberty and security of the person. The question for this court is whether that violation accords with the

principals of fundamental justice found in the basic tenets of our legal system. In *Morgentaler*, the Supreme Court affirmed that:

> One of the basic tenets of our system of criminal justice is that, when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory. The criminal law is a very special form of governmental regulation, for it seeks to express our society's collective disapprobation of certain acts and omissions. When a defence is provided, especially a specifically-tailored defence to a particular charge, it is because the legislator has determined that the disapprobation of society is not warranted when the conditions of the defence are met (*Morgentaler*, *supra* at para. 51).

[195] In both *Parker* and *Hitzig*, the Court of Appeal has expressly held that seriously ill individuals must be able to obtain and use marihuana for medical purposes without fear of criminal prosecution. And further that using a criminal prohibition to bar access to a drug for a person who requires it to treat a condition that threatens his/her life and health, is antithetical to our notions of justice.

[196] The *MMAR* were specifically created to provide a mechanism by which such individuals can access medicinal marihuana without the threat of criminal prosecution. They are supposed to provide a defence to such individuals. If they fail to do so, as is argued by the applicant, they have failed to comply with the fundamental principles that govern our system of justice.

[197] The question whether access to medicinal marihuana under the *MMAR* would be effective in the future was specifically left open for re-examination by the Court of Appeal in *Hitzig*. Though the Court concluded that the medical profession's opposition to its role as gatekeeper had not rendered the *MMAR* scheme ineffective, it specifically stated:

> This ***finding of fact is entirely reasonable on the record in this case*** and we would not interfere with it. ***Of course, 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*, *supra* at para. 139). [Emphasis added.]

[198] The evidentiary record before this court however is dramatically different from the record in *Hitzig* and justifies a reassessment of this issue.

[199] Of the eleven applicants in *Hitzig*, four had actually obtained licences under the *MMAR* and their affidavits focused on the issue of the lack of a licit supply of marihuana. Five of the applicants suffered from category two or three illnesses, which at the time required one or two specialists to sign the Health Canada declaration. The affidavits of these individuals spoke to their specific difficulties with the specialist requirements. Mr. Hitzig himself was not a patient, but rather a caregiver. His evidence dealt with the implicit prohibitions against compassion clubs. And the final applicant was a healthy individual who believed smoking marihuana was key to his good health.

[200] In the present case, the court has had the benefit of the evidence of some twenty-one patient witnesses from across the country. Whether *viva voce* or by affidavit, these witnesses, all of whom have serious medical conditions, attested to their difficulties in obtaining or attempting to obtain a physician to sign their Health Canada declarations. This evidence provides a vastly different perspective than the evidentiary record in *Hitzig* which concentrated on the issues of supply and difficulties with the specialist requirement.

[201] What then of the evidentiary record before this court regarding the availability of exemptions under the *MMAR*? This evidence paints a different and disturbing picture.

PATIENT WITNESSES

[202] The body of evidence from Mr. Mernagh and the other patient witnesses is troubling. The whole purpose of the *MMAR* was to make access to medicinal marihuana available to those who need it as the Court of Appeal mandated in *Parker*. The Crown contends that the *MMAR* have done just that, yet the evidence of the patient witnesses demonstrates that that is not what is happening.

[203] The evidence of the patient witnesses, which I accept, showed that patients have to go to extraordinary lengths to acquire the marihuana they need. The court heard how the inability to find a doctor to sign the Health Canada declaration, and the subsequent failure to acquire a licence under the *MMAR*, forced some patients to travel hours to find a source for medicinal marihuana; that evidence does not support the Crown's contention that the regulations are working.

[204] For instance, in St. Catharines, after years of searching, Mr. Mernagh could not find a doctor who was willing to sign his Health Canada declaration. This prompted him to make a trip to see a doctor in Bradford, travelling two hours each way in a vain attempt to procure medical support for his application. In British Columbia, JB, who has been unable to find a doctor to sign his declaration, must regularly travel 950 kms to a compassion centre in Vancouver to get his marihuana. MC, in Montreal, makes a ten hour roundtrip into Ontario to access a physician who is willing to authorize his marihuana use. These trips would be an inconvenience for healthy individuals. For those afflicted with the kind of medical problems that these patients endure, the trips are the acts of desperate people responding to a situation that is oppressive and unfair. KG in Alberta asked at least twenty-six doctors

to sign for her and not one of them would do so. DD was refused by thirty-seven doctors in Vancouver.

[205] All of the patient witnesses suffered from very serious medical conditions. All of them had tried numerous prescription medications with limited success and adverse side effects. And all of them with the odd exception of some who will not break the law, gained significant relief from their symptoms through the use of marihuana. All of them ought to qualify for an exemption. Yet the majority had been unable to find a doctor willing to sign their Health Canada declarations, and those who had, had gone to excessive efforts to do so. Many of the patient witnesses went to doctors in different communities, and in some cases different provinces.

[206] It was submitted by counsel for Mr. Mernagh that in their respective efforts to find a doctor willing to sign their Health Canada declarations, the various patient witnesses had collectively been rejected one hundred and thirteen times.[5] That submission is accurate. It is evident that there is a major problem in obtaining the requisite medical support to procure an exemption under the *MMAR*.

[207] The various refusals occurred in seven different provinces across the country, in centres both large and small, urban and rural. In the vast region of the province of Manitoba, no declaration has been signed north of a line drawn through the extreme south end of the province as illustrated in Exhibit 20. The problem of access to medicinal marihuana is not confined to Ontario but is a problem that stretches from one coast in Canada to the other. I am not sure where the tipping point is in relation to the breadth of this evidence, but I am satisfied that it has been

[5] This figure would include the patient witness MC whose evidence was presented in the Berin trial. Her request for medical approval of her application to Health Canada was rejected by 7 physicians in British Columbia. (Exhibit 21(i))

exceeded in this case. The problem also appears to stem from the appointment of doctors as exclusive "gatekeepers" for access to medicinal marihuana.

PARTICIPATING PHYSICIANS

[208] I am aware that the evidence of the patient witnesses is anecdotal in nature, but as I will discuss below, in light of the context provided by some of the other evidence before the court, I have concluded that it is representative of the experiences of similarly situated individuals nationwide.

[209] Although there was little evidence before the court as to the number of physicians practicing in Canada, evidence contained in the letter of the CMPA dated November 8, 2001 indicates that the CMPA has some "60,000 members—about 95 per cent of the physicians practising in Canada" (See Tab K of Mr. Denault's affidavit).

[210] That same year, according to the affidavit of Jeannine Ritchot dated November 25, 2010, (Ex. 17, p. 6) 727 physicians signed patient declarations for access to medicinal marihuana. Based on the figure of 60,000, only .012% of all of the doctors practising in Canada that year signed a declaration for a patient.

[211] Although there is no evidence as to the number of physicians practicing in Canada in any other year, for the purpose of illustration, assuming that same number of 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.

[212] These miniscule figures suggest that the number of approved applications for the medicinal use of marihuana is a trickle compared to

the demand for this plant therapy. The figures add further weight to my conclusion that the conditions experienced by patient witnesses in their own communities, are representative of the country as a whole. This is particularly so when one compares these numbers with the number of people estimated to be using medicinal marihuana. The findings at p. 39 of the Belle-Isle report paint a realistic picture of what is really happening in Canada. It states:

> The cautions to physicians from the medical associations and the Canadian Medical Protective Association have "put off many doctors who fear reprisal and do not feel they have the necessary knowledge to support their patients' applications. The number of people enrolled in the MMAR is 1399, and ***in light of estimates of hundreds of thousands of medical users, it is clear that most medical users have either chosen not to enrol, or have been unable to find a physician willing to authorize their medical cannabis use".*** [Emphasis added.]

