

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: ***R. v. Beren and Swallow,***
2009 BCSC 429

Date: 20090202
Docket: 131900
Registry: Victoria

2009 BCSC 429 (CanLII)

Regina

v.

**Mathew David Beren
Michael Andrew Swallow**

Before: The Honourable Madam Justice Koenigsberg

Oral Reasons for Judgment (Re Accused Beren)

February 2, 2009

Counsel for the Crown:

P.A. Eccles

Counsel for the accused Beren:
Counsel for the accused Swallow:

K.I. Tousaw
J.W. Conroy, Q.C.

Place of Hearing:

Vancouver, B.C.

INTRODUCTION

[1] **THE COURT:** This case is concerned with the issue of government control of cannabis used for medical purposes. Mr. Beren is prosecuted for production, possession and controlling marijuana for the purposes of trafficking, contrary to ss. 5 and 7 of the ***Controlled Drugs and Substances Act***, S.C. 1996, c. 19 (the “**CDSA**”). Mr. Beren’s defence is that he was producing marijuana in large quantities for medical and research purposes only and this prosecution of him is a breach of his rights of liberty and security of the person under s.7 ***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 (the “**Charter**”). Thus Mr. Beren attempts to continue the evolution of jurisprudence in the direction of easing all government regulation of the availability of marijuana for medical purposes.

[2] The trial of this matter commenced in the late fall of 2005. During the trial a *voir dire* was completed resulting in the admission of evidence of a large marijuana grow operation. The marijuana grow operation was discovered during the execution of a search warrant on May 27, 2004. The Crown closed its case after approximately three days of evidence having proven that the accused, Mr. Beren, was by inference in possession and control of the grow operation and that the number of marijuana plants seized was sufficiently large to be consistent only with production for the purposes of trafficking. Thus, the essential elements of the offences charged were proved.

[3] On May 9, 2007 the defence commenced its case, which is the constitutional challenge to ss. 5 and 7 of the **CDSA**. This case has moved along at a very slow pace for a number of reasons none of which is relevant to this decision. Final argument began in August 2008, and completed in December 2008.

[4] Before and since the arrest of Mr. Beren in May 2004, this and other higher and lower courts have considered various fact patterns involving marihuana, its possession, and production and/or distribution for medical purposes. Several landmark cases have found either the whole of s. 4 of the **CDSA**, or the whole or parts of the Marihuana Medical Access Regulations, S.O.R./2001-227 (the “MMAR”) to be contrary to the accused’s or applicant’s constitutional rights. In October 2003, in what likely remains the seminal decision in this area, the Ontario Court of Appeal released its decision in **Hitzig v. Canada** (2003), 231 D.L.R. (4th) 104, 177 C.C.C. (3d) 449 (Ont. C.A.) (“**Hitzig**”), which struck down several subsections of the MMAR and invited the government to address those specific constitutional deficiencies in order to render s. 4 of the **CDSA** constitutional.

[5] On December 3, 2003, the Governor in Council adopted several amendments to the MMAR. The government repealed a number of provisions which the court in **Hitzig** had found to be invalid, including ss. 41(b) and 54 which provided that:

41. The Minister shall refuse to issue a designated-person production licence... (b) [if] the designated person would be the holder of more than one licence to produce.

.....

54. The holder of a licence to produce shall not produce marihuana in common with more than two other holders of licences to produce.

[6] The defence challenges the MMAR on constitutional grounds, focussing on the failure of the MMAR to provide practical access to medical marihuana for those whose medical conditions would appear to fall within the exemption provided for, despite the amendments following **Hitzig** and a change in policy with respect to the availability of medical marihuana to qualified patients through government supply.

[7] This case seeks to go beyond the Ontario Court of Appeal decision in **Hitzig** on two grounds. Firstly, that the government response to those provisions declared unconstitutional by the court in **Hitzig** is inadequate, in part because of the re-enactment of s. 41(b) as s. 41(b.1) and s. 54 as s. 54.1 of the supply provisions. Secondly, this trial attempts to lay a factual foundation to meet the standards outlined in **Hitzig** in terms of eligibility or access requirements of the MMAR.

[8] In relation to the supply issue, since these submissions were completed in August 2008, the Federal Court of Appeal in **Sftekopoulos v. Canada (Attorney General)**, 2008 FCA 328, 382 N.R. 71 , affirmed the trial court's decision, 2008 FC 33, 3 F.C.R. 399 ("**Sftekopoulos**"), which found that s. 41(b.1) was unconstitutional on a combination of two factors. The first factor was a finding of fact that only 20 percent of those eligible to possess medical marihuana could access it or did access it and, by implication, that the government supply is therefore not practically accessible to most eligible users. Thus, access to a licit supply of medical marihuana remains problematic. The second factor was that the restrictions on holders of licences to produce medical marihuana are essentially arbitrary, as no compelling evidence was found of the state interest served by such restrictions.

[9] This decision will be addressed later in my reasons.

Factual overview

[10] The prosecution of Mr. Beren for trafficking in marihuana is based on the grow operation admitted to and operated by Mr. Beren in order to supply the Vancouver Island Compassion Club (the “VICC”). I find that organisation sought to limit the distribution and/or sale of marihuana to persons with medical conditions supported by letters from physicians. Some of the VICC members either had an Authorization to Possess (“ATP”) or had a physician supporting their use of marihuana as a beneficial treatment for their medical condition.

[11] The Crown submitted that there is evidence relevant to Mr. Beren's culpability in recovered documents which show that Mr. Beren, either directly or by inference, was planning to sell marihuana to persons outside of the VICC. This evidence is capable of more than one interpretation as to whether he was, in fact, planning to sell to anyone, whether they had a medical need or not. Further, there is not sufficient evidence to find that Mr. Beren was growing for any purpose other than the VICC at the time of his arrest.

[12] Factually, this case, in most respects, is on all fours with the **Hitzig** decision. I consider the decision in **Hitzig** to be the current seminal authority on the issues before this court. I will consider the trial decision in **Sftekopoulos** (affirmed by the Federal Court of Appeal) as it takes up the legal gauntlet in this evolving jurisprudence.

Legal context

[13] Although strictly speaking this court is not bound by Court of Appeal decisions in other jurisdictions, it should give full faith and credit to such decisions unless the legal reasoning is essentially and demonstrably flawed, as in, for instance, failing to consider or follow a relevant higher authority, such as a Supreme Court of Canada decision, or unless the factual foundation is demonstrably different in matters relevant to the principles at play, ***Fording Coal Ltd. v. Vancouver Port Authority***, 2006, BCCA 204.

[14] I would add a further reason why Court of Appeal decisions in other Canadian jurisdictions should be followed when such a decision concerns matters of federal jurisdiction, such as the criminal law, or the application of the ***Charter***. It would seem even more compelling to have consistency in the application of the law in such areas. It should not be legal to possess marihuana for medical purposes in Ontario but not in British Columbia. Thus I find the Court of Appeal decision in ***Hitzig*** compelling and I adopt its reasoning in every respect where it is relevant to the facts in this case.

[15] I note that the Crown was not successful in getting leave to appeal the decision in ***Hitzig*** and, in fact, the government did amend the MMAR in response to that decision.

[16] This court keeps in mind the following two principles in weighing the evidence and coming to conclusions. Firstly, Mr. Beren's activity as it comes up against s. 4 of the ***CDSA*** and the MMAR must be judged against the law as it was May 27, 2004. It

is trite law that if a law which was in force in May 2004 is found to be unconstitutional for being contrary to **Charter** values, it was unconstitutional at the time of the arrest. Several amendments have been made to the MMAR since May 2004 in response to challenges to the prohibition of possession and trafficking in marihuana as it used for medical purposes. Further, subsequent court rulings have found all or parts of the exemption scheme sufficiently inadequate so as to render them unconstitutional.

[17] Secondly, there is a two-fold test for a finding that any law or part thereof is unconstitutional for being in breach of s. 7 of the **Charter**. First, it must be found that the impugned legislation deprives the individual of life, liberty and/or security of the person, and second, there must be a finding that, if there is such a deprivation, it is in accordance with the principles of fundamental justice.

FACTUAL BACKGROUND

[18] I take the following factual overview largely, but not exclusively, from the written submissions of the applicant. The Crown took only relatively minor exception to the general factual overview and where that exception was taken, I either accepted or note the qualifications put on those facts by the Crown.

[19] Cannabis is subject to a near absolute criminal prohibition on possession, sale and production. The applicant accepts the constitutional legitimacy of that prohibition for the purposes of this case, it having been found to be constitutionally valid by the Supreme Court of Canada in fairly recent jurisprudence: see, for example, **R. v. Clay**, 2003 SCC 75, 3 S.C.R. 735. The sole exceptions to the absolute prohibition are created by the MMAR, and an associated policy permitting,

but not requiring, Health Canada to supply cannabis to authorized persons. These exceptions apply to the following:

- (a) the Prairie Plant System (“PPS”), the government’s contracted monopoly supplier of cannabis;
- (b) approximately 2,600 individuals, and in some instances, their designated cannabis producers, who have been able to obtain ATPs from Health Canada;
- (c) those holding a personal use production licence (“PPL”); or
- (d) those holding a designated personal production licence (“DPL”) pursuant to the MMAR obtained since those regulations were promulgated by the federal government in July of 2001.

[20] When able to access the legal protections of the federal government’s medical cannabis program, Canadian residents who use cannabis for therapeutic benefit are able to possess dried cannabis legally. Those persons are then able to access a legal supply of cannabis from one of three possible sources: (1) Health Canada, through PPS; (2) by growing pursuant to a licence from Health Canada; or (3) by designating someone to grow for them pursuant to a licence from Health Canada.

[21] The evidence in this case establishes that most of Canada’s medical cannabis users, however, are not protected by the MMAR. Most, therefore, do not access their cannabis from a legal supply source. A portion of those Canadians that

have been able to access the legal protections of the federal government's program do not necessarily obtain all of their cannabis from that legal source. Mr. Beren's position is that the practical effect of the restrictive nature of the MMAR is that, for most Canadians, the exemption created by the regulations is illusory.

[22] The Crown's position is that, given that there is now a supply available to qualified individuals, if those individuals are not getting their marijuana legally, it is a matter of choice. This choice, or lack of choice, is not constitutionally protected.

[23] Some medical cannabis users obtain it from organizations such as compassion societies or compassion clubs. There are several such organizations in Canada, each with varying features. At the heart of this case is the VICC, which is located in Victoria, British Columbia. The VICC employed the applicant, Mr. Mathew Beren. VICC is a registered British Columbia non-profit society. It sells cannabis and cannabis products to its members. In order to qualify for membership in the VICC, a person must have the support of a physician. The VICC membership consists predominantly, though not exclusively, of persons who are not protected by the MMAR; in other words, persons who do not have ATPs.

[24] In 2002, the VICC built the Vancouver Island Therapeutic Cannabis Research Institute (the "VITCRI") on leased property in Sooke, British Columbia. That research institute was created to produce a variety of strains of organically grown cannabis and a hemp placebo for the VICC. This cannabis was intended to be sold in various forms to members and to conduct research into therapeutic application. Mr. Beren assisted with building a production facility on that land (the "Production

Facility”) and acted as the producer of the cannabis it provided to the VICC, thus leading to his arrest.

[25] The Production Facility was raided and shut down by the RCMP on May 24, 2004 and Mr. Beren was arrested and charged with producing cannabis and possessing cannabis for the purpose of trafficking. It is the applicant's position that the VICC existed to meet the needs of medical cannabis users, which by at least 2004 were unmet within the confines of the MMAR. I find that the facts support this position.

