

Barriers to Access for Canadians who Use Cannabis for Medical Purposes

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Background

There is increased interest in the use of cannabis (marijuana) for medical purposes in recent decades. Countries like Canada, the Netherlands, Israel and some states in the United States have developed programs to allow access to cannabis for medical purposes. In Canada, about one million Canadians use cannabis to treat medical conditions.

Court cases in Canada have confirmed the constitutional right of Canadians to choose cannabis as medicine without fear of criminal sanction (e.g. *R. v. Parker, Wakeford v. Canada, Hitzig et. al. v. Canada, R. v. Mernagh, R. v. Smith*). As a result of these cases, the *Marihuana Medical Access Regulations* (MMAR) were established in 2001 as guidelines for Canadians to obtain legal authorization to possess cannabis for medical purposes. As of December 2012, 28,115 Canadians had obtained an authorization to possess cannabis for medical purposes and to obtain it from a legal source, or less than 5% of the estimated 1 million Canadians who use cannabis for medical purposes, which suggests the existence of barriers to access to the federal medical cannabis program.



Key Findings:

- It is difficult for Canadians to find a physician to support their application to access cannabis for medical purposes.
- Only 7% of people who responded to the survey accessed cannabis for medical purposes exclusively from authorized sources.
- Access to cannabis for medical purposes was better where there were medical cannabis dispensaries, though dispensaries are excluded from the regulatory regime (both MMAR and MMPR).
- Access to cannabis for medical purposes varied by medical condition and general quality of health, with people living with HIV/AIDS facing the least barriers.
- Affordability of cannabis for medical purposes is a significant barrier to access that should be addressed under future programs.

To obtain authorization to legally possess cannabis for medical purposes under the MMAR, Canadians were required to obtain the written support of a physician on an application form and then submit it to Health Canada. Those authorized could purchase dried cannabis from Health Canada, produce their own cannabis, or designate a person to grow cannabis on their behalf. As of April 1, 2014, the MMAR will be replaced by the *Marihuana for Medical Purposes Regulations* (MMPR). Under the MMPR, Canadians who wish to use cannabis for medical purposes will need to obtain a medical document directly from a physician or nurse practitioner, similar to a prescription, which they will then submit to one of the new commercial producers licensed by Health Canada. No onsite dispensing will be allowed. Orders will be shipped to authorized patients. Both personal and designated licences to produce cannabis obtained under the MMAR will be phased out. These imminent changes made it timely to look at barriers to access to cannabis for medical purposes under the current MMAR and to examine how the new program might address or exacerbate existing barriers.

In addition to authorized sources of cannabis for medical purposes, medical cannabis dispensaries, also known as compassion clubs, represent a parallel source of cannabis, providing cannabis and related services to over 40,000 Canadians. Medical cannabis dispensaries arose in Canada in 1997 in response to demand for a community-based, safe, and quality controlled source of cannabis for medical purposes. These dispensaries predate, and are not officially recognized by the MMAR, and operate under a legally ambiguous status. Additionally, many Canadians access cannabis for medical purposes through friends, illicit self-production, and the street market.

This summary presents the results from the largest survey of Canadians who use cannabis for medical purposes to date, the Cannabis Access for Medical Purposes Survey (CAMPS). It also provides useful information about the new MMPR and their implications for Canadians who use cannabis for medical purposes.

Methods

The Canadian AIDS Society collaborated with researchers from the University of British Columbia, in Kelowna, British Columbia, from the Centre for Addictions Research of British Columbia at the University of Victoria, the Canadian Association of Medical Cannabis Dispensaries, people who use cannabis for medical purposes and medical cannabis advocates on the Cannabis Access for Medical Purposes Survey. The study was approved by the Behavioural Research Ethics Board of the University of British Columbia.

