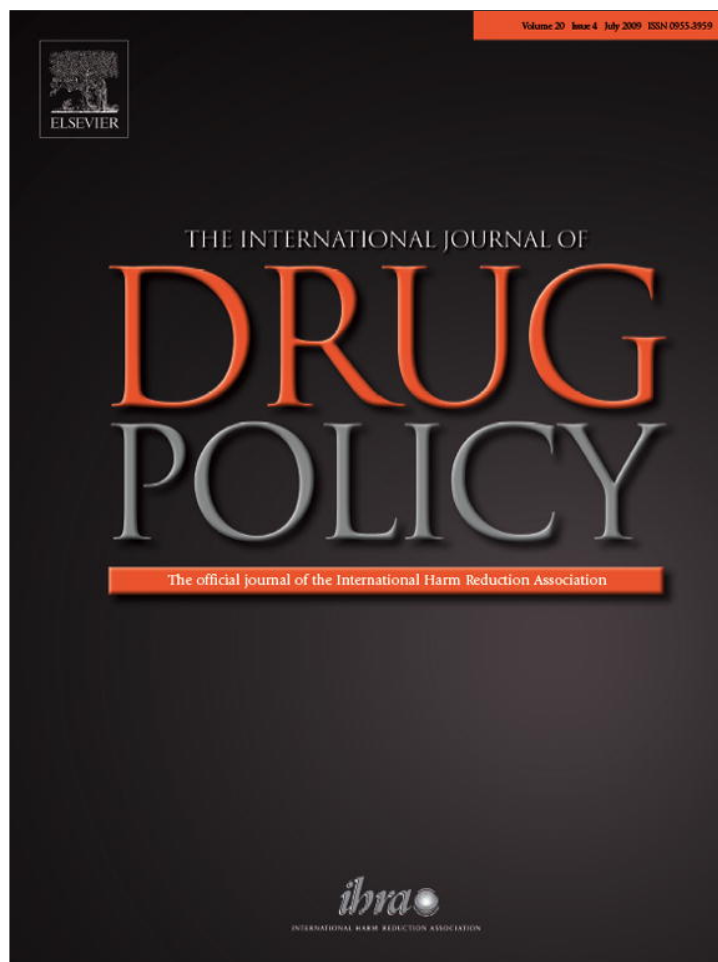


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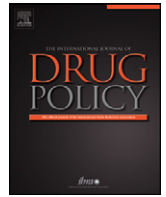
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Commentary

Moral regulation and the presumption of guilt in Health Canada's medical cannabis policy and practice

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ABSTRACT

This paper is a sociological examination of policies and practices in Health Canada's Marihuana Medical Access Division (MMAD) that presume the illicit intentions and inherent "guilt" of medical cannabis users, hampering safe access to a medicine to which many are legally entitled, and raising doubts about this federal programme's overall effectiveness and constitutional legitimacy. Beginning with a brief historical overview of Canada's federal medical cannabis programme, this paper examines the failure of the MMAD to meet the needs of many sick and suffering Canadians through Hunt's [Hunt, A. (1999). *Governing morals: A social history of moral regulation*. Cambridge, UK: Cambridge University Press] work on moral regulation and Wodak's [Wodak, A. (2007). Ethics and drug policy. *Psychiatry*, 6(2), 59–62] critique of "deontological" drug policy strategies. I then cite Tupper's [Tupper, K. W. (2007). The globalization of ayahuasca: Harm reduction or benefit maximization? *International Journal of Drug Policy*, doi:10.1016/j.drugpo.2006.11.001] argument that shifting to a generative metaphor that constructs certain entheogenic substances as potentially useful "tools" rather than regulating them through inherently moralistic prohibitionist policies would better serve public health, and incorporate Young's [Young, I. M. (1990). *Justice and the politics of difference*. Princeton, New Jersey: Princeton University Press] theories of domination and oppression to examine the rise of community-based medical cannabis dispensaries as "new social movements". First-hand accounts by medical cannabis patients, federally funded studies, and internal Health Canada communication and documents suggest that current federal policies and practices are blocking safe access to this herbal medicine. The community-based dispensary model of medical cannabis access is a patient-centered "new social movement" that mitigates the stigmatization and moral regulation of their member-clients by creating opportunities for engagement, empowerment and joint knowledge creation. In light of ongoing Charter challenges and patient criticism, the survival of this federal programme will depend on the government's ability to shift away from policies based on the oppression and moral regulation, and towards consequentialist policies that balance harm reduction and benefit maximization. The effectiveness of such an approach is exemplified by the success of the community-based dispensary model which is currently producing more peer-reviewed research and supplying medical cannabis to a far greater number of patients than Health Canada's Marihuana Medical Access Division.