[213] The footnote twenty-two at page 63 of the article states:

> 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 marihuana for medical purposes (Osborne AC, Smart RG, Adlaf EM. Self reported medical use of marihuana: a survey of the general population. CMAJ. 2000 Jun 13;162 (12):1685-6). 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 (Robin O'Brien, Member of Health Canada's Stakeholder Advisory Committee on Medical Marihuana, Personal Communication, February 2004). [Emphasis added.]

[214] I find as a fact that the physicians of Canada have massively boycotted the *MMAR* and their overwhelming refusal to participate in the medicinal marihuana program completely undermines the effectiveness of the program.

OPPOSITION OF MEDICAL PROFESSION

[215] Evidence of the medical profession's staunch opposition to the gatekeeper role provides further support to both the evidence of the patient witnesses that it is nearly impossible to find a doctor to sign one's Health Canada declaration, and my finding that this phenomenon is a national problem and is not just confined to Ontario.

[216] In my review of the evidence, I have highlighted some of the correspondence and publications which clearly showcase the opposition of the medical profession to being placed in the role of gatekeeper. On the basis of this evidence, I have little difficulty in finding as a fact that the medical profession does not intend to accept the responsibility that Parliament has thrust upon them. This is true despite the contention of the Crown that the 2005 amendments to the *MMAR* responded to the profession's concerns.

[217] While the 2005 amendments addressed some of the issues raised by the profession, they left the majority unresolved. Most notably, the 2005 amendments did nothing to change the fact that doctors are being asked to endorse the use of an untested drug without the safeguards that would normally accompany such a process. It is clear from the continuing negative reactions of doctors to requests to sign declarations that by and large they remain unwilling to play the role they are being asked to perform.

ATTITUDE OF HEALTH CANADA

[218] The widespread shortage of doctors in Canada and their broad based refusal to prescribe marihuana is a perfect complement to Health Canada's policy of maintaining a tight, almost miserly, control over the distribution of medicinal marihuana. The Notes attached to the amendments made on March 11, 2010 (found at Tab 23 of Volume 2 of

the Respondent's Book of Authorities) illustrate Health Canada's attitude:

> While the Program was originally intended to authorize access for a **small number of persons,** it has continued to grow in size since its inception. At present, there are approximately 4,800 persons authorized to possess marihuana under the Program, and this number is expected to grow to at least 6,000 by 2011. [Emphasis added.]

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

[220] However, there is other evidence of Health Canada's preference for tight controls as opposed to a prompt, fair and efficient approval process. Patients complained of lengthy delays in having their applications processed. Patients should not expect their applications to be processed and approved over night. However, the evidence is that some applications were neither approved nor rejected for as long as nine months after submission. That type of delay is inexcusable particularly when it means withholding relief to suffering Canadians. Other patients complained of the refusal by Health Canada staff to return telephone enquiries and once they did, staff threatened to place the patient's file at the bottom of the approval process if the patient insisted on verification of the file's status. This is a punitive measure that has no place in the administrative process.

[221] The evidence of Ms. Richot that wait-times were a problem at one time but have been addressed recently was neither convincing nor credible in the face of the patient evidence, which I prefer and accept.

THE STATISTICS

[222] At this juncture, I propose to address the argument of the Crown that despite all of this, statistics show that physician participation in the program has steadily increased since its inception. Therefore, it is contended by the Crown that physician co-operation cannot be said to have dropped to the point that the medical exemption scheme has become ineffective.

[223] In my view, isolated numbers or statistics rarely provide an accurate or a complete picture. Without context, the numbers, are often meaningless and in some cases, misleading. I don't mean to suggest that the statistics provided by Health Canada are wrong or intentionally misleading, but rather, that they must be viewed in the totality of the circumstances that led to their creation.

[224] Admittedly, the initial impression given by Health Canada's statistics is favourable. Health Canada's statistics show a dramatic increase in doctor participation over the history of the *MMAR*:

- For instance, in 2003, a total of only 499 doctors signed declarations. From January to October of 2010, the total number of signing doctors is 2351 (up 471%) and for 2009, it is 2698 (up 540%).
- From the inception of the program in 2001 through the first ten months of 2010, Health Canada received 25,858 new and renewal applications for authorizations to possess marihuana and issued

20,052 new and renewal ATPs. Each successful application was accompanied by a signed medical declaration.

- From 1998 until Oct 20/10, 5,132 different medical practitioners practising in 859 different communities across Canada signed medical declarations.
- In 2003, Health Canada received 781 new and renewal applications for ATPs and granted 621. Between January 1, 2010 and October 20, 2010, 7385 applications were received (a 945% increase over 2003) and 4650 of those were granted (a 749% increase).

[225] The Crown submits that this statistical evidence must be contrasted with the anecdotal evidence of the patient witnesses which represents only 1/8 of 1% of the number of successful applications. Furthermore, the patient witnesses only represent nineteen communities in seven provinces[6]. It is suggested that this evidence is insufficient to justify a negative conclusion about the program's effectiveness and the applicant has therefore not established the pre-condition for re-visiting this issue, that is, the program has not become "practically unavailable" since *Hitzig*.

[226] Respectfully, I am unable to agree. Although the Crown's numbers have some superficial appeal, they lack context and do not withstand close scrutiny. In addition, the inferences from the statistics that counsel for the Crown urge upon the court are completely at odds with the evidence of the patient witnesses, which I prefer and accept for reasons which I will now detail.

[227] As I have indicated, the government's statistics lack an appropriate point of reference. They may show for example, that 2351

[6] The reference to 19 communities would not be accurate because several of the 21 patient witnesses testified that they tried to access marihuana through doctors in several communities.

doctors signed declarations in the first ten months of 2010, but they do not show how many doctors refused to sign declarations, or how many doctors are practising in Canada. Such information is critical to establishing the actual effectiveness of the program and what inferences might properly be drawn from the statistics given the reality that the actual number of doctors signing declarations represents a tiny percentage of the number of practicing physicians. It is known that there were approximately 60,000 physicians practicing in Canada in 2001 when 727[7] doctors signed declarations. Assuming , for the purpose of illustration, that the same number of physicians practiced in Canada in the two years preceding and the two years following 2001, the shocking percentage of physicians who signed declarations in those years would be:

Year	Number of Physicians who signed Declarations	Percentage of the Number of Physicians in Practice
1999	102	.0017
2000	368	.0061
2001	727	.012
2002	456	.0076
2003	499	.0083

[228] Likewise, the statistics may show that 4650 applications were approved in the first ten months of 2010, but they do not show how

[7] See the affidavit of Jeannine Ritchot Exhibit 17 at p. 6.

many patients who otherwise qualified for an exemption could not submit an application because they were unable to find a doctor to sign their declaration. Without this information, Health Canada's numbers are not helpful because they are inconsistent with the reality that the number of individuals who have been able to obtain a licence to lawfully possess or cultivate marihuana under the *MMAR* is but a small fraction of the number of individuals who otherwise qualify but cannot find a doctor to support their application.

[229] In the face of a reliable body of contrary evidence before the court, this lack of context renders the government's statistics of little value. In my view it is more probable than not that the number of patients who have sought and continue to seek their doctors' approval for the medicinal use of marihuana greatly exceeds the number of applicants who have actually been licensed under the *MMAR* and I so find.

