Medication and Addiction Issues in Personal Injury Litigation

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MEDICATION AND ADDICTION ISSUES IN PERSONAL INJURY LITIGATION

I. Introduction

Our society has evolved significantly in regards to marijuana over the last two decades. Marijuana is increasingly accepted as a "medicine", notably for conditions of chronic pain and depression (along with other disorders), and we are on the cusp of a wholesale change in the legal framework for "recreational" cannabis use in Canada.

As personal injury lawyer, I have long been aware of the widespread use of cannabis amongst some of our clients, both as medicine and as a recreational drug. The changes to the legal framework for medical and recreational marijuana are responding to this public acceptance of marijuana, and "prohibition" of cannabis now appears to be out of touch with widely held societal values.

As a Plaintiff's lawyer, I have also long been aware of the reported medical benefits of marijuana, especially in regards to complaints of chronic pain, and depression. Many of my clients have been "self-medicating" with marijuana for decades. We are now at a stage where this "self-medication" is increasingly becoming acknowledged and condoned by our client's health care practitioners.

In this paper, I explore some of the recent case law that has developed around cannabis as medicine. When are Plaintiff's entitled to reimbursement for cannabis as a "special" damage, are Plaintiff's entitled to payment for cannabis as a Part VII benefit, and are Plaintiff's expected to use cannabis in order to "mitigate" their loss? These are all questions that arise out of a legalized environment for cannabis as medicine.

II. Tort Damage Claims for the Cost of Medical Marijuana

In a number of relatively recent decisions in personal injury cases, British Columbia courts have considered a plaintiff's claim for damages associated with the plaintiff's cost of acquiring "medical marijuana".

Each one of these decisions has been very fact dependent, and it is apparent that the plaintiff must be able to show significant evidence, in order to satisfy the test for an award.
Even though Canadians are now able to obtain access to marijuana for medical purposes through the support of their physician and Health Canada, by following the process set out in the *Marijuana for Medical Purposes Regulations*, SOR/2013-119 [MMRP], and its successor *Access to Cannabis for Medical Purposes Regulations*, SOR/2016-230 [ACMPR], it is by no means a certainty that a plaintiff will obtain the costs of medical marijuana as a tort award of damages.

For example, in *Manoharan v. Kaur*, 2016 BCSC 692, at para. 55, Affleck J. considered the plaintiff’s claim for medical marijuana after first reviewing a useful statement of the law dealing with the costs of future care, as provided in *Dzumhur v. Davoody*, 2015 BCSC 2316, para244. These principles are a useful starting point for our discussion:

[244] The principles applicable to the assessment of claims and awards for the cost of future care might be summarized as follows:

- the purpose of any award is to provide physical arrangement for assistance, equipment and facilities directly related to the injuries;
- the focus is on the injuries of the innocent party... Fairness to the other party is achieved by ensuring that the items claimed are legitimate and justifiable;
- the test for determining the appropriate award is an objective one based on medical evidence;
- there must be: (1) a medical justification for the items claimed; and (2) the claim must be reasonable;
- the concept of "medical justification" is not the same or as narrow as "medically necessary";
- admissible evidence from medical professionals (doctors, nurses, occupational therapists, *et cetera*) can be taken into account to determine future care needs;
- however, specific items of future care need not be expressly approved by medical experts... It is sufficient that the whole of the evidence supports the award for specific items;
- still, particularly in non-catastrophic cases, a little common sense should inform the analysis despite however much particular items might be recommended by experts in the field; and
- no award is appropriate for expenses that the plaintiff would have incurred in any event.

In *Manoharan*, it appears that the plaintiff was not using medical marijuana at the time of trial. However, the plaintiff’s anesthesiologist Dr. Lau, a specialist in pain management, recommended a course of medical marijuana for the plaintiff in the future, but the court refused to accept this recommendation. At para.56, in dealing with the costs of prescription medications, Affleck J. dismissed Dr. Lau’s recommendation:

Dr. Lau recommends a trial of Mabilone or of medical marijuana. The evidence on the appropriateness of cannabinoids for the plaintiff along with the other medications that she expects to take in the future is lacking. I decline to award a sum of money to permit the plaintiff to experiment with cannabinoids;

The high water mark of a plaintiffs’ success in this area is still the decision in *Joinson v. Heran*, 2011 BCSC 727, so it is useful to consider the evidence in that case, and the court’s reasons for decision.
In Joinson, the plaintiff submitted a claim for medical marijuana expenses as part of the costs of future care. The plaintiff had a complicated history of pain management from his accident, and had been prescribed strong pain medication, including morphine and Gabapentin. The plaintiff had been prescribed synthetic THC (Nabilone and Cesamet), and had also been given a Health Canada clearance by his psychiatrist for up to 20 grams of marijuana plant material for smoking per day. This surprising quantity was justified in the opinion of the plaintiff’s psychiatrist, because the plaintiff had an extensive history of recreational marijuana use, and had developed a tolerance to the drug. Together, the plaintiff’s family doctor and psychiatrist believed that he was able to improve his pain control and reduce his reliance on morphine by means of synthetic THC and smoking marijuana, and they supported the plaintiff’s claim at trial.