THE PARTIES' CONTENTIONS AND THE ISSUES

Overview

[26] The principal issue in this case, having determined the essential elements of the charge against Mr. Beren for production for the purposes of trafficking were proven, is whether certain requirements of the MMAR, with respect to access and supply of medical marihuana, violate the rights enshrined in s. 7 of the **Charter**?

[27] Mr. Beren asserts that the MMAR are cumbersome, arbitrary, unduly restrictive and act as a barrier to access to the legal protections of the federal government's program. He also asserts that the MMAR acts as a barrier to an adequate supply of legal medical cannabis, cannabis resin and cannabis by-products. The federal government's policy and operational choices in this area, as embodied by the MMAR, the supply policy, and the operational decisions made by

Health Canada (which administers the program), contravene the rights protected by s.7 of the **Charter** and are contrary to the principles of fundamental justice.

[28] The Crown's position is that there is no breach of s. 7 in relation to the MMAR program: once the amendments were made following **Hitzig**, and once the government provided an adequate supply of marihuana for the purpose of meeting the medical needs of persons in need of medical marihuana through PPS, the MMAR met constitutional muster.

Specific issues

[29] The issues as presented by the defence are that the MMAR are constitutionally defective in two principle areas. The first refers to access to the legal protections of the program, which essentially means that physicians act as gatekeepers. The second area is the ability to legally obtain an adequate supply of medicine.

[30] The access issue arises because of the restrictive nature of the regulations and the cumbersome process required to obtain, amend, and renew an ATP. The unwillingness or reluctance of physicians to act as the sole gatekeepers to legal cannabis is a major contributor to the access problem, as is the requirement that specialists be consulted for category 2 conditions, which are outlined later in these reasons. Other aspects of the bureaucratic regime created to administer the MMAR also engage the access issue, says the applicant, and cause significant delays or disruptions in access to the legal protections created by the program. The result of

the restrictions is that the MMAR acts to prevent rather than facilitate access to those protections.

[31] The supply issue, as set out by the applicant, arises in large part from the MMAR restrictions on the number of plants which may be grown by the holder of a PPL. The following are examples of those restrictions relied upon by the defence: the prohibition on one DPL providing medical marihuana to more than one person with an ATP; the restriction on the number of producers that can pool resources and produce medical marihuana in one physical location; the government's policy decision to provide end-users with the option to purchase only a single strain of pre-ground, gamma-irradiated cannabis from its monopoly supplier; the government's policy decision to cut patients off from the government supply because of their economic inability to afford the medicine; the government's policy decision to not include cannabis resin in by-products within the ambit of the MMAR; and the government's unwillingness to license and regulate the network of community-based dispensaries, the compassion societies, which pre-date the MMAR and currently serve, according to the applicant, and I so find, more end-users than the federal government program.

[32] Mr. Beren submits that the MMAR and Health Canada's policy decisions in this area act as barriers for qualified persons to access a legal and adequate supply of safe and effective medicine.

[33] Mr. Beren's position on the specific issues are set out below.

Access

The **CDSA**, as modified by the MMAR, does not create a constitutionally adequate means for qualified persons to obtain access to the exemption from the absolute prohibition for the following reasons:

(a) the MMAR requirement that a physician be the gatekeeper to the legal protections of the programs acts to render the exemptions from the criminal law practically unavailable to the vast majority of persons who could benefit from the use of medical cannabis;

(b) the MMAR requirement that a specialist in the particular illness or disease be consulted in relation to category 2 applications is an arbitrary restriction on access;

(c) the MMAR requirement that a physician and patient declare that all conventional treatments have been tried or considered and rejected is an arbitrary restriction on access;

(d) the MMAR restriction on the categories of health care professionals that can act as gatekeepers to the legal protections of the program, limiting the gatekeeper role solely to medical doctors, is arbitrary;

(e) the MMAR requirement that authorized persons in category 1 renew their licences on an annual basis is arbitrary; and

(f) significant delays in processing applications under the MMAR, as well as renewals and amendments, undercut the existence of the right and, for terminal patients, make the protection practically unavailable.

Supply

The **CDSA**, as modified by the MMAR and Health Canada's policy on supply, does not create a constitutionally adequate method for qualified persons to obtain a legal, adequate and effective supply of cannabis, for the following reasons:

(a) the MMAR restriction in s. 41(b.1) that prohibits a producer from growing cannabis for more than one authorized person, otherwise known as the one-to-one ratio restriction, is arbitrary;

(b) the MMAR restriction in s.54.1 that prohibits more than three production licence holders from growing at any one physical location, otherwise known as the "three max" restriction, is arbitrary;

(c) the federal government's sale, pursuant to a discretionary policy, of a single strain of non-organic, pre-ground, gamma-radiated dried cannabis to licensed end-users does not rectify the supply problems created by the one-to-one ratio and three max restriction;

(d) the federal government's policy decision to cease providing dried cannabis to persons that are unable to afford it acts to prevent access to a legal supply of cannabis and forces some authorized persons to either obtain cannabis from the black market or to go without;

(e) the Health Canada policy of contacting physicians regarding daily dosages, levels in excess of five or ten grams per day does not facilitate the purposes of the program and is not conducive to the health and healing of the

end-users and acts to prevent or limit access to an adequate lawful supply of medical cannabis; and

(f) the government policy decision to permit only the possession of dried cannabis, which has the effect of not permitting the legal use of cannabis resin or the derivatives made with cannabis resin, such as baked goods, salves and sprays is arbitrary.

HISTORICAL CONTEXT

Medical use of cannabis

[34] Cannabis has a very long history of medical use and a variety of modes of ingestion, with the earliest reports dating back some 4,000 years. The accuracy of the 4,000 year old history may be questionable. A history of the medical use of cannabis appears in the report of the Senate Special Committee on Illegal Drugs, a report which is Exhibit 72 in these proceedings. That history is taken largely from the testimony of Dr. Ethan Russo, a cannabis researcher that the Crown's expert witness, Dr. Harold Kalant, described as credible. The history demonstrates that cannabis has been used throughout the world to treat a variety of symptoms and conditions, many of which are similar to its present therapeutic application.

[35] Another shorter history appears at Tab B to the affidavit of Dr. Kalant, which is Exhibit 148 in these proceedings, and is an article by him confirming the longstanding historical use of medical cannabis. This use predates the inception of cannabis prohibition by hundreds of years. Primary use of cannabis, current and

historical, has been as an analgesic agent. Other therapeutic benefits historically attributed to cannabis include sedative, relaxant, and anti-convulsant actions, all of which also made it useful in the treatment of alcohol and opiate withdrawal.

Analgesia appetite stimulation, anti-pyretic and anti-bacterial effects and relief of diarrhea are also ascribed to the use of cannabis.

[36] The symptoms for which the therapeutic benefit of cannabis are clearly accepted, that is, by both government and all the experts who testified before this court, are:

(a) emesis;

(b) cachexia and anorexia;

(c) pain;

(d) reduction of intra-ocular eye pressure associated with glaucoma (it should be noted here, as the applicant has fairly done, that Dr. Kalant, a world-renowned expert in this area, agreed that cannabis was effective at alleviating the symptom but disagreed that it was a viable treatment option because of the psychoactive effect); and

(e) convulsions associated with epilepsy (Dr. Kalant again testified that the CBD in cannabis was likely the compound that provided Terry Parker, the accused in *R. v. Parker* (2000), 49 O.R. (3d) 481, 146 C.C.C. (3d) 193 (C.A.) ("*Parker*"), with therapeutic benefit and suggested that further research was needed in this neglected area).

[37] Cannabis also has potential therapeutic benefits and/or health protective effects for several other symptoms and conditions. The experts largely agreed that the therapeutic benefits provided by cannabis or cannabinoids in these areas were at least possible. All experts agreed that further research was needed and should be carried out in every area. The primary symptoms and conditions on which evidence was provided were: muscle spasticity; convulsions associated with epilepsy; inflammatory conditions; anxiety and depression; asthma; auto-immune conditions; movement disorders such as dystonia, Parkinson's disease and Tourette's syndrome; opiate and/or alcohol withdrawal; glioma and other cancers; brain disorders such as stroke and Alzheimer's disease; and aging.

[38] The court heard testimony of the number of medical cannabis users in Canada. The Canadian Addiction Survey, described by Dr. Kalant as the most detailed and comprehensive survey of its kind, reported in 2004 that five percent of Canadians over 15 years of age used cannabis for its self-reported medical use, putting the number of medical users at approximately one million persons. Senator Nolin testified that the Senate Special Committee on Illicit Drugs heard evidence in 2001 and 2002 from several witnesses that referenced 400,000 as the working estimate of the total number of medical users. Ms. Belle-Isle, who was accepted to give expert opinion evidence in this trial, is a researcher in the area of epidemiology. She concluded that between 17 and 37 percent of the estimated 58,000 persons living with HIV/AIDS in Canada use cannabis to relieve their symptoms, which puts the range of users within this category at between 9,860 and 21,460. The two primary societies in British Columbia for which membership numbers are in

evidence, the VICC and the British Columbia Compassion Club Society (the “BCCCS”), both have membership criteria that are more restrictive than other such organizations, and together they serve in excess of 4,700 persons. All estimates of users of medical marihuana should be viewed with caution.

[39] The risks of cannabis use are also generally known, though the science continues to evolve and certain assumed risks, such as lung cancer associated with smoking, have been shown to be less likely than previously believed. Of course, it does not follow that it is safe or even safer than cigarette smoking. All experts agree that cannabis is safer than many existing prescription drugs and some over the counter medication.

[40] According to Health Canada:

Marihuana is not a completely benign agent and it has a variety of physiological effects, but aside from the hazard, consequent on smoking, the adverse effects are within the range tolerated for other medications.

[41] The Crown's expert, Dr. Kalant, agreed that the hazards associated with smoking can be ameliorated by using different ingestion methods, such as baked goods, sprays and vaporization. Finally, several witnesses at trial testified that the side effects associated with their medical cannabis use were significantly less than those associated with their conventional treatments.

[42] I accept that the lay witnesses who so testified did so accurately in relation to themselves, particularly because although they were very interested in the outcome

of these proceedings and thus biased, their evidence was corroborated by that of the experts.

Development of the MMAR

[43] The Ontario Court of Appeal decision in *Parker* found s. 4 of the **CDSA** to be unconstitutional because it did not provide for an exemption from criminality for medical users of marihuana. As a result, on July 30, 2001, the MMAR came into effect. Under the original draft of the MMAR, every applicant who sought an authorization to possess cannabis needed to provide a medical declaration or declarations in support of the application. The nature of these requisite medical declarations depended upon the particular category in which the applicant was situated. Category 1 covered illnesses which were terminal and for which there was a prognosis of death within 12 months. Category 2 related to serious illnesses such as cancer, AIDS, multiple sclerosis, spinal cord injury or disease, epilepsy, severe forms of arthritis and specific symptoms associated therewith. Category 3 related to other illnesses and/or symptoms not specifically enumerated in the other categories.

[44] An applicant under category 1 required a declaration from his or her medical practitioner. Category 2 applicants needed to provide a medical declaration from a physician and a specialist, and category 3 applicants at that time needed medical declarations from a physician and two specialists. Medical declarations under each category were required to state that all conventional treatments for the symptoms had been tried or at least been considered. In the case of category 2 applicants, the medical declaration was required to go much further and state that all conventional

treatments were medically inappropriate for reasons specified in the regulations.

