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## **Accommodating the Medical Use of Marijuana: Surveying the Differing Legal Approaches in Australia, the United States and Canada**

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# Accommodating the medical use of marijuana: Surveying the differing legal approaches in Australia, the United States and Canada

Tony Bogdanoski\*

*While the scientific and medical communities continue to be divided on the therapeutic benefits and risks of cannabis use, anecdotal evidence from medical users themselves suggests that using cannabis is indeed improving their quality of life by alleviating their pain and discomfort. Notwithstanding the benefits anecdotally claimed by these medical users and the existence of some scientific studies confirming their claims, criminal drug laws in all Australian and most United States jurisdictions continue to prohibit the possession, cultivation and supply of cannabis even for medical purposes. However, in contrast to Australia and most parts of the United States, the medical use of cannabis has been legal in Canada for about a decade. This article reviews these differing legal and regulatory approaches to accommodating the medical use of cannabis (namely, marijuana) as well as some of the challenges involved in legalising it for medical purposes.*

## INTRODUCTION

Cannabis has been used throughout the world for its unique medicinal properties for thousands of years.<sup>1</sup> However, the therapeutic use of cannabis in the West has a much shorter history<sup>2</sup> and has largely been eclipsed by the recreational use of marijuana and its counter-cultural symbolism since the 1960s.<sup>3</sup> Ironically, the same psychotropic compound in cannabis which attracts recreational marijuana users may also have the greatest therapeutic potential<sup>4</sup> in the symptomatic relief of persons with a wide range of life-threatening and debilitating medical conditions such as cancer, HIV/AIDS, multiple sclerosis and glaucoma. While the scientific and medical communities continue to be divided on the therapeutic benefits and risks of cannabis use, anecdotal evidence from medical users themselves suggests that using cannabis is indeed

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<sup>1</sup> Grinspoon L and Bakalar J, *Marihuana, the Forbidden Medicine* (2nd ed, Yale University Press, New Haven, 1997) p 3.

<sup>2</sup> Grinspoon and Bakalar, n 1.

<sup>3</sup> Hall W, "The Health and Psychological Effects of Cannabis Use" (1994) 6(2) *Current Issues in Criminal Justice* 208 at 208.

<sup>4</sup> Robson P, "Therapeutic Aspects of Cannabis and Cannabinoids" (2001) 178(2) *British Journal of Psychiatry* 107 at 108.

improving their quality of life by alleviating their pain and discomfort.<sup>5</sup> Medical users of cannabis thus contend that they have a particular moral claim, based on medical necessity, to use and access the drug which should legally set them apart from recreational users, whose claim to the drug is instead largely<sup>6</sup> based on pleasure. Notwithstanding the benefits anecdotally claimed by these medical users, criminal drug laws in all Australian and most US jurisdictions continue to prohibit the possession, cultivation and supply of cannabis even for medical purposes. This situation persists even though government-commissioned reports<sup>7</sup> in both Australia and the US cautiously recommended that these laws be amended to make an exception for legitimate medical users to grow and use limited amounts of cannabis until effective pharmaceutical alternatives to the natural plant became available. However, in contrast to Australia and most parts of the United States, Canada has legalised the medical use of cannabis for about a decade now. This article reviews these differing legal and regulatory approaches to accommodating the medical use of cannabis (namely, marijuana) as well as some of the challenges involved in legalising it for medical purposes.

## **CONTESTED BENEFITS AND RISKS OF CANNABIS AND MARIJUANA AS MEDICINE**

### **Historical Uses of Cannabis as Medicine**

The first documented therapeutic use of the cannabis plant allegedly dates back around 5000 years to ancient China.<sup>8</sup> However, it is Irish doctor William Brooke O'Shaughnessy who is widely credited<sup>9</sup> as having introduced cannabis into Western pharmacopoeia in the 1830s, after recognising its analgesic, anticonvulsant and relaxant effects on patients while stationed with the British East India Company at the

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<sup>5</sup> See, eg, Ogborne A et al, "Who is Using Cannabis as a Medicine and Why: An Exploratory Study" (2000) 32(4) *Journal of Psychoactive Drugs* 435; Swift W et al, "Survey of Australians Using Cannabis for Medical Purposes" (2005) 2(1) *Harm Reduction Journal* 18 <http://www.harmreductionjournal.com/content/2/1/18> viewed 20 August 2009.

<sup>6</sup> The other legitimate, non-medical use of marijuana and the cannabis plant would be for religious purposes; however, this is just as contentious as the medical use of marijuana, if not more so. See Lesley Frank, "Accommodating Religious Drug Use and Society's War on Drugs" (1990) 58(5) *George Washington Law Review* 1019.

<sup>7</sup> NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes* (2000); US National Academy of Sciences, Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base* (1999).

<sup>8</sup> Grinspoon and Bakalar, n 1.

<sup>9</sup> Grinspoon and Bakalar, n 1, p 4. See also Conrad C, *Hemp for Health: The Medicinal and Nutritional Uses of Cannabis Sativa* (Healing Arts Press, Rochester, 1997) pp 20-21.

Medical College of Calcutta. O'Shaughnessy treated patients with cannabis in the form of a tincture since the administration of cannabis through methods such as smoking was unheard of in the West until the late 19th century.<sup>10</sup> It has even been reported that Queen Victoria's court physician treated her menstrual cramps with cannabis tincture.<sup>11</sup> The therapeutic use of cannabis during this period was so popular that over one hundred papers were published in Western medical journals testifying to its effectiveness for a wide variety of ailments.<sup>12</sup> Cannabis was widely used by the medical profession as a therapeutic agent between the 1830s and the first couple of decades of the 20th century to treat conditions and symptoms such as neuralgia, convulsions, rheumatism, asthma, childbirth pain and dysmenorrhea (painful menstruation),<sup>13</sup> after which its popularity declined with the rise of stronger opium derivatives and the first synthetic analgesic, aspirin.<sup>14</sup>

### Contemporary Uses of Cannabis as Medicine

#### *Cannabis Preparations and Methods of Cannabis Use*

The three main types of cannabis preparations – marijuana, hashish and hash oil – are largely derived from the female *cannabis sativa* plant.<sup>15</sup> Marijuana is prepared from the dried leaves and flowering heads of the cannabis plant and is by far the most commonly used form of cannabis among recreational users.<sup>16</sup> Marijuana is typically smoked in the form of a hand-rolled cigarette (a “joint”) or through a water pipe (a “bong”), with users inhaling the marijuana deeply and holding their breath to maximise absorption into the lungs.<sup>17</sup> However, smoked marijuana is also by far the most popular form and method of cannabis use among medical users for therapeutic purposes.<sup>18</sup> Cannabis is also commonly baked into foods and eaten by users. Hashish,

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<sup>10</sup> Grinspoon L, “Whither Medical Marijuana” (2000) 27(3) *Contemporary Drug Problems* 3, 4.

<sup>11</sup> Grinspoon and Bakalar, n 1.

<sup>12</sup> See Mikuriya T (ed), *Marijuana: Medical Papers 1839-1972* (Midi-Comp Press, California, 1973).

<sup>13</sup> Grinspoon L, “On the Pharmaceuticalization of Marijuana” (2001) 12(5) *International Journal of Drug Policy* 377 at 378.

<sup>14</sup> Grinspoon, n 13 at 377.

<sup>15</sup> Copeland J et al, *Evidence-Based Answers to Cannabis Questions: A Review of the Literature*, Australian National Council of Drugs Research Paper No 11 (2006), p 2.

<sup>16</sup> Australian Institute of Health and Welfare, Australian Government, *2007 National Drug Strategy Household Survey: First Results*, Drug Statistics Series No. 20 (2008), p 50: only 11.5% and 5.6% had used hashish or hash oil, respectively, with the remainder using marijuana.

<sup>17</sup> Hall W et al, *The Health and Psychological Effects of Cannabis Use*, Commonwealth of Australia National Drug Strategy Monograph Series No 44 (2001), p 8.

<sup>18</sup> Hall et al, n 17, p 9.

the dried cannabis resin derived from the sticky liquid secretion of the flowering heads and upper leaves of the female plant, is typically mixed into “cannabis cookies” and other food preparations, although it can also be smoked or made into a tea or butter as well.<sup>19</sup> Hash oil, generally the most potent form of cannabis and the least used, is a liquid form of cannabis that results from dissolving marijuana or hashish into a solvent such as alcohol and then extracting the resultant liquid (oil).<sup>20</sup>

*The Psychotropic Nature and Pharmacology of Cannabis*

The main psychoactive compound of cannabis, delta-9-tetrahydrocannabinol (THC), varies depending on the particular genetic strain of the plant and the conditions in which it was grown.<sup>21</sup> The THC component of the cannabis plant is highest in the flowering heads, generally yielding between 5 to 14 per cent THC, whereas cannabis leaf contains lower THC content ranging from 0.5 to 4 per cent THC.<sup>22</sup> Incidentally, the same psychoactive and intoxicating compound responsible for the “high” many users report from using marijuana has also shown the greatest therapeutic potential in the medicinal context.<sup>23</sup> Thus, marijuana generally contains between 0.5 to 14 per cent THC, depending on the amount of flowering heads and leaf that is used. On the other hand, hashish contains between 2 to 10 per cent THC and hash oil contains between 16.5 to 60 per cent THC, however, these cannabis preparations are not as commonly used by either recreational or medical users.<sup>24</sup> Smoked cannabis, whether as marijuana, hashish or hash oil, is the preferred method of use among users because they can more effectively titrate the dose and its effects are almost immediate.<sup>25</sup> The effects of smoked marijuana typically peak after about 20 minutes and last between 1 to 2 hours depending on the strain of the plant.<sup>26</sup> The effects of eaten cannabis, which requires absorption through the walls of the stomach and intestines rather than the

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<sup>19</sup> Grotenhermen F and Russo E (eds), *Cannabis and Cannabinoids: Pharmacology, Toxicology and Therapeutic Potential* (Routledge, 2002), p 350.

<sup>20</sup> Hall et al, n 17.

<sup>21</sup> Copeland et al, n 15. Hydroponically grown cannabis is generally much more potent than its non-hydroponically grown equivalent.

<sup>22</sup> Copeland et al, n 15.

<sup>23</sup> Robson, n 4.

<sup>24</sup> Copeland et al, n 15.

<sup>25</sup> Campbell A, *The Australian Illicit Drug Guide* (Black Inc, Melbourne, 2001), p 59.

<sup>26</sup> Campbell, n 25.

walls of the lungs, takes about 1 to 2 hours to peak but can last up to 4 hours depending on how much food is in the stomach.<sup>27</sup>

Pharmacological research<sup>28</sup> has revealed that there are chemicals in the cannabis plant, generally called cannabinoids, which specifically act upon two receptors in the human body, CB<sub>1</sub> and CB<sub>2</sub>. At least 66 cannabinoids have been isolated from the natural plant,<sup>29</sup> of which THC and cannabidiol (a non-psychoactive cannabinoid) have shown the most promise as therapeutic constituents of the cannabis plant for a wide variety of conditions, including pain and nausea. The CB<sub>1</sub> receptor is found primarily in the brain and is involved in pain modulation, regulation of food intake, mood and movement control whereas the lesser-understood CB<sub>2</sub> receptor is almost exclusively found in the immune system and is thought to act as an anti-inflammatory modulator in the body.<sup>30</sup>

#### *Medical Conditions For Which Cannabis (Marijuana) is Used to Provide Relief*

As Kassirer has observed, medical users of cannabis (particularly, marijuana) are using the drug in the relief of a range of life-threatening and debilitating medical conditions:

The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana.<sup>31</sup>

Notably, marijuana is being used to stimulate appetite in HIV/AIDS-related anorexia, decrease nausea and vomiting caused by cancer chemotherapy, reduce muscle spasticity from multiple sclerosis, and decrease intra-ocular pressure from glaucoma.<sup>32</sup> Marijuana is also popular among HIV/AIDS and cancer patients as an

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<sup>27</sup> Campbell, n 25. See also Grotenhermen and Russo, n 19, for differences between smoking and eating cannabis.

<sup>28</sup> See US Institute of Medicine, above n 7, p 53.

<sup>29</sup> Burns T and Ineck J, "Cannabinoid Analgesia as a Potential New Therapeutic Option in the Treatment of Chronic Pain" (2006) 40(2) *Annals of Pharmacotherapy* 251 at 252.

<sup>30</sup> US Institute of Medicine, n 7. See also Pertwee R, "Pharmacology of Cannabinoid CB<sub>1</sub> and CB<sub>2</sub> Receptors" (1997) 74(2) *Pharmacology and Therapeutics* 129.

<sup>31</sup> Kassirer J, "Federal Foolishness and Marijuana" (1997) 336(5) *New England Journal of Medicine* 366 at 366. See also Higgins Wolfson L, "A Quality of Mercy: The Struggle of the AIDS-Afflicted to Use Marijuana as Medicine" (1999) 22 *Thomas Jefferson Law Review* 1 at 31.