The study borrowed from a participatory approach; the research team consisted of academic researchers, representatives from community-based and non-governmental organizations, and people who use cannabis for medical purposes. We collected 628 online surveys from current users of cannabis for medical purposes across Canada in 2011-2012. Organizations and media that serve people who use cannabis for medical purposes as well as dispensaries assisted with promoting the national survey (e.g., Canadian AIDS Society, Canadian Aboriginal AIDS Network, social media). No identifying data (i.e., IP addresses) were collected, to ensure confidentiality.

The survey included questions on demographics, detailed use of cannabis for medical purposes, communications with health care providers, access to and experiences with the federal medical cannabis program and a supply of cannabis for medical

purposes, and general health and well-being. All reported percentages are based on number of responses for each question, indicated in parentheses.

Barriers to access to cannabis for medical purposes were defined as areas of poor fit between people who use cannabis for medical purposes and the federal medical cannabis program that enables legal access. We looked at access to authorization to possess cannabis for medical purposes, as well as access to a source of cannabis for medical purposes. We considered *accommodation*, *accessibility*, *availability*, *affordability*, and *acceptability*.

To look at *accommodation*, we used responses to questions that broadly represent the extent to which respondents' needs for access were met by the program with a focus on general obstacles, physician access, the application process and a source of cannabis for medical purposes. To analyze *accessibility*, we compared users of cannabis for medical purposes across provincial regions and types of community (urban, suburban and rural). To analyze differences in *availability*, we examined variability in access across medical conditions and general health status. To analyze the *affordability* of cannabis for medical purposes, we compared access across income groups and examined the extent to which the impact of cost-related barriers varied according to general health status. Finally, to examine *acceptability*, we described respondents' perceptions of health care providers' attitudes and communication.

Results

Who Responded

The 628 respondents were 71% male, 29% female and 0.5% transgender and other genders, 92% Caucasians and 7% First Nations and Metis. The mean age was 39 years. The median household income was \$30,000 - \$39,999. Most (96%) had completed secondary school and 58% had completed some post-secondary education. Responses were obtained from all ten Canadian provinces and one of the three territories, and respondents reported living in urban (47%), suburban (32%), and rural or remote areas (22%). Respondents reported using cannabis for anxiety and depression, pain, arthritis, spinal pain, HIV/AIDS, multiple sclerosis, cancer, epilepsy and a variety of other illnesses. They used cannabis to manage symptoms such as pain, nausea, mood, spasticity and others.

Accommodation

Accommodation refers to the appropriateness of the federal medical cannabis program (under the MMAR in effect at the time of this study) to meeting the needs of those who use cannabis for medical purposes. The majority of respondents experienced obstacles to accessing cannabis for medical purposes. They described these obstacles as affecting their mood, enjoyment of life, sleep, general activity, normal work outside or inside the home, and relationships. Most respondents reported discussing the use of cannabis for medical purposes with a physician, and almost one third of respondents reported that they had sought a new physician in relation to their use of cannabis for medical purposes, with the majority of those changing physicians more than once. Among respondents who discussed cannabis for medical purposes with their physicians, more than a quarter of them reported that physicians recommended they access cannabis for medical purposes but refused to endorse their application for authorized access.

