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Commentary

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

Rebecca A. Penn*

Dalla Lana School of Public Health, University of Toronto, 6th Floor, 155 College Street, Toronto, ON M5T 3M7, Canada

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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.

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 marihuana 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,

* Tel.: +1 416 909 9313.
E-mail addresses: rebecca.penn@mail.utoronto.ca, rebecca.penn@utoronto.ca

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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 (Willetts, 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.