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Introduction

With the goal of examining and explaining the failure of the Health Canada's Marihuana Medical Access Division (MMAD) to legally protect and meet the needs of the majority of sick and suffering Canadians who use cannabis for therapeutic purposes, this

paper examines first-hand accounts by medical cannabis patients, federally funded studies, and internal Health Canada communication and documents. I then examine the government's federal policies and practice through the lens of Hunt's (1999) work on moral regulation, and apply Wodak's (2007) critique of "deontological" drug policy strategies to the MMAD, citing Tupper's (2007) argument that re-considering certain entheogenic substances as potentially useful "tools" rather than regulating them through inherently moralistic prohibitionist policies would better serve both individual and public health. I conclude by incorporating Young's (1990) theories of systemic domination and

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oppression, and examine the role of community-based medicinal cannabis dispensaries as emerging “new social movements” and effective alternatives and/or complements to Canada’s centralized federal monopoly on production, distribution and legal access.

Health Canada’s medical cannabis programme

“Government is a more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes (Dean 1999, p. 11).” (Chen, 2003, p. 214)

In 1999 Health Canada initiated a centralized federal medicinal cannabis programme in response to an Ontario court decision. The 1998 case focused on Jim Wakeford, a person living with AIDS who faced cannabis possession and cultivation charges for attempting to grow a supply of medical cannabis to treat symptoms of his condition. The Ontario Superior Court recognized his legal right to access cannabis without fear of arrest, and instructed Health Canada to create a process allowing for legal access to this medicine. Health Canada responded by pointing to existing legislation – Section 56 of the *Controlled Drugs and Substances Act* (CDSA) – that would grant qualified applicants a federal exemption from the section of the CDSA addressing cannabis possession (Wakeford v. the Queen, 1999).

The following year, the Ontario Court of Appeals heard the case of Terry Parker who had been charged with cannabis possession and cultivation while growing a personal supply to alleviate symptoms of his epilepsy. The appellate court struck down the Section 56 programme as unconstitutional when it was revealed that the process granted total discretion to approve or reject potential applicants to the Health Minister. The court also struck down Section 4 of the CDSA as it relates to cannabis possession for all Canadians, but suspended the ruling for 1 year in order to allow the government time to introduce fair and appropriate regulations enabling access to medicinal cannabis for those with a legitimate medical need (Parker v. the Queen, 2000). As a result of these legal rulings, the constitutional validity of Canada’s cannabis control regulations is now dependent on the existence of a working and effective federal medicinal cannabis programme.

Since these initial developments, Health Canada has created the Marijuana Medical Access Division (or MMAD, formerly known as the Office of Cannabis Medical Access, or OCMA) to act as the governing body overseeing the implementation of the Marijuana Medical Access Regulations (MMAR), which replaced the Section 56 exemption process for medical cannabis in 2001 (Canada Gazette, 2005). On 9th January 2003 – in a ruling stemming from a lawsuit initiated by medicinal cannabis users and suppliers – the Ontario Supreme Court upheld the right for patients to have access to a safe, legal source of cannabis and once again found the federal programme unconstitutional for creating what provincial judge Lederman called the “illusion of access.” The court gave the government until 9th July 2003 to put forward a legal supplier for medical users authorized under the Marijuana Medical Access Regulations (Hitzig v. Canada, 2003). On 8th July 2003, with the announcement that Health Canada would soon accept written requests by federally authorized users for the cannabis being grown under contract by Prairie Plant Systems (PPS), Canada became the second country in the world (following the U.S.) to put in place a system for access to medical cannabis through a centralized, government-administered programme.

Despite research by the Canadian Center for Substance Abuse (2004) indicating that about 4% of Canadians aged 15 and older (or about one million Canadians) used cannabis for self-defined medical reasons, the number of applicants per month declined steadily between April of 2002 and July 2005, with the MMAD only approving 47 of the 299 applications received between January and September of 2004. In fact, participation in the programme shrank by 34 people in the three months between July and October of 2004, dropping from 781 down to 747 authorized users (Health Canada, 2004), suggesting that the vast majority of Canada’s medical cannabis patients were using this medicine without the federal authorization or legal protection.