[230] Thus, rather than closing the door left open by the court in *Hitzig*, I find that the evidence before this court, swings that door wide open to reveal the sad reality that under the current legislative scheme, legal access to medicinal 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.

[231] The next question to be asked is: Is the practical unavailability of the defence, caused by the legislation?

[232] For s. 7 to be fully engaged, the deprivation of rights must result from government action or legislation (See *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429 at para. 81). Here, the Crown argues that any difficulties that may exist in accessing the medical marihuana

scheme are not the fault of the legislation. How individual doctors choose to exercise the authority conferred upon them by the *MMAR* does not impact the constitutionality of the legislation. For the reasons that follow I am unable to agree with this submission.

[233] In *R. v. Big M Drug Mart Ltd*, [1985] 1 S.C.R. 295 at p. 331 [*Big M*], the Supreme Court stated that, "...both purpose and effect are relevant in determining constitutionality; either an unconstitutional purpose or an unconstitutional effect can invalidate legislation." This means that, "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" (*Morgentaler*, *supra* at para. 37).

[234] Through the *MMAR*, Parliament has delegated sole responsibility over access to medicinal marihuana for seriously ill persons to a profession that is largely unwilling or unable to accept it. The effect of this blind delegation is that seriously ill persons who need marihuana to treat their symptoms are branded criminals simply because they are unable to overcome the barriers to legal access put in place by the legislative scheme.

THE *MORGENTALER* DECISION

[235] In *Hitzig***,** the Court of Appeal affirmed Parliament's choice of medical doctors as gatekeepers to medicinal marihuana access. The court held that whether marihuana was an appropriate treatment for a patient's symptoms was essentially a medical question and therefore it was appropriate to appoint doctors to answer it. The Crown relies on this finding in support of its position that the legislation is not the cause of the alleged unconstitutionality. If it was entirely appropriate and

constitutional to appoint doctors, whatever doctors may or may not be doing is not the fault of the legislation.

[236] In this regard, the Crown relies on *Morgentaler* in an attempt to distinguish the case at bar. The Court, in *Morgentaler* invalidated s. 251 of the *Criminal Code* on the basis that it violated the right to security of the person guaranteed by s. 7 of the *Charter*.

[237] Section 251 criminalized abortions not procured in accordance with the strict requirements set out therein. In particular, it required the approval of a therapeutic abortion committee composed of not less than three qualified medical practitioners appointed by the board of the hospital where the procedure would take place, which itself had to be accredited or approved. The Court held that these requirements rendered a legal abortion practically unavailable and accordingly it struck down the provision.

[238] The Crown says the problem in *Morgentaler* was inherent in the legislation itself. It was not the fact that particular committees were not approving applications for the procedure; but rather, that the legislation set out criteria that were almost impossible to meet, by virtue of the fact that only one in five Canadian hospitals had the ability to create such a committee.

[239] In this case, the Crown says, the legislation imposes no such requirements; all doctors are able to sign the requisite declaration under the *MMAR*. Therefore, the failure of doctors to do so cannot be said to be a product of the legislation itself. Doctors may have many reasons for not signing, none of which, it is argued**,** affect the constitutionality of the legislation.

[240] It is true that the *MMAR* impose no specific requirements on doctors in terms of length or type of practice; however, to say that the legislation imposes no barriers to obtaining a doctor willing to participate in the scheme, is to take a myopic view of the situation, a view that I cannot accept.

[241] The legislation requires physicians to endorse the use of an untested drug in the absence of any of the typical safeguards that would normally accompany such an act. It can hardly be said the failure of the medical profession to wholeheartedly undertake this task is the fault of anything other than the legislation which forced it upon them.

LITTLE SISTERS* AND *ELDRIDGE

[242] Before I express my reasons for this conclusion in further detail, I pause to deal with the alternate argument raised by the Crown to support its position that the problem is not the constitutionality of the *MMAR* but the actions of the doctors.

[243] In oral submissions the Crown relied on the decisions of the Supreme Court of Canada in *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, [2000] 2 S.C.R. 1120 and *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, for the proposition that legislation is not rendered unconstitutional because it is carried out in an unconstitutional manner by those charged with its implementation. Accordingly, the *MMAR* are not rendered unconstitutional simply because individual doctors are choosing not to sign declarations.

[244] This argument can be dealt with briefly. First and foremost, both of those cases dealt with government actors. That is not the situation

here. Doctors are not government employees nor are they government-like in nature so as to bring them under the ambit of the *Charter*.

[245] Moreover, this court is not being asked to determine whether the doctors are acting constitutionally. They are under no obligation to do so. We are not dealing with the invalid application by government actors of otherwise valid legislation. We are dealing with legislation that fails to provide a workable, constitutionally mandated exemption from criminal prosecution that government is obligated to provide.

THE GATEKEEPER ROLE

[246] I accept and of course I am bound by the Court of Appeal's ratio that doctors are the logical gatekeepers for a substance used to treat medical problems. Doctors routinely perform this function for approved pharmaceuticals regularly.

[247] Nor can it be disputed that Parliament has the right to impose a requirement for an independent medical opinion as a pre-requisite to legal access to marihuana. However, Parliament does not have the right to impose conditions on access which violate *Charter* rights.

THE PROBLEMS WITH THE *MMAR*

[248] The overarching 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.

[249] This court heard evidence that there has been little in the way of clinical trials or scientific research on both the safety and efficacy of marihuana. Marihuana is not an approved drug under the *Food and Drug Regulations*, C.R.C., c. 870. It has not undergone the rigorous testing and review required by all other drugs, and physicians are

required to declare that they are aware of this fact as part of the requisite declaration (See s. 6(1)(f) of the *MMAR*).

[250] Though the declaration does not contain the express language of prescription, authorization or endorsement, it would be naive to suggest that it is anything less than those things. The physician, by signing the declaration, is enabling the patient to use marihuana as medicine. Signing a declaration thus puts physicians in the unacceptable (to the doctor) position of supporting the use of a substance which may harm the patient.

[251] This concern is prevalent throughout the correspondence of the various medical associations, including the CMA which is in evidence before this court. In its July 15, 2003 correspondence to the Minister of Justice, the CMA strongly reiterated this concern and provided some ten suggestions which would resolve the problems that in the words of the association, made the *MMAR* “unfeasible” (See Exhibit 22A, Tab J). Among these suggestions were the creation of a registry of authorized physicians, access to medicinal marihuana as a clinical trial, education, and liability protection. Notably, none of these suggestions were adopted by Parliament and they remain live issues today.

[252] It is not simply the lack of clinical trials and rigorous testing that renders the declaration problematic but also the general lack of knowledge within the profession on the therapeutic use of marihuana. The evidence before me indicated that physicians themselves felt they lacked the necessary knowledge of the drug to give advice about or recommend the use of marihuana to patients. Furthermore, it is clear that Health Canada has made no real attempt to deal with this lack of knowledge.

[253] The Crown contends that in fact Health Canada does educate physicians by the posting on its web site of a detailed educational document entitled “Information for Health Care Professionals.” This document provides a summary of peer-reviewed literature and international reviews concerning potential therapeutic uses and harmful effects of marihuana, and a “Daily Amount Fact Sheet (Dosage)” which provides the public with information on marihuana amounts.