Category 3 applications required even further explanation from the medical specialist as to why all other treatments were medically inappropriate. In addition, the second specialist was required to review the applicant's medical file and discuss the applicant's case with the first specialist.

[45] Once authorized under the MMAR, the patient had only two legal options for producing his or her medicine. Patients could produce their own medicine or they could designate another individual to attend to the production. The other individual was barred from being compensated for the production and was also prohibited from producing for more than one authorized patient.

[46] As indicated in the introduction to these reasons, on October 7, 2003 the Ontario Court of Appeal released its decision in *Hitzig*. The court concluded that the requirement that category 3 patients obtain the declarations of two specialists was a violation of s. 7 of the *Charter*. It also concluded that the failure to provide a lawful source of medical marihuana violated s. 7. Accordingly, the court invalidated one access provision which required the approval of a second specialist for category 3 patients. It also invalidated those supply provisions which prevented designated growers from receiving compensation (s. 34(2)), from growing for more than one authorized patient (s. 41(b)) and from growing in combination with more than two other designated growers (s. 54). By invalidating these impugned provisions, the court concluded that the remaining provisions of the MMAR could continue to operate in a constitutionally sound manner.

[47] The court also pointed out that the decision cleared the way for Health Canada to licence the network of unlicensed suppliers that the government had, until then, been relying on to supply medical cannabis illegally. The court also stated that the government could choose how to address these particular deficiencies, at paragraph 172:

...we acknowledge that the Government could choose to address the constitutional difficulty by adopting an approach fundamentally different from that contemplated in the *MMAR*. The alternatives range from the Government acting as the sole provider, to the decriminalization of all transactions that provide marijuana to an ATP holder. Indeed, even if the Government is content with the solution contained in the *MMAR* as modified by our order, it may seek to impose reasonable limits provided they do not impede an effective, licit supply, for example on the amount of compensation that a DPL holder can claim or on the size of the operation that a DPL can undertake.

[48] Health Canada responded to the decision in two ways. First, with respect to the access issue, in June 2005, regulations were enacted to merge the enumerated illnesses of categories 1 and 2 into one new category. Under the new category 1, an authorization of the stated illnesses can be obtained upon the declaration of one family physician. The new category 2 relates to debilitating symptoms that are not specifically enumerated in category 1. Under this category there is no longer a need to obtain a declaration from a specialist; however, the signing physician must declare that he or she has consulted with a specialist unless the family physician is also designated as a specialist in the area relevant to the patient's illness.

[49] Second, with respect to the supply issue, on December 3, 2003, Health Canada reinstated most of the restrictions initially placed upon designated producers which had been invalidated by the Ontario Court of Appeal in *Hitzig*. The producer

can now be compensated for his or her efforts, but s. 41(b), the one-to-one ratio restriction, and s. 54, the three max restriction, were re-enacted as ss. 41(b.1) and 54.1, respectively. Accordingly, the producer still cannot grow for more than one patient and cannot grow in common with more than two other designated producers.

[50] In addition, the regulations were amended to permit designated producers to ship cannabis to the authorized persons that they produce for, and the requirement that designated producers keep records of their production activities was removed.

[51] In the Regulatory Impact Analysis Statement accompanying the 2003 amendments, Health Canada provided four reasons for reinstating the one-to-one ratio and the three max restrictions on designated producers:

Health Canada re-instated the limits on production of marihuana previously found in subsection 41(b) and section 54 of the MMAR in order to ensure consistency across programs within the Drug Strategy and Controlled Substances Programme, and more specifically to:

- (a) maintain control over distribution of an unapproved drug product, which has not yet been demonstrated to comply with the requirements of the FDA and its regulations;
- (b) minimize the risk of diversion of marihuana for non-medical use;
- (c) respect Canada's obligations as a signatory to the United Nations' *Single Convention on Narcotic Drugs, 1961*, as amended in 1972, concerning cultivation and distribution of cannabis; and
- (d) continue progress toward Health Canada's vision of a supply model wherein marihuana for medical purposes would be, among other things;
 - (i) subject to product standards;
 - (ii) produced under regulated conditions; and

(iii) distributed to authorized persons via a pharmacy-based system.

[52] This constitutes the essential justification presented by the Crown with respect to the second stage of the s. 7 analysis which I will engage in later in these reasons, commencing at paragraph 86.

[53] Recognizing that reinstating restrictions on designated producers would impede access to a lawful supply, Health Canada attempted to provide an acceptable alternative. On July 8, 2003, Health Canada put in place an interim policy allowing authorized patients to purchase cannabis it had been producing for research purposes under contract with PPS in Flin Flon, Manitoba since 2001. Upon the re-enactment of the restrictions on designated producers on December 3, 2003, Health Canada also changed its policy for distribution of the PPS product. PPS was given authority to distribute, on a cost recovery basis, cannabis seeds for those who wished to produce their own medicine, and dried cannabis for those who could not produce their own medicine. Patients who purchase seeds for self-production or for their designated producers are also entitled to purchase an interim four-month supply of dried cannabis pending the first harvest. Dried cannabis is shipped by courier directly to the patient or to the patient's physician. Purchase price of the dried cannabis is five dollars a gram, based upon a production cost of \$2.60 a gram, with the remaining cost related to shipping.

Statistics on the operation of the MMAR

[54] The statistics on the operation of the MMAR as of September 2002, the first month for which Health Canada provides statistics on their website, was that;

Possession of Dried Marihuana

- 864 persons were authorized to possess marihuana for medical purposes:
 - 376 held an ATP under the MMAR; and
 - 488 held an exemption for possession under s. 56 of the **CDSA**.

Cultivation/Production of Marihuana

- at least 265 persons were allowed to cultivate or produce marihuana for medical purposes:
 - 248 held personal use production licence under the MMAR;
 - 17 held a designated person production licence under the MMAR; and
 - an unknown number held an exemption for cultivation and production under s. 56 of the **CDSA**, though in December 2002 Health Canada reported that of the 389 persons then remaining with s. 56 exemptions, “a large number” also had exemptions for production.

[55] The statistics on the operation of the MMAR as of May 2004, the month of Mr. Beren's arrest, are as follows:

Possession of Dried Marihuana

- 733 persons were authorized to possess marihuana for medical purposes:
 - 622 held an ATP under the MMAR; and
 - 112 held an exemption under s. 56 of the **CDSA**.

Cultivation/Production of Marihuana

- 542 persons were allowed to cultivate or produce marihuana for medical purposes:
 - 381 held personal use production licences under the MMAR;
 - 65 held a designated person production licence under the MMAR;
 - 94 held an exemption for cultivation and production under s. 56 of the **CDSA**; and
 - two held a designation person exemption for cultivation under s. 56 of the **CDSA**.

Distribution of Dried Marihuana and Marihuana Seeds

- 54 persons were accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*;

- 26 persons had received marihuana seeds for medical persons under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*;
- six persons had received dried marihuana for up to four months and had received seeds for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*.

[56] The most recent statistics on the operation of the MMAR, as of May 2, 2008 are:

Possession of dried marihuana

- 2,639 persons are currently authorized to possess marihuana for medical purposes, and of these, 555 are ordinarily resident in British Columbia.

Cultivation/Production of Marihuana

- 1991 persons are currently allowed to cultivate or produce marihuana for medical purposes;
 - 1,615 hold a personal use production licence under the MMAR;
and
 - 276 hold a designated person production licence under the MMAR.

Distribution of Dried Marihuana and Marihuana Seeds

- 539 persons are currently accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*;
- 592 persons have received marihuana seeds for medical persons under *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*; and
- 91 persons are receiving dried marihuana for up to four months and have received marihuana seeds for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes*.

History of the VICC and VITCRI

[57] Much of the evidence of the history and operation of the VICC and of its research facility and the Production Facility, as well as the uses and efficacy of cannabis, was given by Philippe Lucas. Mr. Lucas is the founding director of the VICC and VITCRI. As a result of his stated and obvious bias, both as to the value of cannabis as a medicine, and his interest in the prosecution because of his relationship to the accused, I place no or very little weight on his testimony and writings unless corroborated by other more disinterested testimony or other less biased documentary evidence. The following history, then, I find as fact based on

the whole of the evidence of Mr. Lucas, the documents tendered by him and unobjected to, and the evidence of Deputy Chief Bill Naughton.

[58] The VICC, founded by Mr. Lucas, was incorporated under the **Society Act**, R.S.B.C. 1996, c. 433, in November 1999. Its stated purpose is to provide a safe, consistent and reasonably priced supply of cannabis and cannabis products for individuals who have been recommended marijuana for the treatment of various medical conditions by a physician. In order to join the VICC, a potential member must fill out an application form. That form requires that the individual's conditions and/or symptoms be disclosed and that the applicant describe his or her previous and existing experiences with medical cannabis and their use of conventional pharmaceutical drugs. A physician must also sign the application, including a declaration disclosing: the patient's condition and treatment; the fact that the physician and patient have discussed the potential risks and benefits of medical cannabis; the fact that the physician would consider prescribing cannabis if legally able to do so; and that if the patient chooses to use cannabis the physician will continue to monitor the patient and provide advice. The VICC contacts physicians to confirm this information before processing a membership application.

[59] I accept in principle that these conditions have to be adhered to, however, no doubt from time to time, one or more of these conditions which the VICC states is their objective has not been strictly observed. Mr. Lucas testified that the registration and orientation process takes approximately 35 minutes to finalize once a potential member brings in a completed form. At the time of his testimony in May 2007, the VICC had approximately 665 members whose applications had been

supported by 269 different physicians. Members must also sign a contract upon joining that releases the VICC from liability. Furthermore, the potential member agrees not to redistribute cannabis obtained from the VICC. The organization has a zero tolerance policy for such behaviour. Mr. Lucas testified that the VICC has expelled a total of seven members for redistribution of small amounts of cannabis and that he personally handled these expulsions.

[60] From 1999 through to mid 2003, the VICC obtained cannabis from a network of contracted producers. In the fall of 2002, Mr. Lucas leased an outbuilding in Sooke, British Columbia, and assisted with the construction of the Production Facility, for the purpose of establishing the VITCRI. The Production Facility commenced operations in January 2003 and produced cannabis for VICC members and was preparing to do research by growing non-psychoactive hemp as the placebo. Mr. Beren agreed with Mr. Lucas and the VICC that he would produce several strains of organic cannabis for the VICC members and for research purposes at the Production Facility location for a fixed salary.

[61] The objectives were three-fold: one, to produce multiple strains of organic cannabis exclusively for members of the VICC in a manner in which the VICC controlled all production inputs and in quantities sufficient for the members to cease relying on outside producers; two, to ultimately reduce the cost of cannabis to end-users; and three, to produce high quality organic cannabis and a hemp placebo for research purposes.

[62] The VICC was able to put aside approximately one kilogram of cannabis, which included leaf, for a chronic pain study that Mr. Lucas had proposed and received funding for from the U.S.-based Marihuana Policy Project. That research project entitled "Comparison of the Effects of Smoked Whole Plant Cannabis of Different THC Concentrations in Non-Treatment Naïve Single Patients with Chronic Pain", has since been approved by an institutional review board and submitted to Health Canada for final approval. The VICC is the clinical research site for this study.

[63] The Production Facility has also produced approximately one kilogram of hemp, non-psychoactive cannabis, to use as a placebo. All cannabis produced was completely organic and was tested for THC content, heavy metals and biological impurities to ensure a safe, standardized and organic product for distribution to medical users and for research purposes. I accept that the standards and protocols testified to were in fact those standards and protocols put in place, but I can make no finding that in fact those standards and protocols were met.

