



Commentary

Establishing expertise: Canadian community-based medical cannabis dispensaries as embodied health movement organisations



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ABSTRACT

In this commentary, I describe how, through both advocacy and the generation of new knowledge, community-based medical cannabis dispensaries have contributed to the broader dialogue regarding the legal and safe provision of medical cannabis in Canada. By employing an embodied health movement framework (Brown et al., 2004), this analysis highlights the role of dispensaries in creating new knowledge, challenging existing practices, and advancing their agenda to legitimise cannabis as a therapeutic substance and offer an alternative model for its provision. Although the community-based, holistic approach that dispensaries offer has not been adopted by the Canadian government, dispensaries have achieved success in being recognized as credible stakeholders and experts in the ongoing debate on the legal provision of medical cannabis in Canada.

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Introduction

In June 2013, the Canadian government announced the new medical cannabis regulatory framework: The *Marihuana for Medical Purposes Regulations* (MMPR). These regulations represent the most recent effort on the part of Health Canada to enact court rulings to provide “reasonable access to a legal supply of marijuana for medical purposes” while also “protecting public safety” (Health Canada, 2013). This regulatory framework continues to exclude community-based medical cannabis dispensaries (henceforth referred to as dispensaries) as legal providers of cannabis to patients for whom it is prescribed, notwithstanding evidence that they are cost-effective and successful models for providing patients with medical cannabis (Canadians for Safe Access, 2004; Lucas, 2008a; Nolin & Kenny, 2002; VICS, 2009). This impending legislation prompts a reflection on the role dispensaries have played in promoting the issue of cannabis as a therapeutic substance and the need for a regulated approach to its dispensation.

In this commentary, I describe how, through both advocacy and the generation of new knowledge, dispensaries contribute to the broader debates regarding the legal and safe provision of medical cannabis. By employing an embodied health movement (EHM) framework (Brown et al., 2004), my analysis highlights the role of dispensaries in creating new knowledge, challenging existing practices, and advancing their agenda

to legitimise cannabis as a therapeutic substance and offer an alternative model for its provision. Further, I document how dispensaries have established a basis of expertise, have filled service delivery and research gaps in the Health Canada program and broadened the field of knowledge on medical cannabis.

To begin, I briefly describe the current policy landscape of medical cannabis and provide an overview of the Canadian regulatory framework and the role of dispensaries, and I outline the theoretical framework of EHMs. The following sections are organised around each of the characteristics of EHMs (embodiment and lived experience, the challenge to scientific and medical knowledge, and collaboration with scientists and policy-makers). I conclude by suggesting that, dispensaries have successfully established credibility and expertise in certain institutional contexts (such as the courts), and they continue to present a viable alternative to both the current and pending approaches to the regulated provision of medical cannabis in Canada.

An evolving policy landscape

In recent years, the international policy landscape has been evolving in response to increased dialogue about the medicalisation, decriminalisation, and legalisation of cannabis. Currently, in the U.S., 20 states and the District of Columbia have legalized medical cannabis and four states have pending legislation (Procon.org, 2013). In Israel, New Zealand, New South Wales Australia, and eight European states, partial legal access to medical cannabis has been implemented (ADCA, 2013; ENCOD, 2013; Fletzer, 2012; Kershner,

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2013). However, Canada, in 2001, was the first country to provide a regulatory framework for approved patients to legally access cannabis for medical purposes.

In 2000, a ruling of the Ontario Court of Appeals determined that the prohibition of cannabis under the Controlled Drugs and Substances Act was unconstitutional to the extent that it did not provide for access by patients (CFDP, 2000). In response, Health Canada developed the *Marihuana Medical Access Program* (MMAP). Under the MMAP, patients could apply for permission from Health Canada to possess and use cannabis for medical purposes. They could also apply for a license to grow their own cannabis or delegate someone else to do so, or they could purchase cannabis from Health Canada. Problems associated with the program included the high cost and unsatisfactory quality of government supplied cannabis, low patient registration, and medical associations discouraging doctors from signing the necessary health declarations for patients (CAMCD, 2013a,b; New South Wales, 2013).

The MMAP has faced numerous legal challenges due to its significant barriers and its difficult application process. Court rulings have compelled the government to amend the regulatory framework to address these issues. The most recent amendments involve the phasing out of MMAP and the transition to the *Marihuana for Medical Purposes Regulations* (MMPR) by April 1st 2014. This new framework will disallow individuals or their delegates from cultivating cannabis, and eliminates Health Canada Authorisation for individuals to possess and use cannabis. Instead, Health Canada will license producers to grow and dispense medical cannabis through the commercial courier services to individuals who have a prescription from their doctor or nurse practitioner. Community-based dispensaries remain illegal and are not identified as having a role within the new regulatory framework.