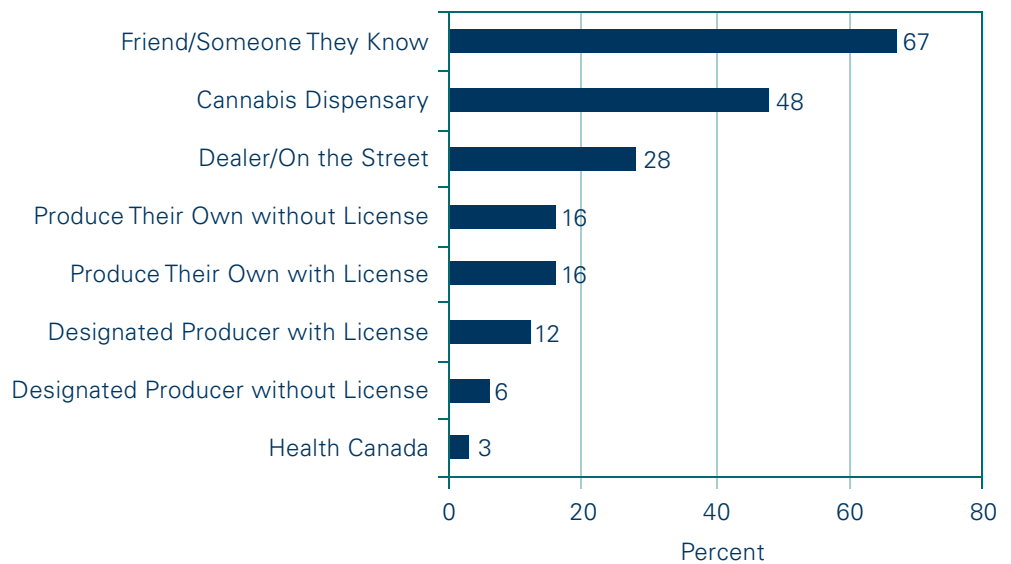
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... only 7% of respondents accessed cannabis for medical purposes exclusively through authorized sources.

Nearly half of respondents had applied for a federal authorization to possess cannabis for medical purposes, of which two thirds had received authorization at the time of the survey. Among applicants to the federal medical cannabis program, more than half found the process difficult or very difficult, and almost half reported being somewhat or completely unsatisfied with the program.

Under the MMAR, only 7% of respondents accessed cannabis for medical purposes exclusively through authorized sources. The federal program made available a single strain of dried cannabis, whereas almost every respondent identified access to a specific preferred strain, a variety of strains, and/or alternative cannabis products (e.g. baked goods, tinctures) as important options. Indeed, less than one third of respondents accessed cannabis for medical purposes from authorized sources (i.e. licensed self-production, licensed designated producer, direct purchase from the federal program), and more than three quarters of respondents who had access to authorized sources also accessed cannabis for medical purposes from unauthorized sources (i.e. dispensary, friend, street, unlicensed self-production, unlicensed designated producer) (Figure 1).

Figure 1:
Reported Sources of Cannabis for Medical Purposes under the MMAR



Almost one third of respondents reported producing their own cannabis for medical purposes, of whom half were licensed to do so for personal use. About one third of self-producers reported that it was difficult or very difficult to learn to cultivate cannabis. Other reported difficulties associated with self-production included arrest and break-ins. The most important reason for self-producing was quality, followed by price, avoiding the black market, selection of a specific strain of cannabis, and safety. Of those who reported that someone else produced cannabis for medical purposes for them, two thirds had designated producers who were licensed. More than a third of them reported having difficulties finding a designated producer.