The Canadian Senate Special Committee on Illegal Drugs highlighted medical access issues in their 2002 report *Cannabis—Report of the Senate Special Committee on Illegal Drugs*, which found that:

while a process that authorizes the possession and production of marijuana has been established in Canada, this has not ensured that cannabis is suitably available to those in need. . . we have come to the conclusion that the MMAR have become a barrier to access. Rather than providing a compassionate framework, the regulations unduly restrict the availability of cannabis to those who may receive health benefits from its use. (Nolin, 2003)

According to the Senate report, one of the main reasons for the small number of participants in the programme was reluctance by physicians to support the applications of patients who claimed to be benefiting from the use of medical cannabis. Citing a perceived lack of information on dosage, side effects, and alternate routes of administration to smoking, both the Canadian Medical Association (CMA) and the Canadian Medical Protection Agency (which insures nearly 95% of Canada’s physicians) initially made recommendations that doctors not participate in the federal programme.

In response to the Hitzig court ruling, Health Canada officially amended the MMAR application process in 2005 to remove the medical specialist recommendation that was required for all applicants that were not deemed terminally ill, and the CMA and CMPA have since issued some limited statements of support. However potential applicants continue to face resistance a medical community more familiar with pharmaceutical products than herbal medicines.

In a federally funded report examining the human rights, ethical and legal challenges faced by people living with HIV/AIDS who choose to use medical cannabis, the Canadian AIDS Society found that although between 14 and 37% of people living with HIV/AIDS use cannabis to alleviate the symptoms of their condition, many have faced hurdles accessing the federal programme (Belle-Isle, 2006). The report states that:

. . . access to the federal program remains hindered by barriers such as a lack of awareness of the program’s existence, mistrust in the government, misinformation about the program and difficulty in finding a physician to support their application. Thousands of seriously ill Canadians must therefore choose between breaking the law to use the therapy of their choice, or going without, which in many cases compromises their well-being and quality of life. (p. 2)

Despite the ongoing controversy and criticisms surrounding Canada’s federal MMAR programme, the majority of the general public strongly supports the medical use of cannabis for those who might benefit from this therapeutic option. According to the Project Canada Survey Series conducted annually by sociologist Reginald

Bibby since 1975, 93% of Canadians support the use of cannabis for medical reasons (Maclean's Magazine, 4th July 2006).

Oppression, moral regulation and the MMAD

As a result of court challenges, critical policy reviews, and ongoing complaints from Canadians who benefit from the medical use of cannabis, a number of significant problems with Health Canada's Marihuana Medical Access Division have become apparent (Belle-Isle, 2006; Lucas, 2008; Nolin, 2003). After nearly a century of Canadian policies intended to prevent illicit substance use by highlighting attributable harms to individuals and society, and criminalizing and often incarcerating end-users, the government was forced by the Ontario Court of Appeals to accept the therapeutic potential of medical cannabis, effectively contradicting much of its previous messaging on illicit substance use (Nolin, 2003). As Erickson (1998) notes in regards to Canada's role in the international war on drugs:

...opposing claims makers have been able to perpetuate, over many decades, and in many countries, a drug panic combined with a punitive moral crusade against the undifferentiated target of illicit drug users. The persistence of the "dope fiend" mythology suggests a Durkheimian interpretation to maintain a moral consensus on the unacceptability of all illicit drug use behaviours.

Since the goals of the "war on drugs" cannot be supported by evidence-based research, then policy makers need to promote and instil a moral imperative to selectively designate certain substances – such as alcohol or tobacco – as socially acceptable; and others – such as cannabis, cocaine and heroin – as morally offensive, in order to justify their continued criminalization. As Hunt (1999) notes, moral regulation "involves the deployment of distinctively moral discourses which construct a moralized subject and an object or target which is acted upon by means of moralizing practices. Moral discourses seek to act on conduct that is deemed to be intrinsically bad or wrong" (pp. 6–7).

In the case of Health Canada's federal medical cannabis programme, this "moral discourse" has taken the form of bureaucratic policies that seek to over-regulate and monitor the behaviour of Canadians who benefit from the therapeutic use of cannabis, and that presume the illicit intent – rather than innocence – of cannabis patients and those individuals and organizations who attempt to assist them. Even the medical community is not immune from this governmental overreach, and Health Canada bureaucrats now insinuate themselves in this doctor–patient relationship by contacting physicians whom they believe may be recommending too large an amount.

Internal email communication from March 2007 between Barrie Jones, a pharmacist tasked with contacting physicians in regards to what Health Canada deems to be high daily use recommendations, and MMAD Director Ronald Denault shows an awareness of the negative impact these calls are having on both patients and doctors:

I still feel that we need a meeting with the officers to clarify the criteria with regards to the high daily amount calls... The bad reactions that I have encountered tend to come from the renewals (e.g. "You called me about the same thing last year... don't you read the files? etc., etc.). Calling the physicians about renewal files seems to annoy the applicants a lot more than calling for the new ones. I also feel that we may be going more into the realm of influencing rather than informing with renewals. (Canadians for Safe Access, 2008).

