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# Medical use of cannabis in Australia: “Medical necessity” defences under current Australian law and avenues for reform

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*The possession of cannabis is an offence in all Australian jurisdictions. No exception is made for medical use under any of the State and Territory Drug Acts, nor the Commonwealth’s pharmaceutical regulation scheme. Nevertheless, questions remain about the scope for defences argued on the basis of necessitous medical use. More fundamentally, the increasingly favourable light in which the medical use of cannabis is growing to be seen by state and national legislatures overseas raises important questions about the need for reform of Australian drug laws. This article explores those questions.*

## INTRODUCTION

The medical use of cannabis is controversial. In most parts of the world, it is also illegal, but this is no longer the case in others. Several countries have introduced laws which permit the medical use of cannabis. These include the Netherlands, Canada and the United States.

Australia, meanwhile, has seen no major revision of its drug laws designed to accommodate the medical use of cannabis, although New South Wales has twice engaged with the potential for reform in this area.<sup>1</sup> The possession of cannabis remains an offence in all Australian jurisdictions. Only a few, very limited authorisations to possess cannabis are provided by legislation. Medical use is not among them.

While no express legislative provision authorises medical use of cannabis anywhere in Australia, questions remain about the scope for defences based on necessitous medical use. More fundamentally, the preponderance of scientific evidence and the global trend of law reform – both of which are increasingly favourable to medical use of cannabis – raise important questions about the need for reform of Australian drug laws to accommodate and regulate medical use of cannabis.

This article explores those questions. It is divided into three parts, beginning with a brief explanation of the rationale for, and sources of, Australian drug laws, and a short review of evidence for the medical uses of cannabis, in order to provide background to the topic and place it in context. The second part analyses the scope for defences argued on the basis of necessitous medical use of cannabis, focusing on the possible application of the common law defence of necessity and its statutory equivalent, “sudden or extraordinary emergency”. The third part examines the legal and practical operation of medical cannabis regimes in selected overseas jurisdictions, with a view to determining their suitability as models for Australian law reform. The article concludes with a final assessment of the analysis in each part, and makes recommendations for reform.

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<sup>1</sup> In 2003, then-Premier of New South Wales Bob Carr announced that the State would trial the medical use of cannabis following the recommendation of a working party appointed by the Premier in August 1999: Working Party on the Use of Cannabis for Medical Purposes, *Report of the Working Party on the Use of Cannabis for Medical Purposes* (August 2000). The trial never took place: Editorial, “Medical Marijuana”, *The Sydney Morning Herald* (Sydney) (22 May 2003). More than a decade later, a cross-party parliamentary committee again recommended reform to allow the medical use of cannabis in New South Wales: General Purpose Standing Committee No 4, Parliament of New South Wales, *The Use of Cannabis for Medical Purposes* (2013) p xvii. Those recommendations were also rejected: Hawke S, “Medical Marijuana Debate: NSW Rules out Approving Cannabis for Terminally-ill Patients”, *ABC News* (online) (16 November 2013), <http://www.abc.net.au/news/2013-11-16/nsw-rules-out-medical-marijuana-for-terminal-patients/5096476> viewed 20 May 2014.

## BACKGROUND AND CONTEXT

### Rationale for, and sources of, Australian drug laws

Australian drug laws serve two distinct, and sometimes conflicting, policy objectives: the prohibition of recreational use, on one hand, and the authorisation and regulation of medical use on the other. The prohibitive aim is achieved through statutes in each jurisdiction which create criminal offences for possession, supply, production, and trafficking of certain listed drugs (Drug Acts).<sup>2</sup> But because many of the drugs which those Acts prohibit may also be used for medical purposes, the creation of criminal penalties for possessing them has made it necessary to establish a separate legislative scheme to facilitate their use in medicine.

The medical use of otherwise prohibited drugs is authorised through the Commonwealth's pharmaceutical regulation scheme under the *Therapeutic Goods Act 1989* (Cth) (TG Act). The Therapeutic Goods Administration (TGA) is the regulatory body responsible for administering the scheme, which centres on the "scheduling" of substances under a legislative instrument known as the *Poisons Standard*.<sup>3</sup> Substances are organised into nine schedules according to a number of criteria, "such as the purpose of use, potential for abuse, safety in use and the need for the substance".<sup>4</sup>

Schedules 2 and 3 of the *Poisons Standard* are the least restrictive,<sup>5</sup> and require only that the substances therein listed be sold by, or with the advice of, a pharmacist or other licensed person. Drugs included in these schedules include certain preparations of the common painkillers paracetamol, codeine and ibuprofen.<sup>6</sup> Schedule 4 drugs are known as "Prescription Only Medicines", the use and supply of which is restricted to circumstances where use or supply is ordered by persons permitted under State or Territory legislation to prescribe drugs (doctors). These include the anxiolytic diazepam and some other benzodiazepines, and most antibiotics.<sup>7</sup>

Schedules 8 and 9 are more restrictive categories. Schedule 8 drugs "should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence".<sup>8</sup> This category includes the stimulants amphetamine, dexamphetamine, methylphenidate and methamphetamine, and stronger opiate painkillers like hydrocodone and oxycodone.<sup>9</sup> Although amphetamine-type stimulants are more commonly associated with recreational use (or abuse), they are nevertheless recognised as having legitimate medical uses and may therefore be lawfully used in medicine.<sup>10</sup>

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<sup>2</sup> *Drugs Misuse Act 1986* (Qld); *Misuse of Drugs Act 1981* (WA); *Drug Misuse and Trafficking Act 1985* (NSW); *Drugs, Poisons and Controlled Substances Act 1981* (Vic); *Misuse of Drugs Act 2001* (Tas); *Controlled Substances Act 1984* (SA); *Misuse of Drugs Act* (NT); *Drugs of Dependence Act 1989* (ACT).

<sup>3</sup> *Therapeutic Goods Act 1989* (Cth), s 52D(2)(b); Therapeutic Goods Administration, *Poisons Standard 2013*, F2013L01607 (22 July 2013) p iv (*Poisons Standard*). Because the Commonwealth has no power with respect to the regulation of pharmaceutical products under the *Constitution*, the *Therapeutic Goods Act* is not in itself binding upon the States and Territories (it does, however, prevent substances from being imported if they have been included in Sch 9), but adopting Acts in each State and Territory have integrated the *Poisons Standard* into the law of their respective jurisdictions, creating a statutory mechanism for the lawful medical use of the drugs included in Schs 2, 3, 4 and 8: See, for example, *Health (Drugs and Poisons) Regulation 1996* (Qld), reg 5, Appendix 9 (definition of "current Poisons Standard"); *Poisons and Therapeutic Goods Act 1955* (NSW), s 31.

<sup>4</sup> *Poisons Standard*, n 3, p iv.

<sup>5</sup> Schedule 1 is intentionally blank. Schedules 5, 6 and 7 relate to substances which are not commonly regarded as drugs.

<sup>6</sup> *Poisons Standard*, n 3, pp iv, 35, 41, 43-44.

<sup>7</sup> *Poisons Standard*, n 3, pp iv, 76.

<sup>8</sup> *Poisons Standard*, n 3, p iv.

<sup>9</sup> *Poisons Standard*, n 3, pp 209-211.

<sup>10</sup> It is worth noting that the use of stimulant medications is far from uncommon in Australia. Nationally, stimulant prescriptions increased by 92 per cent in the past decade, reaching a total of 480,930 by 2010: Buckmaster L, "Large Increase in Stimulant Use for ADHD in Australia: New Study", *FlagPost: Information and Research from Australia's Commonwealth Parliamentary Library* (27 January 2011), <http://parliamentflagpost.blogspot.com.au/2011/01/large-increase-in-stimulant-use-for.html> viewed 20 May 2014. Although some additional requirements are imposed on doctors seeking to prescribe stimulant medications, their

Schedule 9, the most restrictive category, lists drugs “which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research”.<sup>11</sup> Drugs in this category supposedly have no legitimate medical use. These include 3,4-methylenedioxymethylamphetamine (MDMA), lysergic acid diethylamide (LSD) and, most importantly for present purposes, cannabis.<sup>12</sup>

The *Poisons Standard* does, however, accommodate the medical use of certain cannabis-derived drugs: the synthetic delta-9-tetrahydrocannabinol (THC)<sup>13</sup> preparations dronabinol and nabilone, and the botanical extract nabiximols.<sup>14</sup> The TGA includes these drugs in Sch 8 (drugs which “should be available for use”, subject to certain restrictions).<sup>15</sup> Evidently, then, the TGA accepts that THC has legitimate medical uses and should therefore be available, at least in synthetic form. The TGA also implicitly recognises the legitimate medical uses of other cannabinoids by including nabiximols in Sch 8. That decision was made in 2010,<sup>16</sup> suggesting that the TGA considered more recent evidence that the combined effect of multiple cannabinoids may be warranted for the treatment of conditions where THC alone is not effective.

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use by patients is largely unmonitored. Methylphenidate and dexamphetamine are frequently prescribed for the treatment of attention deficit-hyperactivity disorder (ADHD) in school-age children. This is significant because it demonstrates that, despite their high potential for abuse, the TGA was willing to recognise that these drugs “should be available for use”, and provided a statutory mechanism for their use to be authorised by including them in Sch 8. It should also be noted that, while methamphetamine is included in Sch 8, it is not currently available in Australia because no “sponsor” has applied to add a methamphetamine product to the Australian Register of Therapeutic Goods (ARTG): see n 15 below.

<sup>11</sup> *Poisons Standard*, n 3, p iv.

<sup>12</sup> *Poisons Standard*, n 3, pp 213-214.

<sup>13</sup> THC is the principal psychoactive constituent of cannabis. It is one of about 400 psychoactive chemicals found in cannabis. These chemicals, known as “cannabinoids”, can produce effects subjectively like or unlike THC; when taken together in conjunction with THC (as when natural cannabis is used), they synergistically produce effects which THC alone cannot replicate to the same extent, or at all.

<sup>14</sup> *Poisons Standard*, n 3, p 210. Dronabinol is an enantiometrically pure synthetic THC preparation (that is, one containing only the levorotary ((-)-*trans*- $\Delta^9$ -tetrahydrocannabinol) isomer) marketed in the United States under the trade name “Marinol”. Nabilone is a racemic synthetic THC preparation (that is, one containing both the dextrorotary and levorotary ((+)(-)- $\Delta^9$ -tetrahydrocannabinol) isomer) marketed in the United States and Canada under the trade name “Cesamet”. Nabiximols is a botanical extract of *Cannabis sativa* prepared as an orcomucosal mouth spray which includes a variety of cannabinoids in a standardised composition (THC, cannabidiol, cannabinol, cannabigerol, annabichromene, cannabidiolic acid, tetrahydrocannabinolic acid, tetrahydrocannabivarov, and cannabidivarov, where THC and cannabidiol – in approximately equal proportions – comprise not less than 90 per cent of the total cannabinoid content) marketed in Australia under the trade name “Sativex”. Another synthetic cannabinoid, rimonabant, which is a “selective CB1 receptor antagonist which was used to treat obesity for some time”, is currently in Sch 4, “but was withdrawn from the market due to severe side effects”: Department of Health and Ageing, *Final Decisions and Reasons for Decisions by Delegates of the Secretary to the Department of Health and Ageing* (July 2011) p 1. Dronabinol and nabiximols are subject to additional restrictions on their availability by their inclusion in Appendix D. Strangely, nabilone (along with other, arguably more dangerous drugs such as dexamphetamine and methylphenidate) is not.

<sup>15</sup> It should be noted that, although the TGA has determined that these drugs “should be available for use” by including them in Sch 8, only one is presently available: nabiximols. This is because a therapeutic good is not able to be sold in Australia until a “sponsor” – usually a pharmaceutical company – applies to have their product added to the Australian Register of Therapeutic Goods. For nabiximols, this did not occur until 26 November 2011, after Novartis Pharmaceuticals Australia Pty Ltd applied to sell nabiximols under the trade name “Sativex”: Therapeutic Goods Administration, *Public Summary for ARTG Entry 181978* (5 September 2013), <http://www.ebs.tga.gov.au> viewed 20 May 2014. Although dronabinol and nabilone are available in Canada, the United States and the United Kingdom, the pharmaceutical companies which sell them in those jurisdictions have not yet applied to register them in Australia: NSW Parliamentary Research Service, *Medical Cannabis*, Issues Backgrounder No 1 (February 2013) p 7. The TGA does, however, recognise “that there are circumstances where patients need access to therapeutic goods that are not on the ARTG”, and for this reason manages the Special Access Scheme (SAS) which “provides for the import and/or supply of an unapproved therapeutic good for a single patient, on a case by case basis”: Therapeutic Goods Administration, *Special Access Scheme* (16 April 2014), <http://www.tga.gov.au/hp/access-sas.htm> viewed 8 June 2014.