<sup>32</sup> See Grinspoon and Bakalar, n 1, for a specific discussion of how marijuana helps to treat and relieve the symptoms of each of these diseases.

analgesic for drug-induced peripheral neuropathy.<sup>33</sup> It is also used in the relief of non-life-threatening, disabling chronic pain unresolved by conventional analgesics.<sup>34</sup> However, cannabis and marijuana does not always need to be used for symptomatic relief; its use typically arises when legally available medications fail to arrest the individual's pain and suffering or these medications do not work as effectively in providing symptomatic relief for the individual.

The most prominent advocate of the medical use of marijuana is arguably Angel McClary Raich, the Californian woman at the centre of various constitutional challenges to US federal drug policy prohibiting the medical use of marijuana,<sup>35</sup> discussed later in this article. Throughout the litigation process Raich has claimed, with the support of her family doctor, that since 1995 she has suffered from an “inoperable brain tumor, life-threatening wasting syndrome, several chronic pain disorders, seizure disorder, nausea, scoliosis, TMJ, and many other documented medical conditions”.<sup>36</sup> Further, Raich has maintained that her suffering “cannot be controlled by synthetic medications”<sup>37</sup> because she is “violently allergic and [has] severe multiple chemical sensitivities to almost all pharmaceutical medicines”.<sup>38</sup> Consequently, Raich uses cannabis:

about every two waking hours — by smoking it, by inhaling it as a vapor, by eating it in foods, or by applying it topically as a balm. She says that it relieves her chronic pain and boosts her appetite, preventing her from becoming emaciated because of a mysterious wasting syndrome. Raich and her doctor maintain that without access to the eight or nine pounds of privately grown cannabis that she consumes each year, she would die.<sup>39</sup>

As Raich's family doctor, Dr Frank Lucido has explained:

Angel has no reasonable legal alternative to cannabis for the effective treatment or alleviation of her medical conditions or symptoms associated with the medical conditions because she has tried essentially all other legal alternatives to cannabis and the alternatives have been ineffective or result in intolerable side effects.<sup>40</sup>

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<sup>33</sup> Grinspoon and Bakalar, n 1, pp 100-108 (AIDS); pp 23-44 (cancer).

<sup>34</sup> Grinspoon and Bakalar, n 1, pp 109-122.

<sup>35</sup> Okie S, “Medical Marijuana and the Supreme Court” (2005) 353(7) *New England Journal of Medicine* 648 at 648.

<sup>36</sup> Angel Justice: Angel's Story, *Who is Angel McClary Raich?* <http://www.angeljustice.org/section.php?id=6> viewed 21 July 2009.

<sup>37</sup> Angel Justice: Angel's Story, n 36.

<sup>38</sup> Angel Justice: Angel's Story, n 36.

<sup>39</sup> Okie, n 35.

<sup>40</sup> Angel Justice: Angel's Story, n 36.

With the passage of time, Raich has credited the use of cannabis with not only saving her life but allowing her to lead a normal life by relieving her ailments, which at one point left her confined in a wheelchair for a continuous period of three-and-a-half years.<sup>41</sup>

An estimated 115,000 people have legally obtained marijuana in the United States in those US States which have legalised its medical use, mainly in California.<sup>42</sup> However, it is not possible to know the exact number of medical users in both North American and Australian jurisdictions where cannabis use is entirely prohibited since users naturally do not want to bring their illegal activities to the attention of the authorities. Researchers have therefore understandably had problems in recruiting medical users to their surveys, even when participants are assured anonymity. Most studies which exist only involve a relatively small number of participants. Notwithstanding these limitations, some small-scale studies exist. A Canadian study<sup>43</sup> in 2000 among 50 self-identified medical users showed that marijuana was being used for a wide range of ailments, the most common being for HIV/AIDS-related problems, followed by chronic pain, depression and anxiety. Almost all of the interviewees smoked marijuana on a daily basis and reported using marijuana for its sedative, analgesic, antispasmodic, appetite stimulating and anticonvulsant properties.<sup>44</sup>

A similar Australian study<sup>45</sup> in 2005 among 128 medical users of marijuana in NSW showed that more than half of those using the drug did so for chronic pain, followed by depression, persistent nausea and weight loss. In Australia it has been reported that marijuana use is common among HIV-positive gay men as well as people with cancer,<sup>46</sup> a finding which has been reinforced by studies in other jurisdictions.<sup>47</sup> As in the Canadian study, almost all of the interviewees (91%) in the

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<sup>41</sup> Angel Justice: Angel's Story, n 36.

<sup>42</sup> Okie, n 35 at 649.

<sup>43</sup> Ogborne A et al, "Who is Using Cannabis as a Medicine and Why: An Exploratory Study" (2000) 32(4) *Journal of Psychoactive Drugs* 435.

<sup>44</sup> Ogborne et al, n 43 at 442.

<sup>45</sup> Swift et al, n 5.

<sup>46</sup> NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes: Executive Summary* (2000), vol 1, p 10. See also Sweet M, "Call for Marijuana to Ease Patients' Suffering", *Sydney Morning Herald* (13 November 1995).

<sup>47</sup> See also, eg, Canadian AIDS Society, *Cannabis as Therapy for People Living with HIV/AIDS: "Our Right, Our Choice"* (2006) <http://www.cdnaids.ca/web/casmisc.nsf/pages/cas-gen-0112> viewed 20 August 2009.

Australian study smoked the drug, with 86% of the participants reporting that they got “great relief” from smoking marijuana.<sup>48</sup> Significantly, the researchers in the Australian study found that “no one believed [marijuana] had been detrimental to their condition or symptoms”.<sup>49</sup> However, it could be argued that these surveys “may not be representative of the experiences of all medicinal users” and might reflect sampling bias since users who do not like the psychoactive side effects of marijuana may discontinue using the drug and subsequently be less likely to be surveyed about their experiences.<sup>50</sup> Nevertheless, these studies “still provide important information” on those who maintain they benefit from using the drug and document the challenges they have faced in accessing marijuana to treat their ailments.<sup>51</sup>

### **Health Risks Associated with Cannabis (Marijuana) Use**

Terminally ill users of marijuana who are seeking immediate relief from their pain and suffering are not overly concerned, if at all, with the potentially negative long-term risks associated with marijuana use.<sup>52</sup> However, chronically ill users of marijuana must decide whether the possible long-term risks outweigh the short-term benefits gained from using the drug. The *possible* health risks associated with marijuana use include carcinogenicity, respiratory and cardiovascular problems, cognitive impairment and dependency and withdrawal syndromes.<sup>53</sup> Recent research suggests that marijuana use may contribute to the development of periodontal disease<sup>54</sup> and some types of testicular cancer.<sup>55</sup> Marijuana use may also affect the ability of patients to undergo necessary organ transplants as a result of a lowered immune system brought about by its use.<sup>56</sup> However, other studies have shown similar

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<sup>48</sup> Swift et al, n 5.

<sup>49</sup> Swift et al, n 5.

<sup>50</sup> Swift et al, n 5.

<sup>51</sup> Swift et al, n 5.

<sup>52</sup> Kassirer, n 31.

<sup>53</sup> Hall W and Liccardo Pacula R, *Cannabis Use and Dependence: Public Health and Public Policy* (Cambridge University Press, New York, 2003), pp 38-100. See also Hall W, “Challenges in Reducing Cannabis-Related Harm in Australia” (2009) 28(2) *Drug and Alcohol Review* 110; Hall W, “The Adverse Health Effects of Cannabis Use: What Are They, and What Are Their Implications For Policy?” (2009) 20(6) *International Journal of Drug Policy* 458.

<sup>54</sup> Murray Thomson W et al, “Cannabis Smoking and Periodontal Disease Among Young Adults” (2009) 299(5) *Journal of the American Medical Association* 525.

<sup>55</sup> Daling J et al, “Association of Marijuana Use and the Incidence of Testicular Germ Cell Tumors” (2009) 115(6) *Cancer* 1215.

<sup>56</sup> Coffman K (ed), “The Debate About Marijuana Usage in Transplant Candidates: Recent Medical Evidence on Marijuana Health Effects” (2008) 13(2) *Current Opinion in Organ Transplantation* 189.

survival rates between liver transplant patients who did and did not use marijuana for medical purposes.<sup>57</sup>

The risk popularly associated with general cannabis use among the general public – that it causes or may cause mental illness – is also the most contentious. It has been argued that the large majority of cannabis users will not develop mental illnesses as a result of using cannabis<sup>58</sup> but that it can trigger the onset or relapse of mental illness in predisposed people and exacerbate their symptoms generally.<sup>59</sup> However, it has also been argued that cannabis use *may* indeed precipitate mental illness in both predisposed and non-predisposed populations.<sup>60</sup> Despite the fact that both arguments are inconclusive, the latter view is shaping public policy as well as leading to renewed government attempts in Australia to warn the public about the dangers of cannabis use – arguably at the expense of persons requiring its medical use. While the Commonwealth is focusing its efforts on tackling the recreational use of marijuana, particularly among teenagers and young adults,<sup>61</sup> it has neglected medical users of marijuana by failing to fund, at the same time, any studies or trials into the therapeutic benefits of marijuana and other cannabis derivatives.

Ultimately, the scientific and medical research communities continue to be divided on the health risks associated with cannabis use as well as its therapeutic benefits<sup>62</sup> and, more importantly, whether its contested benefits are outweighed by its

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<sup>57</sup> Ranney D, “Marijuana Use in Potential Liver Transplant Candidates” (2009) 9(2) *American Journal of Transplantation* 280: “current substance abuse policies do not seem to systematically expose marijuana users to additional risk of mortality”.

<sup>58</sup> Hall W and Degenhardt L, “Cannabis Use and Psychosis: A Review of Clinical and Epidemiological Evidence” (2000) 34(1) *Australian and New Zealand Journal of Psychiatry* 26.

<sup>59</sup> Rey J and Tennant C, “Cannabis and Mental Health” (2002) 325 *British Medical Journal* 1183 at 1183. See also MacLeod J et al, “Psychological and Social Sequelae of Cannabis and Other Illicit Drug Use by Young People: A Systematic Review of Longitudinal, General Population Studies” (2004) 363 *Lancet* 1579.

<sup>60</sup> Boyce A and McArdle P, “Long-Term Effects of Cannabis” (2008) 18(1) *Paediatrics and Child Health* 37; Moore T et al, “Cannabis Use and Risk of Psychotic or Affective Mental Health Outcomes: A Systematic Review” (2007) 370 *Lancet* 319; Caldeira K et al, “The Occurrence of Cannabis Use Disorders and Other Cannabis-Related Problems Among First-Year College Students” (2008) 33(3) *Addictive Behaviors* 397.

<sup>61</sup> See Commonwealth of Australia, Department of Health and Ageing, *National Cannabis Strategy 2006-2009* (2006).

<sup>62</sup> For some recent evidence-based, peer-reviewed studies concluding that cannabis (in particular smoked marijuana) is beneficial in the treatment of symptoms associated with HIV/AIDS, cancer, multiple sclerosis and intractable pain, see Abrams D et al, “Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial” (2007) 68(7) *Neurology* 515; Haney M, “Dronabinol and Marijuana in HIV-Positive Marijuana Smokers: Caloric Intake, Mood, and Sleep” (2007) 45(5) *Journal of Acquired Immune Deficiency Syndromes* 545; Abrams D et al, “Short-Term Effects of Cannabinoids in Patients with HIV-1 Infection: A Randomized, Placebo-Controlled Clinical

alleged health risks.<sup>63</sup> This has led professor of medicine and former editor of the *New England Journal of Medicine*, Jerome Kassirer to argue that the inability of science to definitively prove or discount the effectiveness of marijuana (and cannabis generally) as a therapeutic agent, even after many years of research and debate, means that the anecdotal evidence of those using it “medicinally” should prevail where it demonstrably improves their quality of life by removing their pain or discomfort.<sup>64</sup>

## THE LEGAL STATUS AND REGULATION OF CANNABIS FOR MEDICAL PURPOSES

### Socio-Political Objections to Legalising Cannabis for Medical Purposes

In addition to the possible health risks outlined above, a number of non-medical concerns have also been raised with the legalisation of cannabis for medical purposes. Unfortunately, the controversial nature of drug law reform generally polarises public debate and makes it “difficult for policymakers to treat this complex issue with disinterest and objectivity”.<sup>65</sup> As de Launey has remarked, “public debate on cannabis law reform is guaranteed to provoke passionate and often negative responses”.<sup>66</sup> Mainstream politicians and legislators, in particular, are loath to be portrayed as supporting liberal drug laws. However, in the context of the legalisation of cannabis for medical use, this is ironic because there is widespread public support for this issue. The most recent National Drug Strategy Household Survey in 2007 showed that around 68% of Australians support “a change in legislation permitting the use of marijuana for medical purposes” and about 74% support “a clinical trial for people to

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Trial” (2003) 139(4) *Annals of Internal Medicine* 258; Guzman M, “Cannabinoids: Potential Anticancer Agents” (2003) 3 *Nature Reviews Cancer* 745; Ware M et al, “Cannabis Use for Chronic Non-Cancer Pain: Results of a Prospective Survey” (2003) 102(1-2) *Pain* 211; Soderpalm A et al, “Antiemetic Efficacy of Smoked Marijuana: Subjective and Behavioral Effects on Nausea Induced by Syrup of Ipecac” (2001) 69(3-4) *Pharmacology, Biochemistry and Behavior* 343; Doblin R, “Marijuana as Antiemetic Medicine: A Survey of Oncologists’ Experiences and Attitudes” (1991) 9(7) *American Journal of Clinical Oncology* 1314; Collin C, “Randomized Controlled Trial of Cannabis-Based Medicine in Spasticity Caused by Multiple Sclerosis” (2007) 14(3) *European Journal of Neurology* 290; Russo E et al, “Chronic Cannabis Use in the Compassionate Investigational New Drug Program: An Examination of Benefits and Adverse Effects of Legal Clinical Cannabis” (2002) 2(1) *Journal of Cannabis Therapeutics* 3.