Additionally, despite complaints from licensed users concerned about the significant loss of privacy, Health Canada currently allows police officers to contact the MMAD in order to confirm the legal status of patients during drug-related investigations. This policy decision was rationalized by Health Canada in a "Regulatory Impact Analysis Statement" that accompanied the government's new policies:

...communication of information to police without explicit consent from authorized and licensed persons may be perceived as a loss of privacy. However, the potential loss of privacy is offset by the greater social good that will be derived from confirming necessary information to police" (Health Canada, n.d.).

By placing law enforcement interests over the privacy rights of cannabis patients, Health Canada has lost sight of its legal and ethical responsibility to the primary stakeholders of this program, and blurred the distinction between public health and criminal justice. Young (1990) suggests that this is a form of domination, stating that "people experience bureaucratic domination not only as workers, but also as clients and consumers subject to rules they have had no part in making, which are designed largely to convenience the provider or agency rather than the consumer" (p. 78).

In response to patient complaints, Health Canada has defended their programme by claiming that the MMAR and its underlying bureaucracy are perhaps imperfect, but impartial and therefore legal. However, bureaucratic depoliticization does not inherently imply the "justness" of laws or policies. Young (1990) cites Habermas in arguing that legal validity does not always mean that rules or policies are either fair or effective:

Formalizing collective action through explicitly articulated rules and procedures... separates it from normative inquiry and commitment. Decisions and actions will be evaluated less according to whether they are right or just than according to their legal validity, that is, whether they are consistent with the rules and follow appropriate procedures. This uncoupling of legal rationality from normative reasoning constitutes the meaning of bureaucratic depoliticization. (p. 77)

VanderPlaat (1997) further elaborates Habermas' concept, identifying two forms of "systemic oppression":

First, there is the oppression that results from **the unequal distribution of an access to resources**. That is what traditional approaches to intervention attempt to compensate for and ameliorate. The second form of systemic oppression derives from **the over-reliance on scientific discourse and technocratic rationalization as the basis for instrumental decision making**. This privileging of "scientism" not only justifies material and social disparities but also discursively disarms political challenges to the status quo. (p. 145)

These two types of oppression are readily apparent in the MMAD's restrictive access and supply policies. Health Canada argues that only the federal government is qualified to determine who can produce, distribute, and have access to medical cannabis by citing selective interpretations of the United Nations' 1961 *Single Convention on Narcotic Drugs* and its supplementary treaties (the 1971 *Convention on Psychotropic Substances* and the 1988 *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*) which initially required that a centralized federal agency control the production and distribution of all narcotics (Belle-Isle, 2006). However, the government's reliance on international treaties to limit production and distribution is

directly contradicted by exceptions for medical and research purposes explicitly written into the Single Convention, and by its own policy of licensing hundreds of individual production facilities. The treaty repeatedly affirms the importance of medical access to controlled substances, stating that “the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and . . .adequate provision must be made to ensure the availability of narcotic drugs for such purposes”. Furthermore, articles 1, 2, 4, 9, 12, 19, and 49 contain clear regulatory exceptions relating to the “medical and scientific” use of controlled substances ([Single Convention on Narcotic Drugs, 1961](#)). Finally, Health Canada’s requirement that further research be conducted to assess “the safety, efficacy, and therapeutic usefulness of this presently unapproved drug product” ([Canada Gazette, 2005](#)) prior to loosening restrictions on access, production, and distribution is directly contradicted the Conservative government’s decision to cut all federal funding to medical cannabis research in the fall of 2006.

Hunt (1999) suggests that another important aspect of moral regulation is the creation of seemingly arbitrary divisions or categories between those being oppressed, which involves:

...what Foucault has called ‘dividing practices’ . . .Such a distinction has two immediate consequences; first it moralizes the categories, delineates between good and bad; second, it operates as a legitimization for the differential treatment of the divided categories – for example, the deserving poor are granted relief that is denied to the undeserving poor. (p. 8).

These dividing practices represent some of the most highly criticized characteristics of Health Canada’s medical cannabis programme. As of October 2007 only 2261 Canadians were benefiting from the legal protection offered through the federal programme ([Health Canada, n.d., 2007](#)), leaving the overwhelming majority of medical cannabis patients vulnerable to arrest and prosecution. [Belle-Isle \(2006\)](#) reports that only 26% of the people living with HIV/AIDS who use medical cannabis she contacted for her study had an authorization to possess cannabis from the government, and only 1.7% obtained their supply from Health Canada (pp. 2–3). Despite suffering from similar health conditions, respondents in her study do not benefit from equal legal protection under the government’s medical cannabis policy. The MMAD’s onerous application process and restrictive inclusion criteria create an arbitrary distinction between the “legitimate patients” that have been able to negotiate the medical system and successfully overcome the MMAR’s bureaucratic obstacles, and “illegal users” who have been unable to obtain medical support for their federal application and are therefore subject to the full force of the criminal justice system.