<sup>16</sup> Therapeutic Goods Administration, *Poisons Standard Amendment No 1 of 2010*, F2010L00966 (14 April 2010) p 3. The Advisory Committee on Medicines Scheduling’s (ACMS) first considered adding nabiximols to Sch 8 in October 2009 after it was brought to the Committee’s attention that certain jurisdictions were unable to allow patients to access nabiximols through the SAS because it was, at that time, captured by Sch 9. The Committee agreed to list it in Sch 8, but advised that it needed to be added to Appendix D, paragraph 3 – which applies to medicines that are not included in the ARTG and therefore not approved for use in Australia – in order to limit access through the SAS for clinical trials provided by an authorised prescriber

It is instructive, therefore, to consider the evidence which satisfied the TGA that dronabinol and nabilone should be included in Sch 8. Moreover, given that similar statutory bodies and legislatures in the Netherlands, Canada and the United States have decided that natural cannabis should be available in addition to synthetic THC – and that the TGA decided in 2010 that a botanical extract of natural cannabis should be available in addition to dronabinol and nabilone – it is worth considering the evidence for the medical use of cannabis to determine whether it, too, might someday be rescheduled less restrictively. Understanding the evidence for the medical use of cannabis and cannabinoids is also relevant to the discussion of defences based on necessitous medical use because, although the availability of dronabinol, nabilone and nabiximols may be claimed to remove any need to use cannabis,<sup>17</sup> there are significant differences between those drugs and natural cannabis in terms of their effects upon patients.

### **Evidence for the medical uses of cannabis and cannabis-derived drugs**

The degree of evidence for the relative therapeutic efficacy of cannabis and cannabis-derived drugs depends on the proposed use. Some uses have been studied extensively; others are largely anecdotal. Substantial research has explored the use of cannabis and derivatives to treat nausea, vomiting, appetite loss and wasting syndrome, especially in human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and chemotherapy patients. Research into the use of cannabis and derivatives for treating spasticity and pain is also significant, especially in multiple sclerosis (MS) patients. The majority of studies indicate that cannabis and derivatives provide medical benefits for those conditions. Evidence for these uses is provided below. Issues specific to the use of natural cannabis over synthetic cannabis derivatives are also addressed below.

#### ***For the treatment of nausea, vomiting, appetite loss and wasting syndrome***

Cannabis provides relief from nausea and vomiting, due to its interaction with cannabinoid receptors in the parts of the brain that control vomiting. It can therefore ease the nausea experienced by HIV/AIDS patients and patients receiving chemotherapy for cancer.

Substantial scientific evidence supports this. A 2002 review of 72 controlled studies concluded that “cannabinoids exhibit ... therapeutic potential as anti-emetics and appetite stimulants in ... cancer and AIDS”.<sup>18</sup> Darmani, citing 194 entries in the online medical journal database MEDLINE on the anti-emetic properties of cannabis and cannabinoids, summarises the weight of studies as providing “significant evidence [which] supports the selective use of ... cannabinoids for the treatment of nausea and vomiting in some patients treated with chemotherapy”.<sup>19</sup> Ben Amar’s 2006 review of cannabis’ therapeutic effects cites 31 studies conducted during the 1970s and 1980s investigating the anti-emetic

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only. This was done in May 2010. After nabiximols was added to the ARTG in the form of “Sativex” in November 2012, however, the ACMS recommended that nabiximols be shifted from paragraph 3 of Appendix D to the less restrictive paragraph 1, which applies to medicines approved on the ARTG for use in Australia, whilst still requiring a prescription or order from an authorised medical practitioner. That recommendation was accepted and implemented on 1 September 2013: Department of Health and Ageing, *Final Decisions and Reasons for Decisions by Delegates of the Secretary to the Department of Health and Ageing* (June 2013) pp 34-36. Curiously, in the same decision, the delegate accepted an ACMS recommendation to add yet another amphetamine-type stimulant, lisdexamfetamine, to Sch 8, but despite noting that it carries “all the risks of the amphetamines” and “[a]mphetamines are well established as substances of abuse”, chose not to add it to Appendix D, making its availability less restrictive than for nabiximols.

<sup>17</sup> Any argument against necessitous medical use of cannabis based on the availability of cannabis-derived drugs should also be considered in light of the fact that, owing only to the apparently commercial decisions of pharmaceutical companies, neither dronabinol nor nabilone is presently able to be purchased in Australia, notwithstanding the TGA’s approval of their use in medicine: see n 15. Moreover, although nabiximols is now able to be purchased in the form of “Sativex”, it is only allowed for the “specified indication” “as treatment for symptom improvement in patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy”: Therapeutic Goods Administration, *Public Summary for ARTG Entry 181978* (5 September 2013), <http://www.ebs.tga.gov.au> viewed 20 May 2014. This still leaves cancer and HIV/AIDS patients without any lawfully-available cannabis-derived drug.

<sup>18</sup> Smith P, *Cannabis on the Brain* (Dunmore Press, Palmerston North, 2002) p 12.

<sup>19</sup> Darmani N, “Anti-emetic Action of Deltahydrocannabinoid and Synthetic Cannabinoids in Chemo-Therapy Induced Nausea and Vomiting” in Onaivi S, Sugiura T and Di Marzo V (eds), *Endocannabinoids: The Brain and Body’s Marijuana and Beyond* (Taylor & Francis, New York, 2006) p 3.

effects of cannabis and cannabis-derived drugs, of which 29 determined that cannabis-type treatments were significantly superior to placebo and other anti-emetic drugs.<sup>20</sup>

The data from these and other studies led to the approval of dronabinol and nabilone as anti-emetics in Canada (1995 and 1982, respectively) and the United States (1985). Since their medical uses were well-established by the time of the TG Act’s inception in 1989, both drugs were included in Sch 8 of the very first *Poisons Standard*.

### **For the treatment of spasticity and pain**

Cannabis has confirmed anti-convulsant properties, which may assist in the treatment of spasticity caused by MS and spinal cord injuries, and in relieving pain caused by these conditions.

Scientific evidence for these uses is also significant: medical literature reviews from 1999, 2000, and 2006 conclude that available literature supports the efficacy of cannabis and derivatives as analgesics.<sup>21</sup> There has likewise been significant investigation into the use of cannabis and derivatives in treating MS, with the vast majority of studies and reviews showing a potential therapeutic effect.<sup>22</sup> The weight of the evidence is such that the TGA decided to add the botanical extract nabiximols to Sch 8 of the *Poisons Standard*.

### **Issues specific to natural cannabis**

Relatively few studies have investigated the use of natural cannabis,<sup>23</sup> but this dearth is not due to a lack of scientific interest. Many international medical professional bodies – including the Australian Medical Association – have issued official opinions calling for more research into the medical use of cannabis, citing anecdotal reports from cancer and HIV/AIDS patients that suggest that natural cannabis may, in some cases, be therapeutically preferable to synthetic THC.<sup>24</sup> Unfortunately, bureaucracy and prohibitionism stifle research into these claims.<sup>25</sup> Nevertheless, existing evidence from limited controlled studies, combined with considerable anecdotal evidence from patients, has convinced the national legislatures of the Netherlands and Canada, and 22 State legislatures in the United States, that natural cannabis should be available for medical use in addition to the longstanding availability of synthetic THC. This may also provide a sufficient evidentiary foundation for defences against cannabis offences argued on the basis of necessitous medical use as explored below.

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<sup>20</sup> Ben Amar M, “Cannabinoids in Medicine: A Review of their Therapeutic Potential” (2006) 105 *Journal of Ethnopharmacology* 1 at 3-11.

<sup>21</sup> Walker J et al, “Pain Modulation by the Release of the Endogenous Cannabinoid Anandamide” (1999) 96(21) *Proceedings of the National Academy of Sciences* 12198; Walker J and Huang S, “Cannabinoid Analgesia” (2000) 95(2) *Pharmacology and Therapeutics* 127 at 127-135; Atha M, *Cannabis and Pain Relief: A Literature Review* (Independent Drug Monitoring Unit, 2006), <http://www.idmu.co.uk/oldsite/pdfs/canpain.pdf> viewed 20 May 2014; Ben Amar, n 20 at 9-11.

<sup>22</sup> Pacher P, Batkai S and Kunos G, “The Endocannabinoid System as an Emerging Target of Pharmacotherapy” (2006) 58 *Pharmacology Review* 389 at 398, quoted in Irvine G, “Legalisation of Medicinal Cannabis in New South Wales” (PhD Thesis, Southern Cross University, 2011) p 41.

<sup>23</sup> Just three of the 31 anti-emetic studies cited by Ben Amar, for example, investigated the use of smoked cannabis to alleviate nausea and vomiting in chemotherapy patients: Ben Amar, n 20 at 9. Two of these used smoked cannabis only as a substitute for dronabinol where dronabinol failed. Only one directly compared smoked cannabis to dronabinol. It involved a randomised, double-blind, crossover, placebo-controlled clinical trial conducted in Canada involving 20 chemotherapy patients. Thirty-five per cent of the 20 subjects stated that they preferred dronabinol whereas 20 per cent preferred smoked cannabis, however, seven individuals reported unwanted side effects in the form of time distortion and hallucinations: four with dronabinol, two with smoked cannabis, and one with both, suggesting that a greater incidence of unwanted side effects is associated with dronabinol than smoked cannabis. More recently, a 2003 study conducted in the United States which compared dronabinol and smoked cannabis to a placebo concluded that they were both superior to the placebo, but indicated a higher incidence of unwanted side effects associated with dronabinol than smoked cannabis.

<sup>24</sup> Australian Medical Association, *Cannabis Use and Health – 2014*, <https://ama.com.au/node/2556> viewed 8 June 2014. See generally Marijuana Policy Project, *State-By-State Medical Marijuana Laws* (2013) pp P1-P27.

<sup>25</sup> See generally Topp L, “Medical Cannabis: Lost in Politics” (2006) 4(2) *Of Substance* 12; Bostwick J, “Blurred Boundaries: The Therapeutics and Politics of Medical Marijuana” (2012) 87(2) *Mayo Clinic Proceedings* 172; Cohen PJ, “Medical Marijuana 2010: It’s Time to Fix the Regulatory Vacuum” (2010) 38(3) *Journal of Law, Medicine and Ethics* 654.



## SCOPE FOR DEFENCES BASED ON THE NECESSITOUS MEDICAL USE OF CANNABIS

### Introduction

The possession, cultivation and trafficking of cannabis are offences in all Australian jurisdictions.<sup>26</sup> Only a few, very limited authorisations to possess cannabis are provided by legislation.<sup>27</sup> Medical practitioners cannot prescribe cannabis,<sup>28</sup> but they can obtain approval to prescribe the cannabis-derived synthetic drugs dronabinol and nabilone, and the botanical extract nabiximols.<sup>29</sup>

While no express legislative provision authorising the medical use of cannabis exists anywhere in Australia, the scope for defences based on the necessitous medical use of cannabis remains largely unexplored.<sup>30</sup> This part considers whether the defence of necessity – or its statutory equivalent, “sudden or extraordinary emergency” – is available to a defendant in respect of cannabis possession, where his argument is based on the necessitous medical use of cannabis.<sup>31</sup> Given that the English Court of Appeal answered a similar question in the negative in *Quayle v The Queen; Attorney-General's Reference (No 2 of 2004)* [2005] 1 WLR 3642 (*Quayle*), it might be assumed that an Australian court faced with similar circumstances would apply similar reasoning and just say, “no”. It is argued here that this may not necessarily be the case.

<sup>26</sup> *Criminal Code Act 1995* (Cth), ss 302.1-302.5, 303.1-303.6, 308.1; *Drugs Misuse Act 1986* (Qld), ss 4, 4A, 6(1), 8, 9; *Misuse of Drugs Act 1981* (WA), ss 4, 6, 7; *Drug Misuse and Trafficking Act 1985* (NSW), ss 3(1), 4, 10(1), 23, 25; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), ss 4, 70, 71, 72B, 73; *Misuse of Drugs Act 2001* (Tas), ss 3(1), 7, 12, 22, 24, 25, 27; *Controlled Substances Act 1984* (SA), ss 4(1), 32, 33B, 33K, 33L(2); *Misuse of Drugs Act* (NT), ss 3, 5, 7, 9; *Drugs of Dependence Act 1989* (ACT), ss 162, 169, 171, 600. All States and Territories except Queensland have also criminalised the use of cannabis: *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>27</sup> *Poisons Standard*, n 3, p iv; *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.