Community-based medical cannabis dispensaries

The history of dispensaries is tightly entwined with the work of the U.S. AIDS movement and drug reform activists of the 1980s and 1990s. At that time, there was an upsurge of anecdotal evidence from folk experimentation suggesting that cannabis was effective for treating symptoms associated with chronic and critical illnesses such as HIV/AIDS, cancer, multiple sclerosis, and glaucoma (Jones & Hathaway, 2008). Two models evolved from those first underground dispensaries that opened in San Francisco. The first type of dispensary was designed as a 'social club' model (Grinspoon, 1999). In addition to providing medical cannabis, this model provided services such as alternative therapies, support groups, counselling, advocacy, and, later, research. A second type was modelled after a conventional delivery system for medicine and did not offer these additional services.

Community-based dispensaries have been operating in Canada since 1997, predating the *Marihuana Medical Access Program*. Due to the current ambiguous legal status of dispensaries and the lack of regulations overseeing them, exact numbers are very hard to come by. Estimates suggest that there are approximately fifty dispensaries currently operating in Canada, serving about 30 000 patients – nearly half of whom are participants in Health Canada's program (CAMCD, 2012, 2013a; Health Canada, 2013). Canadian dispensaries have been modeled after those in the United States. While some are registered non-profit societies, others are officially "for profit" enterprises; but the 'social club' models typically offer more "patient-centered" services than the "dispensary-style" organisations.

The focus of this commentary is on dispensaries that are best described as fitting the 'social club' model: specifically, those that are community-based, provide additional services and are actively engaged in both advocacy and research activities – although it is

important to note that there are variations in services, products, and practices. All dispensaries have strict guidelines for membership and for provision of cannabis, including, at minimum, a doctor's note confirming a patient's condition. They offer a variety of strains of cannabis to address various symptoms, and offer alternatives to dried cannabis in the forms of cannabis-infused oils and butters, tinctures, and baked goods (Willets, 2009).

The Canadian federal government does not recognise dispensaries as operating legally and this has meant that dispensaries operate under the threat of police action. However, prosecution against dispensary operators has rarely been successful. Since 2001, no less than five court rulings found the *Marihuana Medical Access Program* to be unconstitutional and unduly restrictive (Tousaw, 2013). Therefore, police tend to 'look the other way' (Reinhart, 2010), allowing dispensaries to operate 'under the radar'. It is unknown how the new regulations will influence police action towards dispensaries.

In 2011, the Canadian Association of Medical Cannabis Dispensaries (CAMCD) was formed as an advocacy group to represent dispensaries across Canada. It has been a vocal participant in Health Canada's stakeholder consultation processes for amending the regulatory framework. Although they have failed to achieve their primary goal of recognition by Health Canada as legal providers of medical cannabis, a few of CAMCD's recommendations have been adopted into the new framework (for example, nurse practitioners are now included as prescribers) (CAMCD, 2012; Health Canada, 2011).

CAMCD continues to have concerns with the accessibility of medical cannabis for patients under the new framework, particularly in terms of affordability, the restriction of products to dried cannabis only, and the quality of care that patients will receive (CAMCD, 2013b). Further, although dispensaries may apply for licenses to produce cannabis, they are not permitted to dispense on-site, thereby thwarting their efforts to provide a community-based, patient-centred service.

By discussing dispensaries as embodied health movement organisations, I emphasise their role in mobilising patients under a politicised collective illness identity and in presenting a challenge to medical and scientific practice. In doing so, I illustrate how they establish not only new knowledge and a model for distribution of medical cannabis, but also a model for research and the provision of health services.

Embodied health movements (EHMs)

Brown et al. (2004) have argued that scholarship on social movements has paid insufficient attention to movements related to health despite their prevalence and importance in affecting social change. In order to address this gap, they developed a typology of 'health social movements' (HSMs) as a specific class of social movements. They define HSMs as "collective challenges to medical policy and politics, belief systems, research and practice that include an array of formal and informal organisations, supporters, networks of cooperation, and media" (p. 52). HSMs challenge political power, professional authority, and personal and collective identity.