<sup>63</sup> See Moran M, “Medical Use of Marijuana Divides AMA Delegates” (2009) 44(1) *Psychiatric News* 18; Moran M, “Medical Marijuana Verdict Elusive Despite Study, Debate” (2009) 44(1) *Psychiatric News* 10.

<sup>64</sup> Kassirer, n 31.

<sup>65</sup> Pickerill J and Chen P, “Medical Marijuana Policy and the Virtues of Federalism” (2007) 38(1) *Publius: The Journal of Federalism* 22 at 23. See also Stern R and DiFonzo H, “The End of the Red Queen’s Race: Medical Marijuana in the New Century” (2009) 27(4) *Quinnipiac Law Review* 673.

<sup>66</sup> de Launey C, “The Real Value of a Cannabis Plant” (1996) 21(3) *Alternative Law Journal* 127 at 127.

use marijuana to treat medical conditions”.<sup>67</sup> Similarly, at least ten national surveys conducted in the US between 1997 and 2005 have shown that around 70% of the American public,<sup>68</sup> and more than 90% of Canadians,<sup>69</sup> support the legalisation of marijuana for medical use.

The socio-political concerns outlined below are routinely raised in relation to the legalisation of cannabis (marijuana) for medical purposes.

#### *Legalisation Undermines Existing Criminal Drug Laws and Encourages Recreational Use*

It has been argued that legalising cannabis for medical use will also lead to demands for the legalisation of its recreational use.<sup>70</sup> However, this argument fails to realise that giving medical users, with legislatively prescribed medical conditions, statutory rights to access the drug for their ailments is entirely different to giving the general public a right to access the drug for pleasure. These two issues cannot be conflated with one another because they are entirely different matters. The legalisation of cannabis for medical purposes does not inevitably lead to the legalisation (or decriminalisation) of the recreational use of the drug, and this has not been the experience in the US among those States which have legalised the medical use of cannabis.<sup>71</sup> A study by the United States General Accounting Office in 2002 did not find any increase in marijuana use among people living in States which had legalised marijuana for medical use compared to those living in States which had not done the same.<sup>72</sup> However, the view that allowing the medical use of cannabis leads to the recreational use of cannabis, or at the least undermines existing criminal drug laws, is strongly held by many politicians and lawmakers, as the South Australian Attorney-General recently stated:

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<sup>67</sup> Australian Institute of Health and Welfare, Australian Government, *2007 National Drug Strategy Household Survey: First Results*, Drug Statistics Series No. 20 (2008), pp 42-43. See also Dunkerley S, “Australians Back Medical Marijuana, Heroin Injecting Rooms”, *The Courier-Mail* (29 August 2008).

<sup>68</sup> Mitchell Pickerill and Chen, n 65 at 35.

<sup>69</sup> Lucas P, “Regulating Compassion: An Overview of Canada’s Federal Medical Cannabis Policy and Practice” (2008) 5 *Harm Reduction Journal* 5 <http://www.harmreductionjournal.com/content/5/1/5> viewed 24 August 2009.

<sup>70</sup> Crites-Leoni A, “Medicinal Use of Marijuana: Is the Debate a Smoke Screen for Movement Toward Legalization?” (1998) 19(2) *Journal of Legal Medicine* 273; Garner D, “Up In Smoke: The Medical Marijuana Debate” (1999) 75 *North Dakota Law Review* 555 at 585.

<sup>71</sup> See O’Keefe K and Earleywine M, *Marijuana Use by Young People: The Impact of State Medical Marijuana Laws* (Marijuana Policy Project, 2005).

<sup>72</sup> US General Accounting Office, *Marijuana – Early Experiences with Four States’ Laws That Allow Use for Medical Purposes* (2002).

We are not going to allow our anti-drugs system to be breached in this way because once the breach was opened up for so-called medicinal cannabis it will just lead to cannabis for everyone.<sup>73</sup>

Surveys across the world have continually shown that recreational marijuana use is highest among teenagers and young adults.<sup>74</sup> It is sometimes argued that the legalisation of marijuana for medical use would run counter to government attempts to deter use among young people<sup>75</sup> and that legalisation would send a mixed message to society that marijuana use is generally acceptable because it is used by some people as a therapeutic agent.<sup>76</sup> However, the better view, arguably, is that the “use of the drug by those already sick might “de-glamorise” it and thereby do little to encourage use among others”.<sup>77</sup>

#### *Legal Cannabis May Be Diverted to Illicit Channels*

Giving medical users the right to use marijuana and grow cannabis raises the question that some legitimate cannabis may be diverted to illegitimate channels. While this argument appears to have great merit, especially in the light of increasing abuse of prescription narcotics in the community, this has not led to addictive painkillers such as morphine and oxycodone being outlawed on the basis that they may be diverted from legitimate users to non-medical users. Compared to cannabis, opioids actually have a greater acute toxicity as they produce respiratory depression,<sup>78</sup> yet their criminal diversion has not led to calls for dangerous opioids to be criminalised. The issue of prescription drugs of addiction being diverted to illicit channels should therefore not be intertwined with the debate as to whether or not to legalise the medical use of cannabis since there is always the possibility that any legal drug may be obtained for an improper purpose. Further, the fact remains that the number of medical users eligible for a legal supply of cannabis or marijuana would be a small

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<sup>73</sup> ABC News, “Relax Cannabis Laws for Chronic Pain: Magistrate”, 1 May 2009, <http://www.abc.net.au/news/stories/2009/04/30/2557477.htm> viewed 24 August 2009.

<sup>74</sup> For example, in Australia, 20% of 14-19 year-olds and 49.5% of 20-29 year-olds have tried marijuana; 12.9% and 20.8% of those are current users, respectively: Australian Institute of Health and Welfare, Australian Government, 2007 *National Drug Strategy Household Survey: First Results*, Drug Statistics Series No. 20 (2008), p 28.

<sup>75</sup> Crites-Leoni, n 70; Garner, n 70.

<sup>76</sup> See US Institute of Medicine, n 7, p 101: any answer to the question whether society’s perception of marijuana’s benefits will increase its abuse within the general population “remains conjecture”.

<sup>77</sup> Gorman DM and Huber Jr JC, “Do Medical Cannabis Laws Encourage Cannabis Use?” (2007) 18(3) *International Journal of Drug Policy* 160 at 160.

<sup>78</sup> Gable R, “Comparison of Acute Lethal Toxicity of Commonly Abused Psychoactive Substances” (2004) 99(6) *Addiction* 686.

fraction of the estimated number of recreational users. The amount of cannabis which may therefore be diverted would be very unlikely to significantly add to the overall supply of the drug which already exists in the black market for recreational users.<sup>79</sup>

#### *Cannabis is a Gateway Drug*

The legalisation of cannabis for medical use is sometimes opposed on the basis that it is a ‘gateway drug’.<sup>80</sup> According to this theory, drug addicts begin by experimenting with alcohol and tobacco, move onto “soft” illicit drugs such as marijuana and then progress to trying and later getting addicted to “hard” drugs such as heroin. However, the reason that marijuana is often a precursor for many users of “hard” illicit drugs is that marijuana users are commonly exposed to a wide range of illicit substances in accessing their marijuana from street dealers, thus giving users the opportunity to purchase and experiment with harder drugs.<sup>81</sup> In any event, the gateway drug theory does not relate to the issue of the legalisation of cannabis for medical purposes in a way that would be relevant if the recreational use of the drug was proposed. This is because the legalisation of cannabis for medical purposes does not involve the general public but a small, identifiable class of persons requiring the drug for medical reasons.

#### *Cannabis Impairs Psychomotor Skills*

There is currently controversy whether cannabis intoxication impairs psychomotor skills.<sup>82</sup> While some researchers have claimed that driving under the influence of cannabis is not as dangerous as driving while intoxicated by alcohol,<sup>83</sup> recent research suggests that driving under the influence of cannabis may be becoming a greater risk to driver safety than drink driving.<sup>84</sup> Regardless of which view is correct, this

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<sup>79</sup> See Hall W et al, “Allowing the Medical Use of Cannabis” (2001) 175(1) *Medical Journal of Australia* 39.

<sup>80</sup> See Tarter R et al, “Predictors of Marijuana Use in Adolescents Before and After Licit Drug Use: Examination of the Gateway Hypothesis” (2006) 163(12) *American Journal of Psychiatry* 2134.

<sup>81</sup> Hall et al, World Health Organisation Project on Health Implications of Cannabis Use, *A Comparative Appraisal of the Health and Psychological Consequences of Alcohol, Cannabis, Nicotine and Opiate Use* (1995): “exposure to other drugs when purchasing cannabis on the black market, increases the opportunity to use other illicit drugs”.

<sup>82</sup> Copeland et al, n 15, p 56. See also Jones A et al, “Driving Under the Influence of Cannabis: A 10-Year Study of Age and Gender Differences in the Concentrations of Tetrahydrocannabinol in Blood” (2008) 103(3) *Addiction* 452.

<sup>83</sup> Copeland et al, n 15, p 58.

<sup>84</sup> Ferguson D et al, “Is Driving Under the Influence of Cannabis Becoming a Greater Risk to Driver Safety Than Drink Driving? Findings From a Longitudinal Study” (2009) 40(4) *Accident Analysis and Prevention* 1345.

controversy should not ultimately limit the availability of cannabis for medical purposes since users can simply be advised or warned against driving while using the drug, similar to the warnings that patients are given in regard to driving after using pharmaceutical medications.

### **Constraints Imposed by International Law**

Signatory nations to the *United Nations Single Convention on Narcotic Drugs 1961* (“the Single Convention”), such as Australia, have an obligation to pass domestic laws that accord with its objects. The spirit and intention of international drug control treaties such as the Single Convention is to essentially eliminate the manufacture and trafficking of illicit drugs, including cannabis. However, the Single Convention also recognises that some drugs may have medicinal properties and scientific applications and makes exceptions to its general provisions when illicit narcotics are manufactured, distributed and used for “medical or scientific purposes”.<sup>85</sup> Indeed, the Preamble to the Single Convention states that “the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and adequate provision must be made to ensure the availability of narcotic drugs for such purposes”. It is therefore theoretically possible for signatory nations to the Single Convention to conduct trials and research into otherwise illicit drugs such as cannabis, as well as pass domestic medical cannabis legislation, without being in breach of their international obligations because it would relate to a legitimate therapeutic use of cannabis. In contrast, a signatory state would be in breach of their obligations under international drug treaties if they legalised or deregulated the recreational, non-medical use of cannabis or any other illicit drug.<sup>86</sup>

However, the International Narcotics Control Board (INCB), which is charged by the United Nations with administering<sup>87</sup> a number of international drug treaties including the Single Convention, has arguably approached the issue in a less-than-flexible manner. It has continually stated that further evidence of the therapeutic value

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<sup>85</sup> Articles 1, 2, 4, 9, 12, 19, and 49 of the Single Convention all contain general provisions with exemptions for medical and scientific purposes.

<sup>86</sup> See Boister N, “Decriminalising the Personal Use of Cannabis in the United Kingdom: Does International Law Leave Room for Manoeuvre?” [2001] *Criminal Law Review* 171.