[64] The VICC has participated in other research, including the nausea and pregnancy study with the University of Victoria and the University of British Columbia entitled "Survey of Medicinal Cannabis and Use Among Childbearing Women, Patterns of its Use in Pregnancy and Retroactive Self-Assessment of its Efficacy Against Morning Sickness", published in the peer-reviewed journal of Complimentary Therapies and Clinical Practice in January 2006. This represents the first time that a compassion club-based study has been accepted for publication in a peer-reviewed journal. The VICC also participated in a federally-funded examination of human

rights and ethical concerns associated with access to medical cannabis by persons living with HIV/AIDS, entitled "Our Right, Our Choice: Cannabis as Therapy for People Living with HIV/AIDS," conducted by the Canadian AIDS Society. Mr. Lucas was on the steering committee of the study, and a federally-funded study of the Patrons of Compassion Societies being conducted by Andrew Hathaway of the Centre for Addiction and Mental Health, entitled "Cannabis as Self Medication, a Study of Compassion Clubs and Clients".

[65] Additionally, the VICC is a partner in a five-year, five million dollar meta study being proposed by Patricia Ericksen, entitled "Substance Use, Stigma and Normalization, the Social Transformation of Drug Use in Modern Society," which is currently making its way through the federal approval process. Lastly, Mr. Lucas has conducted an examination of the federal medical cannabis program entitled "Regulating Compassion, an Overview of Canada's Medical Cannabis Policy and Practice", which has been published in the peer-reviewed *Harm Reduction Journal*. Mr. Lucas has also received a Graduate Research Fellowship from the Center for Addiction Research of British Columbia, to conduct a study entitled "Changes in Pharmaceutical Opiate Use Rates of New Members of a Community Based Medical Cannabis Dispensary Suffering From Chronic Pain", which is currently being conducted by the VICC.

[66] At the time of Mr. Beren's arrest, the VICC apparently had approximately 400 members, all with physician support for their membership. Most were not protected by the MMAR. At the time of this trial the VICC's membership had grown to between 700 and 800 persons. Most are still not protected by the MMAR.

[67] Health Canada's statistics demonstrate that as of the time of Mr. Beren's arrest there were actually fewer people protected by the MMAR, including s. 56 exemptees, than there were in September 2002, three months after the regulations were promulgated. Also as of May 2004, very few of the 734 authorized persons were accessing the PPS product (up to 86) and Health Canada was unaware of the legal source of supply for 132 of them.

[68] The membership of the VICC at that time was approximately 400, meaning that the VICC alone supplied vastly more medical cannabis users than those who accessed the PPS product through Health Canada, at least according to these statistics. In fact, the VICC was the source of cannabis for as many medical users as all three supply options provided for by the MMAR.

[69] In the nearly four years since Mr. Beren's arrest, the federal government's program has grown, largely due to easing the restrictions in the Phase II amendment process in 2005, according to testimony from a Health Canada official. An additional 1,905 persons have become authorized to possess dried cannabis, representing approximately 475 new entrants into the program each year. An additional 1,449 cannabis producers have been licensed, representing approximately 362 new producers per year. An additional 485 authorized persons have accessed the PPS product and not obtained production licences, representing approximately 121 persons per year that have listed the federal government as their source of legal supply. As of May 2008, the federal government was unaware of the source of supply of 109 authorized persons (2,639 authorized persons less 1991 with production licences less 539 accessing the PPS product). Finally, Health Canada's

statistics demonstrate that a total of 555 persons ordinarily resident in British Columbia have obtained an ATP and the corresponding right to access medical marihuana through a legal supply source.

[70] I will briefly summarize the evidence of the witnesses and particularly the lay witnesses who testified as users of medical marihuana. A fair summary of the evidence of the lay witnesses, all of whom use cannabis to alleviate symptoms of serious medical conditions such as HIV/AIDS and hepatitis C, fibromyalgia, degenerative disk disease, irritable bowel syndrome and disintegrating arthritis and others, is that with one exception, from 2000 to 2007, they have had difficulties obtaining licit cannabis. However by 2006, all but one had found a physician to support applications for ATPs, and in at least three cases, after a few failed attempts, they received the support of a specialist. All of these witnesses were less than enthusiastic about government-supplied cannabis and found the requirements to obtain a legitimate source of cannabis from the government frustrating; in some cases, demeaning. All preferred to deal with a compassion club as they agreed that the quality of the product, as well as the supportive atmosphere for obtaining it, provided welcome psychological support for them, all of whom suffer from serious debilitating conditions.

[71] Most medications which provide serious pain relief for conditions in which pain is a primary and constant symptom rely on the psychological state of the patient to assist with pain relief. That is, the belief in the pain relief is an important factor in actually obtaining relief. In addition, the side effects of most serious pain medications and other drugs were not experienced by these witnesses as a result of

taking marihuana for relief, similar to that which they hoped to obtain from more conventional and quite strong pain medications. This anecdotal and subjective evidence was corroborated by several experts, such as Dr. Kalant and Dr Melamede, who is a researcher, professor and the former chair of the biology department at the University of Colorado (Colorado Springs). Dr Melamede has taught the senior-level course on endocannabinoids and medical cannabis each year since 2002.

[72] Thus, the evidence in this trial demonstrates that the source, the form, and the atmosphere in which cannabis is obtained, in all probability increases the effectiveness of the substance. Barriers to obtaining this type of cannabis, from a safe and supportive source which the patient believes will provide effective pain relief, contributes to the frustration of seriously ill patients. In the MMAR regime, generally patients must spend months, if not years, persuading their physicians of the benefits of cannabis for them, finding a specialist who is sympathetic to their perceived need for such unorthodox medication, completing an application and finally, if successful, receiving cannabis from the government. However, it is alleged, that this source lacks a supportive network of belief in the efficacy of different strains, lacks the benefits of belief in organic growing methods, and, perhaps most important, lacks a supportive environment in using an unorthodox medication.

[73] Several of the lay witnesses also testified as to a delay of weeks, sometimes months, in getting their government supply after applying for it.

ANALYSIS OF THE ISSUES

Introduction

[74] I now turn, with this factual background, to an analysis of the applicant's challenge to s. 7. The MMAR creates specific conditions which must be met in order to have access to a supply of marihuana for medical purposes. Parliament has recognized that marihuana may be medically beneficial for some persons with some diseases. It has been accepted that s. 7 rights of patients with a specified medical condition are engaged by the accessibility or inaccessibility of medical marihuana. Further, Canadian courts have recognized that dignity, respect for it, and its presence for the individual is an important fundamental personal right capable and worthy of **Charter** protection. Thus, these and other factors provide part of the legal context for any analysis of the application of s. 7 to both the access and the supply issues raised in this case.

[75] Section 7 of the **Charter** reads as follows:

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.

[76] The legal analysis for a s. 7 claim has two steps, which are outlined in **Hitzig** at paragraph 75:

- 1) Has the government action resulted in a threshold violation of one or more of the rights described in s. 7?
- 2) If there is a threshold violation, is it inconsistent with the principles of fundamental justice?

Threshold Violation of section 7

[77] As I have already indicated, I adopt, wherever applicable, the legal analysis outlined in *Hitzig*. The court in *Hitzig* explained that there are two main issues to examine within the first stage of the s. 7 analysis, at paragraphs 76-78. First, a court must identify the individual interest(s) that is allegedly infringed upon and determine whether it falls within meaning of the phrase “life, liberty and security of the person”. Second, if the interest is protected under s. 7, a court must examine whether the interest(s) has been infringed upon by a form of state conduct, which is not limited to simply the criminal realm. If both steps are satisfied, then a threshold violation of s. 7 is established and a court must move onto the second stage.

[78] In the second stage, a court must identify and articulate the principles of fundamental justice engaged by the facts of the case. Subsequently, the court must determine whether the threshold violation identified in the first stage is inconsistent with the principles of fundamental justice.

[79] Importantly, the court in *Hitzig* instructs courts to be sensitive to the context of the claim. The court states, at paragraph 78:

78 All parts of the s. 7 analysis must be sensitive to the specific context in which the claim is made. Context for the present purposes includes the factual matrix in which the claims are advanced, the nature of the alleged rights affected by the state conduct, the nature of the interference with those rights by the state, and the interests relied on by the state in support of its conduct. Context encompasses the effect as well as the purpose of the impugned state conduct. Where legislative provisions are in play, context refers to the language of the statute and the legislative and common law history leading up to the enactments of the challenged provisions.

[80] In *Hitzig*, the Ontario Court of Appeal addressed the first stage, whether there was a threshold violation of s. 7, with respect to both the access and supply issue by first providing context of the claim, at paragraphs 80-85:

80 This question must be addressed in the context of those with the medical need to take marihuana. It is they who are entitled to a constitutionally sound medical exemption from criminal sanction for possession.....

82 For the purposes of this discussion the *MMAR* are best viewed in the context of the *CDSA* as constituting a regulatory regime which places strict controls, backed by criminal sanctions, on the acquisition and the use of marihuana by those who have medical need of it.

83 Our analysis at stage one is greatly assisted by the reasons of this court in *R. v. Parker*.....In that case, the context in which the rights to liberty and security of the person were considered was identical to this case in its most important aspect. There, as here, those whose s. 7 rights were at stake require access to marihuana for medical reasons, to treat the symptoms of serious medical conditions. There, as here, the state had placed barriers between them and the marihuana necessary for their health.

84 However, in one particular respect, the context in *Parker* was somewhat different. There Mr. Parker's rights to liberty and security of the person had to be considered in the context of a simple and unqualified criminal prohibition against possessing marihuana. Here the context is the *MMAR*, which permit the possession of marihuana without criminal sanction but only if specific eligibility conditions are met and only by making certain presumptions concerning the source of supply.

85 As we have described, the main eligibility conditions set by the *MMAR* begin by requiring that an individual have a symptom associated with a medical condition that fits within one of three specific categories. The individual must have support from a physician willing to declare that all conventional treatments have been tried or at least considered and that marihuana would mitigate the symptom, with benefits that outweigh the risks. The physician must also specify the daily dosage limit for the individual. For categories two and three the physician cannot be the individual's general practitioner but must be a specialist. And for category three, the support of a second specialist is required.

[81] In this case the amendments which implemented some of these restrictions were in place at the time of Mr. Beren's arrest. The relevant restrictions are set out at paragraphs 48-50.

[82] The court continued its discussion with respect to context at paragraphs 86-90:

86 An individual with the medical need to take marihuana who cannot meet these conditions cannot obtain a medical exemption and is subject to the criminal sanction against possessing marihuana found in s. 4 of the *CDSA*. An individual with the same need who has not obtained a medical exemption for any other reason is subject to the same sanction. In the same way, an individual with this need who possesses more than the authorized amount of the medication is subject to the criminal sanction, even if that individual has obtained a medical exemption.

87 Thus, while the medical exemption scheme means that individuals who need to take marihuana for medical reasons are not automatically subjected to criminal sanction, the *MMAR* set up stringent conditions with which these individuals must attempt to comply in order to use the medication they require. If they do not do so they must risk conviction and imprisonment or forego their serious medical needs.