One subtype of HSM is termed EHM (embodied health movement). EHMs address illness experience, disease and disability, and contested illnesses, and are defined as "organised efforts to challenge knowledge and practice concerning the aetiology, treatment, and prevention of disease" (Brown et al., 2004, p. 54). They have three characteristics:

- (1) An emphasis on embodied experience.
- (2) The challenge they pose to existing medical and scientific knowledge and practice.

- (3) The involvement of activists in collaborating with scientists and health professionals.

This commentary explores these three characteristics of an EHM as core features of the cannabis movement and the work of dispensaries.

Characteristic #1: an emphasis on embodied experience

Embodiment – or ‘lived bodily experience’ – may be thought of as an experience that is mediated through social norms and constructions, and it is strongly tied to identity. From the perspective of an EHM framework, identities represent the intersection of social constructions of illness and the personal illness experience of a biological disease process (Brown et al., 2004, p. 55). In EHMs, identities are typically constructed around disease categories (e.g., breast cancer), however the medical cannabis movement includes individuals with a variety of chronic illnesses. The collective identity of members of this movement is therefore not constructed around disease categories, but rather around their therapeutic use of cannabis and their struggles to secure legal access to cannabis.

Politicising a collective illness identity

Embodied experience provides the foundation upon which a politicised collective illness identity may be formed. Such an identity is critical for mobilising people and resources. Brown et al. (2011) define a collective illness identity as “the cognitive, moral, and emotional connection an individual has with a broader community of illness sufferers and their allies” (p. 22), and state that politicised collective illness identities emerge when disease groups experience their conditions in ways that contradict scientific and medical explanations and when these contradictions are identified as a source of inequality. In the medical cannabis movement, the lived experiences of both illness and cannabis use as a therapeutic substance provides a platform upon which a collective identity is established. This collective identity is politicised primarily by the lack of institutional support for medical cannabis from the government, law enforcement, scientific bodies, and health professionals, and the criminalisation of medical cannabis patients. Dispensaries provide spaces that nurture a collective illness identity and support its politicalisation (Hathaway, Erickson, & Lucas, 2007). They work to transform the framing of medical cannabis from being an individual issue to a social problem, and they challenge governmental, medical, and scientific institutions that continue to frame cannabis as an illegal, dangerous drug.

Establishing new frames

In their critical discourse analysis of nearly two-thousand articles published in major Canadian newspapers between 1997 and 2007, Haines-Saah et al. (2013) argue that a discourse of ‘privileged normalisation’ informs portrayals of cannabis and its users, in which cannabis (not specified as medicinal) is “acceptable for use by some people at particular times and places, while its use by those without power and status is routinely vilified and linked to deviant behaviour” (p. 1). Schneider and Ingram (1993) argue that there is strong pressure for policy-makers to provide beneficial policies for those who are “powerfully, positively constructed” but to devise punitive, punishment-oriented policies for those negatively constructed (p. 334). Here, power is measured by votes, wealth, and the propensity of the group to mobilise into action. A positive social construction is linked to descriptors such as ‘deserving’, ‘honest’, and ‘good’ citizens. Given this, an imperative for dispensaries is to reframe medical cannabis users as legitimate patients deserving of care and compassion, rather than as deviant or irresponsible. They

have also framed the issue as one of constitutional rights and have used the court system to advance this framing.

The debate on medical cannabis frequently found in the media largely centres around the therapeutic benefits of cannabis and the rights to its access for patients on the one hand, and the public health risks associated with cultivation, diversion, misuse, and crime, on the other hand. CAMCD’s accreditation program reflects the commitment of dispensaries to address these public health concerns and to demonstrate a regulated, community-based approach to the provision of cannabis for therapeutic purposes and “to support medical cannabis dispensaries in providing the highest quality of patient care” (CAMCD, 2012).

Characteristic #2: the challenge to existing medical/scientific knowledge

EHM activists differ from other social movement activists that confront science and the production of knowledge because they “judge science based on intimate, firsthand knowledge of their bodies and their illness” (Brown et al., 2004, p. 56). The confrontation with science involves questioning the use of the dominant scientific and medical paradigms that include a positivist, biomedical model that privileges quantifiable, empirical evidence over qualitative and/or anecdotal evidence. Dispensaries, in contrast, accept anecdotal evidence and personal testimonies of the therapeutic benefits of cannabis as credible evidence for its efficacy. They argue that the wealth of anecdotal evidence is reason for gathering further empirical evidence for the safe and effective use of medical cannabis (Lucas, 2008b). They also call for more participatory research. As Brown et al. (2004) state, EHMs do not necessarily challenge science per se, but rather how science is done.