Additionally, delays in re-registrations have resulted in the absurd situation in which some medical cannabis patients are legally protected from arrest one day, and exposed to prosecution on the next. This was the case with Tom Shapiro, a person suffering with HIV/AIDS whose renewal was delayed because the MMAD lost the pictures he had sent for his new authorization card. This is Tom’s story, in his own words:

At approximately 5:20 pm Tuesday January 31, 2006 Saskatchewan time, I was just finishing up my supper when there was a loud rapping at my front door (which was in plain view to me). I saw a policeman in a tactical squad type outfit at the door. I said “it’s open” and he opened the screen door and said “it’s the police, we have a warrant to search the premises for an illegal grow operation” . . .One of the police officers wearing a mask had their gun drawn and pointed it at my step-son in the computer room where my wife was also. My wife who had

never been in cuffs in her life was in tears. I told the officer in charge that if he were to call Health Canada on this matter they should be able to clear this up. He told me that he did call them before coming over here and that they said they didn’t know me nor have they ever heard of me. I was flabbergasted! I said that was not possible as I have had a license for about five years now and renewed every time. The officer said that’s not what he was told. I showed him my expired license and he said it was expired so unless I had one more current he had no choice but to take everything away and possibly charge one or maybe all of us with breaking the law. It took Ottawa over three hours to get to the police and said that they didn’t have access to all information at this time of night. All they could tell them was that my license was expired and I was in error of the law. . .I was charged with producing a controlled substance without proper authorization. Health Canada lied to me and left me for the wolves that day. (Excerpted from personal email communication with Tom Shapiro dated February 4th, 2006.)

That Tom could be legally supported by Health Canada as a legitimate medical cannabis grower one day, and then charged as a drug producer/dealer the next as a result of a bureaucratic oversight rather than any change in his health condition or behaviour vividly illustrates both the very real threat of arrest faced by all Canadian medical cannabis users, and the failures of the federal programme to protect them. [Young \(1990\)](#) notes that misapplied, poorly considered bureaucratic processes can unintentionally result in the structural oppression of individuals:

In this extended structural sense oppression refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms. . . (p. 41)

Without the legal protection offered by the Health Canada programme, neither the police nor the MMAD bureaucrats saw Tom as a person living with HIV/AIDS cultivating his own medicine. Instead they presumed his guilt, seeing only a stereotypical “grow-op” run by a “pothead” drug dealer; thus explaining the difference between overt oppression at the hand of ill-intentioned individuals or institutions, and the much more quiet and common systemic oppression that regularly impacts medical cannabis patients.

Health Canada also defends the strict restrictions on medical cannabis access as necessary to minimize the risk of cannabis diversion to the general public, which is largely a consequence of pressure from police organizations to maintain the prohibitionist policies that have become the basis of their core funding. Implicit in these restrictive regulations is the suggestion that medical cannabis users – people living with cancer, HIV/AIDS, MS, Hepatitis C and chronic pain – cannot be trusted to produce or use cannabis without succumbing to the lure of black-market diversion. However, since this is already the most popular illicit substance in the world, and has been used illegally by 44% of Canadians ([Canadian Center for Substance Abuse, 2004](#)), such onerous regulations and heavy-handed enforcement practices seem to be both ineffective and largely unjustified ([Nolin, 2003](#)). [Erickson and Hathaway \(2004\)](#) suggest that:

...as risk profiling produces targets for public-health policy, new forms of social control become evident. Assigning blame to drug users as a high-risk group for health problems, and a vector of contagion to the larger society, provides a strong rationale for their stigmatization (p. 76).