[254] Furthermore, it was argued that it is not Parliament’s responsibility to educate doctors or influence their medical decision making. The fact that some doctors refuse to sign because they are not well informed is not the fault of the *MMAR*. Health Canada only has the responsibility to permit access to the drug, not to market it or to educate doctors about it.

[255] It is true that in normal circumstances one would not expect government to be involved in the medical training of doctors; however, this situation is hardly normal. This situation involves an untested and unapproved drug. Despite this, doctors are asked to authorize the use of this drug without the safeguards that would be provided for example, in a clinical trial. The legislation essentially asks doctors to do something that is outside of their knowledge and expertise; it asks them to perform a function that is arguably no longer a medical one.

[256] Having chosen to confer on physicians the sole responsibility for the therapeutic distribution of an untested drug, despite their lack of experience and training in its use, and despite their fierce opposition to this role, it was incumbent on Parliament to ensure their preparation for, and acceptance of the responsibilities imposed upon them to ensure the regulatory scheme would serve its intended purpose. To do otherwise, as Parliament has done, is akin to delegating the responsibility to guard

Canada's borders to the militia without providing the training or the weapons to do so. If there was a successful invasion, could Parliament say that the blame for the successful invasion falls on the shoulders of the ill equipped militia? The answer is obvious.

[257] In order to fulfil its obligation to permit access to the drug, Parliament must take the necessary steps to ensure that access is a reality. In the unique situation that has arisen under the *MMAR*, this involves providing the necessary education and training to permit physicians to perform the role they've been given without fear that they may be doing something to harm the patient or to open themselves up to liability. How best to accomplish this is a question for Parliament, but it is a question that should be answered through meaningful consultation with physicians and their professional associations.

[258] The Crown's argument that it has no control over the medical profession, while factually true, does nothing to alter this conclusion. In my view, the lack of control argument only serves to reinforce the conclusion that it was incumbent on Parliament to work with the medical profession to address its concerns before imposing the responsibility on them for approving the use of medicinal marihuana. Had this been done, while still lacking "control," Parliament would have had some assurance that doctors would be willing and able to participate in the scheme, and by extension, some assurance that the scheme would accomplish what it was put in place to do.

[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.

[260] A legislative scheme that delegates responsibility to a profession that refuses to accept it, and lacks the training to manage it, resulting in circumstances that put doctors in jeopardy both with their regulatory bodies, as well as their insurers is fundamentally flawed. The government must be accountable for the failure of the scheme that it engineered and put in place, for it is the ill-conceived legislation that has led to the unnecessary barriers to access to medicinal marihuana by those who need it and who are otherwise entitled to have it.

[261] It is one thing for Parliament to delegate responsibility for the carrying out of its medical marihuana policy. However, it must nevertheless remain accountable for the manner in which that responsibility was delegated and way the responsibility is being discharged. In the final analysis, although responsibility can be delegated, accountability cannot, and I find that the barriers to access to medicinal marihuana and the widespread exposure to the risk of criminal prosecution under the *MMAR* are the direct result of the legislation.

[262] The lack of a viable exemption to the offence of production of marihuana contrary to s. 7(2)(b) of the *CDSA* deprives Mr. Mernagh of his s. 7 right to liberty and security of the person in a manner that does not accord with principles of fundamental justice.

SECTION 1

[263] Having found that the current scheme of medical exemption under the *MMAR* violates s. 7, it remains to consider whether the offensive aspects of the *MMAR* constitute a reasonable limit that is demonstrably justified in a free and democratic society.

[264] The very nature of the analysis under s. 7 involves a balancing between the interests of the state and the interests of the individual, and

many of the factors I considered in concluding that the *MMAR* do not accord with principles of fundamental justice are also germane to the s. 1 analysis. Although it may be rare for legislation which violates s. 7 to be saved by s. 1, the two inquiries are distinct and a separate inquiry into s. 1 must be undertaken (See *R. v. Mills*, [1999] 3 S.C.R. 668).

[265] The relevant criteria to establish that a *Charter* violation is reasonably justified were set out in *R. v. Oakes*, [1986] 1 S.C.R. 103 [*Oakes*]. There the Court held the burden of proof lay with the Crown to establish firstly that “the objective, which the measures responsible for a limit on a *Charter* right or freedom are designed to serve, must be "of sufficient importance to warrant overriding a constitutionally protected right or freedom": *R. v. Big M Drug Mart Ltd.*, *supra*, at p. 352” (*Oakes*, *supra* at para. 69). And secondly, “...once a sufficiently significant objective is recognized, then the party invoking s. 1 must show that the means chosen are reasonable and demonstrably justified. This involves "a form of proportionality test": *R. v. Big M Drug Mart Ltd.*, *supra*, at p. 352”(*Ibid.*).

[266] The proportionality test involves three distinct components:

> First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Second, the means, even if rationally connected to the objective in this first sense, should impair "as little as possible" the right or freedom in question: *R. v. Big M Drug Mart Ltd.*, *supra*, at p. 352. Third, there must be a proportionality between the effects of the measures which are responsible for limiting the *Charter* right or freedom, and the objective which has been identified as of "sufficient importance" (*Oakes*, *supra* at para. 70).

[267] As I have noted earlier, it is not the purpose of the *MMAR* which offends s. 7, but the unconstitutional effects. Accordingly, I accept the court's finding in *Hitzig*, that the objectives of the *MMAR* of seeking "to provide a medical exemption while pursing the objectives of better health and safety and effective narcotic drug control consistent with Canada's international treaty obligations" are pressing and substantial (*Hitzig*, *supra* at para. 148).

RATIONAL CONNECTION

[268] As affirmed by the Supreme Court in *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567 at para. 48 [*Hutterian*]:

> To establish a rational connection, the government "must show a causal connection between the infringement and the benefit sought on the basis of reason or logic": *RJR- MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 153. The rational connection requirement is aimed at preventing limits being imposed on rights arbitrarily. The government must show that it is reasonable to suppose that the limit may further the goal, not that it will do so.

[269] As I have previously noted, the requirement for a doctor's declaration in and of itself is not problematic. The problem here is that Parliament appointed physicians as exclusive gatekeepers without first addressing the issues raised by the physicians that might have achieved their co-operation, with the result that the vast majority of people who are suffering from disorders, need marihuana and are entitled to it, have been unable to get a doctor to sign their declarations. Thus, while the requirement for physician involvement may be rationally connected to the objectives of health and safety and effective drug control, the requirement in its current form is not.

[270] The current declaration which requires medical doctors to endorse the use of an unapproved and untested drug without any

safeguards does nothing to promote the individual's health and welfare. In fact, the scheme is making people sicker, by preventing needy individuals from legally accessing the medicine they require. As was the case in *Parker,* "the legislation works in opposition to one of the primary objectives and thus could be described as "arbitrary" or "unfair": *R. V. Keegstra* (1990), 61 C.C.C. (3d) 1 (S.C.C.) per Dickson C.J.C. at 53 and per McLachlin J. (dissenting) at 114" (*Parker*, *supra* at para. 192).

[271] In addition, because the scheme is not working to deliver marihuana to those who need it and are entitled to it, these sick and vulnerable people are driven either to compassion centres (an illegal source of the drug which is subject to police raids and harassment), or to the black market to obtain the medicine they require. Driving people to the black market promotes crime and the illegal trafficking of drugs and can hardly be said to be rationally connected to the objective of drug control.

[272] Having found that the requirement for the doctor declaration in its current form is not rationally connected to the *MMAR*'s objectives of promoting health and safety and effective narcotic control, it is not, strictly speaking, necessary to proceed further with the s. 1 analysis; however, in the event that I am mistaken, I will continue.