Accessibility

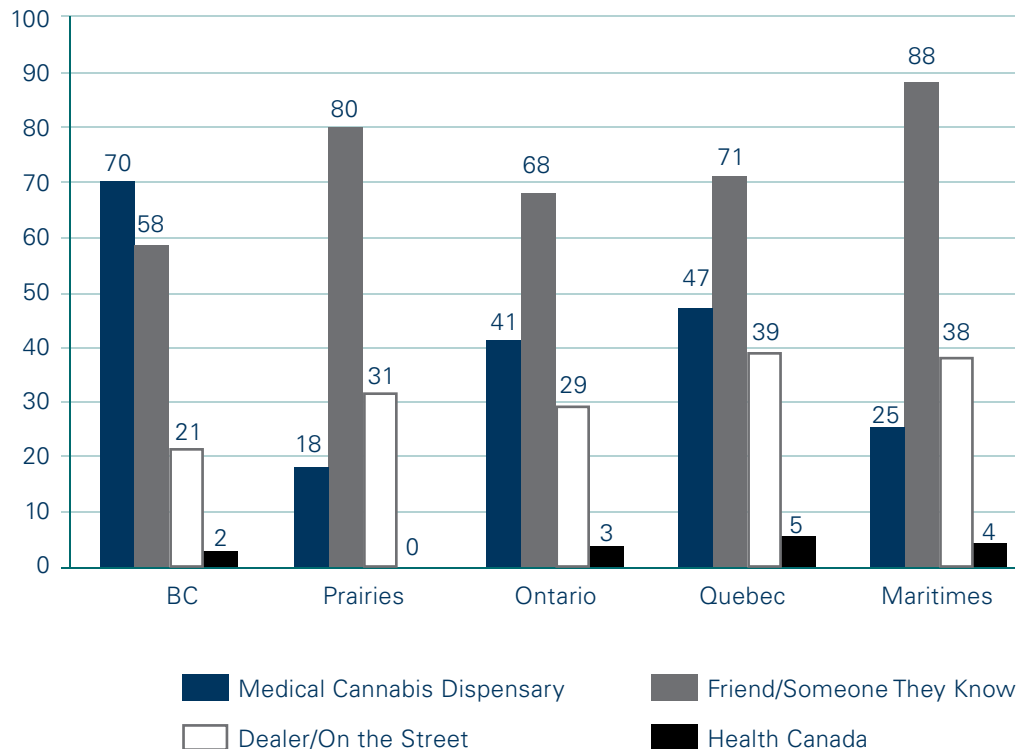
We looked at accessibility in terms of provincial region of residence and community type (i.e. rural, suburban, and urban) both to physicians to obtain support for an authorization to possess cannabis for medical purposes and to a source of cannabis. The rate of experiencing obstacles to access cannabis for medical purposes did not differ according to provincial region or community type. The proportion of those who had spoken to a physician regarding the use of cannabis for medical purposes varied according to region, with the highest level in British Columbia and the lowest in the Maritimes. Respondents from rural areas were more likely than urban or suburban respondents to discuss the use of cannabis for medical purposes with physicians. The proportion of respondents who reported changing physicians for reasons related to the use of cannabis for medical purposes did not vary across provincial regions and community types. Rural residents were more likely to report having received federal authorization to possess cannabis for medical purposes compared to suburban and urban dwellers.

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With regard to access to sources of cannabis for medical purposes, there were regional differences in the proportion of respondents who accessed medical cannabis dispensaries, with higher levels in British Columbia and Ontario and lower levels in the Prairies and Maritimes. Not surprisingly, more residents of the Prairies and Maritimes obtained cannabis from a friend or acquaintance, while less did so in British Columbia. Figure 2 provides a detailed breakdown of sources of cannabis by provincial region. Self-production of cannabis differed by community type, with the highest level of self-production among respondents from rural areas, followed by suburban and urban residents.

Figure 2:
Sources of Purchased Cannabis for Medical Purposes by Provincial Region



A greater proportion of individuals with HIV/AIDS and arthritis discussed the use of cannabis for medical purposes with physicians, whereas respondents with anxiety/depression as a primary condition were less likely to do so.

Respondents who reported *fair to poor* general health were more likely than respondents who reported *good to excellent* general health to discuss the use of cannabis for medical purposes with a physician, to have obtained federal authorization, and to access cannabis for medical purposes through authorized means.

Availability

We looked at how medical conditions and general quality of health impact availability of physicians to support applications to access cannabis for medical purposes, the responsiveness of the federal government's administrative process, and the availability of sources of cannabis for medical purposes. The rate of experiencing obstacles to access to cannabis for medical purposes differed across medical conditions, such that individuals who identified HIV/AIDS as their primary condition were less likely to report obstacles. A greater proportion of individuals with HIV/AIDS and arthritis discussed the use of cannabis for medical purposes with physicians, whereas respondents with anxiety/depression as a primary condition were less likely to do so. Respondents with HIV/AIDS were also relatively less likely than other patients to change physicians for reasons related to the use of cannabis for medical purposes. Having physicians recommend cannabis for medical purposes but refuse to endorse applications for authorized access was less prevalent among respondents with HIV/AIDS, and more common among respondents with chronic pain that was not due to spinal injury or arthritis.