Accordingly, it is very difficult for a bureaucracy to problematize recreational cannabis use without implying a similar public health risk in medical use. If cannabis comes to be viewed by society as a safe and effective medicine rather than a dangerous drug of use, then the very foundation for its prohibition – that it is a dangerous substance under any circumstances – may be at risk. Since enforcement of cannabis prohibition in Canada is a \$350 million dollar a year business accounting for over 70% of drug enforcement spending, it has also been suggested that police organizations may be motivated to support the prohibition of cannabis by financial interests (Nolin, 2003). In addition to societal risks like drug diversion, healthcare bureaucracies are particularly wary of institutional risks that could lead to political embarrassment or liability. In an essay on political interference by the ruling Conservative government in Vancouver's safe consumption site, HIV/AIDS researcher Small (2007) suggests that:

Political interference in Canadian healthcare takes place through the veil of institutional risk management. Healthcare bureaucracies are ruled by a risk management culture. Institutional risk management is the perceived risk to the institution in terms of lawsuit or political risk due to media embarrassment. There is a marked difference between institutional and societal risk. Whereas societal risk refers to a danger to people in a society, institutional risk pertains to a threat to regulatory bodies or to the legitimacy of the very procedure of regulation or the rules themselves. (pp. 22–23)

In light of the available evidence, it is reasonable to infer that the MMAD's policies are designed first and foremost to protect elected officials and bureaucrats from public embarrassment or legal challenges, and that the stigmatization of medical cannabis users as potential criminals and drug dealers is reflective of this questionable prioritization. Chen (2003) notes in addressing the agenda of the "New Right", that "governance in forms of risk management and criminal punishment assume the governed... as the evil and dangerous individuals, who no longer deserve considerations of circumstances" (p. 215). As is evident in the case of Tom Shapiro, the supposed impartiality of bureaucratic processes like the MMAR often make no concessions for circumstance, common sense or compassion.

Consequentialism and maximizing the benefits of medical cannabis

In a recent examination of ethics and drug prohibition, Wodak (2007) suggests that the morally and ideologically driven drug policies that have dominated the last hundred years are based on "deontological approach" to illicit drugs. He states that in deontological ethics:

...decisions are based mainly on the duties of an individual and the rights of others. This means that an individual's behaviour or decisions can be considered wrong if quite acceptable outcomes eventuated. In a deontological approach, how goals are accomplished is considered more important than what is achieved. (p. 59)

In light of the federal government's continued defense of a medical cannabis programme that is only protecting a tiny percentage of Canada's medical cannabis population, it is apparent that the MMAR is largely based on a deontological approach that places a higher priority on maintaining an ideologically driven "war on drugs" than on a constitutional obligation to protect legitimate medical cannabis patients from stigma, persecution and arrest. This

is in contrast to a "consequentialist approach", in which the end-results of a policy are the basis for judging whether it is successful or not. In reference to the ongoing public policy arguments around "harm reduction" approaches to substance use, Wodak suggests that:

This debate is essentially a conflict between 'consequentialists', more concerned to evaluate interventions by considering their impact, while the 'non-consequentialist' critics of harm reduction prefer to evaluate interventions by considering their moral worth. However, all participants in this debate have to consider the morality of ignoring clear scientific evidence and thereby condemning future generations to endemic HIV." (p. 61)

I submit that his conclusion is equally applicable to the bureaucrats and elected officials that work at and oversee the MMAD. In light of recent evidence that cannabis not only helps relieve the symptoms of a number of serious conditions, but might also increase the success rate of both HIV/AIDS and hep-C treatment (Abrams et al., 2007; Sylvestre et al., 2006), the Canadian federal government has a moral, ethical and constitutional obligation to ensure that this programme addresses the needs and legally protects the rights of these seriously ill patients. As Wodak suggests, the consequences of ignoring this evidence may be to condemn some Canadians to altogether unnecessary sickness and suffering.

I would further suggest that these legal and ethical responsibilities extend well beyond simply reducing the perceived individual and social harms of cannabis use: the federal government has to initiate policies that maximize the personal and public health potential of medical cannabis. In an essay on the globalization of ayahuasca, an entheogenic plant-based medicine from the Amazon basin that, like cannabis, has a long history of traditional use, Tupper (2007) suggests that:

"Rather than essentializing psychoactive substances as inherently dangerous, to regard them as tools – ancient technologies for altering consciousness... allows for a realistic assessment of their potential benefits and harms according to who uses them, in what contexts and for what purposes". (p. 5)

Although this theory is consistent with Wodak's "consequentialist approach" in that both seek to replace the long history of morally driven policies on substance use with more evidence-based approaches, he insists that the conceptual shift necessitates a move beyond policies simply based on the concept of harm reduction:

To the extent that policy-makers or practitioners emphasize a behaviour's potential risks, the harm reduction policy approach is justified. However, the tool metaphor for psychoactive substances warrants a corollary notion of "benefit maximization", the other side of the harm reduction coin. Instead of approaching drug policy from a deficit perspective... the tool metaphor opens discursive avenues for realistic policy considerations of benefits as well as harms. (p. 5)