Policy makers often cite a lack of rigorous controlled studies and conclusive research as reasons for their hesitancy to change the status of cannabis from a Schedule I to a Schedule II substance and yet they have not funded or offered sufficient support for such research. In 2001, Health Canada established the *Medical Marijuana Research Program* that included a 5-year, \$7.5 million clinical research grant. This appeared to be a victory for medical cannabis activists. However, since the research program was established in 2001, only three clinical research proposals have been approved, and in 2006, all federal financial support for medical cannabis research in Canada ended (Lucas, 2008a). In the last two consultations for the amendments to the federal framework, CAMCD advocated for the inclusion of research as a priority objective (CAMCD, 2011). This is still not reflected in the current iteration of the program.

Characteristic #3: collaborations with researchers, health professionals, and policy-makers

Partnerships with scientists and health professionals are key resources to be mobilised to advance an EHM. Dispensaries need medical, political, and scientific allies to help them press for increased funding for research and for recognition of their work, and testimonies by scientists to policy-makers strengthen the claims of patients and advocates. In Epstein’s (1995) analysis of the AIDS movement, he credits activists with establishing a basis of expertise in the science and politics surrounding HIV treatment. Members of the medical cannabis movement have adopted this strategy, and many have become ‘activist-experts’ by partnering with scientists, medical professionals, and politicians in order to establish both cognitive and cultural authority (Ceccoli, 2003; Epstein, 1995; Turner, 2001).

Dispensaries have taken advantage of their unique position to address gaps in knowledge about medical cannabis by establishing their own extensive research agenda. In addition to having a high-quality supply of multiple strains of cannabis often lacking in other research facilities, dispensaries have members who are willing to share their experiences and to participate as subjects in medical cannabis research (Lucas, 2008b; Lucas, Black, & Capler, 2004). The early studies done by the Vancouver Island Compassion Society (VICS) were largely qualitative or observational studies rather than quantitative or clinical trials. These have been described as “pragmatic investigations of phenomena” (Lucas, 2008b). One such study was a symptom-strain survey that elicited information from members about which strain (sativa or indica) was helpful for which symptoms. The results of this survey provided staff with information that allowed them to more confidently recommend the use of indicas for pain-relief and sativas for nausea or loss of appetite (Lucas, 2008b).

Dispensaries quickly realized the need to participate in the peer-review process in order to have their studies accepted by the scientific community. To accomplish this, partnerships were developed with university researchers. For example, VICS teamed with a researcher from the University of California, San Francisco, Dr. Diana Sylvestre, to produce the first peer-reviewed medical cannabis research to take place in a community-based dispensary (Lucas, 2008b). The first dispensary-based clinical trial to pass ethics review in North America was produced by the partnership between University of British Columbia and VICS (Lucas, 2008b).

Epstein (1995) discusses the importance of learning the language and culture of experts in order for activists to present themselves as credible. EHMs blur the lines between experts and lay people. Through working with scientists and medical experts, dispensaries gain power and authority by not just obscuring the boundary between expert and layperson, but by being seen to have eliminated it. Brown et al. (2004) state that some members of EHMs have become so versed in the policy and scientific literature that they serve on peer review panels.

Similarly, dispensaries have been represented by their members in such forums as Canada’s Office of Cannabis Medical Access (OCMA) Stakeholders Committee, the Special Senate Committee on *Illegal Drugs*, and the Senate Committee on *Use of Marijuana for Therapeutic Purposes*. Most recently, CAMCD participated in the 2011 and 2012 stakeholder consultations for amendments to the federal regulatory framework. By working with scientists, medical professionals, and policy-makers, activists are penetrating the world of science, medicine and policy. Medical cannabis activists may then be described as “activist-experts” (using Epstein’s term [1995, p. 414]) and their collaborating scientists “issue advocates” (using Pielke’s term [2007, p. 2]).

Court rulings have acknowledged the beneficial role of dispensaries and considered expert testimonies of activist-experts in their rulings. For example, on February 9th, 2009, B.C. Provincial Judge Higinbotham ruled that “[VICS] has provided that which the government was unable to provide: a safe and high quality supply of cannabis to those needing it for medicinal purposes” (VICS, 2009). The Ontario Court of Appeals recommended that Health Canada should seek to work with dispensaries to improve access to medical cannabis for legitimate users (Canadians for Safe Access, 2004; Lucas, 2008a). Despite not being legally recognised by the government, dispensaries have been accepted as legitimate participants in government consultations with stakeholders and have had their recommendations advanced in these venues. For example, both the Special Senate Committee on *Illegal Drugs* and the OCMA Stakeholder Advisory Committee recommended the adoption of a community-based model of medical cannabis distribution such as that offered by dispensaries (Lucas, 2008a; Lucas et al., 2004). This demonstrates the medical cannabis movement’s success in engaging with

decision-makers as ‘activist-experts’ and suggests that they are increasingly being perceived as cognitive and cultural authorities by dominant social and political institutions.