<sup>87</sup> Article 9(4) of the Single Convention states the INCB “shall endeavour to limit the cultivation, production, manufacture and use of drugs to an adequate amount required for medical and scientific purposes, to ensure their availability for such purposes and to prevent illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs”.

of marijuana and its cannabinoid components is needed<sup>88</sup> and has thereby questioned on numerous occasions the legitimacy of programs currently operating in American, Dutch and Canadian jurisdictions allowing the medical use of cannabis (marijuana).<sup>89</sup> This is despite the fact that these programs nevertheless accord with international law by validly falling within the medical and scientific exceptions of the Single Convention and has led to claims that the INCB is interfering in the legitimate sovereign affairs of signatory nations.<sup>90</sup>

## The Legal Status of Cannabis for Medical Purposes in Australia

### *The Prohibition of Cannabis in Australia*

Cannabis is a prohibited plant in all Australian jurisdictions.<sup>91</sup> Thus, its possession,<sup>92</sup> cultivation<sup>93</sup> and trafficking<sup>94</sup> is a criminal offence in all Australian jurisdictions except in the very rare and limited circumstances where cannabis is used, possessed,

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<sup>88</sup> Pisik B, “UN Report Rebutts Arguments for Legalizing Pot”, *Washington Times* (27 February 2002).

<sup>89</sup> International Narcotics Control Board of the United Nations, *Report of the International Narcotics Control Board for 2004*, UN Doc E/INCB/2004/1 (2004), 28; *Report of the International Narcotics Control Board for 2002*, UN Doc E/INCB/2002/1 (2002), 21.

<sup>90</sup> Fazey C and Bewley-Taylor D, “Prohibition, Pragmatism and Drug Policy Repatriation” (2003) 14(2) *International Journal of Drug Policy* 141 at 141: “[i]mposing one form of social policy on the world in the form of drug prohibition has not worked and has created a great deal of harm”.

<sup>91</sup> See *Criminal Code Act 1995* (Cth), Pt 9.1, Div 314; *Drug Misuse and Trafficking Act 1985* (NSW), ss 3(1), 4; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 4(1); *Drugs Misuse Act 1986* (Qld), ss 4, 4A; *Controlled Substances Act 1984* (SA), s 4(1); *Misuse of Drugs Act 1981* (WA), s 4; *Misuse of Drugs Act 2001* (Tas), s 3(1); *Criminal Code Act 2002* (ACT), s 600; *Misuse of Drugs Act 1990* (NT), s 3.

<sup>92</sup> See *Criminal Code Act 1995* (Cth), s 308.1; *Drug Misuse and Trafficking Act 1985* (NSW), ss 10(1), 23; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 73; *Drugs Misuse Act 1986* (Qld), s 9; *Controlled Substances Act 1984* (SA), s 33L; *Misuse of Drugs Act 1981* (WA), ss 6,7; *Misuse of Drugs Act 2001* (Tas), ss 24,25; *Drugs of Dependence Act 1989* (ACT), ss 169,171; *Misuse of Drugs Act 1990* (NT), s 9.

<sup>93</sup> See *Criminal Code Act 1995* (Cth), ss 303.1-303.6 (cultivation only for commercial purposes); *Drug Misuse and Trafficking Act 1985* (NSW), ss 6, 23(1); *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 72B; *Drugs Misuse Act 1986* (Qld), ss 4, 8; *Controlled Substances Act 1984* (SA), ss 33B, 33K; *Misuse of Drugs Act 1981* (WA), s 7; *Misuse of Drugs Act 2001* (Tas), ss 7, 22; *Criminal Code Act 2002* (ACT), Pt 6.4; *Drugs of Dependence Act 1989* (ACT), s 162; *Misuse of Drugs Act 1990* (NT), ss 3(6), 7.

<sup>94</sup> For the sale or supply of proscribed drugs, see: *Criminal Code Act 1995* (Cth), ss 302.1-302.5; *Drug Misuse and Trafficking Act 1985* (NSW), ss 23, 25; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), ss 70, 71 (includes sale but not supply); *Drugs Misuse Act 1986* (Qld), s 6(1); *Controlled Substances Act 1984* (SA), s 32; *Misuse of Drugs Act 1981* (WA), ss 6(1)(c), 7(1); *Misuse of Drugs Act 2001* (Tas), ss 12, 27; *Criminal Code Act 2002* (ACT), Pt 6.2; *Misuse of Drugs Act 1990* (NT), s 5. Possession with intent to supply is also a distinct offence in all jurisdictions, except in Queensland and the Northern Territory: see *The Laws of Australia* (Lawbook Co, 2009) 10.6 “Drug Offences” at [10.6.650].

produced or distributed in the context of medical or scientific research.<sup>95</sup> All jurisdictions except Queensland have also criminalised the use<sup>96</sup> of cannabis. As there have not been any medical or scientific studies or trials so far into the use of cannabis for therapeutic use in Australia, and none of the Australian jurisdictions otherwise allow the medical use of marijuana or cannabis generally, it is thus unlawful for medical users to access cannabis.

*The Failure to Implement a Legal Regime of Cannabis for Medical Use: The Case of NSW*

In October 1999, former NSW Premier Bob Carr announced<sup>97</sup> that his State Government would investigate the use of cannabis for medical purposes. This followed calls by the Australian Medical Association and the NSW Law Society for the drug to be legally made available to persons suffering from debilitating and terminal illnesses and for whom no legally available medications were effective.<sup>98</sup> This led Carr to declare the State Government had a “moral obligation to explore”<sup>99</sup> making cannabis available to those who medically required it. The State Government proceeded to commission a Working Party on the Use of Cannabis for Medical Purposes (“the Working Party”) that would examine and report back in July 2000 about the feasibility of introducing a trial involving the medical use of cannabis in NSW.<sup>100</sup>

The terms of reference of the Inquiry required the Working Party, *inter alia*, to assess the efficacy and safety of cannabis for medical purposes, to establish if and how cannabis should be supplied for medical use and how diversion for recreational

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<sup>95</sup> See *Poisons Standard 2009* (Cth), Sch 1, Introduction, vii. See also *Drug Misuse and Trafficking Act 1985* (NSW), s 23(4)(b),(c); *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 20(3); *Controlled Substances Act 1984* (SA), ss 56, 57; *Poisons Act 1964* (WA), ss 41, 41A; *Poisons Act 1971* (Tas), s 55(2); *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT), Pt 21.1; *Misuse of Drugs Act 1990* (NT), s 19K. There is no such exception in Queensland: *The Laws of Australia* (Lawbook Co, 2009) 10.6 “Drug Offences” at [10.6.880].

<sup>96</sup> See *Drug Misuse and Trafficking Act 1985* (NSW), s 12; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 75; *Controlled Substances Act 1984* (SA), s 33L(1)(b); *Misuse of Drugs Act 1981* (WA), s 6(2); *Misuse of Drugs Act 2001* (Tas), s 24(a); *Misuse of Drugs Act 1990* (NT), s 13.

<sup>97</sup> Premier of New South Wales, “Government to Consider Cannabis for Medicinal Purposes” (Press Release, 19 October 1999).

<sup>98</sup> Whelan J, “Lawyers, Doctors Back Cannabis”, *Sydney Morning Herald* (1 October 1999); Ellicott J, “GPs, Law Back Marijuana Rethink”, *The Australian* (1 October 1999).

<sup>99</sup> NSW Legislative Assembly, *Questions Without Notice*, 19 October 1999, p 1513 (Bob Carr).

<sup>100</sup> NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes: Executive Summary* (2000), vol 1, p 9.

use or trafficking could be avoided.<sup>101</sup> The key findings of the Working Party were that crude cannabis or herbal marijuana was unlikely ever to be prescribed in Australia by the medical profession but that medical users should nevertheless be permitted to grow a limited number of cannabis plants and use herbal marijuana as part of a two-year trial until pharmaceutical cannabinoids became available.<sup>102</sup> Following the release of its report in August 2000, the Working Party proceeded to ask for public submissions on the recommendations of its report. The results of those submissions were later published by the Working Party in another report<sup>103</sup> released in July 2001. Significantly, 72% of the submissions received were in favour of the recommendations of the Working Party.<sup>104</sup> Only 11% of submissions were against the introduction of a marijuana trial for medical purposes.<sup>105</sup> The submissions raising the greatest concern related to recommendations about the development of alternative ways of using cannabis rather than smoking,<sup>106</sup> the medical conditions to be covered by any trial,<sup>107</sup> patients being able to grow their own plants<sup>108</sup> and the certification by doctors of users' medical conditions.<sup>109</sup>

In June 2002, NSW Greens MP Lee Rhiannon called for the State Government to take quicker action in implementing the marijuana trials recommended by the Working Party after notifying the Legislative Council that one of her constituents, who had a large cyst on his brain, was arrested and charged with the possession of marijuana and cultivation of cannabis that he was growing and using for therapeutic purposes.<sup>110</sup> The continued delay by the State Government to introduce these trials also led some patient support groups to rally in front of State Parliament.<sup>111</sup> Eventually, in May 2003, Carr stated that “after a long period of careful

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<sup>101</sup> NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes: Main Report* (2000), vol 2, p 113.

<sup>102</sup> NSW Office of Drug Policy, *Report on Consultation on the Findings and Recommendations of the Working Party on the Use of Cannabis for Medical Purposes* (2001), p 3.

<sup>103</sup> NSW Office of Drug Policy, n 102.

<sup>104</sup> NSW Office of Drug Policy, n 102, pp 5, 20. See also Constantinou A, “Bob Carr Tries Dope: Medicinal Marijuana on Trial in NSW” (2003) *Drugs in Society* 17.

<sup>105</sup> NSW Office of Drug Policy, n 102.

<sup>106</sup> See NSW Department of Premier and Cabinet, n 100, p 30 (Recommendation 8).

<sup>107</sup> See NSW Department of Premier and Cabinet, n 100, p 33 (Recommendation 13).

<sup>108</sup> See NSW Department of Premier and Cabinet, n 100, p 34 (Recommendations 15 and 17).

<sup>109</sup> See NSW Department of Premier and Cabinet, n 100, p 36 (Recommendation 19).

<sup>110</sup> NSW Legislative Council, *Questions Without Notice*, 26 June 2002, p 3766 (Lee Rhiannon).

<sup>111</sup> Australian Associated Press, “Picketers Call for Medical Use of Cannabis” (3 September 2002). See also NSW Legislative Council, *Adjournment Debate*, 3 September 2002, p 4404 (Richard Jones).

deliberation”,<sup>112</sup> the State Government was on the verge of releasing a draft exposure bill to establish a four-year trial of cannabis for medical purposes.<sup>113</sup> However, Carr was particularly cautious in the manner in which he announced this, so as not to be portrayed by the Opposition or by anti-drugs campaigners as being “soft” on drugs. Carr reiterated his strong opposition to the legalisation or decriminalisation of the recreational use of marijuana<sup>114</sup> and reminded Parliament that his attempts to establish a marijuana trial for medical users were justified because the Working Party had found overwhelming support for a trial from the community and expert groups.

While the Working Party supported medical users and their caregivers growing a limited amount of cannabis “to allow [users] to avoid resorting to the black market”,<sup>115</sup> the State Government was opposed to this because it felt surplus cannabis and marijuana grown for legitimate reasons could be diverted into the recreational market.<sup>116</sup> It is for this reason that Carr announced that medical users would be able to access herbal marijuana from a new Office of Medicinal Cannabis within the NSW Department of Health.<sup>117</sup> However, the marijuana trials never eventuated amid protracted delays<sup>118</sup> and an Office of Medicinal Cannabis was never created.<sup>119</sup> As a result of the failure to implement these trials in NSW, cannabis continues to be a prohibited illicit substance for medical users. However, the failure to implement these trials cannot be said to lie solely with the NSW Carr Government since the federal Howard government at the time was known to have given only very limited support to the medical use of cannabis and, even then, as long as it did not involve smoking the drug.<sup>120</sup> Some have argued that it was in fact the former federal Howard government

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<sup>112</sup> NSW Legislative Assembly, *Questions Without Notice*, 20 May 2003, p 696 (Bob Carr). See also Australian Associated Press, “Carr Unveils Four-Year Cannabis Trial” (20 May 2003); Reuters, “Australian State to Allow Marijuana for Pain Relief” (21 May 2003).

<sup>113</sup> Carr, n 112.

<sup>114</sup> ABC Television, “Cannabis Trial Won’t Lead to Decriminalisation: Carr”, *Lateline*, 20 May 2003, <http://www.abc.net.au/lateline/content/2003/s859641.htm> viewed 30 May 2009.

<sup>115</sup> Hall et al, n 79.

<sup>116</sup> NSW Legislative Assembly, *Questions Without Notice*, 21 May 2003, p 862 (Bob Carr).

<sup>117</sup> See Carr, n 112, p 697.

<sup>118</sup> See NSW Legislative Council, *Questions and Answers*, 4 September 2003, p 301 (Lee Rhiannon); NSW Legislative Council, *Questions Without Notice*, 4 December 2003, p 5845 (Lee Rhiannon and John Della Bosca); NSW Legislative Council, *Questions Without Notice*, 30 March 2004, pp 7647-7648 (Lee Rhiannon and John Della Bosca).