Respondents who reported *fair to poor* general health were more likely than respondents who reported *good to excellent* general health to discuss the use of cannabis for medical purposes with a physician, to have obtained federal authorization, and to access cannabis for medical purposes through authorized means. However, comparisons according to general health of respondents identified no differences with regard to experiencing obstacles, changing physicians related to the use of cannabis for medical purposes, or having physicians recommend cannabis for medical purposes but refuse to endorse an application for authorization.

With regard to sources of cannabis for medical purposes, the proportion of licensed versus unlicensed self-producers was consistent across medical conditions. However, self-producers who reported *fair to poor* general health were more likely to be licensed than were those who reported *good to excellent* general health. The proportion of self-producers who reported difficulty in learning to cultivate was consistent across medical conditions and general health quality. The proportion of respondents reporting difficulties finding a designated producer was stable across medical conditions and health quality.

Affordability

Affordability refers to costs associated with cannabis for medical purposes and ability to pay according to income. Costs to access cannabis for medical purposes occur both in the process of obtaining physician support for authorization to possess and in obtaining a supply of cannabis. Many applicants were charged by their physician for the service of having their application completed, with charges ranging from \$10 to \$800. A relatively smaller proportion of the lowest income group and a larger proportion of the \$40,000-60,000/year group was charged.

Among participants who reported buying cannabis for medical purposes, the median amount spent was \$200 per month. More than half of respondents reported that they were *sometimes or never* able to afford to buy a sufficient quantity of cannabis to relieve their symptoms, and approximately one third reported that they often or always choose between cannabis and other necessities (e.g. food, rent, other medicines) because of lack of money.

Approximately two thirds of respondents who reported *fair to poor* general health were *sometimes or never* able to afford enough cannabis for medical purposes compared to almost half of respondents who reported *good to excellent* health. Respondents reporting poorer health were also nearly twice as likely to report choosing between cannabis for medical purposes and other necessities.

A higher proportion of respondents in the lowest annual income group obtained authorization to possess cannabis for medical purposes compared to respondents from higher income groups. Income was not associated with discussing the use of cannabis for medical purposes with a physician or with changing physicians for reasons associated with the use of cannabis for medical purposes. Income was also not associated with accessing cannabis from an authorized source.

Acceptability

Acceptability refers to patients' perceptions of physicians' attitudes regarding cannabis for medical purposes and of the federal program, as well as patient-physician communications. Respondents reported some reluctance regarding communication with physicians related to cannabis for medical purposes. Approximately half of the respondents reported that they had at some time wanted to discuss cannabis for medical purposes with a physician but had not done so. Among respondents who wanted to discuss cannabis for medical purposes but did not, more than one third had not discussed cannabis for medical purposes with *any* physician. The most frequent reason for not doing so despite a desire to do so was "don't feel comfortable," followed by "illegal," and "can't afford cannabis".

Although respondents were *current* users of cannabis for medical purposes, we asked about *past* avoidance of cannabis for medical purposes. Respondents expressed concerns regarding potential reactions from physicians and others. The most frequently cited reason for avoiding cannabis for medical purposes was "I could be discriminated against," followed by "Doctors might find it annoying to be asked about cannabis," "Discussing cannabis could distract a doctor" and "It could make me drowsy".