88 We have also described the constraints on the sources of supply of marihuana for those with the medical need to use it that accompany the *MMAR*. Apart from the wholly theoretical option of obtaining marihuana from a licensed dealer, an individual must declare that the exemption is sought in respect of marihuana that comes from one of two sources in order to get a medical exemption. Either the individual is to produce it personally or it is to be produced for him or her by a licensed designated person who cannot be paid for doing so and who can neither grow marihuana for more than that individual nor in combination with more than two other designated producers. The third option in the *MMAR* (that is, obtaining the marihuana from a dealer licensed under the *NCR*) is theoretical only since there are now no such dealers.

89 Where individuals cannot grow the marihuana they require (and many cannot for a variety of reasons, including their health) and cannot secure a designated producer (for a various reasons, including the

constraints imposed by the *MMAR* on these producers) they go beyond the declarations they have made if they seek to acquire the medication they need in any other way. And anyone who would supply marihuana to them would face the criminal prohibition in s. 5 of the *CDSA*.

90 Given this context, we turn to whether the rights to liberty and security of the person of those with the medical need to take marihuana are engaged by this scheme of medical exemption.

[83] In examining the first stage of the s. 7 analysis, the court determined that both the right to liberty and right to security of the person were engaged based on the facts of the case. The right to liberty was analyzed in two ways. First, individuals with medical conditions requiring the use of marihuana were at risk of criminal prosecution and imprisonment, should individuals not meet the eligibility requirements set out in the *MMAR*. Second, viewing the right to liberty more broadly, individuals should have the right to make decisions of fundamental personal importance. If the state attempts to regulate such decisions it must do so in accordance with the principles of fundamental justice. The right to security of the person included the right to access medication which was reasonably required to treat a serious medical condition when such access was interfered with by threat of criminal sanction.

[84] The court's analysis of whether a threshold violation of s. 7 had occurred, commences at paragraph 91:

91 As *R. v. Parker*...points out, the liberty interest of these individuals can be considered in two ways. First, viewed more narrowly, their right to liberty is at risk in the context of this medical exemption due to the threat of criminal prosecution and imprisonment arising from their need to possess and use marihuana for medical purposes. This risk manifests itself in several ways. The risk clearly exists for those who do not have an ATP because they cannot clear

the eligibility hurdles set up by the *MMAR*. It also exists for those with medical need who do not have an ATP for any other reason (although in each case that other reason may be a factor in assessing compliance with the principles of fundamental justice). Further, even for those with an ATP, this aspect of the liberty interest is at risk should they stray outside the conditions set for their possession by the *MMAR*. For example, the *MMAR* authorize an ATP holder to possess marijuana, but only in a strictly limited quantity, beyond which there is no exemption.

92 The right to liberty can also be properly viewed more broadly, to include the right to make decisions of fundamental personal importance... Viewed in this way, s. 7 requires that if the state seeks to interfere with these decisions, it must comply with the principles of fundamental justice in doing so. Like the other rights encompassed by s.7 this aspect of the right to liberty is protected not just in the context of the criminal law, but against any deprivation that occurs as a result of an individual's interaction with the justice system and its administration.

93 Here, as in *Parker*, there is no doubt that the decision by those with the medical need to do so to take marijuana to treat the symptoms of their serious medical conditions is one of fundamental personal importance. While this scheme of medical exemption accords them a medical exemption, it does so only if they undertake an onerous application process and can comply with its stringent conditions. Thus, the scheme itself stands between these individuals and their right to make this fundamentally important personal decision unimpeded by state action. Hence the right to liberty in this broader sense is also implicated by the *MMAR*.

94 It is equally clear that the right to security of the person of those with the medical need to use marijuana is implicated in the circumstances of this case. In *Parker*... this court reviewed the jurisprudence and concluded that this right encompasses the right to access medication reasonably required for the treatment of serious medical conditions, at least, when that access is interfered with by the state by means of a criminal sanction. In *Gosselin*,... (which postdated *Parker* by two and one-half years) the Supreme Court of Canada made clear that this interference by the state need not be by way of the criminal law, provided it results from the state's conduct in the course of enforcing and securing compliance with the law.

95 In this case, the *MMAR*, with their strict conditions for eligibility and their restrictive provisions relating to a source of supply, clearly present an impediment to access to marijuana by those who need it for their serious medical conditions. By putting these regulatory

constraints on that access, the *MMAR* can be said to implicate the right to security of the person even without considering the criminal sanctions which support the regulatory structure. Those sanctions apply not only to those who need to take marihuana but do not have an ATP or who cannot comply with its conditions. They also apply to anyone who would supply marihuana to them unless that person has met the limiting terms required to obtain a DPL. As seen in *Rodriguez v. British Columbia (Attorney General)*...a criminal sanction applied to another who would assist an individual in a fundamental choice affecting his or her personal autonomy can constitute an interference with that individual's security of the person. Thus, we conclude that the *MMAR* implicate the right of security of the person of those with the medical need to take marihuana.

[85] Given that threshold issue within the first stage of the s. 7 analysis had been met, the court went on in *Hitzig* to determine whether the interests at stake were infringed upon by some form of state conduct. This analysis starts at paragraph 97:

97 In its narrower aspect, the right to liberty is clearly violated because those with the medical need to use marihuana are exposed to conviction and imprisonment if they do not meet the eligibility conditions for or otherwise do not possess an ATP or if they acquire and possess marihuana outside the strict conditions of the ATP. In those circumstances, they are subject to the criminal prohibition in s. 4 of the *CDSA*.

98 It is no answer at this stage of the s. 7 analysis to say that there is no risk to the right to liberty because those in medical need can possess marihuana lawfully simply by applying for an ATP, meeting the eligibility conditions and observing the other conditions that are part of the ATP process. While the reasonableness of these conditions may be relevant in determining whether the *MMAR* conform to the principles of fundamental justice they clearly represent significant barriers imposed by the state standing between those with medical need and their use of marihuana, unaffected by criminal sanction. Simply put, the *MMAR* do not remove the real risk of conviction and imprisonment for those who must acquire and use marihuana to meet their medical needs. The *MMAR* thus interfere with this aspect of their right to liberty.

...

103 The medical exemption scheme puts those people at risk of prosecution and imprisonment when they use the medication they need but do not have an ATP or cannot observe its conditions. Moreover, the *MMAR* provide them with very limited and ineffective access to marihuana through their own PPL or from a DPL holder. Apart from this, the criminal prohibition in s. 5 of the *CDSA* applies to anyone who would supply them with marihuana. The reality of supply thus is that this criminal sanction stands between those in medical need and the marihuana they require. That is the effect of the *MMAR*.

104 Even apart from these criminal sanctions for non-compliance, the *MMAR* constitute significant state interference with the human dignity of those who need marihuana for medical purposes. To take the medication they require they must apply for an ATP, comply with the detailed requirements of that process, and then attempt to acquire their medication in the very limited ways contemplated by the *MMAR*. These constraints are imposed by the state as part of the justice system's control of access to marihuana. As such, they are state actions sufficient to constitute a deprivation of the security of the person of those who must take marihuana for medical purposes. They are state actions within the administration of justice that stand between those in medical need and the marihuana they require.

105 In summary, we conclude that the *MMAR* constitute a scheme of medical exemption which deprives those who need to take marihuana for medical purposes of the rights to liberty and security of the person. This is a threshold violation of s. 7. We are therefore required to turn to the question of whether this deprivation is in accordance with the principles of fundamental justice.

[86] Thus, on the facts of this case, I adopt as applicable this analysis and similarly find that Mr. Beren's s. 7 rights to liberty and security of the person are engaged by the restrictions imposed on producing marihuana for persons who take marihuana for medical purposes.

Fundamental Justice

[87] Having found a threshold violation of Mr. Beren's s. 7 rights, we move on to the second stage of the analysis. At this stage the court must determine which principles of fundamental justice are engaged based on the facts of this case and

whether the threshold violation is inconsistent with those principles. As the court in *Hitzig* made clear, context is critical to determining which principles of fundamental justice are engaged. This analysis begins at paragraph 106:

106 The phrase "the principles of fundamental justice" in s. 7 is of necessity general and abstract. The court must articulate with as much precision as possible the core principles of our legal system engaged by the specific state action in issue and the specific alleged deprivation of the individual's rights. In articulating the operative principles, the court must avoid describing those principles at a level of generality that suggests little more than a personal assessment of the wisdom of the impugned state conduct. The principles of fundamental justice are not the constitutional equivalent of equity's Chancellor's foot...

107 Context is crucial to both the identification of the operative principles of fundamental justice and the determination of whether any threshold violation of an individual's rights under s. 7 is consistent with the principles of fundamental justice at play...The *Hitzig* applicants assert the right to make a fundamental personal decision concerning how best to treat serious symptoms associated with life threatening medical problems...The Government has recognized since 1999, that for some seriously ill individuals, marihuana is a medically useful and appropriate medication. The Government has accepted that those individuals must be able to obtain and use marihuana for medical purposes without fear of criminal prosecution. At the same time, however, the Government is obliged to protect the public health and safety of all of its citizens through the regulation of the medicinal use of substances like marihuana. The Government contends that public health and safety concerns include potential health risks from long-term use, the Government's need to comply with stringent international controls on the use and distribution of marihuana, and the Government's obligation to combat the criminal drug trade, which includes the illicit distribution of marihuana for non-medical purposes.

108 The nature of the individual right asserted and the purpose animating the Government action are important contextual considerations at the second stage of the s. 7 analysis. The actual effect of the state action is an equally important contextual consideration. State action that may on its face be benign or even promote individual interests may, in its actual operation, be inconsistent with the principles of fundamental justice...The *Hitzig* applicants stress the effects of the scheme implemented by the *MMAR* in asserting a violation of their s. 7 rights both in respect of the supply issue and the eligibility issue.

[88] The court then goes on to deal with the supply issue, which is the issue most at play in Mr. Beren's challenge, and the principles of fundamental justice, starting at paragraph 109:

109 It is undeniable that the effect of the *MMAR* is to force individuals entitled to possess and use marihuana for medical purposes to purchase that medicine from the black market. As Lederman J. put it at para. 159 [of the trial decision]:

As a result, the regulatory system set in place by the *MMAR* to allow people with a demonstrated medical need to obtain marijuana simply cannot work without relying on criminal conduct and lax law enforcement.

110 Lederman J. found that the absence of a legal supply of marihuana for people entitled to possess and use it under the *MMAR* resulted in a breach of s. 7, holding at para. 160:

To my mind, this aspect of the scheme offends the basic tenets of our legal system. It is inconsistent with the principles of fundamental justice to deny a legal source of marijuana to people who have been granted ATPs and licences to produce. Quite simply, it does not lie in the government's mouth to ask people to consort with criminals to access their constitutional rights.

111 We agree with the conclusion reached by Lederman J. He does not, however, expressly identify the principle or principles [on which he relied].

[89] The discussion of the principles of fundamental justice as it applies to the supply issue in *Hitzig* is largely taken up by the facts under consideration at that time; that is, that there was no available government supply of marihuana, either seeds or dried marihuana, which eligible patients could access if they could not grow their own or find someone else to grow it for them. As set out earlier in these reasons, significant amendments and policy decisions brought forward by the government prior to May 2004 changed the legal landscape. However, some part of the analysis is still applicable to the facts here and I quote from and adopt the

following paragraphs again from the Ontario Court of Appeal in **Hitzig**, beginning at paragraph 119:

119 There is an alternative approach to the second stage of the s. 7 inquiry which also leads to the conclusion that the provisions in the *MMAR* are inconsistent with the principles of fundamental justice. This alternative approach begins by recognizing that it is a principle of fundamental justice within our legal system that the individual rights identified in s. 7 may be subordinated, at least to some extent, to substantial and compelling collective interests...