<sup>119</sup> NSW Legislative Council, *Adjournment Debate*, 26 February 2008, p 5406 (Lee Rhiannon).

<sup>120</sup> Commonwealth of Australia, *Parliamentary Debates*, House of Representatives, 2 June 2003, p 15633 (Parliamentary Secretary to the Minister for Foreign Affairs). See also Price S, “State Marijuana Trial Hits Snag”, *The Sun-Herald* (19 December 2004).

that was ultimately responsible for the failure of these trials in NSW.<sup>121</sup> The co-operation of the Federal Government was pivotal for any marijuana trials to be established since it would have most likely involved importing cannabis plants from Canada and distributing cannabis via the proposed Office of Medicinal Cannabis.<sup>122</sup>

*Availability of the Defence of Medical Necessity in Australia*

The main concern of medical users of cannabis relates to the drug's illegal status<sup>123</sup> and the fear of being arrested for accessing and using it.<sup>124</sup> This concern overshadows any other concern they might have in relation to the drug, including its possible health risks. Such a concern is not unfounded: around one quarter of the participants in a NSW study reported that they had in fact been convicted, arrested or cautioned by the police for using marijuana for medical purposes.<sup>125</sup> Arguably, studies such as these could be criticised on the basis that those who are, or have been, arrested for cannabis or marijuana offences are more likely to participate in surveys than those who have never been arrested. The proportion of total cannabis users arrested in any year is actually relatively small and hovers around 2%, whether in Australia, Canada or the US.<sup>126</sup> However, it appears that laws criminalising cannabis have the effect of deterring legitimate medical users, who are statistically more likely to be older law-abiding adults, than recreational users who are likely to be teenagers or young adults.<sup>127</sup>

Insofar as the medical use of cannabis is illegal, medical users are capable of being arrested for using or growing the drug to alleviate their symptoms. However, it is an unsettled question whether medical users of cannabis charged with criminal drug offences such as possession, cultivation or trafficking can use the defence of necessity (also sometimes referred as “duress of circumstances”) in Australia.<sup>128</sup> The essence of any defence of necessity to a criminal charge is that the defendant “was compelled by

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<sup>121</sup> See Sikora K, “Medical Use of Cannabis Trial Reopens Drug Debate”, *Daily Telegraph* (19 May 2008): “The medical use of cannabis was squashed by former Prime Minister John Howard”.

<sup>122</sup> NSW Legislative Assembly, *Questions Without Notice*, 12 May 2004, p 8888 (Bob Carr); NSW Legislative Council, *Questions Without Notice*, 1 September 2004, p 10570 (John Della Bosca).

<sup>123</sup> Swift et al, n 5. See also Canadian AIDS Society, n 47.

<sup>124</sup> Swift et al, n 5.

<sup>125</sup> Swift et al, n 5.

<sup>126</sup> Hall and Pacula, n 53, p 179.

<sup>127</sup> Hall and Pacula, n 53, p 181.

<sup>128</sup> Heilpern D and Rayner G, “Drug Law and Necessity” (1997) 22(4) *Alternative Law Journal* 188 at 188.

a threat or danger to commit the crime charged” and that the “threat or danger must have been of such a nature as to exert immense pressure on the person because of its imminence, suddenness, or gravity”.<sup>129</sup> In Australia, the defence of necessity appears to have been accepted and judicially confined to cases where defendants have been charged with procuring an abortion,<sup>130</sup> though it has also been accepted recently in the context of the separation of conjoined twins where surgery is necessary to save the life of one of the twins but may lead to the death of the other twin.<sup>131</sup> No significant authority exists from the higher courts in Australia<sup>132</sup> on the existence of a common law defence of necessity in relation to the use, possession, cultivation or trafficking of cannabis or marijuana for medical use. However, there have been a number of lower court decisions in which magistrates have exercised their discretion to acquit medical users of marijuana and dismiss their cannabis charges upon evidence by users that their cannabis use was motivated by a desire to relieve their medical conditions and symptoms.

For example, *In the Appeal of Terrence Lee Falconer* (unrep, Lismore District Court, 22 March 1991) Lismore District Court dismissed fines of \$500 imposed by the Local Court on the defendant for cultivation of 6 cannabis plants and for being in possession of less than 1 gram of marijuana on the basis of his good character and legitimate medical need. The defendant called his family doctor to give evidence that he was in fact suffering from AIDS and to testify that the defendant’s smoking of marijuana was demonstrably beneficial by relieving his nausea and allowing him to eat. In doing so, the defendant’s doctor also referred to studies from the United States indicating that the highly toxic medications AIDS patients take often cause severe nausea and pain and that these side effects are not always resolved by legally available analgesics and anti-emetics.<sup>133</sup> In 1999, Lismore District Court also

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<sup>129</sup> Butt P (ed), *Butterworths Concise Australian Legal Dictionary* (3rd ed, Butterworths, Sydney, 2004) p 292, citing *R v Loughnan* [1981] VR 443 and *Re Appeal of White* (1987) 9 NSWLR 427.

<sup>130</sup> See *K v Minister for YACS* [1982] 1 NSWLR 311, 318: “there is no legal wrongdoing... on reasonable grounds that the termination of pregnancy was necessary to preserve the woman involved from serious danger to her life or physical or mental health and that in the circumstances the danger of the operation was not out of proportion to the danger intended to be averted”. See also *R v Wald* (1971) 3 NSWDCR 25; Heilpern and Rayner, n 128 at 189-191.

<sup>131</sup> See *Queensland v Nolan* [2002] 1 Qd R 454, applying *Re A (Children) (Conjoined Twins: Surgical Separation)* [2000] 4 All ER 961. Further, see Grubb A, “Conjoined Twins: Re A Down Under” (2002) 10(1) *Medical Law Review* 100.

<sup>132</sup> Heilpern and Rayner, n 128.

<sup>133</sup> For further examples, see Puls D, *HIV/AIDS Sentencing Kit* (3rd ed, HIV/AIDS Legal Centre, Sydney, 2000), p 21. See also Dent J, “Cannabis Accepted as Pain Reliever”, *Sydney Morning Herald*

overturned the criminal conviction and \$1,000 fine imposed by the Byron Bay Local Court on lymphoma patient who had used marijuana for unresolved pain.<sup>134</sup>

While the defence of necessity may help medical users of cannabis to access the drug for symptomatic relief, it has been argued that, in reality, it is of little assistance to them. The statutory or judicial recognition of a defence of medical necessity to a charge of cannabis use, possession or cultivation does little to promote the rights of medical users because it is inherently defensive in nature and relies heavily upon judicial, prosecutorial and police discretion.<sup>135</sup> Further, others have argued that the medical necessity defence “does little to allow access to a legal and regulated supply of medical marijuana and the prohibitive court costs involved in arguing the defence often preclude defendants from using it”.<sup>136</sup>

## **The Legal Status of Cannabis for Medical Purposes in the United States of America**

### *Partial Legalisation in 13 States – and Growing*

Thirteen states in the United States of America currently have statutory medical marijuana laws giving medical users the right to access cannabis for a prescribed number of conditions: Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont and Washington.<sup>137</sup> The state of California became the first jurisdiction in the world to legalise cannabis for medical purposes following the enactment of the *Compassionate Use Act*<sup>138</sup> in 1996 following a favourable voter-initiated referendum. In contrast, the US Federal Government has continually opposed these State laws from the outset on the basis that cannabis (including marijuana) is a federally prohibited<sup>139</sup> drug. The US Supreme

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(5 January 2000): defendant sentenced to 28 days’ home detention and random drug testing for possessing and cultivating marijuana for his chronic back pain.

<sup>134</sup> Puls, n 133.

<sup>135</sup> See LeVay A, “Urgent Compassion: Medical Marijuana, Prosecutorial Discretion and the Medical Necessity Defence” (1999) 41(3) *Boston College Law Review* 699 at 740: “although prosecutorial discretion potentially can bring the law into conformity with the values of the community, like all types of discretion, it has a high potential of abuse”.

<sup>136</sup> Kyriagis M, “Marijuana – Just What the Doctor Ordered? A Review of the Medico-Legal and Political Debate in the United States of America on Medicinal Use of Marijuana and Implications for Australia” (1997) 20(3) *University of New South Wales Law Journal* 594 at 617.

<sup>137</sup> Armour S, “Medical Marijuana Laws Vary Among States”, *USA Today* (17 April 2007); Associated Press, “Medical Pot Measure OK’d, “Victory for the Patients and their Families”” (5 November 2008).

<sup>138</sup> *Compassionate Use Act 1996*, Cal Health & Safety Code Ann § 11362.5 (West Supp 2005).

<sup>139</sup> *Controlled Substances Act*, 21 USC §§ 801–41 (2000), part of the *Comprehensive Drug Abuse Prevention and Control Act of 1970*, Pub L No 91-513, 84 Stat 1236.

Court has also held<sup>140</sup> that it is constitutionally permissible for the Federal Government to regulate even purely intra-state cannabis grown for medical purposes that does not cross state borders, under the constitutional doctrine of commingling, using its interstate trade and commerce power,<sup>141</sup> arguably disrespecting the self-regulation of the states. However, the Supreme Court has done this without invoking the Supremacy Clause to invalidate the otherwise inconsistent State medical marijuana laws that had been passed by those states.<sup>142</sup> The extent of the Federal Government's opposition to State medical marijuana laws even led it at one stage to threaten to revoke the licenses of doctors who had recommended or even discussed marijuana or cannabis generally with their patients.<sup>143</sup> The US Supreme Court, however, has held<sup>144</sup> that such threats are a constitutional violation of the First Amendment free speech rights of doctors and patients since "an integral component of the practice of medicine is the communication between a doctor and a patient".<sup>145</sup>

*United States Federal Drug Policy and the Defence of Medical Necessity*

United States federal drug policy that cannabis has no recognised medical use gained momentum following President Nixon's declaration of a "war on drugs" in 1972.<sup>146</sup> The notion of cannabis or marijuana as medicine has long been regarded a hoax by the US Federal Government.<sup>147</sup> The US Federal Government classifies cannabis (including marijuana) as a Schedule I controlled substance,<sup>148</sup> a category which contains illicit narcotics that have a high potential for abuse and which cannot be

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<sup>140</sup> *Gonzales v Raich*, 545 US 1 (2005). See Gu W, "States' Right to Initiative: Medical Marijuana" (2008) 7(2) *Culture, Society and Praxis* 13 at 16.

<sup>141</sup> *United States Constitution* art I, § 8, cl 3.

<sup>142</sup> *United States Constitution* art VI, cl 2.

<sup>143</sup> Golden T, "Doctors are Focus of Plan to Fight New Drug Laws", *New York Times* (23 December 1996). See also Pomerantz K, "Silence is a Fence Around Wisdom": How *Conant v Walters* Broke Down the Fence by Securing Physicians' First Amendment Right to Recommend Medical Marijuana to their Patients" (2003) 37(5) *Loyola of Los Angeles Law Review* 1771.

<sup>144</sup> *Walters v Conant*, 540 US 946 (2003), affirming *Conant v Walters*, 309 F 3d 629 (9th Cir, 2002).

<sup>145</sup> *Conant v Walters*, 540 US 946, 636 (2003). The threats also amounted to a violation of the common law doctor-patient privilege. Further, see Grey M, "Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship" (1996) 30(1) *University of Richmond Law Review* 249; Tuller D, "Doctors Tread Thin Line on Marijuana Advice", *New York Times* (28 October 2003).

<sup>146</sup> See McGuire S, "Medical Marijuana: State Law Undermines Federal Marijuana Policy – Is the Establishment Going to Pot?" (1997) 7 *San Joaquin Agricultural Law Review* 73 at 76.

<sup>147</sup> Grinspoon, n 13 at 379. See also US Department of Justice, *Exposing the Myth of Medical Marijuana* <http://www.justice.gov/dea/ongoing/marijuana.html> viewed 21 August 2009, Drug Enforcement Agency and US Department of Justice, "Medical" Marijuana – The Facts <http://www.usdoj.gov/dea/ongoing/marinol.html> viewed 21 August 2009.