<sup>28</sup> In Queensland, this is achieved through an express provision: *Health (Drugs and Poisons) Regulation 1996* (Qld), reg 270A. In other States and Territories, an approval to prescribe cannabis cannot be obtained simply because cannabis is included in Sch 9 of the *Poisons Standard*, and no provision is made for the prescription of drugs in that category. Victoria appears to be the only exception to the general rule that cannabis may not be prescribed in Australia. Victorian medical practitioners may apply for a permit to prescribe Sch 9 poisons: *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 33B. Accordingly, it is technically possible to obtain approval to prescribe cannabis in Victoria, but it is practically impossible due to bureaucratic restrictions. In New South Wales, the *Poisons Standard* has been varied to include THC in Sch 8 “[t]o enable possession and use via issuance of an authority, other than under the *NSW Drug Misuse and Trafficking Act 1985*”: *Poisons and Therapeutic Goods Act 1966* (NSW), s 8; Department of Health (NSW), *New South Wales Poisons List* (1 September 2012) p 8; Therapeutic Goods Administration, *Australian State & Territory Variations from Part 4 of the Poisons Standard* (26 November 2013), <http://www.tga.gov.au/industry/scheduling-st-variations-p4.htm> viewed 20 May 2014. It is unclear whether this may also allow authorisation to be given for the possession of cannabis.

<sup>29</sup> *Poisons Standard*, n 3, pp 202, 228; *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s 34A; *Poisons and Therapeutic Goods Act 1966* (NSW), s 28A; *Health (Drugs and Poisons) Regulation 1996* (Qld), regs 58, 77; *Controlled Substances Act 1984* (SA), s 18A; *Poisons Act 1964* (WA), s 23; *Poisons Act 1971* (Tas), ss 26-27; *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT), s 20; *Poisons and Dangerous Drugs Act* (NT), s 31C.

<sup>30</sup> A number of commentators have speculated “that possession or supply of a ... drug ... could be justified on the basis of medical necessity”: Schloenhardt A, *Queensland Criminal Law* (Oxford University Press, Oxford, 2008) p 352. See, for example, Heilpern D and Rayner G, “Drug Law and Necessity” (1997) 22(4) *Alternative Law Journal* 188.

<sup>31</sup> In Australia, the common law defence of necessity is available in those jurisdictions which continue to rely on common law as a major source of criminal law (common law jurisdictions). These include New South Wales, Victoria and South Australia. Sudden or extraordinary emergency is available in the jurisdictions which have confined their criminal law to “Codes” designed to supplant the common law (Code jurisdictions). These include Queensland, Western Australia, the Commonwealth, the Northern Territory and the Australian Capital Territory: *Criminal Code Act 1899* (Qld), Sch 1 (*Criminal Code* (Qld)); *Criminal Code Act Compilation Act 1913* (WA), Sch (*Criminal Code* (WA)); *Criminal Code Act 1995* (Cth), Sch 1 (*Criminal Code* (Cth)); *Criminal Code Act 1983* (NT), Sch 1 (*Criminal Code* (NT)); *Criminal Code 2002* (ACT) (*Criminal Code* (ACT)). Tasmania also has a Code: *Criminal Code Act 1924* (Tas), Sch 1 (*Criminal Code* (Tas)). However, the common law continues to govern criminal defences in Tasmania: *Criminal Code* (Tas), s 8. For this reason, necessity is available in Tasmania as well.

## Rationale and elements

### **Necessity**

The common law recognises that situations can occur whereby a person is justified in breaking the law to avoid a greater harm than that which would result from obeying it, or should be excused from breaking the law if compliance would impose an intolerable burden on him. This concession gives rise to the defence of necessity, which operates to absolve an accused of criminal responsibility for an act which would otherwise be a crime.

The leading authority on necessity in the Australian common law jurisdictions is the joint judgment of Young CJ and King J in *R v Loughnan* [1981] VR 443 (*Loughnan*), which formulated a test involving three elements:

First, the criminal act or acts must have been done only in order to avoid certain consequences which would have inflicted irreparable evil upon the accused or upon others whom he was bound to protect ... The [second] element of imminent peril means that the accused must honestly believe on reasonable grounds that he was placed in a situation of imminent peril ... The [third] element of proportion simply means that the acts done to avoid the imminent peril must not be out of proportion to the peril to be avoided. Put in another way, the test is: would a reasonable man in the position of the accused have considered that he had any alternative to doing what he did to avoid the peril?<sup>32</sup>

### **Sudden or extraordinary emergency**

The statutory equivalent of necessity in Code jurisdictions is “sudden or extraordinary emergency”. In an explanatory note to the draft provision which would become s 25 of the *Criminal Code* (Qld) – the first such provision to be enacted and upon which all subsequently adopted equivalent provisions are based – Sir Samuel Griffith, the man who singlehandedly wrote each of its constituent words, described what he intended to achieve with those words as follows:

The section gives effect to the principle that no man is expected (for the purposes of the Criminal Law, at all events) to be wiser or better than all mankind. It is conceived that it is a rule of the Common Law, as it undoubtedly is a rule upon which any jury would desire to act. It might, perhaps, be said that it sums up nearly all Common Law rules as to excuses for an act which is *prima facie* criminal.<sup>33</sup>

A few years later, in deciding upon what was possibly the first case to consider the provision which he himself had written, Griffith CJ described s 25 as a rule of common sense as much as a rule of law.<sup>34</sup>

The elements of sudden or extraordinary emergency are set out prescriptively in the various statutory formulations of the defence.<sup>35</sup> Although those formulations differ slightly in phraseology, they are generally regarded as comprising three common elements: a circumstantial element involving either circumstances of emergency in fact or circumstances which caused the defendant to believe an emergency existed; a subjective element involving the defendant’s belief that the emergency was either a sudden or extraordinary one, such that the offending conduct was either *a* reasonable response to the emergency or the *only* reasonable response to the emergency; and an objective element involving a test of reasonableness to determine whether that subjective belief was reasonable.

### **Possible application to cannabis possession offences**

The potential application of these defences to cannabis offences is analysed below. For convenience, the three elements of sudden or extraordinary emergency are paired with the three elements of necessity referred to in *Loughnan* (although they are not directly equivalent).

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<sup>32</sup> *R v Loughnan* [1981] VR 443 at 448.

<sup>33</sup> Griffith SW, *Draft of a Code of Criminal Law* (Government of Queensland, 1897) p 13 fn 2. In an explanatory covering letter to the Attorney-General, Griffith invited “special attention” to this note, adding that, “No part of the Draft Code has occasioned me more anxiety”, but also, “I regard no part of the work with more satisfaction”: Letter from Sir Samuel Walker Griffith to the Attorney-General of Queensland (29 October 1897) p x.

<sup>34</sup> *Webster & Co v Australasian United Steam Navigation Co Ltd* [1902] St R Qd 207 at 216-217.

<sup>35</sup> *Criminal Code* (Qld), s 25; *Criminal Code* (WA), s 25; *Criminal Code* (Cth), s 10.3, *Criminal Code* (ACT), s 41; *Criminal Code* (NT), s 43BC.

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***Irreparable evil/emergency******Common law***

The first element of necessity means that the criminal act of possessing cannabis must have been done to avoid certain consequences which would have inflicted “irreparable evil” upon the accused or other whom he was bound to protect. The majority in *Loughnan* left the limits of “irreparable evil” undefined, but indicated that further refinement of that concept would be desirable:

The limits of this element are at present ill-defined and where those limits should lie is a matter of debate. But we need not discuss this element further because the irreparable evil relied upon in the present case was the threat of death and if the law recognises the defence of necessity in any case it must surely do so where the consequence to be avoided was the death of the accused. We prefer to reserve for consideration if it should arise what other consequence might be sufficient to justify the defence.<sup>36</sup>

In a 1991 article, Yeo identified in that passage a tendency toward restricting the availability of necessity by recognising specific types of harm:

[The passage] clearly shows their Honours’ view that the common law will recognise only certain types of threatened harm as opposed to every threat which might overwhelm the wills of the accused and ordinary persons. A similar approach has emerged under English common law. The English Court of Appeal has recently recognised the defence of excusatory necessity or what it calls “duress of circumstances”. In specifying the elements of this defence, the court followed developments in the law of duress to recognise specific types of threatened harm, namely, of “death or serious physical injury”.<sup>37</sup>

Yeo went on to warn against going down the English path in this respect:

It would ... be premature to restrict the application of the defence ... by specifying a limited list of threats ... To insist, as the English Court of Appeal appears to have done, that the defence of necessity is confined to cases involving threats of death or serious physical injury is to rule out a defence in cases where the accused “could not reasonably be expected to resist” a threat of less harm than death or serious physical injury.<sup>38</sup>

That category of cases includes those involving the medical use of cannabis. As explained above, the established medical uses of cannabis include the treatment of nausea, vomiting, appetite loss, wasting syndrome and spasticity. Rather than avoiding death or serious physical injury, these uses are intended to alleviate significant suffering resulting from symptoms of serious medical conditions. Thus, to insist that necessity be confined to cases involving death or serious physical injury would be to rule out the availability of the defence in cases involving the medical use of cannabis – which is exactly what the English Court of Appeal did in *Quayle*.<sup>39</sup>

Australian courts, meanwhile, appear to have heeded Yeo’s warning. Although most Australian cases on necessity concern situations involving danger of death or serious physical injury, nothing like the precise judicial confinement to cases of that type which has taken place in English common law can be found in Australian authorities. Indeed, some abortion cases from Victoria and New South Wales – which draw upon the principles of necessity to determine whether an abortion is lawful – refer to types of threatened harm less than death or physical injury, such as danger to mental health.<sup>40</sup> It appears, therefore, that there is no need for danger of death or physical injury under Australian common law. “Irreparable evil” can encompass threats of less harm than death or physical injury, and may therefore apply to at least some forms of threatened harm which medical use of cannabis may be intended to avoid, such as the suffering which cancer or HIV/AIDS patients might endure if lawful medications prove ineffective.

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<sup>36</sup> *R v Loughnan* [1981] VR 443 at 448.

<sup>37</sup> Yeo S, “Necessity Under the Griffith Code and the Common Law” (1991) 15 Crim LJ 17 at 22.

<sup>38</sup> Yeo, n 37 at 22-23.

<sup>39</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [77].

<sup>40</sup> See, for example, *R v Davidson* [1969] VR 667 at 672; *R v Wald* (1971) 3 NSWDCR 25 at 29; *CES v Superclinics (Aust) Pty Ltd* (1995) 38 NSWLR 47 at 59-60, 80.



### *Criminal Codes*

The position with respect to “sudden or extraordinary emergency” is much clearer: there is no reference to specific types of threatened harm in any statutory formulation of the defence. The offending conduct must have been carried out in response to, or under circumstances of, “sudden or extraordinary emergency”. That term is not further explained or defined.<sup>41</sup>

Although (as in common law cases on necessity) references to specific types of harm – usually death – are commonplace in case law on sudden or extraordinary emergency, the defence has never been confined to circumstances involving any specific type of harm. There have even been cases in Western Australia where it has been held that circumstances involving danger to property can amount to “sudden or extraordinary emergency”, whether coupled with danger of physical injury or not.<sup>42</sup>

Decisions such as these demonstrate that “there is no restriction on the nature of the threat before the defence can be relied on”.<sup>43</sup> Certainly, no such intention is readily apparent from the words chosen by Griffith, nor from his explanatory annotations. None of the subsequently adopted variations on his original choice of words suggest any intention to restrict the nature of emergency by reference to specific types of threatened harm either; each adopting legislature has deemed the adjectives “sudden” and “extraordinary” – available in the alternative – sufficient descriptors of the emergency circumstances considered appropriate to warrant excuse from criminal responsibility. There is, therefore, no reason to assume that the threat of suffering from symptoms which can only be alleviated by using cannabis cannot amount to “sudden or extraordinary emergency”.

### ***Imminent peril/suddenness***

#### *Common law*

The second element of necessity means that the accused must have reasonably believed that he was placed in a situation of imminent peril. This does not require that circumstances of imminent peril existed in fact, but rather forms the first part of the objective standard which Australian common law imposes in relation to necessity (the second part, the “element of proportion”, is discussed below). Accordingly, it is only necessary to demonstrate that the accused honestly believed he was in imminent peril, and that this subjective belief was reasonable.