Answers to an open-ended question related to physicians' perceived negative response to cannabis for medical purposes included: "After multiple negative responses from doc, I've stopped broaching the subject."; "He shut me down every time I brought it up." Several responses also indicated concern that discussing cannabis for medical purposes with a physician might have a negative impact on their patient/physician relationship: "fear of getting no treatment at all"; "fear of losing my doctor"; "I am afraid they will black list me as a patient and I would not have access to health care!" Compared to their communication with their physician regarding other medical issues, half of the respondents were less satisfied with their communication about the use of cannabis for medical purposes, and almost one third reported that they often or always felt discriminated against by their physician because of their use of cannabis for medical purposes.

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Our results reveal that finding a physician to support an application to access cannabis for medical purposes is a challenge for many respondents.

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Discussion

Our results suggest that, under the MMAR, Canadians faced substantial barriers to both legal authorization to possess cannabis for medical purposes and access to a source of cannabis for medical purposes. In addition, based on our findings, we conclude that many of these barriers do not appear to be addressed by the new MMPR and that the MMPR may exacerbate some barriers to access, particularly with regard to affordability.

Our results reveal that finding a physician to support an application to access cannabis for medical purposes is a challenge for many respondents. Despite the existence of a legal framework, a substantial number of chronically and seriously ill Canadians continue to access cannabis for medical purposes without legal authorization and from illegal sources. Under the MMAR, the federal medical cannabis program does not appear to be well-suited to meet the needs of Canadians who use cannabis for medical purposes.

Under the new MMPR, Canadians will need to obtain a medical document, similar to a prescription, from a physician or nurse practitioner in order to have legal access to cannabis for medical purposes. Given the reservations physicians had with signing a medical declaration on the application form under the MMAR, it is possible that physicians will be even more reluctant to prescribe cannabis for medical purposes within the new regulatory framework, as noted in a recent statement by the Canadian Medical Association citing insufficient clinical evidence regarding the use of cannabis for medical purposes. Our findings support the need to build a stronger body of evidence regarding the appropriate medical uses of cannabis for specific conditions as well as the need to better inform physicians of the evidence that *does* exist. Nurse practitioners will be allowed to prescribe cannabis for medical purposes under the new MMPR in jurisdictions where they can prescribe, though it remains to be seen whether this will result in better access to cannabis for medical purposes.

The current system also fails to accommodate access to a legal source of cannabis for medical purposes. Among those in our sample who managed to obtain access to authorized sources of cannabis for medical purposes under the MMAR (direct purchase from Health Canada, licensed self-production or licensed designated production), only 7% of them accessed cannabis for medical purposes exclusively from authorized sources. This situation suggests substantial barriers to efficient and acceptable authorized access to a source of cannabis.

The MMAR did not include medical cannabis dispensaries within the regulatory system, nor do the new MMPR. The omission of dispensaries from the revised regulatory framework may serve to maintain barriers to access. Our findings suggest that access to cannabis for medical purposes was associated with the presence of medical cannabis dispensaries. In British Columbia and Ontario, where there are numerous medical cannabis dispensaries, residents were more likely to access cannabis for medical purposes from a dispensary, as expected. Specifically, BC has the greatest density and longest history of dispensaries, and BC residents were more likely to have discussed cannabis for medical purposes with a physician and less likely to purchase cannabis for medical purposes from a friend or acquaintance. These findings suggest that services offered by medical cannabis dispensaries may reduce barriers by increasing options for sources of cannabis for medical purposes, available strains and products, *accessibility* in terms of geographic location and storefront services, and *acceptability* in terms

of increasing physician consultation around cannabis for medical purposes and reducing prevalence of illegal access through friends and acquaintances.

Access to cannabis for medical purposes varied by medical condition and general quality of health. In particular, our findings indicate that respondents living with HIV/AIDS experienced fewer obstacles, were more likely to discuss cannabis for medical purposes with physicians, less likely to change physicians related to cannabis for medical purposes, and less likely to have physicians recommend cannabis for medical purposes but refuse to endorse authorization. The relatively lower levels of obstacles faced by people living with HIV/AIDS may be attributed to several factors, including the relatively more established efficacy of the therapeutic uses of cannabis for the management of symptoms related to HIV/AIDS, the long history of grassroots advocacy for the use of cannabis for medical purposes by the HIV/AIDS movement, and the potentially greater alliance between health care providers and persons living with HIV/AIDS. Further research into factors that have facilitated access to cannabis for medical purposes among people living with HIV/AIDS might help develop strategies to improve access for other groups.