<sup>148</sup> *Controlled Substances Act*, 21 USC §§ 801–41 (2000).

accessed for therapeutic purposes.<sup>149</sup> In view of the fact that cannabis (namely, marijuana) is used medicinally by some seriously ill persons, marijuana law reformers such as NORML, the National Organization for Reform of Marijuana Laws, have brought an enormous amount of litigation<sup>150</sup> against the US Federal Government since the 1970s to have cannabis reclassified to the less restrictive Schedule II category, which contains drugs of addiction that can be accessed for therapeutic purposes. Ironically, the US Federal Government and cannabis law reformers have spent more resources on litigation than on funding research into the therapeutic effects of cannabis (marijuana).<sup>151</sup>

Complicating the issue is the fact that the US Federal Government continually denies scientific and university researchers the appropriate licenses from the National Institute on Drug Abuse to grow cannabis for medical research purposes.<sup>152</sup> It has also been reluctant to provide researchers with cannabis from its sole plantation at the University of Mississippi,<sup>153</sup> although in 2000 the Drug Enforcement Administration allowed a northern Californian county to give away federally grown cannabis and marijuana as part of an AIDS study.<sup>154</sup> However, examples such as this are extremely rare and the US Federal Government continues to deny the effectiveness of cannabis (marijuana) as medicine despite the anecdotal claims of medical users of the drug. As recently as April 2006, the Food and Drug Administration (FDA) issued an intra-agency statement that “no sound scientific studies supported medical use of marijuana for treatment” and that “no animal or human data supported the safety or efficacy of marijuana for general medical use”.<sup>155</sup> In doing so, it ignored<sup>156</sup> the 1999 report of the

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<sup>149</sup> See Neusch E, “Medical Marijuana’s Fate in the Aftermath of the Supreme Court’s New Commerce Clause Jurisprudence” (2001) 72(1) *University of Colorado Law Review* 201 at 210-211.

<sup>150</sup> See, eg, *National Organization for Reform of Marijuana Laws (NORML) v Ingersoll*, 497 F 2d 654 (DC Cir, 1974); *National Organization for Reform of Marijuana Laws (NORML) v Drug Enforcement Administration (DEA)*, 559 F 2d 735 (DC Cir, 1977); *Alliance for Cannabis Therapeutics (ACT) v Drug Enforcement Administration (DEA)*, 15 F 3d 1131 (DC Cir, 1994). See also Conboy JR, “Smoke Screen: America’s Drug Policy and Medical Marijuana” (2000) 55(4) *Food and Drug Law Journal* 601.

<sup>151</sup> Cohen M, “Breaking the Federal/State Impasse over Medical Marijuana: A Proposal” (2000) 11(1) *Hastings Women’s Law Journal* 59 at 73.

<sup>152</sup> McNeil Jr D, “College is Rebuffed in Request to Grow Medical Marijuana”, *New York Times* (14 December 2004): researchers wanted to grow marijuana independently of the Federal Government, which it claimed was of an inferior quality.

<sup>153</sup> See Brainard J, “Legal Showdown Over Medical Marijuana Pits UMass Against Ole Miss” (2005) 52(2) *Chronicle of Higher Education* 34.

<sup>154</sup> Associated Press, “DEA OKs Studying Pot’s Effect on Patients” (24 November 2000).

<sup>155</sup> US Department of Health and Human Services, Food and Drug Administration, ‘Inter-Agency Advisory Regarding Claims that Smoked Marijuana is a Medicine’ (Press Release, 20 April 2006).

Institute of Medicine.<sup>157</sup> This has led some to argue that the FDA has lost credibility<sup>158</sup> with its latest statement against the use of marijuana for medical purposes, ignoring strong evidence that smoked marijuana, for example, helps to alleviate painful HIV-associated sensory neuropathy.<sup>159</sup> It has again attracted litigation from cannabis law reformers who have commenced litigation for misleading and deceptive conduct.<sup>160</sup>

Even though official federal law and policy deny any medical benefits from using marijuana or cannabis generally, a wealth of case law has emerged from numerous US jurisdictions at the State level in relation to the defence of medical necessity.<sup>161</sup> Where the defence is made out, it can be argued that the courts are impliedly agreeing with defendants that marijuana or cannabis generally can be used as a legitimate medical substance and that it would be unjust to convict them where they are using the drug as a last resort to relieve their symptoms. The defence of medical necessity to a charge of cannabis use, possession and cultivation has been accepted in Florida,<sup>162</sup> New Jersey<sup>163</sup> and Washington (prior to the statutory legalisation of medical marijuana in that State).<sup>164</sup> In contrast, Massachusetts<sup>165</sup> and Minnesota<sup>166</sup> have refused to accept the medical necessity defence for the same cannabis charges. It would appear that the decisions in these cases often hinged upon the personal biases of the judges hearing the matters rather than on the authenticity of

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<sup>156</sup> Twombly R, “Despite Research, FDA Says Marijuana Has No Benefit” (2006) 98(13) *Journal of the National Cancer Institute* 888 at 888.

<sup>157</sup> US Institute of Medicine, n 7.

<sup>158</sup> See Harris G, “FDA Dismisses Medical Benefit from Marijuana”, *New York Times* (21 April 2006). See also “Reefer Madness – Medical Marijuana”, *The Economist* (29 April 2006).

<sup>159</sup> Abrams D et al, “Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial” (2007) 68(7) *Neurology* 515.

<sup>160</sup> United States Newswire, “Patients File Lawsuit Challenging Federal Government on Medical Cannabis, Demand FDA Correct Misinformation” (Press Release, 21 February 2007), citing Abrams et al, n 62.

<sup>161</sup> The defence of medical necessity, however, is unavailable to the operators of compassion club operators or as a defence to the federal *Controlled Substances Act*: see *United States v Oakland Cannabis Buyers’ Cooperative*, 532 US 483 (2001). However, less than 1% of marijuana charges are brought by federal authorities; more than 99% are brought by state-based authorities and so the defence of medical necessity can still be used against state charges where it has been accepted.

<sup>162</sup> *Jenks v State*, 582 So 2d 676 (Fla Dist Ct App, 1991); *Florida v Musikka* (1989) 4 *Florida Law Weekly* 1.

<sup>163</sup> *State v Tate*, 505 A 2d 941 (NJ, 1986).

<sup>164</sup> *State v Diana*, 604 P 2d 1312 (Wash Ct App, 1979).

<sup>165</sup> *Commonwealth v Hutchins*, 575 NE 2d 741 (Mass, 1991). See also Whilton T, “*Commonwealth v Hutchins*: A Defendant is Denied the Right to Present a Medical Necessity Defense” (1993) 27 *New England Law Review* 1101.

<sup>166</sup> *State v Hanson*, 468 NW 2d 77 (Minn App, 1991).

defendants' need to use marijuana or cannabis generally, all of whom were able to adduce evidence from their treating doctors that they were demonstrably deriving benefits from using the drug.

*A Fundamental Right to Cannabis for Medical Purposes in the US Constitution?*

While the common law defence of medical necessity has been accepted a number of times by courts in some parts of the United States, a positive assertion by medical users of cannabis and marijuana that they have a fundamental constitutional right to access and use the drug for the symptomatic relief of their life-threatening and debilitating medical conditions has never been accepted. The recent case of *Raich v Gonzales* 500 F 3d 850 (9th Cir, 2007) illustrates the notion that patients can only assert their need to use cannabis for medical purposes as a shield, in the form of the defence of medical necessity where available, rather than as a sword through the assertion of a positive constitutional right.

In *Raich v Gonzales*, the United States Ninth Circuit Court of Appeals was asked to consider whether the plaintiff, Angel McClary Raich, who suffered from an inoperable brain tumor among many other medical problems,<sup>167</sup> was entitled to an injunction preventing the Federal Government arresting and prosecuting her for cannabis use and possession. Raich argued that her right to use marijuana, borne from medical necessity, was protected by the Fifth and Ninth Amendments to the US Constitution. Significantly, Raich had not been prosecuted for any cannabis offences at any time and therefore presumptively sued the Federal Government so that she did not face the potential of being prosecuted in the future for using marijuana and accessing cannabis, as well as to prevent her cannabis being destroyed in that event. Raich's primary care physician, who had treated her for many years, gave extensive evidence that the marijuana she was smoking every 2 hours was keeping her alive by alleviating her symptoms, including letting her eat by relieving her nausea.<sup>168</sup>

The Fifth Amendment of the US Constitution guarantees that "no person shall... be deprived of *life*, liberty, or property, without due process of law".<sup>169</sup>

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<sup>167</sup> See McKinley J, "Dying Woman Loses Appeal on Marijuana as Medication", *New York Times* (15 March 2007); Barnett R, "Reefer Madness", *Wall Street Journal* (16 March 2007); Medical News Today, "Woman Denied Right to Use Marijuana as Life-Saving Medication", 15 March 2007 <http://www.medicalnewstoday.com/articles/65293.php> viewed 30 May 2009.

<sup>168</sup> See above nn 35-41 and the corresponding text.

<sup>169</sup> Emphasis added.

Further, the Ninth Amendment of the US Constitution protects unenumerated fundamental rights pursuant to the Fifth Amendment by guaranteeing that “[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained [expressly] by the people”. While Raich argued that her right to use and access cannabis for medical purposes, pursuant to the Californian *Compassionate Use Act*, formed part of a wider fundamental right to “mak[e] life-shaping medical decisions that are necessary to preserve the integrity of her body, avoid intolerable physical pain, and preserve her life”,<sup>170</sup> the Ninth Circuit Court of Appeals approached the issue more cautiously. The court ultimately adopted a narrow construction of the asserted right to use cannabis and marijuana as life-sustaining medicine “because judicial extension of constitutional protection for an asserted substantive due process right places the matter outside the arena of public debate and legislative action”<sup>171</sup> and “because guideposts for responsible decision-making in this uncharted area are scarce and open-ended”.<sup>172</sup>

It was clear from the precedents the court chose to apply that it was not willing to find in favour of a right of persons with life-threatening and disabling medical conditions to use cannabis free from government interference and prosecution. However, the court agreed with Raich that “the last ten years have been characterized by an emerging awareness of marijuana’s medical value.”<sup>173</sup> The court also agreed with Raich that the issue of medical marijuana should be treated by the law in the same way that a “narrowly defined fundamental right to engage in consensual sexual activity, including homosexual sodomy, in the home without government intrusion” was recently recognised by the US Supreme Court in the landmark case of *Lawrence v Texas*.<sup>174</sup> However, the Ninth Circuit felt that “the use of medical marijuana has not

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<sup>170</sup> 500 F 3d 850, 864 (9th Cir, 2007).

<sup>171</sup> 500 F 3d 850, 863 (9th Cir, 2007), citing *Washington v Glucksberg*, 521 US 702, 720 (1997). In *Glucksberg*, the US Supreme Court dismissed a substantive due process challenge to the state of Washington’s ban on physician-assisted suicide and in doing so refused to recognise a right to die with dignity as an unenumerated right protected by the Fifth Amendment of the US Constitution.

<sup>172</sup> 500 F 3d 850, 863 (9th Cir, 2007).

<sup>173</sup> 500 F 3d 850, 866-867 (9th Cir, 2007).

<sup>174</sup> 539 US 558, 578 (2003). The US Supreme Court declared unconstitutional provisions in Texas statutes that criminalised homosexual sexual activity, even though those provisions were rarely enforced. The same thing happened in Australia with Tasmanian legislation that criminalised consensual homosexual sex being struck out as inconsistent with the federal *Human Rights (Sexual Conduct) Act: Croome v Tasmania* (1997) 191 CLR 119. That federal Act itself was passed as a result of a human rights complaint (based on the breach of a human right to privacy) by a Tasmanian to the

obtained the degree of recognition today that private sexual conduct had obtained” and could not declare that a right to use the drug was protected by the Fifth or Ninth Amendments to the US Constitution at least for the time being.

While the Ninth Circuit Court of Appeals was sympathetic with Raich’s asserted right to use marijuana and access cannabis for symptomatic relief, it could not ultimately find in her favour because, if it did, the US Supreme Court would have undoubtedly overturned it on appeal on the basis of previous medical marijuana cases in which it refused to recognise marijuana, or cannabis generally, as medicine.<sup>175</sup> Nevertheless, this will undoubtedly lead to future challenges by medical users of cannabis that their right to use the drug is a fundamental constitutional right that should not be interfered with by the Federal or State Governments. Despite its ruling, the Ninth Circuit acknowledged that the day when the use of cannabis to relieve excruciating pain and suffering is declared to be a fundamental constitutional right “may be upon us sooner than expected” if the trend in US States legalising the medical use of marijuana continues. The change from a Bush to Obama administration may also be a decisive factor in this regard since a Democratic leadership is seen as being more likely than a Republican leadership to pass an amendment to the *Controlled Substances Act* legalising the medical use of cannabis.<sup>176</sup> Changes in US federal marijuana policy may already be beginning under the Obama administration, with the current US Attorney-General stating that the new administration will end the Bush administration’s frequent raids on legitimate distributors of marijuana for medical purposes (so-called “cannabis clubs”). The new policy, it seems, “would now be restricted to traffickers who falsely masqueraded as medical dispensaries and “use medical marijuana laws as a shield””.<sup>177</sup>

## **The Legal Status of Cannabis for Medical Purposes in Canada and the Netherlands**

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United Nations Human Rights Committee: *Toonen v Australia*, UN Doc CCPR/C/50/D/488/1992 (4 April 1994).