The court in *Quayle* understood English common law to impose a different standard: “There is ... considerable authority pointing towards a need for extraneous circumstances capable of objective scrutiny by judge and jury.”<sup>44</sup> None of the judgments which the court referenced in that respect are binding authority in Australia, and no similar expressions indicating need for extraneous circumstances are found in Australian authorities.

The court in *Quayle* also approached what it called the “requirements” of “imminence and immediacy” differently, appearing to treat them as requirements of fact rather than as elements of an objective standard. The majority in *Loughnan*, too, doubted that the defence could ever succeed without circumstances of imminence in fact:

[A]ll the cases in which a plea of necessity has succeeded are cases which deal with an urgent situation of imminent peril. Thus if there is an interval of time between the threat and its expected execution it will be very rarely if ever that a defence of necessity can succeed.<sup>45</sup>

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<sup>41</sup> Yeo argues “that the Code’s approach in not specifying the types of threats is to be preferred”: Yeo, n 37.

<sup>42</sup> See, for example, *Dudley v Ballantyne* (1998) 28 MVR 209, where it was held that circumstances which were likely to endanger both life and property were capable of amounting to a “sudden or extraordinary emergency” for the purposes of s 25 of the *Criminal Code* (WA); *Dunjey v Cross* [2002] WASCA 14 at [47], where it was held that a “sudden or extraordinary emergency” may “apply to a situation in which property is in danger”.

<sup>43</sup> Law Reform Commission of Western Australia, *Review of the Law of Homicide: Final Report*, Project No 97 (2007) p 190.

<sup>44</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [73], citing Lord Bingham’s dictum in *R v Hasan* [2005] UKHL 22, the dicta in *R v Abdul-Hussain* [1999] Crim LR 570, Lord Woolf’s dicta in *R v Shayler* [2003] 1 AC 247 and the decisions in *R v Rodger* [1998] 1 Cr App R 1 and *R v Brown* [2003] EWCA Crim 2637.

<sup>45</sup> *R v Loughnan* [1981] VR 443 at 448.

Subsequent Australian cases continued to refer to “imminence” and related concepts such as “urgency” and “immediacy”, sometimes even calling them “requirements”; in other contexts, “imminent peril” has been taken to mean that the criminal act must have been spontaneous, without any planning or deliberation.<sup>46</sup> In light of the High Court decision in *Zecevic v Director of Public Prosecutions (Vic)* (1987) 162 CLR 645, however, later Australian authorities have been more careful in referring to the elements described in *Loughnan*, treating them as relevant factors rather than strict requirements. In *R v Rogers* (1996) 86 A Crim R 542 (*Rogers*), for example, Gleeson CJ stated:

[I]t is now more appropriate to treat those requirements, not as technical legal considerations, but as factual considerations relevant ... to the issue of an accused person’s belief as to the position in which he or she is placed, and as to the reasonableness and proportionality of the response.<sup>47</sup>

In *Behrooz v Secretary of Department of Multicultural and Indigenous Affairs* (2004) 219 CLR 486, Gleeson CJ explained further that, in contrast to United States authorities, the court in *Loughnan* regarded imminence as evidentiary rather than a strict legal requirement:

In ... *Loughnan* ... [and] ... *Rogers*, consideration was given to the principles according to which a person, confronted in prison with some peril involving a threat to life or safety, may lawfully take steps, proportionate to the danger, to avoid the threat. Such steps do not ordinarily involve remaining at large in the community for an indefinite period. Thus, for example, there are United States authorities which make it a condition of pleading necessity as an excuse for escaping from prison that the prisoner, after escape, must report immediately to the proper authorities when he has attained a position of safety from the immediate threat. The Supreme Court of Victoria, in *Loughnan*, said this was a matter of evidentiary significance, rather than a legal condition.<sup>48</sup>

The High Court considered Gleeson CJ’s comments in *Rogers* again in 2009, citing with approval his rejection of “the view that the defence of necessity required proof of urgency and immediacy as technical elements”.<sup>49</sup>

Australian common law therefore differs from that of England in this respect. There is no “requirement” of imminence per se. It may be the case that, as the majority said in *Loughnan*, “if there is an interval of time between the threat and its expected execution it will be very rarely if ever that a defence of necessity can succeed”,<sup>50</sup> but it is nevertheless possible that “[a]n action may be rendered necessary by circumstances that are not urgent or immediate”.<sup>51</sup>

### *Criminal Codes*

Much like the use of “imminent peril” in the second element of necessity, the use of “sudden or extraordinary emergency” in statutory expressions of the defence does not require that such circumstances existed in fact, only that the accused reasonably believed an emergency situation existed.<sup>52</sup>

Moreover, although “sudden” connotes “a sense of immediate danger, one which will occur almost instantaneously unless the accused takes countervailing action”, its use in statutory expressions of the defence does not impose requirements of imminence or immediacy as a necessary component of

<sup>46</sup> See, for example, Fletcher GP, *Rethinking Criminal Law* (Little Brown & Co, Boston, 1978) pp 811-812; Colvin E and McKechnie J, *Criminal Law in Queensland and Western Australia* (5th ed, LexisNexis, Chatswood, 2008) p 387. Compare *Pagawa v Matthew* [1986] PNGLR 154. See also *R v Dudley and Stephens* (1884) All ER 61.

<sup>47</sup> *R v Rogers* (1996) 86 A Crim R 542 at 546. See also *Bayley v Police* [2007] SASC 411 [37]; *Warnakulasuriya v The Queen* [2012] WASCA 10 at [129].

<sup>48</sup> *Behrooz v Secretary of Department of Multicultural and Indigenous Affairs* (2004) 219 CLR 486 at [15].

<sup>49</sup> *Taiapa v The Queen* (2009) 240 CLR 95 at [37].

<sup>50</sup> *R v Loughnan* [1981] VR 443 at 448.

<sup>51</sup> *Warnakulasuriya v The Queen* [2012] WASCA 10 at [129].

<sup>52</sup> *Criminal Code* (Cth), s 10.3(2)(a); *Criminal Code* (ACT), s 41(2)(a); *Criminal Code* (NT), s 43BC(2)(a); *Criminal Code* (WA), s 24 (3)(a)(i). Although s 25 of the *Criminal Code* (Qld) makes no reference to subjective beliefs of the accused, it has been held that the defence is available in instances in which the accused honestly and reasonably believed an emergency situation existed even when in fact it did not: *R v Pius Piane* [1975] PNGLR 52; *R v Webb* [1986] 2 Qd R 446 at 449.

the emergency circumstances.<sup>53</sup> This is made clear by the words of the provisions understood according to their ordinary meaning. The emergency may be “sudden” or “extraordinary”. There is, as many legal academics argue, no need to read requirements of “imminence” into the defence.<sup>54</sup> Case law in Code jurisdictions confirms this, with one notable exception.

Queensland is the only Code jurisdiction that reads such requirements into the “sudden or extraordinary emergency” provision. *R v Gardner* [2012] QSC 73 provides a recent example. There, the accused asked whether the “sudden or extraordinary emergency” defence applied to his circumstances. The prosecutor submitted “that it is limited to cases where the defendant is confronted by sudden and extreme circumstances where the danger is imminent and extreme”.<sup>55</sup> Atkinson J accepted this submission, adding that it is “supported by ... the common law”.<sup>56</sup> In reaching this conclusion, her Honour referred to the element of imminence in *Loughnan* as quoted by Gleeson CJ in *Rogers*,<sup>57</sup> although somewhat curiously she did not cite Gleeson CJ’s rejection, a few paragraphs later in his judgment, of the view that necessity requires proof of urgency and immediacy.<sup>58</sup>

Despite dealing with precisely the same formulation of the defence until the 2008 amendment, Western Australian courts have never interpreted it as containing any requirement of imminence. *Smith v Western Australia* [2010] WASCA 205, which concerned the defence as it stood before 2008, is typical of the approach taken in Western Australia, emphasising the natural and ordinary meaning of the words “sudden or extraordinary emergency”:

The words “sudden”, “extraordinary” and “emergency” are all words in common, everyday usage and it would be unnecessary, indeed it would have been an affront to the intelligence of the jury, for ... [the trial judge] to define them. His Honour was clear in his summing up that the relevant emergency had to be either sudden or extraordinary. At no time did he give the jury the impression that the emergency had to be both sudden and extraordinary.<sup>59</sup>

Western Australian jurisprudence on s 10.3 of the *Criminal Code* (Cth) is even clearer. In *Nguyen v The Queen* [2005] WASCA 22 (*Nguyen*), the Court of Appeal of Western Australia held that “[t]he circumstances in which the defence may be raised include a sudden emergency or an extraordinary emergency. It is not necessary for the emergency to be both sudden and extraordinary.”<sup>60</sup>

Similarly, in *Warnakulasuriya v The Queen* [2012] WASCA 10 (*Warnakulasuriya*), the court held:

It is unnecessary for an emergency to be both sudden and extraordinary. The emergency may be either sudden or extraordinary ... The term “extraordinary emergency”, in its natural and ordinary meaning, does not necessarily connote circumstances involving an existing, imminent or anticipated danger that

<sup>53</sup> *Warnakulasuriya v The Queen* [2012] WASCA 10 at [130]. The operative noun “emergency” may itself carry connotations of suddenness or urgency, but these attributes are not universally agreed to be necessary components of the concept which the term describes: see “emergency, n”, *OED Online* (March 2014 update), <http://www.oed.com> viewed 8 June 2014. In any case, the inclusion of the adjective “sudden” in statutory formulations of the defence suggests that the respective legislatures which enacted them intended the phrase to describe two kinds of “emergency”: one which is characterised by suddenness, and one which is not (that second type carries the alternative characterisation of extraordinariness). Otherwise, if suddenness is necessarily inherent to the concept of “emergency”, the adjective “sudden” would be entirely unnecessary. It would be a perversion of the ordinary principles of statutory interpretation to assume that its inclusion was tautological or unintended.

<sup>54</sup> See, for example, Colvin and McKechnie, n 46; Yeo, n 37 at 23-24; Bronitt S and McSherry B, *Principles of Criminal Law* (3rd ed, Thomson Reuters, Sydney, 2010) pp 371-372, 918-919.

<sup>55</sup> He referred to *R v Heenan* [2002] WCA292; *R v Hawton* [2009] QCA 248; *R v Bishio* [2010] QCA 375; *R v Hunt* [2009] QCA 397.

<sup>56</sup> Transcript of Proceedings, *R v Gardner* [2012] QSC 73 (Supreme Court of Queensland, Atkinson J, No 126/2012, 20 March 2012) p 1-10.

<sup>57</sup> Transcript of Proceedings, n 56, pp 1-11-1-12.

<sup>58</sup> *R v Rogers* (1996) 86 A Crim R 542 at 546, cited in *Taiapa v The Queen* (2009) 240 CLR 95 at [37].

<sup>59</sup> *Smith v Western Australia* [2010] WASCA 205 at [169].

<sup>60</sup> *Nguyen v The Queen* [2005] WASCA 22 at [17].

requires immediate action. Circumstances involving an existing, imminent or anticipated danger may constitute an “extraordinary emergency” even though the danger does not require immediate action.<sup>61</sup>

Buss JA reached this conclusion because he understood the phrase “sudden or extraordinary emergency” as used in s 10.3 of the *Criminal Code* (Cth) to bear its “natural and ordinary meaning”. His Honour reasoned that “[t]his is apparent from the statutory text and the decision of the Parliament not to define the phrase or any of the words that comprise it”. In this respect, he referred to the commentary of the Model Criminal Code Officers Committee on the draft provision which became s 10.3:

In response to the submission of the Northern Territory Criminal Law Association, the section has been redrafted so that the words “sudden or extraordinary emergency” are not defined in terms of “an urgent situation of imminent peril” ... but left to the jury as ordinary words in the English language.<sup>62</sup>

Similar comments appear in the explanatory memorandum to the Bill which, upon enactment, became the *Criminal Code* (Cth).<sup>63</sup> Although the reasoning in *Nguyen*, *Warnakulasuriya* and *Ajayi* with respect to the absence of any need for immediacy under s 10.3 of the *Criminal Code* (Cth) was supported by the availability of the Committee’s commentary and the explanatory memorandum, those decisions were ultimately based on ordinary principles of statutory interpretation. This reasoning should apply to all statutory formulations of the defence because the relevant words – that is, “sudden or extraordinary emergency” – are identical in each jurisdiction, and bear the same meaning when properly construed. Accordingly, the defence may apply to cases concerning necessitous medical use of cannabis, even though the circumstances might involve an “existing danger” rather than a sudden, unexpected occurrence – such as the ongoing suffering from symptoms of HIV/AIDS or cancer, which might have been present for quite some time – and that danger may not strictly *require* immediate action, in the sense that the accused could simply go on suffering from those symptoms without fear that any further harm – such as death – might result from failing to alleviate the accused’s suffering through the use of cannabis.