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Individuals who identified anxiety and/or depression as primary reasons for using cannabis for medical purposes were less likely to discuss its use with physicians. This difference may reflect characteristics of these conditions, such as shyness and social anxiety, and reduced communication may be associated with depression and anxiety. It may also reflect stigmas associated with mental illness and with cannabis use, which may create a barrier to open patient-caregiver communication. Alternatively, this finding may reflect perceived reluctance on the part of physicians to recommend cannabis to manage psychiatric symptoms. Given the prevalence of anxiety and depression in the general population, and the substantial problems with current pharmacological treatments such as benzodiazepines and SSRIs, our findings of high levels of unauthorized use of cannabis to address these conditions suggest that further effort is required to better determine the antidepressant and anti-anxiety properties of cannabis.

Poorer health was associated with higher rates of physician communication and authorized access. Perhaps this finding indicates that Canadians wait until they are in desperate need of therapeutic options where other options have failed before they gather enough courage to speak to their physician about the use of cannabis for medical purposes. Perhaps physicians are more comfortable supporting the use of cannabis for medical purposes for Canadians who are in poorer health. More research could shed light on this finding. No differences according to general health status were observed with regard to experiencing obstacles to access, changing physicians related to cannabis for medical purposes and physicians recommending cannabis for medical purposes but refusing to endorse applications for authorized access. Nevertheless, our findings indicate that over a quarter of patients in poor health had the experience of physicians recommending cannabis for medical purposes and refusing to assist with authorization. This finding points to the need for further education to address reluctance on the part of physicians to assist patients in obtaining legal access to cannabis for medical purposes.

Affordability of cannabis for medical purposes is a significant barrier to access for many. Under the MMAR, Health Canada offered its cannabis at \$5 CDN per gram, plus applicable taxes. Cannabis on the street market ranges between as low as \$7 per gram to as high as \$28 per gram in Canada's northernmost region. Medical cannabis dispensaries tend to follow street market prices or offer cannabis at slightly lower cost, sometimes with sliding scale prices or limited donations for lower income

The widely reported financial strain of cannabis for medical purposes highlights the need for developing approaches to mitigate financial barriers and integrate cannabis for medical purposes within a subsidized medicine framework. This is increasingly important under the new MMPR, since Canadians who use cannabis for medical purposes no longer have the cost-effective options of producing their own cannabis or obtaining a designated producer.

clients. The new commercial licensed producers offer cannabis between \$6 and \$12 per gram, confirming that the price of cannabis for medical purposes increased as indicated in the government's Regulatory Impact Analysis Statement regarding the new MMPR.

Our findings reveal that over half of respondents indicated that financial considerations interfered with their ability to treat symptoms with cannabis. Lower income individuals were most vulnerable to this obstacle, with approximately half of participants in the lowest income group reporting having to choose between cannabis for medical purposes and other necessities. However, even a third of the highest income group reported difficulty affording cannabis for medical purposes. Affordability appeared to disproportionately impact the most seriously ill patients, such that the group who reported fair to poor health were twice as likely as healthier patients to report having to choose between cannabis for medical purposes and other necessities. Surprisingly, the lowest income group were more likely to have obtained authorization to possess, which suggests that it is the cost of cannabis per se, rather than the cost of obtaining authorization, that presents the primary barrier to affordability. The widely reported financial strain of cannabis for medical purposes highlights the need for developing approaches to mitigate financial barriers and integrate cannabis for medical purposes within a subsidized medicine framework. This is increasingly important under the new MMPR, since Canadians who use cannabis for medical purposes no longer have the cost-effective options of producing their own cannabis or obtaining a designated producer.