<sup>175</sup> See *United States v Oakland Cannabis Buyers’ Cooperative*, 532 US 483 (2001).

<sup>176</sup> See Froom A, “US Drug Agency Blunts Supply of Marijuana for Research” (2009) 15(3) *Nature Medicine* 223: “[w]ith all sides firmly entrenched, medical marijuana advocates hope that the Obama administration will reverse” current federal government policy.

<sup>177</sup> Johnston D and Lewis N, “Obama Administration to Stop Raids on Medical Marijuana Dispensers”, *New York Times* (19 March 2009). See also Morris K, “The USA Shifts Away from the “War on Drugs”” (2009) 373 *Lancet* 1237; Dinan J and Gamkhar S, “The State of American Federalism 2008 – 2009: The Presidential Election, the Economic Downturn, and the Consequences for Federalism” (2009) 39(3) *Publius: The Journal of Federalism* 369 at 374.

In contrast to the prohibition of cannabis in Australia and the partial legalisation of cannabis in the US for medical use in 13 US states, Canada and the Netherlands are among the very few countries in the world which have legislated in favour of the medical use of cannabis. However, it must be recognised that different processes and pressures led to the legalisation of cannabis for medical purposes in Canada and the Netherlands.

#### *Legalisation of Cannabis for Medical Purposes in the Netherlands*

The legalisation of cannabis for medical purposes in the Netherlands by legislative amendment to the Dutch *Opium Act* in 2000, was a largely uncontroversial event<sup>178</sup> in a country renowned for its legal and social tolerance of cannabis coffee shops and recreational use of marijuana. Dutch pharmacies became the first in the world<sup>179</sup> to dispense dried marijuana leaves to patients, on a doctor's prescription, in January 2003. The Dutch Ministry of Health, Welfare and Sport is in charge of administering the Office of Medicinal Cannabis and, in accordance with the UN *Single Convention on Narcotic Drugs 1961*, maintains a monopoly over the trade and cultivation in cannabis for medical purposes.<sup>180</sup> On the other hand, the legalisation of cannabis for medical purposes in Canada, in 2001, followed almost 3 years of litigation challenging the constitutionality of laws that prevented seriously ill patients accessing marijuana for symptomatic relief, similar to the US. Significantly, these constitutional challenges, which ultimately led to the legalisation of cannabis for medical purposes in Canada, were premised upon human rights arguments that could spur similar challenges in other common law jurisdictions such as Australia.

#### *Human Rights Challenges to Canada's Prohibition of Cannabis for Medical Purposes*

Canadian courts have struck out statutory provisions prohibiting all uses of cannabis as a breach of the human rights of medical users of cannabis, pursuant to the Canadian *Charter of Rights and Freedoms*. Challenges to Canada's prohibition of cannabis for medical purposes began in 1998 when Jim Wakeford was charged and prosecuted for the possession of marijuana and cultivation of cannabis which he grew and used in the

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<sup>178</sup> See Reuters, "Dutch Want Cannabis Registered as Regular Medicine" (15 November 2007).

<sup>179</sup> Richburg K, "For Dutch in Pain, Drugstores Offer Pot by Prescription", *Washington Post* (11 February 2004).

<sup>180</sup> See Netherlands, Ministry of Health, Welfare and Sport, Office of Medicinal Cannabis (Office of Medicinal Cannabis), [http://www.minvws.nl/en/folders/gmt/office\\_of\\_medicinal\\_cannabis.asp](http://www.minvws.nl/en/folders/gmt/office_of_medicinal_cannabis.asp) viewed 7 December 2009.

treatment of his HIV/AIDS condition. The Ontario Superior Court in *Wakeford v Canada* 173 DLR 4th 726 (1999) held that medical users of cannabis such as Wakeford had a constitutional exemption from the operation of criminal drug laws insofar as the use, possession and cultivation of cannabis was concerned. Further, the Court held that not only did medical users of cannabis have a legitimate right to access marijuana without fear of arrest, it instructed the Federal Government to institute a centralised medical cannabis program to distribute marijuana to patients such as Wakeford. The Canadian Government pointed to section 56 of the federal *Controlled Drugs and Substances Act 1996*, which empowered the federal health department to grant exemptions to persons to access illicit drugs for medical or scientific purposes, as allowing it to institute this centralised medical cannabis program.<sup>181</sup>

The following year, in *R v Parker* 146 CCC 3d 193 (2000), the Ontario Court of Appeal declared section 56 of the federal *Controlled Drugs and Substances Act 1996* unconstitutional because it failed to provide an adequate exemption for persons requiring cannabis for medical purposes.<sup>182</sup> Section 56 of the *Controlled Drugs and Substances Act 1996*, which provided for a ministerial exemption from provisions of the Act to classes of persons requiring access to otherwise illicit narcotics through the issuing of permits, was found by the Court of Appeal to have been an inappropriate delegation of unfettered ministerial discretion by the Federal Government. The Court of Appeal gave the Federal Government one year to enact appropriate exemptions to the *Controlled Drugs and Substances Act* so as to allow clearly identifiable classes of persons with prescribed medical conditions, the right to access a permit to use the drug without being subject to the unfettered discretion of the federal health minister. In response to the outcome of *Parker*, the Canadian Federal Government introduced the Medical Marijuana Access Regulations<sup>183</sup> under the *Controlled Drugs and Substances Act* which came into force on 30 July 2001. Part 1 of the Regulations gave

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<sup>181</sup> Lucas, n 69; Lucas P, "Moral Regulation and the Presumption of Guilt in Health Canada's Medical Cannabis Policy and Practice" (2009) 20(4) *International Journal of Drug Policy* 296 at 297. See also Bogdanoski T, "A Dose of Human Rights: An Antidote to the Criminal Prohibition of Cannabis for Medical Use?" (2009) 33 *Crim LJ* 251.

<sup>182</sup> The defendant had been charged with cultivating marijuana, however, the Court accepted that he only did so to treat his epileptic seizures. See Associated Press, "Pot Prohibition Unconstitutional, Rules Court of Appeal" (31 July 2000).

<sup>183</sup> S.O.R.2001-227 June 4 2001. Canadian documents and laws use the spelling 'marihuana' for marijuana.

medical users with a range of life-threatening and chronic illnesses such as cancer and HIV/AIDS, the right to apply for a permit to use and possess marijuana for symptomatic relief. Part 2 of the Regulations, among other things, addressed the need to have a renewable one-year license to cultivate cannabis for medical purposes and placed restrictions on the number of plants that could be legally grown by medical users or their caregivers.

However, shortly after the Medical Marijuana Access Regulations commenced, a group of medical users of marijuana in conjunction with the co-founder of the Toronto Compassion Club brought an action in the Ontario Superior Court of Justice challenging the constitutional validity of the Regulations. In *Hitzig v Canada*, 171 CCC 3d 18 (2003), Lederman J struck down the Regulations as unconstitutional because they failed to provide a legal governmental supply of marijuana to medical users. By failing to provide a legal source of cannabis to medical users, the Regulations placed patients in a position where they had to procure marijuana from street dealers. Lederman J accurately declared that the Regulations breached “the right to life, liberty and security of the person” guaranteed by section 7 of the Canadian *Charter of Rights and Freedoms* and held:

Laws which put seriously ill, vulnerable people in a position where they have to deal with the criminal underworld to obtain medicine they have been authorized to take, violate the constitutional right of security of the person.<sup>184</sup>

Lederman J accepted the submissions of the plaintiffs that the Regulations “throw up so many barriers to gaining access to marijuana for medicinal use that this medicine effectively remains unavailable to many seriously ill people”.<sup>185</sup> The Regulations may have allowed medical users or their designates to legally grow a limited amount of cannabis for medical use, however, the Regulations did not provide for those who were unable to grow their own supply or could not find a designate to do so on their behalf. Ultimately, Lederman J held that the law would be brought into disrepute by “asking people to consort with criminals to access their constitutional rights”.<sup>186</sup> The Canadian Federal Government’s appeal<sup>187</sup> to the Ontario Court of Appeal was unanimously dismissed, with the appellate court reinforcing Lederman J’s finding that medical users who could not grow their own cannabis were effectively forced into

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<sup>184</sup> 171 CCC 3d 18 (2003) at [142].

<sup>185</sup> 171 CCC 3d 18 (2003) at [64].

<sup>186</sup> 171 CCC 3d 18 (2003) at [160].

<sup>187</sup> *Canada v Hitzig*, 177 CCC (3d) 449 (2003) (Doherty, Goudge and Simmons JJA).

obtaining their cannabis from the black market, which involved placing them at “risk of being cheated and even subjected to physical violence”<sup>188</sup> by street dealers.

As a result of these judicial decisions, referred to by one commentator as “court-ordered compassion”,<sup>189</sup> the Canadian federal health department (Health Canada) was forced to establish and administer an Office of Cannabis Medical Access in order for the Medical Marijuana Access Regulations to remain constitutionally effective.<sup>190</sup> However, there remain some significant problems with the Canadian medical marijuana program.<sup>191</sup> In particular, the number of patients and medical users officially registered to use the drug remains very small because many doctors are still reluctant to support applications for permits since the drug has not been evaluated for safety and efficacy in controlled clinical trials.<sup>192</sup> Lucas has also argued that access to cannabis for medical purposes in Canada is still being made difficult by:

bureaucratic policies that seek to over-regulate and monitor the behaviour of Canadians who benefit from the therapeutic use of cannabis, and that presume the illicit intent – rather than innocence – of cannabis patients and those individuals and organizations who attempt to assist them. Even the medical community is not immune from this governmental overreach, and Health Canada bureaucrats now insinuate themselves in this doctor–patient relationship by contacting physicians whom they believe may be recommending too large an amount.<sup>193</sup>

## **CHALLENGES TO LEGALISING CANNABIS FOR MEDICAL PURPOSES: THE ROLE OF DOCTORS, “CANNABIS CLUBS” AND HERBAL MARIJUANA**

### **The Role of Doctors in Medical Marijuana Programs**

As mentioned above, North American experience has demonstrated that the involvement and support of medical practitioners is often central to proposals allowing the medical use of cannabis. Where cannabis is legal for therapeutic purposes, doctors have been co-opted in the facilitation of medical cannabis schemes primarily through the certification of patients’ medical conditions and patients’ inability to use or derive benefits from legally available medications. Thus, doctors are often required to certify that cannabis or marijuana use is demonstrably relieving

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<sup>188</sup> 177 CCC (3d) 449 at [22].

<sup>189</sup> Lucas, n 69.

<sup>190</sup> Nickerson C, “Canada Set to Dispense Marijuana as Medicine”, *Boston Globe* (10 July 2003).

<sup>191</sup> Lucas, n 181.

<sup>192</sup> Lucas, n 181. See also Wayne Hall and Louisa Degenhardt, ‘Medical Marijuana Initiatives: Are They Justified? How Successful Are They Likely to Be?’ (2003) 17 *CNS Drugs* 689.

<sup>193</sup> Lucas, n 181 at 298.

patients' symptoms or conditions by, for example, relieving their nausea or allowing them to eat. Eligibility to access cannabis or marijuana for medical use is therefore ultimately "based on a medical decision [and] it is doctors who must function as "gatekeepers" in allowing or denying patients' access to medicinal cannabis for their conditions".<sup>194</sup> However, North American experience has also shown that many of these "gatekeepers" are hostile to generally being involved in medical cannabis or marijuana schemes<sup>195</sup> because the drug is a "substance of no set concentration without real quality assurance and which, whether effective or not, would have some deleterious health impacts".<sup>196</sup> It is therefore advisable that in any medical cannabis scheme responsibility is primarily placed on applicants. As Greens MP Kerrie Tucker stated in her unsuccessful bid to legalise the medical use of cannabis in the ACT in 2004, in relation to the role of doctors:

While the onus is on doctors to verify that the applicant has an identified condition or disease and that other treatments are not providing relief from pain or discomfort, the doctor is not required to prescribe the drug. The responsibility for taking on the risk, managing the administration of the drug and indeed controlling its effect, and carrying the responsibility for any adverse health consequences, remains with the applicant.<sup>197</sup>

The role of doctors in medical cannabis or marijuana schemes should therefore be limited to making a declaration that a patient has a prescribed medical condition which has not been responding to conventional medications, rather than actually "prescribing" the drug.

### **The Role of "Cannabis Clubs" and Caregivers**

In the interests of medical users who are too sick to access their own cannabis or marijuana, jurisdictions that have legalised the medical use of marijuana often permit designated caregivers to grow cannabis or obtain marijuana on behalf of medical users in their care. Aside from the concern that caregivers may abuse their privileges and divert legal cannabis into the black market, there is little controversy in allowing caregivers to act as agents for sick patients.<sup>198</sup> As mentioned above, the amount of

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<sup>194</sup> Irvine G, "Rural Doctors' Attitudes to and Knowledge of Medicinal Cannabis" (2006) 14(1) JLM 135 at 135.