120 The application of this approach to the principles of fundamental justice requires that the court determine whether there is a substantial and compelling state interest served by the impugned state action which has resulted in the threshold violation of the individual rights identified in s. 7. If the action is in furtherance of a substantial and compelling interest, then the question becomes whether the state action imposes an undue burden on the individual's rights...Determining when the balance struck by the state can be said to effect a fair balance between state interests and individual rights can be a very difficult question which pushes the court to the brink of the forbidden world of policy-driven decision making.

[90] I note that in this case, as in all cases dealing with our **Charter**, it is always important for courts to remember where the boundary is between legislative and judicial law making. Courts are not Parliaments. However, we must enforce laws that are consistent with the **Charter** and declare as invalid those which are not. This brings the court into social and political areas. Courts, and judges within these courts, must remain independent of the government, and the government must respect that. That requires that courts respect where the boundaries are and not enter the fray unless compelled by the law as promulgated by Parliament in the **Charter**.

[91] The court in **Hitzig** did not find that the *MMAR* served a substantial and compelling collective interest which could justify the lack of a legal source of medical

marihuana. This analysis, starting at paragraph 121, is specifically applicable to this case:

121 In this case, however, the Government's attempt to rely on the assertion that the *MMAR* serve a substantial and compelling collective interest justifying the absence of any legal source of medical marihuana fails at its most basic level. The substantial and compelling interest advanced by the Government is the need to preserve and promote public health and safety. We accept that this can be a substantial and compelling collective interest for the purposes of s. 7 of the *Charter*. However, a scheme which depends on the criminal black market and which forces individuals to go to the black market to obtain necessary medical treatment cannot possibly further public health and safety. In fact, it has the opposite effect. By failing to provide for a lawful source of medical marihuana, the *MMAR* not only compromise individual rights, but undermine the very collective interests which the Government contends are promoted by these regulations...

122 Our conclusion that a scheme which does not provide for lawful access to medical marihuana is inconsistent with s. 7 of the *Charter* should not surprise anyone who has read this court's decision in *Parker*...or the decision of the Alberta Court of Queen's Bench in *R. v. Krieger*...Although neither case dealt with the *MMAR*, both made it clear that any medical exception to the criminal prohibition against possession of marihuana would have to address not just possession, but also the means of obtaining the drug needed for the medical purpose. In determining that the prohibition against cultivation of marihuana in the former *Narcotic Control Act*, R.S.C. 1985, c. N-1, was unconstitutional absent an adequate medical exception, Rosenberg J.A. said in *Parker*...:

...

However, it is apparent from these reasons and the reasons dealing with the cultivation offence under the Narcotics Control Act that if the cultivation prohibition had been before this court, I would hold that it too infringes Parker's s.7 rights. *Since there is no legal source of supply of marihuana, Parker's only practical way of obtaining marihuana for his medical needs is to cultivate it. In this way, he avoids having to interact with the illicit market and can provide some quality control.* [Emphasis added.]

...

124 We read Rosenberg J.A. as requiring "a practical way of obtaining" the necessary medical marihuana as an integral part of any legitimate medical exemption. We also read him as clearly eliminating the black market as a suitable means of obtaining the necessary medical marihuana.

[92] Having found the MMAR eligibility or access regulations engaged s. 7 rights, the court then discussed the balancing of state interests on liberty and security of the person, at paragraphs 133-135:

133 The legal context for this analysis is best provided by the balancing approach to the principles of fundamental justice that we already have described. Here, it is useful to begin with the words of McLachlin J. (as she then was) in *Cunningham v. Canada*, [1993] 2 S.C.R. 143 at 151-52, 80 C.C.C. (3d) 492:

The principles of fundamental justice are concerned not only with the interest of the person who claims his liberty has been limited, but with the protection of society. Fundamental justice requires that a fair balance be struck between these interests, both substantively and procedurally. [Emphasis added.]

134 This approach is elaborated in *Godbout*... [*Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844, 152 D.L.R. (4th) 577] at 899-900, where La Forest J. said this on behalf of the three judges who dealt with s. 7 in that case:

But just as this Court has relied on specific principles or policies to guide its analysis in particular cases, it has also acknowledged that looking to "the principles of fundamental justice" often involves the more general endeavour of balancing the constitutional right of the individual claimant against the countervailing interests of the state. In other words, deciding whether the principles of fundamental justice have been respected in a particular case has been understood not only as requiring that the infringement at issue be evaluated in light of a specific principle pertinent to the case, but also as permitting a broader inquiry into whether the right of life, liberty or security of the person asserted by the individual can, in the circumstances, justifiably be violated given the interests or purposes sought to be advanced in doing so. To my mind, performing this balancing test in considering the fundamental justice aspect of s. 7 is both eminently sensible and perfectly consistent with the aim and

import of that provision, since the notion that individual rights may, in some circumstances, be subordinated to substantial and compelling collective interests is itself a basic tenet of our legal system lying at or very near the core of our most deeply rooted juridical convictions. We need look no further than the *Charter* itself to be satisfied of this. Expressed in the language of s. 7, the notion of balancing individual rights against collective interests itself reflects what may rightfully be termed a "principle of fundamental justice" which, if respected, can serve as the basis for justifying the state's infringement of an otherwise sacrosanct constitutional right.

135 Related to this principle is the concept described by Sopinka J. in *Rodriguez*...where he said that if the state action which causes the deprivation does little or nothing to enhance the state's interest, it can properly be seen as arbitrary and not in accordance with fundamental justice. In such circumstances there cannot possibly be a fair balance between the individual's rights and the collective interests...

Access

[93] The court in *Hitzig* then analyzed the access issue in relation to the concept of fundamental justice, at paragraphs 138-143:

138 The second attack on the eligibility barriers created by the *MMAR* focuses on the use of physicians as gatekeepers in the sense that every application must be supported by a doctor and it is that doctor who must declare that marihuana is recommended to mitigate the symptom involved. It is argued that this places unwarranted power to determine whether an individual receives a medical exemption in the hands of physicians rather than letting the individual decide for him or herself or having the Minister of Health do so. It is further argued that the serious concerns of several central medical groups about the gatekeeper role for physicians means that doctors will not assist individuals to obtain medical exemptions.

139 Again, we do not agree. 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. The second argument is answered by Lederman J.'s finding 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. 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.

140 The third attack on the eligibility conditions of the *MMAR*, and the one focused on in the argument before us, rests on the requirement that the physician support for a medical exemption for individuals in category 2 and category 3 must come from specialists. Again, the Hitzig applicants make two arguments in mounting the attack.

141 First, they say that because marihuana is an untested medication there is no justification for requiring medical support beyond the individual's own general practitioner since the specialist has no knowledge advantage. They say that when this is combined with the practical difficulties that exist in accessing specialists, particularly in rural areas, the specialist requirements for categories 2 and 3 constitute an unreasonable barrier which significantly interferes with those in medical need from accessing the medication they require.

142 In our view, this argument too does not succeed. In order to qualify for a medical exemption, both individuals in category 2 and those in category 3 must have a declaration from a specialist practising in an area of medicine relevant to the treatment of the individual's medical condition causing the symptom to be mitigated. The declaration must say that all conventional treatments for the symptom have been tried or considered and why each is medically inappropriate. The requirement for a declaration in this form serves substantial and compelling state interests. First, it serves the state interest in protecting the health and safety of its citizens in relation to an untested drug. Second, it serves the state interest in complying with international conventions aimed at restricting the use of drugs such as marihuana save for legitimate medical and scientific purposes. A specialist in the treatment of the particular medical condition is likely to have more knowledge than a general practitioner of the complete range of possible treatments, including ones that may just be emerging. The specialist requirement thus better assures that marihuana is used only if no other more conventional medication is effective. Given that marihuana is an untested drug, this is a substantial and compelling state interest. So too is compliance with international conventions that are designed to restrict the use of drugs save for legitimate medical and scientific purposes a state interest which the specialist requirement also serves.

143 Moreover, on this record, the Hitzig applicants simply have not shown that the specialist requirement is a significant impediment to obtaining a medical exemption. Only one of these applicants, Ms. Devries, can point to any difficulty, due to a lack of access, in getting specialist support for her application, and there is some doubt that this individual sought actively to meet this requirement, because she first spoke to a specialist only a few days before her cross-examination in this proceeding. Here as well, Lederman J.'s finding of fact, at paras. 154-56, 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.

[94] Returning then to the access issue in this case, the applicant submits that this court should revisit *Hitzig* on the facts before this court. That raises the question of whether the facts in this case engage the invitation in *Hitzig* to reconsider whether the justification for physicians as gatekeepers has become arbitrary. In other words, is the risk or harm sought to be prevented by the requirement outweighed by the risk or harm of preventing access?

[95] The answer on the facts here has to be no. Although some of the requirements may cause some patients delay or even denial of access for the relief sought, the potential harm to any seriously ill patient where the authorized treatment for the illness and the properties of marihuana may be contraindicated remain very real and unstudied. Further, these issues are essentially medical issues and thus, while the drug remains unapproved and research into its medicinal efficacy for any particular medical condition is still preliminary, there is ample justification for the requirement or hurdles to access set by the MMAR.

[96] Factually, the anecdotal evidence in this case supports the proposition that it is becoming increasingly easy to obtain a physician's support for a licence to possess marihuana. Only one witness before the court could not, by the time of trial, obtain a physician's support, and she admitted that she knew of physicians who were providing support for other patients but she was choosing not to ask for herself. She may have had very good reasons for not so choosing, but it does not support the proposition that such physicians are, in fact, unavailable.

[97] Thus, there is no factual foundation in this case to find that access to physicians willing to provide necessary support for the acquisition of a licence to possess has decreased since 2002 or 2003. On the contrary, it would appear inferentially, from the evidence before this court, to have increased. Thus, the MMAR provisions dealing with eligibility are not contrary to fundamental justice and therefore are not in breach of s. 7. There is no basis for this court to move beyond the decision in *Hitzig* on this issue.

Supply

[98] The Crown asserts, with persuasive arguments, that because the amendments to the MMAR precede the date of this offence, May 27, 2004, the sole issue in this case is whether the regime created by the MMAR, as set out in the 2003 regulations, adequately provided for a safe, secure and reliable supply of cannabis to those individuals who are constitutionally entitled to possession and use of cannabis for the treatment of a serious medical condition. The Crown's position is that those regulations now do so provide.

[99] On the supply issue, following ***Hitzig*** the government made dried marihuana available to those holding an ATP, in dosages approved by their physicians. This supply was not available as part of the factual foundation before the ***Hitzig*** court, thus the Crown submits the government is not breaching any notion of fundamental justice by restricting choice of supply when it makes certain limitations. Thus, says the Crown, at the time of Mr. Beren's arrest, supply was available in one of three ways: an ATP holder could grow their own marihuana; could obtain it from a single person licensed to produce it for them; or could obtain a supply from the government source of supply through PPS.

[100] The applicant, Mr. Beren, submits that the MMAR failed to adequately provide for a safe, secure and reliable supply of cannabis for those with a legitimate medical need for it. Given, says the applicant, that s. 7's guarantee of liberty and security of the person encompasses the right to make decisions of fundamental personal importance without interference from the state, any interference by the state to restrict the choice of supplier of medical marihuana without adequate justification of the state interest(s) requiring protection breaches an individual's s. 7 rights.

[101] Essentially, says the applicant, many seriously ill patients believe that particular strains and specific levels of strength of certain cannabis deliver to them specific and needed relief. The applicant argues that patients cannot necessarily get this kind of relief from one strain or the one strain produced by the government supplier, PPS.