MIMIMAL IMPAIRMENT

[273] At the minimal impairment stage of the analysis the court must ask:

> ...whether the limit on the right is reasonably tailored to the pressing and substantial goal put forward to justify the limit. Another way of putting this question is to ask whether there are less harmful means of achieving the legislative goal. In making this assessment, the courts accord the legislature a measure of deference, particularly on complex social issues where the

> legislature may be better positioned than the courts to choose among a range of alternatives (*Hutterian*, *supra* at para. 53).

[274] The court goes on to add that the deference owed to government is neither "blind" nor "absolute." Rather, "The test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner" (*Hutterian*, *supra* at para. 55).

[275] In my view, it is at this stage of the analysis that the inadequacies of the *MMAR* are most clear, and I cannot agree with the Crown's submission that the *MMAR* minimally impair the s. 7 right.

[276] While Parliament is not required to choose the least intrusive means available, it must "demonstrate that the measures employed were the least intrusive, in light of both the legislative objective and the infringed right" (*RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 96). A limitation that completely impairs a constitutional right by offering an illusory defence to criminal liability can hardly be said to achieve this balance. It is not a minimal, but rather a significant impairment of the s. 7 right.

[277] The appointment of doctors as gatekeepers under the *MMAR* in a manner that requires them to disregard their professional duties and opens them up to liability was neither the only, nor the least intrusive means open to Parliament to fulfill its objective of providing a medical exemption for medicinal marihuana use in a manner that promotes health, safety and effective drug control.

[278] As discussed earlier, the CMA desperately sought to be involved in the development of the *MMAR* and repeatedly voiced its opposition to the path chosen by Parliament. In so doing, it proffered a number of suggestions that would have allowed for its endorsement of the scheme

and the participation of doctors (Exhibit 22(A) Tab J). These suggestions, which included treating medicinal access to marihuana as a clinical trial, would have promoted the objectives of Parliament, while at the same time making doctor participation tenable, and therefore only placing minimal restrictions on the ability of medically ill persons to obtain legal access to medicinal marihuana.

[279] Another alternative to the exclusive appointment of doctors as gatekeepers would have been to allow other health practitioners to make declarations, practitioners such as naturopaths or herbalists who by the very nature of their training have a more extensive knowledge of alternative forms of medicine. Again, this was not and has not been done.

[280] An option urged by counsel for the applicant (and mentioned by the CMA in conjunction with its other suggestions) is the creation of a registry. This would have allowed patients to seek out physicians with knowledge of medicinal marihuana who were willing to sign declarations for those who qualified. As it stands now, while there are some doctors willing to sign declarations, unless a patient is lucky enough to stumble across one, they could go on searching endlessly for the doctor who would approve.

[281] The specialist requirement is a specific example of failure of Parliament to adequately tailor the means of obtaining its objectives to the objectives themselves. It was argued by the Crown, that the requirement is minimally intrusive because it does not require the specialist to see the patient or approve of the use of marihuana, but only to say that he/she has reviewed the case.

[282] However, there is a doctor shortage in Ontario and based on the affidavit materials, in many other parts of the country. Many patients

have difficulty obtaining the services of a family doctor. Specialists are even fewer in number and to get to see a specialist requires a referral from the family doctor, if the patient has one. In addition to these access issues, one must question the likelihood of a specialist permitting his/her name to be associated with the use of a drug that has not been clinically tested by a patient that the specialist has not seen. And if the specialist has not seen the patient, how is he to be paid for his "review" as the *MMAR* require.

[283] Further, given the medical profession's historic reliance on clinically tested drugs, how likely is it that the specialist would be able to concur with the general practitioner's declaration that medicinal marihuana be authorized for use on the grounds that other treatments are ineffective or inappropriate.

[284] In my view, the requirement of specialist involvement guarantees another level of delay and imposes an additional barrier between the patient and medicinal marihuana. The road to marihuana approval is a virtual obstacle course which few patients can navigate. Rather than providing access to medicinal marihuana, the *MMAR* raise so many barriers to access that the defence is meaningless and illusory for most patients.

[285] While, the changes to the specialist requirement may have removed the barrier of being seen by a specialist, they have not removed the basic problems that still plague the system and render it unconstitutional.

[286] One further specific requirement that causes more impairment than necessary is the requirement for the physician to declare that conventional treatments have been tried or considered, and have been found to be ineffective or medically inappropriate. In view of the

evidence as to the side effects caused by many of the oft-prescribed opioid medications, and their addictive qualities, it is not readily apparent how it is justified to permit the use of medicinal marihuana only as a drug of last resort, given its reputation as a fairly benign drug compared to the opioids.

[287] Surely the patient has the right to prefer marihuana over the opioids, whose harmful side effects have already been documented in these reasons.

[288] Suffice to say, there exist a number of less intrusive options to the current iteration of the *MMAR* which would allow Parliament to meet its objectives while respecting the right of sick individuals to make decisions about their healthcare without fear of criminal prosecution. While it is for Parliament, and not for this court to decide which of these alternatives ought to be pursued, it is clear that the *MMAR* cannot be said to be minimally impairing.

PROPORTIONALITY OF EFFECTS

[289] The final stage of the "*Oakes* test" requires the court to assess the proportionality of the effects of the legislation. The question can be thought of as a consideration of whether the overall effects of the law on the applicant's rights are disproportionate to the beneficial nature of Parliament's objectives.

[290] The deleterious effects of the *MMAR* on Mr. Mernagh and other similarly situated individuals are clear. Seriously ill persons who need marihuana to treat their symptoms are forced to choose between their health and their liberty. If they choose their health, they must go to significant lengths to obtain the marihuana they need, including lengthy trips to purchase the drug, resort to the black market, and living with the

constant stress that at any time they could be subject to criminal prosecution. These already sick individuals must further cope with the added stress of the stigma and social rejection of friends, family and members of the public who see them as criminals. This is not to mention the real fear of losing one's doctor simply by inquiring about the drug and damage to the patient-doctor relationship.

[291] The beneficial effects of the legislation are harder to quantify. While its objectives are laudable, they are not being met. Rather than promote health – the regulations have the opposite effect. Rather than promote effective drug control – the regulations drive the critically ill to the black market. It can hardly be said that legislation which has failed to serve the very purpose for which it has been put in place can be of any real benefit. It is true that the long term effects of marihuana use have not been studied, but what studies have been conducted have not deterred medicinal users from pursuing this drug in preference to the many narcotics that are generally promoted by the medical profession for the treatment of their disorders. Surely, the right to choose belongs to the patient, not to government that has failed to create the environment for better research into the drug's effectiveness and harmful qualities.

[292] Furthermore, numerous courts have addressed the therapeutic qualities of marihuana and concluded that by comparison to alcohol and tobacco (neither of which are prohibited substances), and the many opioids that have flooded the offices of physicians and the streets, marihuana is a relatively benign drug.

[293] The characteristics of marihuana were detailed by the Supreme Court in *R. v. Malmo –Levine; R. v. Caine*, [2003] 3 S.C.R. 571 at para. 192, where the Court stated:

The findings of fact made by the trial judges in Caine and Clay are similar in all respects (they are set out in full in Para. 40 of the reasons for judgment of Howard Prov. Ct. J. in the Caine appeal, and in para. 25 of the reasons for judgment of McCart J. in the Clay appeal). In Clay, McCart J. made the following findings of fact, which were accepted by [page 664] Rosenberg J.A. at the Court of Appeal for Ontario (at Para. 10):

1. Consumption of marihuana is relatively harmless compared to the so-called hard drugs and including tobacco and alcohol.