Thus, as with ayahuasca, the concept of "harm reduction" alone may not be suitable to maximize the potential health benefits of medical cannabis. A great deal of research indicates that cannabis is far less dangerous and addictive than currently legal substances like alcohol and tobacco, and safer than many over-the-counter or prescription pharmaceuticals (Grinspoon & Bakalar, 1998; Grotenhermen & Russo, 2002; Nolin, 2003), leading some to suggest that the greatest potential harms of cannabis use stem from its illegality rather than its actual use. This includes arrest and legal

prosecution, as well as other risks characteristic of this unregulated black-market, such as poor quality or adulterated product, and the threat of violence associated with illicit drug distribution (Belle-Isle, 2006; Nolin, 2003). In light of this evidence, harm reduction policies designed to promote informed decision-making, prevent the spread of infectious disease, and reduce the likelihood of addiction and overdose – such as needle-exchange, supervised consumption sites, detox, drug maintenance or substitution programs – do not readily apply to the use and distribution of medical cannabis.

The concept of benefit maximization does not exclude the basic principles of harm reduction; it complements them. In the Tri-Council Policy on Ethics in Human Research (Government of Canada, 2005), both “minimizing harms” and “maximizing benefits” are described as “guiding ethical principles” in medical and social research and cited as equal parts of a harm/benefit analysis, suggesting that a public policy based solely on one or the other may not be as fair, balanced or effective as one giving both equal weight and consideration. By not developing policies that would seek to maximize the personal and public health potential of medical cannabis, Health Canada is not only failing to meet its constitutional obligation to protect Canadians who use medical cannabis from arrest and prosecution, it is also missing a unique opportunity to improve the health outcomes of some of Canada’s sickest citizens.

Medical cannabis dispensaries; a patient-centered, community-based response to moral regulation

During the late 1980s, as rates of HIV and AIDS began to rise in San Francisco, underground dispensaries offering cannabis to those needing it for medical purposes were established by people living with HIV/AIDS and drug policy reform activists. With the successful passage of a state-level ballot initiative titled “Proposition 215” in 1996, California became the first U.S. state to challenge the federal prohibition on cannabis by allowing for its legal medical use and distribution. Within a few weeks dozens of “compassion clubs” opened, and although they often had varied policies and practices, their common goal was facilitating access to cannabis for medical users (Grinspoon, 1999). There are now over 250 community-based medical cannabis dispensaries in California, and it is estimated that they currently supply over 200,000 medical cannabis users (Gieringer, 2006). A number of other U.S. states that have approved the use of medical cannabis are currently exploring different community-based distribution models, including Rhode Island, New Mexico, Washington, and Oregon.

Seven well-established compassion clubs or societies exist in Canada. The Victoria-based Vancouver Island Compassion Society (VICS), of which the author is founder and Executive Director, has taken an evidence-based approach to medical cannabis, using the knowledge and experience of its staff to develop an extensive research agenda, which includes hepatitis C research with Dr. Diana Sylvestre and the University of California, San Francisco; nausea and pregnancy research with the University of Victoria and the University of British Columbia (Wesfall, Jansenn, Lucas, & Capler, 2006); and an examination of the changes in the use of pharmaceutical opiates and quality of life of in patients suffering from chronic pain who use medical cannabis being conducted by this author, and supported by the University of Victoria and the Center for Addictions Research of British Columbia.

Despite their illegality, this loose network of compassion clubs and societies provides over 11,000 critically and chronically ill Canadians access to a safe supply of cannabis within an environment conducive to healing (Belle-Isle, 2006). Although England, Israel and Holland have recently witnessed limited (licit and illicit) experiments with community-based access, Canada and the U.S. are the

only two nations where these organizations have become the primary source of medical cannabis for patients.

Community-based dispensaries as “new social movements”

The inability of Canadian medical cannabis users to affect progressive change in the federal programme is a result of entrenched institutional resistance, rather than lack of engagement or action. Although medical cannabis users have been invited to participate in a number of government-sponsored consultations, their concerns have gone largely unheeded by policy makers. This is well-reflected in the “Regulatory Impact Analysis Statement” that accompanied changes to the MMAR in 2005, which notes that “in presentations to Health Canada, patients often characterized the MMAR requirements and processes for obtaining an authorization to possess marihuana, as onerous, and therefore, an impediment to access”, and then acknowledges that a public consultation on proposed regulatory changes resulted in official responses from 34 individuals and organizations – including the Canadian Medical Association – that ranged from “clearly supportive...to very critical of certain aspects of the proposal”. The Impact Statement inexplicably concludes that “none of the comments submitted led to changes to the regulatory proposal...” (Canada Gazette, 2005).