[102] The court heard evidence that individuals do in fact claim more relief from some specific strains of cannabis. The court heard and accepts as fact that the VICC was set up to both research and supply different strains of different strengths of the plant. The court also heard from such experts as Dr. Kalant that research into the efficacy of cannabis is really in its infancy, but that there is some credible evidence thus far that particular strains and certain strengths of marihuana may provide specific relief for some conditions, such as epilepsy and certain wasting diseases. In general, however, Dr. Kalant testified that the evidence, from a scientific perspective, is not compelling but it is worthy of further research.

[103] The court also heard from Dr. Kalant and Dr. Melamede that in relation to the use of marihuana for medical purposes there is little, if any, evidence that it is harmful, with two exceptions. One, in its smoked form, marihuana possesses the same if not higher risk of harm to an individual's health than cigarettes; this is a known and obvious risk. The court also heard that there are several ways for seriously ill persons to ingest marihuana without smoking it and thus the risk posed by smoking can be obviated.

[104] Second, the court heard inferential evidence that there is a risk that using medical marihuana to medicate certain symptoms of serious illnesses may prevent the seeking of more effective treatments. It is acknowledged that there are a few very specific conditions, such as schizophrenia, for which marihuana is contraindicated. This concern is ameliorated by maintaining physicians as gatekeepers.

[105] These concerns are part of the factual context within which a necessary balance is reached between protection of personal decision making (of fundamental personal importance to an individual) and the duty of the state to protect the health and safety of all of its citizens.

[106] The Crown's position in relation to this issue is clearly set out in their written submissions at paragraph 166:

The liberty interest encompasses the right to make decisions of fundamental personal importance without interference from the state. This does not mean that all choices are worthy of constitutional protection. The Supreme Court of Canada has held that only those "fundamental personal choices" that go "to the core of what it means to enjoy individual dignity and independence" are afforded **Charter** protection. Such decisions must be fundamentally private or inherently personal in nature. Choosing to use marihuana as treatment for serious medical conditions was recognized by the court in **Parker** and **Hitzig** as such a fundamental personal choice. Choice of supplier was not. To the extent that **Sfetkopoulos** stands for the contrary proposition, it is wrongly decided and not persuasive on our facts in any event.

[107] With respect, the Crown's position fails to address the fundamental issue raised by the facts in this case. The Crown recognizes that **Charter** protection will be afforded only to those fundamental personal choices that go to the core of what it means to enjoy individual dignity and independence. However, the Crown does not address why individual dignity and independence are not engaged when seriously ill patients are denied the right to choose medicine which they reasonably believe is most effective for them and available to them without significant delay.

[108] This court is in no position to make judgments about whether, in fact, the choice of different strains made available by a compassion club within a relatively

easy, friendly environment does somehow provide more effective relief than receiving a single strain of irradiated marihuana by mail from PPS, the government supplier. However, the court is well aware that belief in the efficacy of medication, absent it having a deleterious effect, is an important factor in providing healing relief.

[109] In addition, the evidence of Ms. Belle-Isle, who conducts research within the HIV/AIDs community, was supportive of the testimony of individual patients before the court. Her research, as well as that of all other experts who testified, supports the belief that certain strains of cannabis provide greater relief for specific medical conditions. Thus it appears rational for individual patients to have a preference for suppliers who make such claims and can substantiate those claims with research.

[110] The court heard evidence from Dr. Kalant relevant to this issue. Dr. Kalant is perhaps the most experienced and unbiased expert heard from in this trial, and he acknowledged three main points. Firstly, that while there is limited scientific evidence that one strain of cannabis is more effective than another, there is clear scientific evidence that different strains of cannabis can be and are produced with different levels of cannabinoids, some of which likely have real anti-inflammatory or anti-seizure effects. The obvious inference from this is that further research may very well scientifically support the belief of those patients heard from in this trial. Secondly, that individual patients may experience relief from one strain but not another, although these variances may be largely influenced by expectation and belief. He agreed that the hopes and aspirations of the end user might help create the desired effect. Thirdly, that different forms of ingestion and different forms of cannabis products, such as resin, would likely result in different dosage

requirements. Less resin will likely be necessary to obtain a particular and therapeutic effect, and smoking delivers quicker relief, while ingesting baked goods increases duration. However, baked goods require more marihuana than smoking to deliver the relief sought.

[111] The facts referred to by the trial court in the **Sfetakopoulos** decision with respect to the number of individuals who sourced their marihuana from PPS is not compelling evidence that there is anything medically wrong with the government supply. In **Sfetakopoulos**, it was found that only 20 percent of those eligible to possess medical marihuana tried to or took advantage of the government supplier as of 2007 and 2008, five years after PPS made marihuana available. However, it is some evidence, along with the anecdotal and tangentially related other expert evidence, such as that of Ms. Belle-Isle, that there is limited belief in the efficacy of the government supply. This belief is based in large part on the fact that there is only one strain available from PPS and because its form is dried and it is known to be irradiated, an issue which is controversial among many communities, which further leads to a lack of belief in the efficacy of that supply.

[112] There are other issues related to why persons would make the choice to obtain marihuana illicitly, through compassion clubs or other places, or even the criminal black market, which alone would not render the restriction on supply unconstitutional.

[113] It is clear from both the broader research reports and anecdotal evidence given by witnesses that some patients trying to use the licit government supply

experience significant delay due to the complexity of the forms. Applications must also be renewed every year. For a very ill person dependent on marihuana for significant relief from serious symptoms, such a delay and the attendant frustration creates potential medical complications. For some, they have been cut off after incurring significant debt to PPS. This is not a sufficient reason to find that the MMAR are unconstitutional as it is unlikely that the same persons would be able to get their supply if they were unable to pay for it from compassion clubs or other persons who charge for it. However, it can be a reason demonstrating why choice is important for some patients.

[114] This is a brief review of the evidence presented to the court on what remains a significantly controversial issue. The evidence recounted above provides the factual context for the balancing of interests required by the second stage of the s. 7 analysis.

[115] The trial court decision in *Sfetkopoulos*, affirmed by the federal Court of Appeal in October 2008, dealt specifically with the issue of whether, given the government supply as a third source of medical marihuana, the restrictions created by the MMAR in ss. 41(b.1) and 54.1, pass constitutional muster. The trial court's decision was in relation to a judicial review of the Minister's disallowance of an application by an organization, similar to a compassion club, to produce medical marihuana for sale to more than two applicants. The trial court found that the disallowance illustrated that those specific provisions were unconstitutional.

[116] The trial judge, relying on the reasoning in *Hitzig*, determined that both the liberty and security interests of the applicants were negatively affected by s. 41(b.1).

The learned trial judge outlined those interests as follows, at paragraph 10:

10 As for the liberty interests, "liberty" comprehends the right to make decisions of fundamental personal importance. This would include the right to choose, on medical advice, to use marihuana for treatment of serious conditions, that right implying a right of access to such marihuana. It would also include the right not to have one's physical liberty endangered by the risk of imprisonment from having to access marihuana illicitly. With respect to security, this interest includes the similar right for those with medical need to have access to medication without undue state interference.

[117] The trial judge then considered the issue of fundamental justice and whether the individual rights protected by s. 7 could nonetheless be "subordinated to substantial and compelling collective" in that case: at paragraph 11. However, the trial judge did not find a substantial or compelling reason which furthered or enhanced the state's interest and held s. 41(b.1) failed the second stage of the test.

[118] The trial judge's analysis of the facts demonstrates the balancing process between individual core rights and the state's interests as they illuminate the principles of fundamental justice. This analysis is found at paragraphs 12-21.

Beginning at paragraph 12, the trial judge stated:

12 First it must be observed that, according to the government's own statistics, some 80% of persons with ATPs who have been duly authorized to have and use marihuana are not obtaining it from the government source, namely PPS. The evidence shows that many users are unable to grow their own marihuana, either because they are too ill or because their home circumstances do not make it possible. While I have no statistics on the percentage of the market supplied by DPLs, the Regulations remain almost as restrictive as those which were struck down by the Ontario Court of Appeal as creating an undue restraint on an ATP's recognized right to access. The Ontario Court of

Appeal held that, by inference, a large percentage of ATPs were getting their marihuana from illicit sources. The only things that have changed in this respect since that decision is the amendment to the MMAR permitting designated producers to be compensated, and the availability of marihuana and seeds from the government's producer, PPS...

[119] This court heard evidence from experts and several lay witnesses in relation to the problems encountered in obtaining marihuana from PPS, and the perceived inferiority of the product when obtained. The research of Ms. Belle-Isle with HIV/AIDS patients is further supportive evidence of the resistance to using the product grown by PPS.

[120] The trial judge in **Sfetkopoulos** found that the impugned restrictions on supply were unconstitutional:

13 The government's justification for re-enacting the previously invalidated paragraph 41(b) as a new paragraph 41(b.1) was stated in the Regulatory Impact Analysis Statement published with the Regulations of December 3, 2003 amending the MMAR. That justification is as follows (the reference to section 54 is not directly relevant but shows the policy being pursued):

- Paragraph 41(b) will be re-enacted to reinstate on a national basis, the limit on the number of persons for whom one designated person can produce marihuana; under the MMAR, one DPPL holder can cultivate for only one ATP holder; and
- Section 54 will be re-enacted to reinstate on a national basis, the limit on the number of DPL holders who can produce marihuana in common; under the MMAR, a DPL holder is not permitted to produce marihuana in common with more than two other DPL holders.

These limits on the production of marihuana are necessary to:

- maintain control over distribution of an unapproved drug product, which has not yet been demonstrated to comply with the requirements of the FDA/FDR;

- minimize the risk of diversion of marihuana for non-medical use;
- be consistent with the obligations imposed on Canada as a signatory to the United Nations' *Single Convention on Narcotic Drugs, 1961* as amended in 1972 (the 1961 Convention), in respect of cultivation and distribution of cannabis; and
- maintain an approach that is consistent with movement toward a supply model whereby marihuana for medical purposes would be: subject to product standards; produced under regulated conditions; and distributed through pharmacies, on the advice of physicians, to patients with serious illnesses, when conventional therapies are unsuccessful. Such a model would also include a program of education and market surveillance.

In its argument, the government has essentially adopted this rationale for the re-enactment of paragraph 41(b.1). It is therefore necessary to consider whether such reasons provide a basis for saying that paragraph 41(b.1) is in accordance with the principles of fundamental justice. In the particular context of this case I will consider criteria such as that adopted by the Ontario Court of Appeal in *Hitzig*...holding that fundamental justice requires respect for the rule of law and thus cannot countenance a system which forces authorized medical users of dried marihuana to obtain it illicitly. Also I will have regard to the question of whether the limitation in paragraph 41(b.1) is arbitrary, not genuinely connected to the protection of the interests of the state.

[121] I adopt the learned trial judge's reasons as set out herein, and add, where applicable, further evidence brought forward in this case. The trial judge continues at paragraph 14:

14 The first justification offered by the respondent for paragraph 41(b.1) as set out in the 2003 Regulatory Impact Analysis Statement quoted above, is that such a restriction on designated producers limiting them to produce for only one user is for the purpose of maintaining control over distribution of an unapproved drug product. It has not been demonstrated to me why limiting the production of a designated producer to one customer will have this effect. The Regulations only permit such producer to produce marihuana for persons already authorized by the Minister to possess and use marihuana: that is, holders who have an ATP licence. ATP holders are

persons adjudged by the Minister to be legitimate users of this "unapproved drug" and whether the producer grows for one ATP holder or 30 ATP holders the distribution of marihuana would be to persons, and for purposes, already countenanced by the Regulations. Some mention was made of quality control being jeopardized if designated producers could produce for more than one customer. I am unaware that Health Canada imposes any quality control on designated producers now but if it does, or even if it [page414] does not, it can put in place the same kind of quality controls for designated producers with one or many customers. Indeed it seems logical that if designated producers were authorized to produce for many customers there would be economies of scale and a level of income that might make possible even better quality control by the producer. At the same time, a host of one-customer designated producers would be made unnecessary and therefore any control and inspection system Health Canada might wish to impose on designated producers would be simpler and cheaper to operate with fewer producers.