2. There exists no hard evidence demonstrating any irreversible organic or mental damage from the consumption of marihuana;

3. That cannabis does cause alteration of mental functions and as such, it would not be prudent to drive a car while intoxicated;

4. There is no hard evidence that cannabis consumption induces psychoses;

5. Cannabis is not an addictive substance;

6. Marihuana is not criminogenic in that there is no evidence of a causal relationship between cannabis use and criminality;

7. That the consumption of marihuana probably does not lead to hard drug use for the vast majority of marihuana consumers, although there appears to be a statistical relationship between the use of marihuana and a variety of other psychoactive drugs;

8. Marihuana does not make people more aggressive or violent;

9. There have been no recorded deaths from the consumption of marihuana;

10. There is no evidence that marihuana causes a motivational syndrome;

11. Less than 1% of marihuana consumers are daily users;

12. Consumption in so called decriminalized states does not increase out of proportion to states where there is no decriminalization;

13. Health related costs of cannabis use are negligible when compared to the costs attributable to tobacco and alcohol consumption.

[294] The Court also cited the following passage by McCart J. in *Clay:*

> Field studies in Greece, Costa Rica and Jamaica generally supported the idea that marihuana was a relatively safe drug – not totally free from potential harm, but unlikely to create serious harm for most individual users or society (at para. 193).

[295] And the following passage by Howard, Prov. Ct. J. in *Caine:*

> the occasional to moderate use of marihuana by a healthy adult is not ordinarily harmful to health, even if used over a long period of time (at para. 194);

[296] These findings only serve to further demonstrate the disproportionate effects of the *MMAR* on individuals like Mr. Mernagh.

[297] The balancing of effects certainly does not favour the *MMAR*. The regulations have caused and continue to cause a significant adverse impact on patient health; this, despite their purpose of protecting and preserving the health of Canadians. The impairment is great, and the objectives are not being achieved. The applicant is not a criminal yet these regulations treat him as such. As the Court observed in Parker at para. 189:

> a law that has the potential to convict a person who has not really done anything wrong offends the principles of fundamental justice and if imprisonment is available as a penalty, such a law then violates a person's right to liberty under s. 7 of the *Charter*. Imprisonment can only be used to punish blameworthy conduct that is harmful to others.

[298] In my view, this impairment is grossly out of proportion to the objectives of the *MMAR*. The intrusion on the applicant's rights is great and the withholding of the drug will assure his ongoing suffering. Such

being the case, these regulations bear a disproportionate harm to the applicant and others like him that is not justifiable by any standard.

STANDING

[299] Before discussing the appropriate remedy, there is an issue as to the applicant's standing to challenge the marihuana related laws that he is not charged with. Though the applicant is only charged with production of marihuana contrary to s. 7 of the *CDSA*, he asks this court to find that all of the marihuana related laws are unconstitutional by virtue of the absence of a constitutionally sound exemption for medicinal use.

POSITION OF THE PARTIES

[300] Mr. Lewin, counsel for Mr. Mernagh asserts that his client has private interest standing to challenge all of the marihuana provisions because he is directly affected by these provisions; he cites *Bedford v. Canada (Attorney General)*, [2010] O.J. No. 4057 (Sup. Ct.) [*Bedford*], for this proposition. Alternatively, he submits that his client meets the test for public interest standing and can challenge these offences on that basis.

[301] Mr. Wilson, argues that in a criminal proceeding, an accused can only challenge the constitutionality of the offence for which he is charged (unless he can satisfy the test for public interest standing). He cites *Big M*, for this proposition and further states that the comments from *Bedford* are inapplicable to the present context as *Bedford* was a civil case. He argues that his position is further supported by the appellate decisions in *Parker* and *Hitzig*, where the Court declined to grant the full remedy sought by the accused.

DISCUSSION

[302] *Big M* stands for the proposition that, “Any accused, whether corporate or individual, may defend a criminal charge by arguing that the law under which the charge is brought is constitutionally invalid” (at p. 313). In other words, in criminal proceedings standing arises as a right to challenge the constitutional validity of the offence charged. While the case recognized that “an interested citizen” who comes to court looking for a remedy must demonstrate public interest standing, it did not preclude (as the Crown argues) the ability of an accused to challenge a provision related to the one with which he is charged.

[303] Private interest standing arises from a direct relationship between the person and the state. Where an individual is charged criminally or forced to defend a government civil action, private interest standing arises as of right. It requires the individual to establish a direct, personal interest in the impugned provisions (See *Downtown Eastside Sex Workers United Against Violence Society v. Canada (Attorney General)*,[2010] B.C.J. No. 1983 (C.A.)). Provided an individual’s interest in the constitutionality of the law is real and not speculative, he need not wait to be charged to challenge the legislation (*Bedford*, *supra* at para. 49).

[304] *Bedford* was a recent decision of this court which examined the constitutionality of the *Criminal Code* provisions relating to prostitution. It was brought by three applicants; two were former sex workers who wished to return to the profession but felt they could not do so under the current law and the third was actively engaged in sex work. The matter was a civil application and none of the applicants were currently facing charges. The court found that all three women had standing to challenge the law because all three were exceptionally

prejudiced by the application of the challenged laws and had an interest in their validity above and beyond that of a member of the general public (*Bedford*, *supra* at para. 57).

[305] The Crown argues that *Bedford* must be distinguished from the case at bar because it was a civil application and not a criminal prosecution. While the two matters are distinct in that way, I see no reason why the concept of private interest standing cannot be applied to the criminal context. As noted *Big M* does not preclude this possibility, and the Crown concedes that Mr. Mernagh could challenge these provisions if he could establish public interest standing. If Mr. Mernagh has established that he is uniquely prejudiced by each of the marihuana laws he seeks to challenge, he ought to be granted standing to challenge them.

[306] Mr. Mernagh is charged with production of marihuana, this offence by definition includes the offence of possession of marihuana. Mr. Mernagh uses marihuana medicinally and has been unable to obtain a licence to allow him to do so lawfully. By virtue of his medicinal use he has a direct interest in the prohibition against possession of marihuana above and beyond that of an interested citizen. He is uniquely vulnerable to arrest and prosecution and his charge for cultivation is evidence of a direct relationship between Mr. Mernagh and the legislation which prohibits possession.

[307] Contrary to the submission of the Crown, the Court of Appeal's decision in *Parker* actually supports the existence of this relationship. The Crown refers to the Court's decision not to grant a remedy with regards to the cultivation offence as evidence that the Court will not entertain challenges to offences not charged. In *Parker* the accused was charged with and challenged the constitutionality of possession

under the *CDSA* and cultivation under the N*arcotic Control Act.* At the time the Court of Appeal heard the matter, the *Narcotic Control Act* had been repealed; the cultivation offence was therefore not before the court. Nonetheless, the Court unequivocally stated that had the cultivation provision been before the Court, they would have held it to be unconstitutional in the same manner as the possession (*Parker*, *supra* at para. 190).

[308] The Court in *Parker* did not address the issue of standing to challenge the cultivation law because no such issue was raised as (a) this was an appeal not a trial; and (b) the accused did not ask the court to declare the new cultivation offence unconstitutional. It can therefore not be said that the *Parker* decision precludes Mr. Mernagh from challenging the possession offence.