### **Proportion/reasonableness**

#### *Common law*

The third element of necessity – “proportion” – means that the criminal act done to avoid threatened harm must not be disproportionate to the harm avoided. It forms the second part of the objective standard which Australian common law imposes in relation to necessity. The test is whether the accused’s response was reasonable, measured against the reaction of an ordinary person in his position.

In the context of the medical use of cannabis, the test should be satisfied if a reasonable person in the accused’s position – that is, suffering from the same symptoms which the accused sought to alleviate through the use of cannabis – would have considered that he or she had no alternative to using cannabis in order to avoid that suffering. Whether that test is satisfied is a question of fact to be determined in each individual case. Arbiters of fact may well conclude in some cases that a reasonable person in the accused’s position would have considered that he or she had alternatives to using cannabis in order to avoid the harm arising from the symptoms of a particular illness, such as when lawfully available drugs can alleviate those symptoms. But in other cases, it could be concluded that a reasonable person in the position of an accused for whom no lawfully available drugs are effective would consider that, in order to alleviate his or her suffering, he or she had no alternative to cannabis.

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<sup>61</sup> *Warnakulasuriya v The Queen* [2012] WASCA 10 at [49], [85]. See also *Ajayi v The Queen* [2012] WASCA 126 at [33]-[40]; Yeo, n 37 at 22-23.

<sup>62</sup> Model Criminal Code Officers Committee, Standing Committee of Attorneys-General, *Model Criminal Code Chapters 1 and 2: General Principles of Criminal Responsibility* (1992) p 69, quoted in *Warnakulasuriya v The Queen* [2012] WASCA 10 at [53].

<sup>63</sup> Explanatory Memorandum, *Criminal Code Bill 1994* (Cth) pp 30-31.

In considering these conclusions, it is important to remember that, as Gleeson CJ emphasised in *Rogers*, “[t]he relevant concept is of necessity, not expediency, or strong preference”.<sup>64</sup> His Honour continued:

If the [accused], or the jury, were free to consider and reject possible alternatives on the basis of value judgments different from those made by the law itself, then the rationale of the defence, and the condition of its acceptability as part of a coherent legal system, would be undermined ... [T]he accused must have been afforded no reasonable opportunity for an alternative course of action which did not involve a breach of the law.<sup>65</sup>

Thus, the defence of necessity cannot absolve an accused of criminal responsibility where the alternative to using cannabis is the use of other, less effective drugs, or equally effective drugs with more significant side effects. Given that some cannabis-derived drugs may be lawfully obtained in Australia by patients suffering from conditions for which natural cannabis has established therapeutic benefits, and that those drugs are generally as effective as natural cannabis and have similar side-effect profiles, the defence may be ruled out in most cases. But in some cases, evidence may show that an accused’s symptoms do not respond at all to treatment with lawfully available drugs, including cannabis-derived drugs. In those cases, the defence should be left to the jury.

### *Criminal Codes*

Similar tests of objectivity are imposed by the various statutory formulations of sudden or extraordinary emergency, all of which can be satisfied by factual circumstances involving necessitous medical use of cannabis.

The objective test laid down by s 25 of the *Criminal Code* (Qld) requires the defendant’s conduct to be viewed in light of how an ordinary person could reasonably be expected to act in the same circumstances; the emergency must be such that an ordinary person possessing ordinary powers of self-control could not reasonably be expected to act otherwise.<sup>66</sup> It is unclear whether the section encompasses situations involving a choice of “evils”, or whether it is restricted to cases where the accused has no choice at all like the defence of necessity at common law. O’Reagan argues “that the operation of s 25 is not so confined”.<sup>67</sup> Conversely, Yeo argues that the competing “no alternative” formulation “has more to commend itself for being a truer reflection of the theory of excuse”.<sup>68</sup> In any case, the defence could be made out where the evidence is such that a jury could conclude that an ordinary person possessing ordinary powers of self-control in the position of an accused who used cannabis to alleviate his or her suffering could not reasonably be expected to do otherwise.

Section 25 of the *Criminal Code* (WA) provides that reasonable grounds must have existed for the accused to hold two requisite subjective beliefs – that circumstances of sudden or extraordinary emergency existed, and that the conduct was a necessary response to the emergency – and requires that the accused’s conduct was an objectively reasonable response to the emergency in the circumstances he or she believed to exist. The argument that this alternative formulation of the objective standard is wide enough to encompass cases involving a choice of “evils” is stronger because it requires that the accused’s conduct was a reasonable response to the emergency, implying that there may have been other reasonable responses available to the accused. Accordingly, provided that the use of cannabis was a reasonable response to the emergency which the accused reasonably believed to exist, the defence should be available, regardless of whether other reasonable responses – such as the use of lawfully available drugs – were available in fact.

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<sup>64</sup> *R v Rogers* (1996) 86 A Crim R 542 at 546.

<sup>65</sup> *R v Rogers* (1996) 86 A Crim R 542 at 546.

<sup>66</sup> See, for example, *R v Webb* [1986] 2 Qd R 446 at 450, where it was held that the conduct of the accused in respect of an offence of dangerous driving has to be assessed by reference to what might have been expected by a “competent and careful driver” or a “competent and experienced driver”.

<sup>67</sup> O’Reagan R, “The Defence of Sudden or Extraordinary Emergency in the Griffith Code” (1985) 9 Crim LJ 347 at 352. See also *R v Pius Piane* [1975] PNGLR 52; *State v Ampfi* [1985] PNGLR 116.

<sup>68</sup> Yeo, n 37 at 34.



Section 10.3 of the *Criminal Code* (Cth), s 41 of the *Criminal Code* (ACT) and s 43BC of the *Criminal Code* (NT) impose a slightly different test. They require that the accused reasonably believed three things: that circumstances of sudden or extraordinary emergency existed; that committing the offence was the only reasonable way to deal with the emergency; and that the conduct was a reasonable response to the emergency. In order to raise the defence on the basis of necessitous medical use, therefore, the accused must believe that using cannabis was the only reasonable way to deal with the emergency, but the existence in fact of a reasonable alternative does not preclude the availability of the defence.

### Conclusion and further considerations

It can be seen that the defences of necessity and sudden or extraordinary emergency may be capable of applying to circumstances involving necessitous medical use of cannabis. For these reasons, an Australian court faced with a similar question to that which confronted the English Court of Appeal in *Quayle* may give a different answer; at the very least, it would be premature to definitively rule it out. There are some further points of distinction between the Australian situation and that of the United Kingdom which support this conclusion and warrant further consideration. Three are briefly canvassed here.

First, the disjointed legislative framework encompassing Australian drug laws is strikingly dissimilar to the unified, comprehensive approach to drug law in the United Kingdom. This is a function of their different makeups as national political entities. Australia comprises a federation of States and Territories – each with their own political and legislative agenda – drawn together by a federal government with limited, specified legislative powers, whereas the law-making power of the United Kingdom resides entirely in a single national legislature. As a result, unlike the *Misuse of Drugs Act 1971* (UK), the possession offences found in the Australian State and Territory Drug Acts do not form part of a single legislative scheme which “makes the most careful provision regarding the categorisation of drugs and the production, importation, possession, supply, prescription and use of such drugs for medical or other purposes”.<sup>69</sup> The Drug Acts exist solely to achieve prohibitive aims, while the regulation of medical use is left to the Commonwealth, and made binding in the States and Territories through enabling statutes which are (in many cases) entirely separate from the Drug Acts.

Secondly, a number of those State and Territory Drug Acts differ greatly from the *Misuse of Drugs Act 1971* (UK) in their respective formulations of the “possession” offence. The most conspicuous example is Queensland’s, which provides: “A person who *unlawfully* has possession of a dangerous drug is guilty of a crime.”<sup>70</sup> This stands in stark contrast to the equivalent section in the United Kingdom, which states: “Subject to any regulations under section 7 of this Act for the time being in force, *it shall not be lawful* for a person to have a controlled drug in his possession.”<sup>71</sup> The difference between the two provisions is readily apparent from the emphasised text: the Queensland provision does not prohibit possession of “dangerous drugs” absolutely, only “unlawful” possession, whereas the United Kingdom provision expressly declares that “it shall not be lawful” to possess “controlled drugs”, subject to certain, specified regulations made under s 7 of the same Act. Importantly, these include the Secretary of State’s powers to enable doctors to have, prescribe and supply controlled drugs under s 7(3), or exclude the operation of s 7(3) in relation to a drug “if of the opinion that it is in the public interest that its production, supply and possession should be wholly or partly unlawful or unlawful except for ... research or other special purposes” under s 7(4).<sup>72</sup> As the court in *Quayle* observed, the power under s 7(4) has been exercised in relation to cannabis,<sup>73</sup> providing the basis for its conclusion that, although “[n]o legislative step has been taken to remove or

<sup>69</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [54].

<sup>70</sup> *Drugs Misuse Act 1986* (Qld), s 9 (emphasis added).

<sup>71</sup> *Misuse of Drugs Act 1971* (UK), s 5(1) (emphasis added).

<sup>72</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [54], citing *Misuse of Drugs Act 1971* (UK), ss 7(3), (4).

<sup>73</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [54], citing *Misuse of Drugs Regulations 2001* (UK); *Misuse of Drugs (Designation) Order 2001* (UK).

prevent any [defence of ‘medical necessity’] the existence of a potential common law defence [cannot] be regarded as settled ... or as clear in any way which could mean that the policy and scheme of the legislation ... should be viewed as having been conceived, implemented or continued on the basis that such a defence would be potentially available.”<sup>74</sup>

“[T]he policy and scheme of the legislation” in Australia is entirely different, and must be considered on a State-by-State, Territory-by-Territory basis. In Queensland especially, any appeal to *Quayle*-like “general objections”<sup>75</sup> to the availability of defences based on necessitous medical use of cannabis arising from supposed incompatibility with “the policy and scheme of the legislation” is weakened by the use of the word “unlawfully” in the section which prohibits cannabis possession. To adapt Menhennitt J’s reasoning in *R v Davidson* [1969] VR 667, the use of the word “unlawfully” in that section implies that, in certain circumstances, the possession of cannabis may be lawful.<sup>76</sup> Unlike the provision which his Honour considered in that case, “unlawfully” is defined under Queensland’s Drug Act, where it is explained to mean “without authorisation, justification or excuse by law”.<sup>77</sup> This definition reveals that the legislature contemplated that possession of dangerous drugs – including cannabis – could be made lawful in any one of three ways: through authorisation, justification or excuse by law. Authorisation is provided through positive enactments, such as the authorisation to possess dangerous drugs on a doctor’s prescription provided through the *Health (Drugs and Poisons) Regulation 1996* (Qld) and its interaction with the Commonwealth TG Act. No such authorisation applies to cannabis. That leaves two other avenues for lawful possession of cannabis in Parliament’s express contemplation: “justification or excuse by law.” The availability of a defence like sudden or extraordinary emergency seems to be exactly what Parliament had in mind in choosing those words. It provides, by law,<sup>78</sup> an excuse from criminal responsibility for an act which is prima facie criminal.<sup>79</sup> The “policy and scheme of the legislation” in Queensland *should*, therefore, “be viewed as having been conceived, implemented [and] continued on the basis that such a defence would be potentially available”.<sup>80</sup>

Thirdly, although the court in *Quayle* considered – and rejected – the argument that “it is incumbent on the common law to interpret or expand the defence [of necessity] to cover such situations [of necessitous medical use of cannabis]”<sup>81</sup> on the basis of the “human right” to “respect for private and family life”,<sup>82</sup> courts in the two Australian jurisdictions which have enacted a human rights “Charter” or Act (Victoria and the Australian Capital Territory) must consider different rights drawn from a different treaty,<sup>83</sup> and may well arrive at a different conclusion should they be faced with a similar argument from a medical cannabis user. Unlike the *Human Rights Act 1988* (UK), the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT) explicitly require courts “to pay heed to international developments and precedents in human rights in

<sup>74</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [58].

<sup>75</sup> To adopt the phrase which Mance LJ employed to describe the court’s reasoning at [54]-[58] of its judgment in *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642.

<sup>76</sup> *R v Davidson* [1969] VR 667 at 668.

<sup>77</sup> *Drugs Misuse Act 1986* (Qld), s 4 (definition of “unlawfully”).

<sup>78</sup> In the form of *Criminal Code* (Qld), s 25.