The disregard of end-user concerns from a federal programme that should specifically address and reflect their needs amounts to what Young (1990) would describe as structural domination of Canada’s medical cannabis community. She states that:

Domination consists of institutional conditions which inhibit or prevent people from participating in determining their actions or the conditions of their actions. Persons live within structures of domination if other persons or groups can determine without reciprocity the conditions of their action, either directly or by virtue of the structural consequences of their actions. (p. 38)

Young argues that the ideal of bureaucratic impartiality is in fact “an impossibility, a fiction” (p. 103), but also recognizes that society’s overall acceptance of the notion that bureaucracies are impartial allows those who question the neutrality of government policies to be labelled deviant and self-interested:

If oppressed groups challenge the alleged neutrality of prevailing assumptions and policies and express their own experience and perspectives, their claims are heard as those of biased, self-ish special interests that deviate from the impartial general interest. Commitment to an ideal of impartiality thus makes it difficult to expose the partiality of the supposedly general standpoint, and to claim a voice for the oppressed. (p. 116)

It is as a result of Health Canada’s continued failure to address the legitimate needs and concerns of patients that these organizations have emerged as the nation’s major source of medical cannabis-related medicines, research and information. Young’s description of the social insurgency campaigns that she calls “new social movements” makes a rather fitting lens from which to examine the community-based model of medical cannabis access:

Most focus on issues of oppression and domination; they usually seek democratization of institutions and practices, to bring them under more direct popular control. These insurgent campaigns and movements may be divided into three major categories: 1) those that challenged decision-making structures and the right of the powerful to exert their will; 2) those organizing autonomous services; and 3) movements of cultural identity. (p. 83)

Community-based dispensaries fit all three of Young's categories: they challenged the decision-making structure of the federal government in regards to the production and distribution of medical cannabis, and promote individual and community-based empowerment; they are an "autonomous" alternative means of medical cannabis access based on principles of harm reduction and "benefit maximization" (Tupper, 2007); and they have allowed medical cannabis users to regain a cultural identity free of social stigma and the resulting self-imposed isolation. To these three categories I would add a fourth: the creation, adoption and dissemination of new knowledge.

The creation of new knowledge around the use of medical cannabis is a community-based response to the lack of research in this important area of personal and public health as well as an attempt to challenge what Becker (1967) calls the "hierarchy of credibility" (p. 207). This theory suggests that society gives more credence to professional government bureaucrats developing regulations around the use of medical cannabis than to the end-users themselves. The research that has taken place in compassion clubs is a conscious effort to reflect the experiences of the medical cannabis patients whom they serve, and to demonstrate and promote their own expertise and credibility, creating what VanderPlaat (1997) refers to as a "discourse of empowerment". He argues that what distinguishes this approach to knowledge creation is:

...its acknowledgement and deep respect for people's capacity to create knowledge about, and solutions to, their own experiences. Within this discourse, the valid knowledge base from which to initiate social change originates in the collective everyday understandings and experiences of participants rather than in the annals of the social scientific community. (p. 147)

By contrast, through the development and implementation of an oppressive and largely ineffective medical cannabis policy and programme that has actively shunned community-input, stakeholder participation and opportunities for joint knowledge creation, the Canadian federal government has condemned the nation's medical cannabis patients to suffer through the illusionary impartiality of an unresponsive bureaucracy, and it is now apparent that far too few have been able to navigate this onerous process and to benefit from these hard-won constitutional protections.

Discussion

Despite a growing number of court cases, Charter challenges, and federally funded studies urging the Canadian government to improve access to medical cannabis, Health Canada continues to defend and maintain federal policies that oppress and dominate those taking part in their medical cannabis programme, and arbitrarily exclude others who may well benefit from the therapeutic use of cannabis. Current federal policies presume the ill intent or inherent guilt and of Canadian medical cannabis patients, even though there is no evidence that federally authorized users living with serious medical conditions like HIV/AIDS, Hepatitis C and cancer have any intention or desire to become black-market cannabis producers or distributors. In fact, the hurdles they have overcome to become authorized users suggest a strong desire for legal and social legitimacy.

Community-based dispensaries represent a patient-centered new social movement informed by the joint principles of harm reduction and benefit maximization. This consequentialist approach to medical cannabis access empowers participants by creating opportunities for patient engagement and joint research

and knowledge creation, thereby adding to the personal and social health benefits of medical cannabis in Canada, and leading to a greater scientific understanding of the therapeutic potential of this controversial natural medicine.

Conflicts of interest

Philippe Lucas is founder and Executive Director of the Vancouver Island Compassion Society, and is currently a salaried employee of the same. He is also a founder of Canadians for Safe Access, but receives no financial compensation for his work with CSA.

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