[309] Likewise, the Court's decision in *Hitzig* did not deal with the issue of an accused's standing to challenge provisions aside from those charged. The Court in *Hitzig* simply remarked that the remedy sought by the appellants (to declare s. 4 of the *CDSA* of no force and effect), was overly broad and not tailored to the constitutional deficiencies in the *MMAR* (*Hitzig*, *supra* at para. 154-155).

[310] While I would have no problem concluding that Mr. Mernagh has private interest standing to challenge the possession prohibition, the same cannot be said with respect to the offences of trafficking and possession for the purpose. Mr. Lewin argues that these provisions ought to be considered because a constitutional flaw in the *MMAR* necessarily has implications for these offences. That may be true in an appropriate case, but the evidence has not established it is so for Mr. Mernagh.

[311] As previously mentioned, an individual's connection to the impugned law and the particular prejudice must be real and not speculative. Unlike the offence of possession, the court heard no evidence that would demonstrate that Mr. Mernagh is uniquely prejudiced by the offences of trafficking and possession for the purpose of.

[312] Trafficking by definition is established where a person is found to have given or delivered a drug to another (See *R. v. Larson* (1972), 6 C.C.C. (2d) 145 (B.C.C.A.)). It is the giving and not the receiving party who is criminally liable. There was no evidence that Mr. Mernagh provides marihuana to other individuals or that his medical needs require him to do so. Likewise, there was no evidence that he intends to possess marihuana for such a purpose.

[313] While one can conceive of ways in which these provisions may create unique prejudice within the context of the medical marihuana scheme, it has not been established that Mr. Mernagh is so prejudiced. He, therefore, has not established private interest standing to challenge these two provisions.

[314] Counsel for Mr. Mernagh suggested that even if private interest standing were not made out, Mr. Mernagh could still challenge these provisions on the basis of public interest standing. This argument must fail. The test for public interest standing requires the party seeking standing to establish:

> a) There is a serious issue raised as to the validity of the legislation in question;
>
> b) The applicant must be directly affected by the legislation or have a genuine interest in its validity; and

> c) There is no other reasonable and effective way this issue could be brought before the court (*Canadian Council of Churches v. Canada (Minister of Employment and Immigration),* [1992] 1 S.C.R. 236 at para. 37).

[315] Arguably, Mr. Mernagh can satisfy the first two criteria but it cannot be said that there is no other reasonable and effective way to bring the issue before the court.

CONCLUSION ON STANDING

[316] For the aforementioned reasons, I am of the opinion that Mr. Mernagh has standing to challenge the offence of production (as charged) as well as the lesser and included offence of possession. I cannot conclude that he has demonstrated a sufficient relationship between himself and the other two marihuana provisions to allow him to challenge their constitutionality, nor are these offences included in the definition of production.

DISTINCTION BETWEEN S. 24(1) and S. 52(1)

[317] *Charter* violations may be remedied through two provisions.

[318] Section 24(1) of the *Charter* reads:

> Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

[319] Section 52(1) of the *Constitution Act, 1982* provides:

> The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

[320] The two provisions serve different remedial purposes. Where a *Charter* violation arises due to an unconstitutional law, s. 52(1) provides a remedy. By contrast, where the violation is a result of government action, s. 24(1) provides a personal remedy to the aggrieved party (*R. v. Ferguson*, [2008] 1 S.C.R. 96 at para. 61.

[321] In the present case, the applicant submits that it is the *MMAR* and ss. 4 & 7 of the *CDSA* that are unconstitutional. The default basis for a remedy is therefore s. 52(1).

REMEDIES UNDER S. 52(1)

[322] Where a law is found to be unconstitutional, s. 52(1) renders it of no force and effect to the extent of the inconsistency. As the Court points out in *Hitzig*, "This invites some precision in selecting a remedy" (at para. 155). In *Schachter v. Canada*, [1992] 2 S.C.R. 279 [*Schacter*], the Court noted the flexibility bestowed upon it by virtue of these words in s .52(1) and identified the available remedies:

> Depending upon the circumstances, a court may simply strike down, it may strike down and temporarily suspend the declaration of invalidity, or it may resort to the techniques of reading down or reading in… In choosing how to apply s. 52 or s. 24 a court will determine its course of action with reference to the nature of the violation and the context of the specific legislation under consideration (at para. 25).

[323] The goal in applying s. 52(1) is to interfere with the legislation as little as possible; therefore, when only a portion of a statute interferes with the constitution, it is only the offending portion that should be declared of no force and effect; this is known as the doctrine of severance (*Schachter*, *supra* at para. 26).

[324] Similar to the doctrine of severance, a court may also read into the legislation to bring it into conformity with the *Charter*. While severance generally refers to identifying something improperly included in the statute and striking it down, reading in involves incorporating into the statute what has been wrongly excluded (*Schachter*, *supra* at para. 32).

[325] In *Parker*, the Court held that the prohibition on simple possession of marihuana in s. 4 of *CDSA* must be struck down and the declaration of invalidity suspended for twelve months to provide Parliament the opportunity to fill the void. In addition, *Parker* was entitled to a constitutional exemption from the possession offence during the period of the suspended invalidity for possession of marihuana for his medical needs. He was also entitled to the personal remedies granted to him by the trial judge under s. 24(1) of the *Charter*, staying the proceedings for cultivation under the former *Narcotic Control Act* and for possession under the *CDSA*.

[326] In *Hitzig*, the Court found that declaring s. 4 of the *CDSA* to be constitutionally invalid was an overly broad remedy. The *Constitution Act*, 1982 required the court to strike down any law that was inconsistent with the Constitution, but only "to the extent of the inconsistency." Accordingly, the court struck down the second specialist requirement in ss. 4(2)(c) and 7 and those provisions were declared of no force and effect. The result of the constitutional deficiency presented by the absence of a licit supply of marihuana was to declare ss. 34(2), 41(b) and 54 invalid. By targeting these specific sections, the remedy crafted by the court rendered the medical exemption constitutional and also preserved the constitutional integrity of s. 4 of the *CDSA*.

[327] While that approach was justified and feasible in *Hitzig*, the same cannot be said of the present case. Because the court in *Hitzig* only found certain and isolated sections of the *MMAR* to be invalid, it was able to specifically address those provisions in its remedy without altering the overall significance of the legislation. However, in the case at bar I have found that the requirement for a medical doctor's declaration has rendered the *MMAR* unconstitutional. This requirement infects numerous sections of the *MMAR*.

[328] In considering severance, the court must also ask whether the significance of the part which would remain is substantially changed when the offending part is excised. If the remaining portion would be significantly altered in substance without the impugned portion, severance is not appropriate (*Schachter*, *supra* at para. 64). Certainly, that is the case here.

[329] Section 6 of the *MMAR*, which requires the medical practitioner's declaration, is the centre piece of the *MMAR*. If this section were to be struck down, numerous other related sections would also need to be severed. For instance, if the court were to follow the conservative route directed by *Hitzig*, the other relevant sections that would be subject to constitutional invalidity would be sections, 4(2)(b), 5(1)(g)(i)(i)(j), 6, 8, 10(d)m 11(d), 14(b), 62(b), and 69. To sever and invalidate the doctor's declaration requirement and the other related provisions would completely eviscerate the legislative scheme. What remains would be incoherent.

[330] Finally, the court must also consider the significance of the remaining portion and ask the question: Is the remained so significant that Parliament would have enacted it without the severed part? If the

answer is no, as I suggest it would be here, severance is not appropriate. (*Schachter*, *supra* at para. 70).