<sup>79</sup> See n 32 and accompanying text.

<sup>80</sup> Compare *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [58].

<sup>81</sup> *Quayle v The Queen; Attorney-General’s Reference (No 2 of 2004)* [2005] 1 WLR 3642 at [59].

<sup>82</sup> *Convention for the Protection of Human Rights and Fundamental Freedoms*, signed 4 November 1950, CETS No 5 (entered into force 3 September 1953), Art 8; *Human Rights Act 1988* (UK).

<sup>83</sup> The human rights enumerated in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT) are “largely derived” from the rights guaranteed under the *International Covenant on Civil and Political Rights*, signed 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976): see Bogdanoski T, “A Dose of Human Rights: An Antidote to the Criminal Prohibition of Cannabis for Medical Use?” (2009) 33 *Crim LJ* 251 at 258-259.

interpreting domestic law”.<sup>84</sup> It would therefore “seem that non-Australian judgments relating to Charter rights are to be given more weight by courts than has previously been the case”.<sup>85</sup> Accordingly, Bogdanoski argues, “it is conceivable for the Canadian judgments ... to be referred to by ACT and Victorian courts if they are ever asked to consider whether existing criminal drug laws in their jurisdictions infringe the human rights of medical users of the cannabis, since they do not accommodate the medical use of cannabis”.<sup>86</sup>

The Victorian Charter and ACT Act both require that all statutory provisions “must be interpreted in a way that is compatible with human rights”.<sup>87</sup> As a result, a Victorian or an ACT court faced with an argument that the prohibition of cannabis possession under their respective Drug Act must be interpreted in a way that is compatible with the right to “protection from torture and cruel, inhuman or degrading treatment”<sup>88</sup> might, for example, refer to the Canadian judgment in *Hitzig v The Queen* (2003) 177 CCC (3d) 449, in which it was said: “requiring law-abiding citizens who are seriously ill to go to the black market to fill an acknowledged medical need is a dehumanizing and humiliating experience.”<sup>89</sup> This might then lead the court to conclude that, unless the relevant provision is interpreted as containing a “medical necessity” exemption, it would be incompatible with human rights. Whether any court outside Canada is likely to do so, and the extent of its powers in the event that it did, is another question entirely.<sup>90</sup>

Finally, it should be noted that, in the ACT context, the requirement to interpret Territory laws in a way that is compatible with human rights would also extend to its statutory defence of sudden or extraordinary emergency.<sup>91</sup> Accordingly, should an ACT court be persuaded that one or more of the rights enumerated in the ACT Act requires provision to be made for medical use of cannabis, an argument that the defence of sudden or extraordinary emergency should be interpreted so as to encompass situations involving such necessitous medical use would likely be considered more convincing.

## AVENUES FOR REFORM

This part examines medical cannabis regimes in selected overseas jurisdictions. It is divided into three sections according to the basic structure of the models provided: the “prescription model” of the Netherlands, the “statutory exemption model” of Canada and some States of the United States, and the “defence model” of other States in the United States, where a defence of “medical necessity” applying to medical use of cannabis is recognised along with, or instead of, any statutory medical cannabis regime.

### Prescription model: The Netherlands

The Dutch *Opium Act* was amended in September 2003, allowing Dutch pharmacies to provide cannabis legally to patients on a doctor’s prescription.<sup>92</sup> Four types of medical cannabis (Bedrobinol, Bedrocan, Bediol and Bedica, each with standardised THC and cannabidiol contents) are available, in

<sup>84</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 32(2); *Human Rights Act 2004* (ACT), s 31; Bogdanoski, n 83 at 259, citing Allan J, “The Victorian Charter of Human Rights and Responsibilities: Exegesis and Criticism” (2006) 30(3) *Melbourne University Law Review* 906 at 912.

<sup>85</sup> Bagaric M and Faris P, “The Impact of the Victorian Human Rights Charter on Criminal Proceedings” (2007) 31 *Crim LJ* 5 at 10.

<sup>86</sup> Bogdanoski, n 83 at 259.

<sup>87</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 32(1); *Human Rights Act 2004* (ACT), s 30.

<sup>88</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 10; *Human Rights Act 2004* (ACT), s 10.

<sup>89</sup> *Hitzig v The Queen* (2003) 177 CCC (3d) 449 at [22].

<sup>90</sup> Bogdanoski is doubtful, referring to the rejection of a similar argument in *R v Altham* [2006] 1 WLR 3287; Bogdanoski, n 83 at 262.

<sup>91</sup> *Human Rights Act 2004* (ACT), s 30; compare *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 132(1), which refers only to the interpretation of “statutory provisions”. As Victoria is a common law jurisdiction, s 32(1) does not apply to the interpretation of the defence of necessity.

<sup>92</sup> Irvine, n 22, p 93.

the form of dried flower tips from female cannabis plants.<sup>93</sup> The Dutch regime leaves it “up to doctors to determine which conditions would benefit from treatment with medicinal cannabis, and the circumstances under which that would be right for the patient”.<sup>94</sup> They are not limited to any specific conditions in doing so. Essentially, this is no different to the scheme used in Australia for the majority of pharmaceutical drugs, including some cannabis-derived drugs in Sch 8 of the *Poisons Standard*.

Dutch doctors mostly supported the prescription-based medical cannabis scheme in 2003, but there were concerns that legalising the medical use of cannabis would lead to increased recreational use.<sup>95</sup> A study of 200 patients filling prescriptions for cannabis between September 2003 and January 2004 found that the majority suffered from MS- or spinal cord injury-induced spasticity, and more than half had used cannabis before medical use was legalised, suggesting that most medical cannabis users were not new users but instead had previously self-medicated.<sup>96</sup> It was also found that more than 80 per cent continued to obtain cannabis from illegal sources, mainly because it was cheaper.<sup>97</sup> The preference for illegally obtained cannabis must also be seen in light of the Netherlands’ lenient approach to cannabis offences, whereby cannabis remains illegal but tolerated. In this context, some raised fears for the future of the Dutch medical cannabis scheme. Nevertheless, cannabis was dispensed more than 40,000 times to about 6,000 different patients between 2003 and 2010, and the number of patients using cannabis for medical purposes has steadily increased, growing from about 850 in 2006, to more than 1,300 in 2010.<sup>98</sup> Despite increasing medical use of cannabis, overall cannabis use in the Netherlands remains stable.<sup>99</sup> A 2013 study into the prevalence and incidence of prescription cannabis use in the Netherlands identified 5,540 patients using cannabis on a doctor’s prescription.<sup>100</sup> After an initial incidence of about 1,000 new users a year in the first two years of the Dutch medical cannabis scheme, the number of new users stabilised at around 500 per year from 2005-2010.<sup>101</sup> The number of prescription cannabis patients ranged from 800 to 1,300 a year, “which translates into a yearly prevalence rate of 5-8 per 100,000 persons”.<sup>102</sup>

## Statutory exemption model

### Canada

The Canadian medical cannabis regulations were established in 2001 after the Ontario Court of Appeal held in *R v Parker* (2000) 49 OR (3d) 481 that the prohibition on the cultivation and possession of cannabis under the *Controlled Drugs and Substances Act*, SC 1996, c 19 (CDSA) was unconstitutional because it did not provide an acceptable exemption for medical use.<sup>103</sup> The government responded with the *Marihuana Medical Access Regulations*, SOR/2001-227 (MMAR), which aimed to preserve

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<sup>93</sup> Office of Medicinal Cannabis, *Cannabis Bureau*, <http://www.cannabisbureau.nl/en/MedicinalCannabis> viewed 8 June 2014.

<sup>94</sup> Office of Medicinal Cannabis, 92.

<sup>95</sup> Irvine, n 22, p 95; AIDS Council of South Australia, *The Medicinal Use of Marijuana: The History, Therapeutic Potential and Legal Landscape in South Australia* (2010) p 17.

<sup>96</sup> Janes A et al, *Summary of the PHARMO Report: Medicinal Cannabis in the Netherlands* (Pharmo Institute, Netherlands, 2004) pp 2-5.

<sup>97</sup> Janes et al, n 96.

<sup>98</sup> Farma Actueel, *Gebruik Medicinale Cannabis Neemt Toe*, <http://www.farmaactueel.nl/nieuws/19-05-2011/1277/gebruik-medicinale-cannabis-neemt-toe> viewed 20 May 2014.

<sup>99</sup> Farma Actueel, n 98.

<sup>100</sup> Hazekamp A and Heerdink ER, “The Prevalence and Incidence of Medicinal Cannabis on Prescription in The Netherlands” 69 *European Journal of Clinical Pharmacology* 1575.

<sup>101</sup> Hazekamp and Heerdink, n 100 at 1577.

<sup>102</sup> Hazekamp and Heerdink, n 100 at 1577.

<sup>103</sup> Irvine, n 22, p 95; AIDS Council of South Australia, n 95, p 17.

the constitutional validity of the CDSA's cannabis prohibitions by providing a channel for statutory exemption from criminal prosecution for patients who obtain an "authorization to possess" on application to the Minister of Health.<sup>104</sup>

Under the MMAR, applications to the Minister were required to contain a declaration from the applicant and a medical declaration made by the medical practitioner treating the applicant. Applicant declarations needed to – among other things – indicate "that the applicant has discussed the potential benefits and risks of using marihuana with the medical practitioner providing the medical declaration".<sup>105</sup> The requirements of the medical practitioner's declaration included stating "the applicant's medical condition, the symptom that [was] associated with that condition or its treatment", "the maximum quantity of dried marihuana to be authorized, the daily amount of dried marihuana, in grams, and the form and route of administration that the applicant intend[ed] to use" and "that conventional treatments for the symptom [had] been tried or considered and [had] been found to be ineffective or medically inappropriate for the treatment of the applicant".<sup>106</sup> If the requirements were met, the Minister was to "issue to the applicant an authorization to possess for the medical purpose mentioned in the application", unless the applicant was not Canadian or "any information or other item included in the application [was] false or misleading".<sup>107</sup>

Since its introduction in 2001, the scheme put in place by the MMAR was administered through Health Canada's Marihuana Medical Access Program (MMAP), allowing three avenues for patients to obtain a legal supply of cannabis for medical purposes: Health Canada's supply of dried cannabis, personal production by the applicant, or production by a designated person. As of 31 December 2012, 28,115 people held an "authorization to possess", of whom 18,063 also held a "personal-use production licence".<sup>108</sup> Just 5,283 people had indicated that they would access medical cannabis through Health Canada's supply.<sup>109</sup>

That has all changed with the passage of the *Marihuana for Medical Purposes Regulations*, SOR/2013-199 (MMPR), which came into force in June 2013. The new Regulations were introduced because "the Government of Canada was concerned that the Marihuana Medical Access Program ... was open to abuse".<sup>110</sup> The MMPR responds to that concern by removing the option for patients to produce their own cannabis and placing responsibility for production and supply in the hands of licensed commercial producers:

The [new] regulations aim to treat marihuana as much as possible like any other narcotic used for medical purposes by creating conditions for a new, commercial industry that is responsible for its production and distribution. The regulations will provide access to quality-controlled marihuana for medical purposes, produced under secure and sanitary conditions, to those Canadians who need it, while strengthening the safety of Canadian communities. In addition, the new regulations will also provide more choices of marihuana strains and commercial suppliers.<sup>111</sup>

Since 1 October 2013, no new applications for personal or designated person production licences have been accepted by Health Canada. Personal and designated person production was to end on 31 March 2014 with the expiry of all personal-use and designated-person production licences, but as a result of "ongoing litigation and uncertainty arising from court decisions, Health Canada will treat ... [certain] Authorizations to Possess, Personal-Use Production Licences, and Designated-Person

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<sup>104</sup> *Marihuana Medical Access Regulations*, SOR/2001-227 (CAN), regs 4, 11.

<sup>105</sup> *Marihuana Medical Access Regulations*, SOR/2001-227 (CAN), regs 5, 6.

<sup>106</sup> *Marihuana Medical Access Regulations*, SOR/2001-227 (CAN), regs 6.

<sup>107</sup> *Marihuana Medical Access Regulations*, SOR/2001-227 (CAN), regs 11, 12.

<sup>108</sup> Health Canada, *Marihuana Medical Access Program Statistics* (24 January 2013), <http://www.hc-sc.gc.ca/dhp-mps/marihuana/stat/index-eng.php#a12> viewed 20 May 2014.

<sup>109</sup> Health Canada, n 108.

<sup>110</sup> Health Canada, *Backgrounder: Marihuana for Medical Purposes Regulations* (10 June 2013), <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2013/2013-79bk-eng.php> viewed 20 May 2014.