<sup>195</sup> Irvine, n 194. See also Lucas, n 69.

<sup>196</sup> ACT Legislative Assembly, *Schedules of Amendments*, 30 July 2004, p 3013 (Kerrie Tucker).

<sup>197</sup> Tucker, n 196, p 3012. The proposed Bill was the Drugs of Dependence (Cannabis for Medical Conditions) Amendment Bill 2004.

<sup>198</sup> Walsh Jr R, "Populations at Risk for Criminal Liability under Compassionate Use Acts" (1999) 25 *New England Journal on Criminal and Civil Confinement* 275.

legal cannabis used for medical purposes is unlikely to seriously add to the overall supply of cannabis already available for illegal recreational use. In contrast, a great amount of controversy and litigation has arisen in relation to the operation of so-called “cannabis clubs” or “compassion clubs”. The US Federal Government under the previous Bush administration often raided<sup>199</sup> “cannabis clubs” and marijuana dispensaries operating in those States that had legalised the medical use of marijuana on the basis that they were in conflict with federal law even though many complied with local and State laws.<sup>200</sup> However, as mentioned above, this practice of targeting legitimate medical marijuana dispensaries appears to have now ended under the new Obama administration, but only time will tell if this will really happen in practice.

Many medical users of marijuana, especially those who do not have any caregivers, obtain the drug from safe venues such as these “cannabis clubs”.<sup>201</sup> This is especially so in those US States which have legalised the medical use of cannabis because these States do not actually provide users with the drug itself,<sup>202</sup> only statutory immunity from prosecution for limited amounts of marijuana possession, use and, in some instances, cultivation. “Cannabis clubs” are generally not-for-profit organisations which rely on donations from members and exist to give medical users a safe supply of marijuana. Some studies have demonstrated the importance and value of these clubs to medical users. For example, in a 1996 study<sup>203</sup> of members of the San Francisco Cannabis Club, it was reported that cannabis clubs “serve as crucial support mechanisms for people with a wide variety of serious illnesses and conditions” and concluded that “cannabis clubs afford the best therapeutic setting for providing medical cannabis”.<sup>204</sup> Significantly, the study also found that participants not only derived health benefits from the cannabis or marijuana they were using but

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<sup>199</sup> Murphy D, “Arrests Follow Searches in Medical Marijuana Raids”, *New York Times* (23 June 2005).

<sup>200</sup> *United States v Oakland Cannabis Buyers' Cooperative*, 532 US 483 (2001). See also Blaine C, “Supreme Court “Just Says No” to Medical Marijuana: A Look at *United States v Oakland Cannabis Buyers' Cooperative*” (2002) 39(4) *Houston Law Review* 1195.

<sup>201</sup> In NSW, there used to be a Nimbin-based Compassion Club which supplied cannabis cookies by mail order, however, it appears that it was shut down by the police and cannot operate openly: see Australian Associated Press, “Mail Order Medicinal Cannabis to be Offered, Say Activists” (14 October 1999); ABC Radio National, “Police Investigate Mail-Order Cannabis Cookies”, *The World Today* (9 March 2000) <http://www.abc.net.au/worldtoday/stories/s109487.htm> viewed 30 May 2009.

<sup>202</sup> See generally Kreit A, “The Future of Medical Marijuana: Should the States Grow Their Own?” (2002) 151 *University of Pennsylvania Law Review* 1787.

<sup>203</sup> Feldman H and Mandel J, “Providing Medical Marijuana: The Importance of Cannabis Clubs” (1998) 30(2) *Journal of Psychoactive Drugs* 179 at 179.

<sup>204</sup> Feldman and Mandel, n 200.

got “even greater benefits from the social aspects of the clubs” which provided them “important emotional support”.<sup>205</sup> A similar study<sup>206</sup> in 2007 into Canadian cannabis clubs also found that they “promoted health among marginalised people at risk of social exclusion”.<sup>207</sup> Further, it found that these clubs act as “models of outside-the-law social justice that serve the state by serving needy people”.<sup>208</sup>

### **Farm or Pharm: Herbal Marijuana or Pharmaceutical Cannabinoids?**

It has been found that herbal marijuana is unlikely to ever meet the requirements for registration on the Australian Register of Therapeutic Goods (ARTG)<sup>209</sup> because “pharmaceutical companies are unlikely to register a natural plant product that cannot be patented”.<sup>210</sup> Further, most government reports that have looked into legalising the medical use of cannabis have been hostile to herbal marijuana and have recommended the development of pharmaceutical cannabinoids as an alternative to smoking the natural plant.<sup>211</sup> This has led Harvard psychiatrist, and long-time advocate of the medical use of cannabis and marijuana, Lester Grinspoon to observe that:

[w]e are beginning to see two powerful forces collide: the growing acceptance of medical cannabis and the proscription against any use of herbal marijuana, medical or non-medical.<sup>212</sup>

Grinspoon argues that the development of synthetic and botanical cannabis derivatives is leading to the situation where pharmaceutical companies become active stakeholders in the preservation of the status quo<sup>213</sup> – the criminalisation of herbal marijuana, even for those for whom it works effectively – through, for example, the strategic funding of scientific studies to “prove” that pharmaceutical cannabinoids are

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<sup>205</sup> Feldman and Mandel, n 200.

<sup>206</sup> Hathaway A and Rossiter K, “Medical Marijuana, Community Building, and Canada’s Compassionate Societies” (2007) 10(3) *Contemporary Justice Review* 283.

<sup>207</sup> Hathaway and Rossiter, n 203 at 294.

<sup>208</sup> Hathaway and Rossiter, n 203 at 294. See also Lucas, n 181.

<sup>209</sup> Established under the *Therapeutic Goods Administration Act 1989* (Cth).

<sup>210</sup> NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes: Executive Summary* (2000), vol 1, p 9. See also Cohen M, “The Criminalization of Medical Marijuana” (2000) 11(1) *Hastings Women’s Law Journal* 75 at 105-106: “marijuana is a generic product, and the drug companies cannot get patents”.

<sup>211</sup> See, eg, NSW Department of Premier and Cabinet, *Report of the Working Party on the Use of Cannabis for Medical Purposes* (2000); US National Academy of Sciences, Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base* (1999).

<sup>212</sup> Grinspoon L, “On the Future of Cannabis as Medicine” (2007) 2(2) *Journal of the International Association for Cannabis as Medicine* 13 at 14.

<sup>213</sup> See Chapkis W and Webb R, *Dying to Get High: Marijuana as Medicine* (NYU Press, New York, 2008) pp 204-205.

more beneficial than herbal marijuana, or that herbal marijuana has no therapeutic benefits whatsoever. As Grinspoon argues:

Even if pharmaceutical companies invest the many millions of dollars it will take to develop useful cannabinoid products, they will not displace natural marijuana for most purposes. And because the primary, and for many the only, advantage of these drugs will be legality, their manufacturers will have an interest in vigorously enforced prohibition...<sup>214</sup>

In Australia, the situation is further complicated by the fact that pharmaceutical companies have so far shown no interest in pursuing the registration of the synthetic cannabinoid drugs, dronabinol and nabilone (THC in pill form). Thus, neither herbal nor synthetic cannabinoids are generally available in Australia.<sup>215</sup> These synthetic cannabinoid drugs, marketed as Marinol and Cesamet in the United States, have been prescribed for cancer and AIDS patients experiencing nausea and vomiting from their treatments since the 1980s.<sup>216</sup> While the Therapeutic Goods Administration Special Access Scheme allows patients to import pharmaceutical drugs which are not available in Australia,<sup>217</sup> this is not only a financially unviable option for many patients but is also a bureaucratically difficult process.<sup>218</sup> Doctors and researchers who want access to dronabinol and nabilone must also have the written authority of the Director-General of the relevant State Department of Health.<sup>219</sup> In effect, this situation makes the desirability of herbal marijuana and cannabis even greater for patients since it is somewhat easier and cheaper to obtain than pharmaceutical cannabinoids.

One of the major arguments for the legalisation of herbal marijuana or cannabis for medical use has been based on the fact that synthetic medications such as dronabinol and nabilone may have very unpleasant side-effects, including intoxication, sedation or psychotropic effects. Sativex is the latest pharmaceutical cannabinoid and, according to its British manufacturer GW Pharmaceuticals, “enhances the pain relief of THC while modulating the unwanted psychotropic and

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<sup>214</sup> Grinspoon L, “The Shifting Medical View on Marijuana”, *Boston Globe* (17 August 2003).

<sup>215</sup> Hall et al, n 79.

<sup>216</sup> Grinspoon L and Bakalar J, “Marihuana as Medicine: A Plea for Reconsideration” (1995) 273(23) *Journal of the American Medical Association* 1875 at 1875.

<sup>217</sup> See *Therapeutic Goods Act 1989* (Cth), s 19: the Secretary of the federal Department of Health may authorise the importation of a drug not registered on the Australian Register of Therapeutic Goods. However, prohibited substances such as cannabis cannot be imported under the Customs (Prohibited Imports) Regulations 1958 (Cth).

<sup>218</sup> See, eg, Sweet, n 46.

<sup>219</sup> See, eg, NSW Department of Health, *Guide to Poisons and Therapeutic Goods Legislation for Pharmacists* (2007), Pharmaceutical Services Branch, TG 79/27, p 18.

other THC-related side effects,” such as sedation and intoxication.<sup>220</sup> Unlike dronabinol and nabilone, Sativex is not a synthetic cannabinoid but a botanical cannabis extract.<sup>221</sup> Sativex is currently available in Canada, Britain and New Zealand, but it is not currently available in Australia or the United States.<sup>222</sup> It remains to be seen whether Sativex or further pharmacological developments leading to the production of more cannabis-based pharmaceuticals will make the issue of the necessity of using natural cannabis or herbal marijuana obsolete. However, this is highly unlikely because some evidence-based, peer-reviewed studies have concluded that smoking marijuana is superior to the use of pharmaceutical cannabinoids, in particular for the relief of HIV/AIDS symptoms.<sup>223</sup> Grinspoon argues “the few products that have so far been developed [including Sativex] do not measure up to the de facto gold standard, herbal marijuana”.<sup>224</sup> The development of controlled pharmacological medications that utilise the properties of cannabis and marijuana, while eliminating or minimising its deleterious effects will undoubtedly benefit some patients who would no longer require the use of the natural plant. However, it is unlikely that Sativex or any other single pharmaceutical cannabinoid will be a universal panacea because pharmaceutical products do not work for everybody.

## CONCLUSION

It can be seen that Australia, the US and Canada currently have divergent policies and laws in relation to the medical use of cannabis. The fact that such diametrically opposing laws exist across these common law jurisdictions is testament to the inherently controversial nature of legally accommodating cannabis for medical purposes. The issue of cannabis use, in particular marijuana use, continues to divide not only the scientific and medical communities as far as its therapeutic benefits and risks are concerned. There are also socio-political objections that are routinely raised

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<sup>220</sup> GW Pharmaceuticals, *Sativex: Frequently Asked Questions* <http://www.gwpharm.com/faqs.asp> viewed 30 May 2009.

<sup>221</sup> GW Pharmaceuticals, n 220.

<sup>222</sup> GW Pharmaceuticals, Information on Obtaining Sativex, <http://www.gwpharm.com/Sativex1.aspx> viewed 23 July 2009.

<sup>223</sup> See Mirken B, ‘New Studies Destroy the Last Objection to Medical Marijuana’, *Alternet*, 2 May 2007 <http://www.alternet.org/drugreporter/51277> viewed 24 August 2009. See also Abrams D et al, “Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial” (2007) 68(7) *Neurology* 515; Haney M, “Dronabinol and Marijuana in HIV-Positive Marijuana Smokers: Caloric Intake, Mood, and Sleep” (2007) 45(5) *Journal of Acquired Immune Deficiency Syndromes* 545. Further, see n 62.

<sup>224</sup> Grinspoon, n 212.

whenever any proposal is made to legislatively or judicially recognise an exception for medical users of cannabis from the general provisions of criminal drug laws for medical users of cannabis. In contrast to the US and Canada, every Australian jurisdiction currently prohibits the possession, cultivation and supply of cannabis even for medical purposes. In Australia, the situation is further complicated for medical users because pharmaceutical cannabinoid medications are not generally freely available. There are undoubtedly challenges associated with legalising the medical use of cannabis, largely relating to the need to provide an efficient and legal supply of the drug to medical users as well as the appropriate role of doctors in any medical cannabis program. However, these challenges should not be regarded as so insurmountable as to preclude the medical use of cannabis, including marijuana, being legally accommodated in Australia, as it is in Canada and in a growing number of States in the United States.