[331] As I have noted, the doctor's declaration is a central feature of the *MMAR*. Without it, all that remains is the unsubstantiated personal declaration of the applicant. It cannot reasonably be said that Parliament would have enacted the portions of the *MMAR* requiring the patient declaration without some mechanism in place to substantiate the applicant's claims. To do so would likely run contrary to the valid government objectives of promoting health and safety, and effective narcotic control in accordance with Canada's international obligations.

[332] Accordingly, the *MMAR* must be struck in their entirety. In the result, there is no legislative scheme in place to provide an exemption from the prohibitions contained in sections 4 and 7 of the *CDSA*. This brings us back to the situation faced by the court in *Parker*, in which case, those sections would also have to be declared of no force and effect as required by the court in *Parker*.

SHOULD THE DECLARATION BE SUSPENDED?

[333] The final question to be answered is whether to give the declaration immediate effect or suspend it for a period of time to allow government an opportunity to fill the void (*Schachter*, *supra* at para. 78)? The focus of this question is not on the respective roles of the courts and legislatures but rather on a number of factors including:

- Public safety – if giving the declaration immediate effect poses a threat to public safety, suspension is favoured
- Rule of law – if giving the declaration immediate effect poses a threat to the rule of law, suspension is favoured

- Underinclusive legislation – where the law itself is not problematic at large, immediately striking it down would leave people without benefit (*Schachter*, *supra* at para. 79).

[334] All of these factors favour a suspension of the declaration of invalidity for a period of time. Clearly, a declaration of immediate invalidity would expose communities to the sudden surge towards marihuana which would obviously create health issues for uninformed members of the community. In addition, a stay will minimize public confusion over the state of the law regarding marihuana in Ontario and its compatibility with the rest of the country. Finally, a stay will give government a further opportunity to consider its options with regard to this product.

[335] However, the health requirements of many Canadians demand urgent action to relieve their pain and suffering. Given the length of time that the issues raised in this proceeding have gone unresolved, it is long past time for the government to provide the medical access to marihuana that was directed by the *Parker* court over ten years ago and the subsequent decision and reservations expressed in *Hitzig*. Even the Nolin Report predicted *Charter* issues many years ago, yet the government chose to ignore the signs that things were not right with the *MMAR*. Under these circumstances, a stay of twelve months such as was ordered in both *Parker* and *Hitzig*, is no longer appropriate. Every day that goes by, Canadians are being deprived of a drug that they have every right to take to treat their illnesses. In some cases, delay may make the closing days of life more painful than they have to be. Accordingly, a suspension period of something less than twelve months is appropriate, and I would stay the declaration for three months.

ADDITIONAL REMEDIES REQUESTED BY THE DEFENCE

[336] The applicant seeks two additional remedies pursuant to s. 24(1) which are phrased as "alternatives" to the striking down of the legislation: (1) an order personally exempting him and the patient witnesses from the marihuana laws; and (2) an order staying the charge against him pursuant to s. 24(1).

[337] As the Crown rightly points out, these remedies are not alternatives at all as we are dealing with unconstitutional legislation and not unconstitutional government action which means s. 52(1) governs. However, in certain unusual circumstances where it is necessary to provide the applicant with an effective remedy, a s. 24(1) remedy may be granted in conjunction with a s. 52(1) remedy (See for example *Schacter, Ferguson, R. v. Demers*, [2004] 2 S.C.R. 489).

[338] Mr. Lewin appeared to abandon his request for a stay in oral argument. He did argue, although not strenuously, that this court could still grant both Mr. Mernagh and the patient witnesses a constitutional exemption from the operation of the medical marihuana scheme. When pressed for authority for the proposition that this court could grant a remedy to persons not parties to the litigation, Mr. Lewin conceded he was not aware of any but likened doing so to other orders made by the court that impact on third parties such as publication bans. The Crown asserted the court had no jurisdiction to grant a *Charter* remedy to a third party.

[339] There does not appear to be any authority for the remedy sought by Mr. Lewin. Furthermore, consideration of the language of s. 24(1) of the *Charter* which gives the court the ability to grant personal remedies like constitutional exemptions, suggests that there is no jurisdiction to provide a remedy to a person who is not party to the litigation. The

provision specifically requires a party whose rights or freedoms have been infringed to apply to the courts for a remedy. There is therefore no constitutional jurisdiction to award a personal remedy to an individual who has not come before the court to seek one.

[340] As for a constitutional exemption for Mr. Mernagh himself, the Crown argues on the basis of the *Ferguson* decision that constitutional exemptions are no longer a valid constitutional remedy. This argument is only partially correct. The court in *Ferguson* ousted the possibility of a constitutional exemption for a violation of s. 12 of the *Charter* due to a mandatory minimum sentence. The ratio of the case is quite specific in this regard and I do not read the case as overruling *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203 [*Corbiere*].

[341] In *Corbiere* the Court affirmed the principle from *Reference re Remuneration of Judges of the Provincial Court of Prince Edward Island*, [1998] 1 S.C.R. 3, at para. 20, that, “In general, litigants who have brought forward a *Charter* challenge should receive the immediate benefits of the ruling, even if the effect of the declaration is suspended” (at para. 122).

[342] *Ferguson* was concerned with the situation that arises in the face of a mandatory minimum sentence which in most circumstances is constitutional but is found to be unconstitutional on the facts of a particular accused. In such circumstances, it was argued that rather than declare the offence in question to be of no force and effect, the court ought to grant the particular offender a constitutional exemption from the mandatory minimum sentence. The Court in *Ferguson* rejected this argument in part because it would effectively negate s. 52(1) and undermine the intent of Parliament in creating the statutory minimums.

[343] The concerns in *Ferguson* are not present in the entirely different scenario of granting an interim constitutional exemption to an individual who has successfully challenged the constitutionality of legislation during the suspension of a declaration of invalidity. In my view, the *Ferguson* decision does not preclude the availability of a s. 24(1) remedy in conjunction with a remedy under s. 52(1). Rather, it affirms the Court's decision in *Schachter*, at para. 89, that in rare cases where legislation is declared unconstitutional but the declaration is suspended, a remedy under s. 24(1) may be available in conjunction with the suspended declaration under s. 52(1) where it is necessary to provide the claimant with an effective remedy.

[344] Accordingly, I see no reason why Mr. Mernagh should not receive the immediate benefit of this ruling by way of an interim constitutional exemption.

DISPOSITION

[345] For the foregoing reasons, this court declares that:

1. *The Marihuana Medical Access Regulations*, SOR/2001-226 and the prohibitions against the possession and production of cannabis (marihuana) contained in sections 4 and 7 respectively of the *Controlled Drugs and Substances Act*, S.C. 1996, C. 19 are constitutionally invalid and of no force and effect;

2. This declaration of invalidity is suspended for a period of three (3) months;

3. The criminal charge against the applicant is permanently stayed;

4. The applicant is granted a personal exemption to possess and/or produce cannabis (marihuana) during the above noted period of suspension.

_____

Taliano J.

Released: April 11, 2011

CITATION: R. v. Mernagh, 2011 ONSC 2121

COURT FILE NO.: 1640/09

DATE: 2011/04/11

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

HER MAJESTY THE QUEEN

Respondent

- and -

MATTHEW MERNAGH

Applicant

REASONS FOR JUDGMENT

Taliano J.

Released: April 11, 2011