<sup>111</sup> Health Canada, n 110.



Production Licences as extending beyond March 31, 2014 until a decision in *Allard* is rendered”.<sup>112</sup> Other than for those covered by the injunction granted in *Allard v The Queen* [2014] FC 280, these avenues of supply have been replaced by regulated, commercial “licensed producers”. Health Canada continued to provide its own supply of dried cannabis (for a time), but the clear intention was to place primary responsibility for production and supply with private industry, much like the current approach to other pharmaceutical drugs:

Under the new regime, Licensed Producers will set the price for marihuana for medical purposes. Once the first established Licensed Producers have set a price for dried marihuana, Health Canada will align the price of its supply with the market price so as not to undermine the creation of this new industry.<sup>113</sup>

Government-led production and supply ceased entirely on 1 April 2014, and from that point on, the only lawful source of medical cannabis is through “licensed producers”.<sup>114</sup> These new entities must satisfy the requirements set out in regs 21-26 of the MMPR including – among other things – that the individual applicant or, in the case of a corporation applicant, “the senior person in charge”, be “familiar with the provisions of the Act and its regulations and the *Food and Drugs Act*” and that the applicant provide to the Minister “a detailed description of the security measures at the proposed [production] site”, “a detailed description of the method that the applicant proposes to use for keeping records”, and submit to stringent identification, security and background checks for all persons proposed to be involved in production and supply. By 30 September 2013, more than 150 “persons” – mostly corporations – had applied for licensed producer status.<sup>115</sup> The first two such licences were issued earlier that week: to CanniMed Ltd and its subsidiary, Prairie Plant Systems Inc.<sup>116</sup> As at 22 April 2014, Health Canada listed 13 authorised licensed producers on its website but that number is likely to grow.<sup>117</sup>

The application process for patients remains largely the same as under the previous MMAR, requiring the prospective medical cannabis patient to consult with a doctor. The new MPPR no longer speaks in terms of “authorizations to possess”, however (the new scheme centres around what are known as “medical documents”), and applications no longer need to be made to the Minister; once a doctor has given a patient a standard form “medical document”, that document then acts in a similar fashion to a typical prescription, allowing the patient to access the specified strain and quantity from a licenced producer (not pharmacist)<sup>118</sup> of his or her choice.<sup>119</sup> There are also no longer any restrictions on the conditions for which a doctor can support the medical use of cannabis before providing a patient with a “medical document”, and less information is required.<sup>120</sup> Although Health Canada maintains that “[c]annabis is not an approved therapeutic product”, it now publishes its own

<sup>112</sup> Health Canada, n 110; Health Canada, *Statement: Medical Marihuana Access Regulations Update* (28 March 2014), <http://www.hc-sc.gc.ca/dhp-mps/marihuana/access-access-eng.php> viewed 8 June 2014. The “uncertainty” arises from an interlocutory injunction granted on 21 March 2014 by Mason J in *Allard v The Queen* [2014] FC 280.

<sup>113</sup> Health Canada, n 110.

<sup>114</sup> Health Canada, *Transitioning to a New Regime of Licensed Producers* (20 June 2013), <http://www.hc-sc.gc.ca/dhp-mps/marihuana/transition/index-eng.php> viewed 20 May 2014

<sup>115</sup> The Canadian Press, “Medical Marijuana Free Market to Open in Canada”, *CBC Hamilton* (online) (30 September 2013), <http://www.cbc.ca/news/canada/hamilton/news/medical-marijuana-free-market-to-open-in-canada-1.1873089> viewed 20 May 2014.

<sup>116</sup> Graham J, “Medical Marijuana in Canada: Ottawa Awards First Licenses”, *Huffington Post Canada* (online) (23 September 2013), [http://www.huffingtonpost.ca/2013/09/23/medical-marijuana-canada-licenses- n\\_3975909.html](http://www.huffingtonpost.ca/2013/09/23/medical-marijuana-canada-licenses- n_3975909.html) viewed 20 May 2014.

<sup>117</sup> Health Canada, *List of Authorised Licensed Producers under the Marihuana for Medical Purposes Regulations* (22 April 2014), <http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/list-eng.php> viewed 20 May 2014.

<sup>118</sup> In response to objections raised by the Canadian Pharmacists’ Association, the *Marihuana for Medical Purposes Regulations* neither requires nor allows pharmacists to dispense medical cannabis: Canadian Pharmacists’ Association, *New Medical Marijuana Rules Welcome: CPhA* (10 June 2013), <http://www.pharmacists.ca/index.cfm/news-events/news/new-medical-marijuana-rules-welcome-cpha> viewed 20 May 2014.

<sup>119</sup> *Marihuana for Medical Purposes Regulations*, SOR/2013-199 (CAN), regs 108, 129.

<sup>120</sup> *Marihuana for Medical Purposes Regulations*, SOR/2013-199 (CAN), reg 129; compare *Marihuana Medical Access Regulations*, SOR/2001-227 (CAN), regs 5, 6.

“summary of peer-review literature and international news concerning potential therapeutic uses and harmful effects of cannabis ... and cannabinoids” in order “[t]o help health care practitioners”.<sup>121</sup> This appears to be an attempt to allay practitioners’ earlier fears of “reprisal” for prescribing cannabis to their patients.<sup>122</sup>

Whether the MMPR’s emphasis on commercial production and supply will reduce non-medical use of medically-supplied cannabis remains to be seen. What is clear is that the business of medical cannabis is big: revenue from the new industry is expected to reach \$1.3 billion a year by 2024.<sup>123</sup> And, curiously, whatever concerns over cannabis’ therapeutic worth which private industry might have had when patients were able to grow their own appear to have gone up in smoke now that personal production has been banned and the government has announced its intention to leave the game: among the hundreds of applicants eagerly seeking authorisation to produce and supply medical cannabis, pharmaceutical companies (rather than individuals) predominate.

### ***The United States: California***

Twenty-two American States (and the District of Columbia) have enacted laws removing criminal penalties for medical use of cannabis in some way.<sup>124</sup> This section focuses on the Californian medical cannabis regime because it has the most registered users, is the subject of a number of high-profile United States Supreme Court decisions, and is the most widely known of the American medical cannabis regimes.

California’s Medical Marijuana Program (MMP) was established by the *Compassionate Use Act of 1996*, Cal HSC § 11362.5 (Proposition 215). Proposition 215 provides legal protection to patients who have obtained a doctor’s recommendation to use cannabis for medical purposes, by preventing them from being prosecuted for that use.<sup>125</sup> Senate Bill 420 (SB 420) was passed in 2003 to extend and clarify Proposition 215, requiring the California Department of Health (CDPH) to create the MMP as the State agency responsible for developing and maintaining an online registry and verification for “Medical Marijuana Identification cards” (MMICs), which identify patients exempt from prosecution for cannabis possession. SB 420 also clarified that doctors and caregivers who assist qualified patients are protected under Proposition 215.<sup>126</sup>

In order to qualify for the protections afforded by Proposition 215 and SB 420 and obtain an MMIC, patients must be diagnosed with a “serious medical condition”, which is defined as any of the following: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms including but not limited to those associated with MS, seizures including but not limited to those associated with epilepsy, severe nausea, or any other chronic or persistent medical

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<sup>121</sup> Controlled Substances and Tobacco Directorate, Health Canada, *Information for Health Care Professionals: Cannabis (Marihuana, Marijuana) and the Cannabinoids* (Health Canada, 2013).

<sup>122</sup> See *R v Mernagh* [2011] ONSC 2121 at [212]. Many Canadian doctors objected to the role imposed on them by the *Marihuana Medical Access Regulations*. The Canadian Medical Association (CMA) voiced “strong concerns about the ... regulations ... stating that physicians should not be gatekeepers for a proposed medical intervention that had not undergone established regulatory review processes as required for all other prescription medicines”: CMA, *CMA Policy: Medical Marijuana* (4 December 2010), <http://policybase.cma.ca/dbtw-wpd/Policy/pdf/PD11-02.pdf> viewed 20 May 2014. The CMA maintained these concerns in its response to then-draft form *Marihuana for Medical Purposes Regulations*, describing the regulatory proposals as “equivalent to asking doctors to prescribe while blindfolded”: CMA, *CMA Response: Health Canada’s Medical Marihuana Regulatory Proposal* (28 February 2013), pp 3-4, [http://www.cma.ca/multimedia/CMA/Content/Images/Inside\\_cma/Submissions/2013/Proposed-Medical-Marihuana-Regulations\\_en.pdf](http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Submissions/2013/Proposed-Medical-Marihuana-Regulations_en.pdf) viewed 20 May 2014.

<sup>123</sup> Beeby D, “Birth of a Billion-dollar Medical Marijuana Industry in Canada”, *Global News* (online) (29 September 2013), <http://globalnews.ca/news/870996/birth-of-a-billion-dollar-marijuana-industry> viewed 20 May 2014.

<sup>124</sup> These are Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington: Marijuana Policy Project, n 24, p 3; Eddy M, *Medical Marijuana: Review and Analysis of Federal and State Policies* (Congressional Research Service, 2010) p 18; ProCon, “22 Legal Medical Marijuana States and DC”, *Medical Marijuana*, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881#summary> viewed 8 June 2014.

<sup>125</sup> Marijuana Policy Project, n 24, p F23.

<sup>126</sup> Marijuana Policy Project, n 24, p F23.

symptom that either substantially limits the patient’s ability to conduct “major life activities” or may cause serious harm to the patient’s safety or physical or mental health if not alleviated.<sup>127</sup>

Since its inception, the MMP has been accused of vulnerability to “abuse”, largely due to the apparent readiness of Californian doctors to provide patients with recommendations.<sup>128</sup> This readiness appears to stem from the lack of any requirement to include copies of medical records in applying for an MMIC. All that is required is a standard form signed by a doctor stating in writing that the patient has a serious medical condition.<sup>129</sup> In the absence of any medical documentation requirements, almost 74,000 MMICs had been issued by 15 March 2014.<sup>130</sup> Even accounting for population differences, this is disproportionately more than the roughly 6,000 registered Dutch medical cannabis users or 30,000 Canadians. It is likely that many MMIC-holders are actually using cannabis recreationally.

## Defence model

Although the United States Supreme Court has ruled that there is no medical necessity defence under federal law (at least for the time being),<sup>131</sup> a number of State courts have allowed medical necessity to absolve cannabis users of criminal responsibility under State law.<sup>132</sup> Medical necessity has been successfully raised by defendants in respect of cannabis possession offences in Florida,<sup>133</sup> Hawaii,<sup>134</sup> Idaho,<sup>135</sup> Washington<sup>136</sup> and Washington DC.<sup>137</sup> The defence has been refused in Alabama,<sup>138</sup> Georgia,<sup>139</sup> Massachusetts,<sup>140</sup> Minnesota,<sup>141</sup> Missouri,<sup>142</sup> New Jersey,<sup>143</sup> South Dakota<sup>144</sup> and Virginia.<sup>145</sup>

Mathre explains the failure of most American medical necessity cannabis cases by arguing that generally the defence has been struck out where the patient had not tried all legal avenues to obtain medical cannabis.<sup>146</sup> She also points to practical issues in raising the defence, such as the importance of medical and scientific witnesses and the court’s perception of the defendant as an otherwise

<sup>127</sup> *Compassionate Use Act of 1996*, Cal HSC § 11362.7

<sup>128</sup> See generally Lamb J, “Examining the Impact of California’s Medical Marijuana Program on Public Health” (Thesis, Claremont McKenna College, 2010).

<sup>129</sup> California Department of Public Health, *Medical Marijuana Program*, <http://www.cdph.ca.gov/programs/MMP/Pages/MMPFAQ.aspx#5> viewed 20 May 2014.

<sup>130</sup> California Department of Public Health, *Medical Marijuana Program Facts and Figures* (15 March 2014), <http://www.cdph.ca.gov/programs/MMP/Documents/MMP%20Fact%20and%20Figures%204-13-14.pdf> viewed 20 May 2014.

<sup>131</sup> *United States v Oakland Cannabis Buyers’ Cooperative* 532 US 483 (2001); *Gonzales v Raich* 545 US 1 (2005).

<sup>132</sup> Other States have special legislative provisions securing the availability of medical necessity as a defence to cannabis offences or providing a separate “affirmative” defence to cannabis charges in addition to the statutory exemption provided under the State’s medical cannabis regime.

<sup>133</sup> *State v Mussika* 14 FLW 1 (1988); *Jenks v State* 582 So 2d 676 (1991); *Sowell v State* 738 So 2d 333 (1998).