[122] The evidence of Ms. Lasher in this trial on behalf of Health Canada acknowledged that Health Canada does not, at this time, engage in quality control of DPLs. The trial judge in *Sftekopoulos* continues at paragraphs 15-18:

15 As a second rationale, it is said by the government that paragraph 41(b.1) will "minimize the risk of diversion of marihuana for non-medical use."...Again, designated producers, no matter how many customers they have, must confine their sales to persons with an ATP. A designated producer, since he is authorized to grow marihuana now, has a present potential for producing more than his one customer needs and diverting the surplus for illicit sale. This would be true whether he grows for one customer or 25. I suppose that it might be easier, in a grow operation large enough to supply 25 legitimate customers, to conceal a larger potential surplus of production for illicit sale. This is hypothetical and it might equally be said that, as noted above, with fewer designated producers having larger operations, a system of inspection would be much easier to sustain than in the present plethora of single-customer producers. The government also argues that a larger grow operation run by a designated producer with multiple customers would, because of its size, attract theft. But it is also argued by the applicants that a larger operation, because of efficiencies of scale, could have a better security system and indeed could be more secure than the typical home-based self-producer or single-customer designated producer.

16 At this point it may be observed, in respect of both the first and second rationales that it may well be that there could be justification for limiting the size of operations of designated producers, to facilitate supervision and inspection for quality and security. But any new regulations to this end will have to be justified as having a demonstrable purpose rationally related to legitimate state interests. No such justification has been offered to me for paragraph 41(b.1).

17 As the third justification for paragraph 41(b.1) the government has invoked the United Nation's *Single Convention on Narcotic Drugs, 1961*...which, the government says, imposes on it obligations "in respect of cultivation and distribution of cannabis." I have studied the Convention and the affidavit of the Minister's witness on this subject and remain puzzled. The Convention appears to require the Government of Canada to control marihuana as a narcotic drug and to limit its use to medical and scientific purposes. It requires a medical prescription for the supply or dispensation of drugs to individuals and a system of limiting quantities of drugs available to them. It requires that Canada maintain a system to control all persons and enterprises engaged in the trade or distribution of drugs which must be carried out under licence. It would appear that Canada complies with these requirements except for the requirement of a prescription for any cannabis authorized for individual medical use, although the MMAR system may constitute an adequate substitute. The Minister lays particular stress on Article 23 of the Convention which requires that a state permitting the cultivation of marihuana have an Agency to carry out functions under that article. Paragraph 2(d) of Article 23 requires that cultivators of marihuana be required to deliver their total crops to the Agency. According to the Minister, Health Canada has been designated as the Agency for Canada. The Minister argues as follows:

To allow growers to supply to more than one person who is authorized to possess and use marihuana for medical purposes would obligate the Government, in compliance with the *1961 Convention*, to collect all marihuana produced.

This appears to me to be a *non sequitur*. If the Convention requires that all "cultivators" of marihuana must deliver their "total crops" to the Agency (as Article 23 specifies) then presumably holders of PPLs and DPLs, even though they produce for one person, should deliver their "total crops" to Health Canada. That is not done: the MMAR contemplates that production is consumed by a user, whether produced by himself or by his designated producer. I have failed to see how allowing a designated producer to produce for multiple users creates some new problem *vis-à-vis* the Convention which does not already exist. Counsel agreed that the Convention has not been made part of the law of Canada as such although parts of it have been

implemented by Canadian law. To the extent that the MMAR, if they were to permit the holder of the DPL to produce for more than one ATP holder, might conflict with the Convention, this domestic law must prevail over an unimplemented international treaty. Further if to follow the requirements of the Convention were to conflict with Canadian constitutional requirements such as the guarantees in section 7 of the Charter then the Canadian constitution must prevail in this Court.

18 Fourthly, the government says that paragraph 41(b.1) is necessary to "maintain an approach that is consistent with movement toward a supply model" whereby medical marihuana would be produced and made available like other therapeutic drugs, on prescription and through pharmacies. That may well be a laudable goal and if ever reached would make unnecessary litigation such as the present case. But we do not know when this new age will dawn and in the meantime the courts, in their wisdom, have concluded that persons with serious conditions for which marihuana provides some therapy should have reasonable access to it. It is no answer to say that someday there may be a better system. Nor does the hope for the future explain why a designated producer must be restricted to one customer.

[123] I should note here that Dr. Kalant testified that he considered that the stated goal of Health Canada, to maintain an approach consistent with movement toward a supply model, was highly unlikely.

[124] Relevant to the weight to be given to the concerns of the government set out above, is the position taken by the Crown in *Hitzig* in 2003, to openly rely on such organizations as compassion clubs, to provide a supply of medical marihuana when no other licit supply was available. At paragraph 72 of *Hitzig* it is put this way:

72 The premise underlying the *MMAR*, that seriously ill people, some of whom are so sick it is anticipated that they will die within a year, can grow their own medicine, have a friend grow it, or get it on the black market, is puzzling. It is explained, in our view, by the assumption implicit in the *MMAR* and specifically articulated by the Government in its factum, that those who will seek an ATP will be long time medical marihuana users who have an established pattern of self-medication. According to this assumption, these persons will have no

difficulty filling their medical marihuana needs either through cultivation or from "unlicensed" reliable sources.

[125] Thus at that time compassion clubs, which I take to be the "unlicensed" providers, although illegal and from time to time raided by the government, were considered safe and reliable sources of medical marihuana for seriously ill individuals.

[126] The trial decision of **Sftekopoulos** concluded the impugned provisions were not in accordance with the principles of fundamental justice and violated the applicant's s. 7 rights to liberty and security of the person, found at paragraphs 19-21:

19 Consequently, I have concluded that the restraint on access which paragraph 41(b.1) provides is not in accordance with the principles of fundamental justice. First, it does not adequately respond to the concerns motivating the Ontario Court of Appeal judgment in *Hitzig*: that is it leaves those ATP holders who cannot grow for themselves and who cannot engage a designated producer because of the restrictions imposed on the latter by the MMAR, to seek marihuana in the black market. The Ontario Court of Appeal said that this is contrary to the rule of law, to pressure a citizen to break the law in order to have access to something he medically requires. The only factor which has changed since the *Hitzig* case arose is the advent of PPS as a licensed dealer. The Minister argues that any ATP holder, who cannot grow for himself or cannot find a designated producer prepared to dedicate himself solely to that ATP holder, may obtain his dried marihuana or seed from a government contractor, namely PPS. That certainly does provide an alternative avenue of access. But the evidence shows that after four years of this new policy of the government supply of marihuana, fewer than 20% of ATP holders resort to it. The applicants take the position that the PPS product is inferior and not to the taste of most users. They say that PPS only makes available one strain of marihuana for medical use whereas there are several strains which have different therapeutic effects depending on the condition of the user. The evidence as to the quality of the PPS product was almost all hearsay and anecdotal. The expert scientific evidence as to the different therapeutic effects of various

strains mainly indicates that there is great uncertainty and the subject requires further research. I am therefore not prepared to lead a judicial incursion into yet another field of medicine and pass judgment on the quality of the PPS product. In my view it is not tenable for the government, consistently with the right established in other courts for qualified medical users to have reasonable access to marihuana, to force them either to buy from the government contractor, grow their own or be limited to the unnecessarily restrictive system of designated producers. At the moment, their only alternative is to acquire marihuana illicitly and that, according to *Hitzig*, is inconsistent with the rule of law and therefore with the principles of fundamental justice.

20 I also find that paragraph 41(b.1) is inconsistent with the principles of fundamental justice because it is arbitrary in the sense that it causes individuals a major difficulty with access while providing no commensurate furtherance of the interests of the state.

21 For these reasons I find paragraph 41(b.1) to infringe the applicants' rights to liberty and security under section 7 of the Charter and therefore to be invalid.

[127] Adopting the reasoning in *Hitzig* and *Sfetkopoulos*, further bolstered by the evidence before this court, I find ss. 41(b.1) and 54.1 of the MMAR contrary to s. 7 of the **Charter**.

Section 1 of the **Charter**

[128] It is necessary to say something about s. 1 of the **Charter**. Section 1 of the **Charter** raises the possibility of saving these subsections as demonstrably justified in a free and democratic society. Having found that these restrictions are arbitrary, it follows that they do not serve the societal interest invoked to justify them. Because I so found them to be arbitrary, relying on the same reasoning as is found in *Sfetkopoulos* in relation to s. 41(b.1), it seems axiomatic that there can be no rational connection to the objectives stated and the restrictions imposed. I find both of those subsections constitutionally invalid.

REMEDIES

[129] As the matter now stands, the federal Court of Appeal in ***Sfetkopoulos*** declared s. 41(b.1) invalid and refused to suspend that declaration. The case is under appeal to the Supreme Court of Canada.

[130] The applicant seeks broad remedies such as reading in a wholesale exemption to the **CDSA** for medical marihuana users or striking down the whole of the MMAR and other such broad remedies.

[131] The Crown says that whatever remedy, beyond declaring invalidity which the court undertakes, it should stay such remedy for one year to allow the Crown the opportunity to respond as required, to cure the constitutional defect or fill the void through regulation or parliamentary change.

[132] In ***Hitzig***, the Ontario Court of Appeal, in the unusual circumstances of evolving regulations in a highly controversial area, led the way by being very specific as to what was invalid by implication, and then directly inviting the government to cure the constitutional deficiencies, if it could.

[133] The discussions set out above, in both ***Hitzig*** and then ***Sfetkopoulos***, suggest the admissibility of finding a means by which compassion clubs can be licensed or regulated. I use compassion clubs as shorthand for persons who, once licensed and regulated, may grow marihuana and cannabis for more than one ATP holder. In order for such regulation to withstand **Charter** scrutiny it must be done without unduly restricting the ability of such organizations to take advantage of

economies of scale, carry out research on the efficacy of varying strains of cannabis, and/or other desirable activities directed toward improving access to medical treatments to eligible patients.

[134] Such regulation and licensing requires careful thought in drafting. Consistent with the reasoning in **Schachter v. Canada**, [1992] 2 S.C.R. 679, 93 D.L.R. (4th) 1, these provisions, unduly restricting DPLs from growing for more than one ATP or growing in concert with two other DPLs, are hereby severed from the MMAR.

[135] The government, in my view, will need time to put in place appropriate monitoring and enforcement mechanisms in relation to such compassion clubs. Thus, it is appropriate to stay the effect of this declaration of invalidity for one year.

RESULT

[136] In relation to the charges against Mr. Beren, the Crown, having proved beyond a reasonable doubt that Mr. Beren was producing and trafficking in marihuana for the purpose of supplying a compassion club, which in turn was selling the marihuana to most of its members who did not have ATPs, and thus were not licensed to possess, which parts of the MMAR I have found to be valid, is guilty on both counts.

“Koenigsberg J.”