Finally, barriers to acceptability due to stigma and controversy that surrounds the use of cannabis for medical purposes need to be addressed. In light of this stigma and controversy, and evidence from surveys of physicians that indicate discomfort with the use of cannabis for medical purposes, we were not surprised that patients' perception of service providers' attitudes toward people who use cannabis for medical purposes constituted substantial barriers to *acceptability* of services. Our findings point to barriers to frank and open discussions about cannabis for medical purposes and a negative impact on continuity of care.

Indeed, almost half of the respondents had at some point wanted to discuss cannabis for medical purposes with a physician but avoided doing so, most commonly citing fear of discrimination and feelings of discomfort. Reports of patient-physician interaction suggest that such fears may not be unfounded; half of respondents were relatively less satisfied with physician interactions related to cannabis for medical purposes than with interactions that were related to other health issues, and nearly one third reported experiencing cannabis-related discrimination on the part of physicians. The large proportion of patients who changed doctors to access cannabis for medical purposes, and who reported that physicians recommended cannabis for medical purposes but would not sign official authorizations, provides further evidence of lingering discomfort related to cannabis for medical purposes on the part of some physicians. This discomfort may stem from their stated lack of knowledge about the medical use of cannabis and their disapproval of smoking as a route of administration for any treatment. It may also stem from their personal views on cannabis use, which may be an interesting topic for further research. Organizations such as the Canadian Consortium for the Investigation of Cannabinoids have developed programs to help educate physicians on the relative harms and benefits of cannabis for medical purposes, and the past decade has witnessed a notable increase in the international acceptance of the therapeutic potential of cannabis. This increased prominence, together with the concerted efforts of advocates and educators, may play a valuable role in helping to reduce barriers related to acceptability of services.

Limitations of the Study

Our study has several limitations. This one-time survey does not allow us to draw conclusions as to cause and effect. It is also possible that unmeasured factors may play an important role in determining access to cannabis for medical purposes. Our sample consisted of mostly male, Caucasian and well-educated respondents and our findings may not reflect the situation of other Canadians who use cannabis for medical purposes. Respondents who chose to participate in the survey, as well as recruitment through organizations that support people who use cannabis for medical purposes, may bias the results and not represent all Canadians who use cannabis for medical purposes. Our sample may overly represent individuals who are strongly invested in increasing access to cannabis for medical purposes. Conversely, barriers to access to cannabis for medical purposes may be greater for those who may not have access to online resources or organizations that support people who use cannabis for medical purposes. We also focused on barriers to access for those who are using cannabis for medical purposes and did not delve into the barriers for people who may want to use cannabis for medical purposes but are not able to overcome barriers to access. A more systematic approach to recruitment would be required to conclusively determine the extent to which the respondents in our sample are representative of the broader community of Canadians who use cannabis for medical purposes.

Strengths of the Study

Our sample was a relatively large national sample that tapped into both authorized and unauthorized users of cannabis for medical purposes across diverse medical conditions and health statuses. The engagement of both community and academic experts in the construction and dissemination of the survey increased the breadth, relevance and validity of our study. Our examination of issues related to access to cannabis for medical purposes was also guided by a theoretically informed analytical framework.

Conclusions

Strategies need to be developed to encourage more scientific research into the use of cannabis for medical purposes and address the barriers to access and the stigma and controversy that surround the use of cannabis for medical purposes and strain patient-physician relationships.

The ongoing prohibition of cannabis and associated anti-cannabis messages have tarnished its reputation as a potentially beneficial and safe therapeutic option, thwarted scientific inquiry and stigmatized both the plant and its users. Perhaps the current international climate of cannabis policy reform will bring about alternative policies to regulate cannabis and will slowly open doors for more rational and sensible investigation and education regarding its therapeutic uses.



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