<sup>134</sup> *State v Bachman* 595 P 2d 287 (1979).

<sup>135</sup> *State v Tadlock* 34 P 3d 1096 (2001).

<sup>136</sup> *State v Diana* 604 P 2d 1312 (1979); *State v Cole* 874 P 2d 878 (1994).

<sup>137</sup> *United States v Randall* 104 Wash Daily L Rep 2249 (1976).

<sup>138</sup> *Kauffman v Alabama* 620 So 2d 90 (1993).

<sup>139</sup> *Spillers v Georgia* 245 SE 2d 54 at 55 (1978).

<sup>140</sup> *Massachusetts v Hutchins* 575 NE 2d 741 at 742 (1991).

<sup>141</sup> *Minnesota v Hanson* 468 NW 2d 77 at 78 (1991).

<sup>142</sup> *Missouri v Cox* 248 SW 3d 1 (2008).

<sup>143</sup> *New Jersey v Tate* 505 A 2d 941 (1986).

<sup>144</sup> *South Dakota v Ducheneaux* SD 131 (2003).

<sup>145</sup> *Murphy v Com* 31 Va App 70; 521 SE 2d 301 (1999).

<sup>146</sup> Mathre ML, *Cannabis in Medical Practice: A Legal, Historical and Pharmacological Overview of the Therapeutic Use of Marijuana* (McFarlane & Co, Jefferson, 1997) p 29, cited in Irvine, n 22, pp 216-217.

law-abiding citizen, and notes that defending the possession of large quantities of cannabis is difficult even if the defendant objectively needs such a quantity.<sup>147</sup>

More cynically, Bogdanoski argues:

the decisions in these cases often hinged upon the personal biases of the judges hearing the matters rather than on the authenticity of the 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.<sup>148</sup>

Where the defence has succeeded, it has generally been expressed as comprising three elements. In *State of Washington v Diana* 604 P 2d 1312 (1979), for example, adapting the general principles of necessity to the circumstances of an MS sufferer who argued that his use of cannabis was a medical necessity, the Washington Court of Appeals held that his conviction should be set aside if the evidence showed:

- (1) he reasonably believed his use of marijuana was necessary to minimise the effects of MS;
- (2) the benefits from its use are greater than the harm sought to be prevented by the controlled substances law; and
- (3) no drug is as effective in minimising the effects of the disease.<sup>149</sup>

The existence of a medical necessity defence applicable to cannabis charges in some American States may afford a degree of protection to medical cannabis users and is of significant academic interest. Realistically, however, the 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>150</sup> They do not prevent arrest or prosecution, and must be proven in each individual case at trial.

## CONCLUSIONS

The review of evidence for medical uses of cannabis, the analysis of criminal defences based on necessity under current Australian law, and the examination of alternative models for regulation of medical cannabis above, lead to three corresponding conclusions.

First, cannabis does have legitimate medical uses. These include the well-established therapeutic benefit of THC in alleviating nausea in cancer and HIV/AIDS patients. The TGA implicitly recognises this by including dronabinol and nabilone in Sch 8 of the *Poisons Standard*. There is also growing evidence supporting the claim that the composition of cannabinoids found in natural cannabis may provide a greater therapeutic benefit than dronabinol or nabilone in some cases, a fact the TGA implicitly recognised in 2010 when it added nabiximols to Sch 8.

While there may be concerns about the harmful effects associated with certain means of administering natural cannabis, those concerns are not so insurmountable as to warrant excluding cannabis from availability as a therapeutic good entirely. Although smoking natural cannabis is harmful, other routes of administration are available. Vapourisation, for example, achieves the rapid onset of action desired from smoking without exposing patients to the harmful by-products of combustion.<sup>151</sup> This is the route of administration advised under the Dutch and Canadian schemes

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<sup>147</sup> Mathre, n 146, p 29.

<sup>148</sup> Bogdanoski T, “Accommodating the Medical Use of Marijuana: Surveying the Differing Legal Approaches in Australia, the United States and Canada” (2010) 17 JLM 508 at 523.

<sup>149</sup> *State of Washington v Diana* 604 P 2d 1312 (1979); 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 86.

<sup>150</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>151</sup> Abrams DI et al, “Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study” (2007) 82 *Clinical Pharmacology & Therapeutics* 572, cited in Controlled Substances and Tobacco Directorate, n 121, pp 17-18.

and,<sup>152</sup> in all likelihood, would be the route of administration recommended by most Australian doctors who determine that particular conditions or patients require a more rapid onset of action than that which can be achieved through oral ingestion of tablets or an orcomucosal spray.

The TGA’s continuing reluctance to reschedule cannabis from Sch 9 lacks justification. Since it already recognises the legitimate medical use of cannabinoids by including cannabis-derived drugs in Sch 8, it would not compromise principle to do the same for cannabis itself. The argument that it presents an unacceptable risk of abuse does not withstand scrutiny in light of the permitted medical use of other, more dangerous “drugs of abuse” such as dexamphetamine and methylphenidate, and it cannot be argued legitimately that all drugs which have abuse potential should be totally impermissible. If that were the case, none of the opiates commonly used in the treatment of pain would be available. Nor can it be said that the availability of certain preparations of a drug with low abuse potential (like nabiximols) should preclude the availability of other, more abuse-prone drugs of that type (like cannabis). If that were so, strong opiate painkillers with high abuse potential, like oxycodone, would not be available for use when less powerful (and less euphoric) opiates such as codeine prove ineffective. If doctors can be trusted to prescribe drugs like these responsibly, there is no reason to assume that they could not do the same for cannabis. Equally, if patients can be trusted to take those drugs in the manner prescribed, there is no reason to assume they could not do the same when prescribed cannabis.

Secondly, there may be scope within existing Australian drug laws for defences against cannabis charges on the basis of necessitous medical use. Australian courts have taken a much less restrictive approach to the defence of necessity than have English courts. This becomes clear when the reasoning with respect to the three “specific requirements” of the defence referred to in *Quayle* is compared with Australian authorities on the three elements in *Loughnan*. Two of the three specific requirements which prevented the defence from succeeding in *Quayle* – the need for extraneous circumstances and the need for danger of physical injury – do not exist under Australian common law. The third requirement – the need for imminence and immediacy – might be seen as equivalent to the element of “imminent peril” in *Loughnan*, but in light of more recent authorities, should be regarded as a factual consideration rather than a strict legal requirement. Moreover, none of the requirements referred to in *Quayle* are contained in any of the various statutory formulations of the “sudden or extraordinary emergency” defence available in the Code jurisdictions (although in Queensland, judicial interpretation has arguably imported the “element” of immediacy referred to in common law authorities).

These defences may provide some legal protection to medical cannabis users in Australia, but have yet to be argued successfully before a court. In any event, the best they can provide is a shield against criminal punishment in individual cases, and the evidentiary burden of raising them falls to the accused in each case. Australian drug law should therefore be reformed to better accommodate medical use of cannabis by providing statutory authorisation.

Thirdly, the models provided by overseas medical cannabis regimes all have their flaws, but an imperfect model allowing the medical use of cannabis in at least some cases is still better than prohibiting its use outright. Currently, with cannabis in Sch 9, a doctor who determines that cannabis is the best treatment for a patient is unable to prescribe it. That needs to change.

Reform could be achieved in any number of ways. The States and Territories could each individually legislate to allow the medical use of cannabis by providing a statutory exemption from arrest and prosecution for the medical use of cannabis within their own respective jurisdictions, as has been the trend in the United States, or by amending their respective Drug Acts so as to provide a

<sup>152</sup> Office for Medical Cannabis, *Medical Cannabis – Patients’ Guide* (February 2011) pp 6-9, [http://www.cannabisbureau.nl/en/doc/pdf/5089-A5-BMC-Pat-ENG-web\\_35842.pdf](http://www.cannabisbureau.nl/en/doc/pdf/5089-A5-BMC-Pat-ENG-web_35842.pdf) viewed 20 May 2014; Health Canada, *Frequently Asked Questions – For Health Care Professionals* (19 June 2013), <http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/faq-eng.php#a3> viewed 20 May 2014.



complete defence to cannabis possession offences for medical users, as was recently recommended in the context of New South Wales by a cross-party parliamentary committee.<sup>153</sup>

While a State- or Territory-level statutory exemption system modelled on the Californian example could be modified to avoid abuse by non-medical users of the kind which has characterised the MMP, unless it is accompanied by similar exemption at the Commonwealth level, it is likely to place patients in a state of legal limbo similar to that created by the disparity between Californian and federal law in the United States, and create the same problems in terms of lawful supply. Similarly, it is probable that Australian doctors would, like their Canadian counterparts, “fear reprisal” for prescribing cannabis while the nation’s pharmaceutical regulator continues to deny its medical worth. A statutory defence specific to medical cannabis would provide greater assurance to patients than leaving them to rely on the common law defence of necessity or the statutory defence of sudden or extraordinary emergency, but it would still provide little more than a shield against criminal punishment, and leave patients open to the embarrassment, stress and cost of defending themselves against prosecution.

A preferable approach to legislating on a State-by-State, Territory-by-Territory basis would be a national approach which preserves the existing scheme of pharmaceutical regulation. The Netherlands’ prescription-based regime is essentially no different to the current Australian approach to other pharmaceutical drugs, and could be adopted most simply by the Secretary for the Commonwealth Department of Health and Ageing exercising the power to reschedule cannabis from Sch 9 of the *Poisons Standard* to Sch 8 (and impose any further conditions deemed necessary depending on the degree of control over prescriptions desired).<sup>154</sup> This would have the effect of providing a means for medical practitioners to apply for approval to prescribe cannabis in all States and Territories.

This is not a radical proposal. Accommodating medical use of cannabis enjoys widespread support among Australians,<sup>155</sup> and conditional support from the nation’s peak medical professional association and other non-government organisations.<sup>156</sup> Even among elected representatives, support for medical use of cannabis is not confined to the political left: in 2013, a cross-party parliamentary committee in New South Wales – chaired by representatives of The Nationals and The Shooters and Fishers Party, and comprising representatives from the Liberal Party, the Australian Labor Party and The Greens – unanimously agreed “that provision [should] be made for a very small and specific group of patients to use crude cannabis products for medical purposes legally”.<sup>157</sup>

If medical practitioners are concerned that the availability of cannabis for medical use might lead patients to grow their own cannabis and thereby make it harder to monitor medical use – or pharmaceutical companies are concerned that they will lose profit from the sale of drugs with which lawfully available cannabis may compete – they might take comfort from the Canadian model of banning personal production and establishing a burgeoning industry in commercial production and supply similar to the existing market in pharmaceuticals.<sup>158</sup>

Some people may well abuse prescription- or statutory exemption-based schemes to obtain cannabis for non-medical use in other countries, but that is no reason to preclude its medical

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<sup>153</sup> General Purpose Standing Committee No 4, n 1.

<sup>154</sup> *Therapeutic Goods Act 1989* (Cth), s 52D(2).

<sup>155</sup> Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey Report* (2011) pp 170, 177.

<sup>156</sup> Australian Medical Association, n 24.

<sup>157</sup> General Purpose Standing Committee No 4, n 1, p xiii. More recently, the Premier of Queensland expressed qualified support for medical cannabis: Vogler S, “Campbell Newman Gets Behind Medicinal Pot”, *The Courier Mail* (online) (14 January 2014), <http://www.couriermail.com.au/news/queensland/campbell-newman-gets-behind-medicinal-pot/story-fnihsrf2-1226801037682> viewed 8 June 2014.

<sup>158</sup> The New South Wales Working Party on the medical use of cannabis suggested that cannabis was “unlikely to comply with requirements under the Therapeutic Goods Act” because “[d]rugs cannot be registered except on application from a pharmaceutical company and it is unlikely that any pharmaceutical company would seek to register a natural plant product that cannot be patented”: Working Party on the Use of Cannabis for Medical Purposes, n 1, p 74. The authors of that report might be surprised to learn of Canadian private industry’s enthusiasm for the medical cannabis market following the ban on personal production by patients.

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availability in Australia entirely. Prescription-drug abuse already occurs in Australia, and is especially prevalent in the case of benzodiazepines and opiates.<sup>159</sup> But to place those drugs in Sch 9, preventing them from being available on prescription, would cause great injustice to those suffering from the conditions they treat. In light of the evidence for the medical uses of cannabis outlined above, it is equally unjust to those suffering from conditions such as cancer, HIV/AIDS and MS – whose symptoms may be alleviated by cannabis – to leave it in that category. It should be rescheduled.

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<sup>159</sup> Australian Institute of Health and Welfare, n 155, p 145.