Dispensaries have challenged the constitutional legality of Canada’s medical cannabis policy in the courts and fought for the acceptance of medical cannabis as a legitimate therapeutic substance. They continue to argue that medical cannabis is a health issue and that as such the federal government has a responsibility to provide its citizens with safe, legal access. Lucas, Black, and Capler’s *Roadmap to Compassion* (2004) and, most recently, CAMCD’s document *Inclusion of Medical Cannabis Dispensaries in the Regulatory Framework* (2011) clearly articulate a plan for a collaboration between dispensaries, Health Canada, and medical professionals to meet the needs of Canadian medical cannabis patients. This demonstrates the willingness of dispensaries to collaborate with government as part of their effort for effecting progressive social change.

Discussion

Medical cannabis dispensaries have proffered their model of a holistic, community-based approach as a successful and cost-effective alternative to Health Canada’s centralised model. Health Canada’s model has been found by the courts, by patients, and by community and professional groups to be less than successful in its stated mission to provide a safe, legal supply of medical cannabis to Canadians suffering from chronic and critical illnesses. Dispensaries offer a model of service and supply delivery that address many of the concerns and problems that have arisen with the Health Canada framework (such as costs, quality, and efficiency), as well as offering additional support, education, and health care for individuals. Despite this, and contrary to court recommendations, the federal government has not adopted this model and has not made any changes to the legal status of dispensaries. That dispensaries continue to operate (albeit illegally and subject to occasional police raids and disruption) reflects their success in achieving legitimacy and credibility. Dispensaries have simultaneously challenged and collaborated with scientific and medical professionals to expand the understanding of, and therapeutic use of, cannabis. Their engagement with the academic, scientific, medical, and political worlds has helped them to establish cultural and cognitive authority.

An analysis of dispensaries using the framework of an embodied health movement provides a way of understanding how they have established a basis of expertise in medical cannabis that may contribute to the development of an effective medical cannabis program in Canada. However, an EHM framework fails to explain why the community-based dispensary model has not been adopted. It looks at the activities that EHM organisations engage in to advance their cause, but does not address the wider systemic factors that hinder or enable their efforts for social change. In his analysis, Lucas (2009) makes a strong case for the role of institutional resistance as thwarting the goal of legal status for dispensaries. This resistance may reflect an approach to federal decision-making in which “politics trumps science” (Jones & Hathaway, 2008, p. 166). This is consistent with what Haines-Saah et al. (2013) note: that drug policy commentators have framed the story of Canada’s cannabis policies as one of “repeated lost opportunities because any movement toward more liberal policy has been thwarted by political pressures from conservative forces within and beyond Canada” who favour a prohibition approach (p. 2: citing Erickson, 1992; Fischer, Ala-Leppilampi, Single, & Robins, 2003; Martel, 2006).

Decision-makers may need more time for the concept of community-based medical cannabis dispensaries to “soften-up” the system before they embrace it completely (Kingdon, 2003).

Kingdon states that this softening up phase may take many years before the alternative is considered viable and, in fact, this phase may serve as an “enlightenment function” (Weiss, 1977, p. 531) by providing opportunities for policy makers to become more educated about and aware of the option and its potential benefits. Additionally, during this softening up period, spillovers from broader decriminalisation movements and the diffusion of more liberal policies from other jurisdictions (such as those states in the U.S. that permit community-based dispensaries or that have legalised cannabis) may further make the system more amenable to changes that would permit a more effective approach to medical cannabis.

In the meantime, dispensaries continue to challenge the medical, scientific and political institutions by creating new knowledge and advancing new approaches to health care and research. As this commentary is being written, legal challenges to the newly introduced MMPR are being prepared (Baker, 2013). The debate about the legitimacy of medical cannabis and community-based dispensaries continues, but it does so in the context of dispensaries’ mounting expertise, and growing credibility as a viable alternative to the current and pending approaches to the regulated provision of medical cannabis in Canada.

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