Brown J. in Joinson had deep misgivings about the amount of marijuana that the plaintiff was using, and especially the 20 grams per day of plant material which could be smoked. The court commented at para. 419 that this amount was “the equivalent of about 27 joints a day, an amount well in excess of the one to three grams a day recommended by Health Canada.”

Brown J. reviewed the law relating to costs of future care at para. 420, in relation to the evidence of the plaintiff’s physicians:

[420] As a judge of the law, I cannot make orders that directly or indirectly endorse unsanctioned accessing of medical marijuana. At the same time, my role is now to assess medical needs and necessities. It is the responsibility of Dr. Surgenor and Dr. Bright, as Mr. Joinson’s treating physicians, to address professionally these medical questions and to ensure Mr. Joinson’s medical use of marihuana complies with the rules and regulations. Ultimately, however compensation claims for medical use of marihuana, either as a special damage claim or as a future cost of care claim, must be assessed based on recommended guidelines and on costs charged by legally authorized dispensaries. All said, the foundational principle for an award of a cost of future care is that the expense must be both medically justifiable and reasonable on an objective basis. It is not enough to show merely that it is beneficial; the medical evidence must show it is reasonably necessary:
Aberdeen v. Langley (Township), Zanatta, Cassels, 2007 BCSC 993, at para. 198;
Strachan v. Reynolds et al., 2004 BCSC 915, at para. 632.

[421] There is no bright line distinguishing mere benefit and reasonable necessity in this case. But with basic reasoning and application of the above stated legal principles it can be drawn, if roughly. Pain control and its contribution to Mr. Joinson’s ability to function to his maximum potential are core considerations here. Without use of medical marihuana or a synthetic substitute, Mr. Joinson would have to increase his use of morphine, which is detrimental, particularly to his functioning; he does not function as well, physically or mentally, without use of medical marihuana. His treating physicians endorsed this treatment option, supporting him in his use of medical marihuana. Other physicians may disagree, but his family physician and psychiatrist see him on a regular basis and, in this particular instance, are in the best place to consider what is medically necessary.

[422] The issue remains controversial and is one which more research and clinical experience must ultimately decide, or at least reveal clearer parameters for the safe and effective use of medical marihuana or its synthetic derivatives. Meanwhile, I find the medical evidence supports a finding that compensation for some medical use of marijuana is reasonably necessary in this case. However, I cannot find for compensation based on the quantity used by Mr. Joinson in his claim for exemption or on amounts he has been paying to purchase products from the TAGGS dispensary. The award will be based on a maximum of 5 grams per day, and priced as if purchased from a Health Canada legally authorized source, or,
alternatively, at the cost of the medically equivalent amount of a synthetic substitute such as Cesamet.

After reviewing evidence relating to the prices of various instances of marijuana purchase, the court awarded $30,000 to the plaintiff for costs of medical marijuana.

In *Amini v. Mondragao*, 2014 BCSC 1590, the plaintiff’s expert Dr. Hershler testified that he “strongly” recommended that the plaintiff be put on a medical marijuana program using a topical ointment, which would have cost $9000 for a 6 month supply. This evidence was sufficiently persuasive that Greyell J. awarded $6500 for that program, although without providing extensive consideration in the reasons for decision.

However, shortly thereafter in *Mandra v. Lu*, 2014 BCSC 2199, where Dr. Hershler once again recommended a topical medical marijuana ointment, Duncan J. observed at para.75,

In a follow-up report dated October 11, 2012, he also recommended medical marijuana compounded in a topical cream. Dr. Hershler is aware of directives from the Canadian Medical Association and Health Canada about exercising restraint in prescribing medical marijuana. He views these directives to be aimed at smoked cannabis of a particular strain, not those he suggests as a cream or oral supplement. He agreed he is keen to use those types of applications of medical marijuana in the field to assist in the gathering of evidence about its efficacy and modality in pain management.

And at para.98 in *Mandra* the court concluded,

I place no weight on Dr. Hershler’s recommendations for pulsed signal therapy or medical marijuana cream. The former is a service for which he is one of the only providers and the latter is a treatment in its very early experimental stage with minimal empirical evidence to suggest it will assist the plaintiff, if it is even permissible under Health Canada’s medical marijuana exceptions.

Similarly, in *Torchia v. Siegrist*, 2015 BCSC 57, Hyslop J. could not find sufficient evidence for the plaintiff’s claim for medical marijuana damages to succeed. At para.183, the court observed,

[183] Mr. Torchia relies on *Joinson v. Heran*, 2011 BCSC 727. The court in *Joinson*, made an award for marihuana so long as it was ordered from Health Canada. That case is of no importance in the case of Mr. Torchia, as the test still is what is reasonably necessary on the medical evidence so as to promote the medical well-being of the plaintiff. Just because another case finds marihuana useful for one patient does not automatically infer that it is medically necessary for another plaintiff. In *Joinson*, medical marihuana was approved by Mr. Joinson’s psychiatrist to use so that Mr. Joinson’s use of morphine could be reduced. In *Joinson*, there was evidence before the court which led Mr. Justice Brown to conclude:

[418] I accept the medical literature is controversial and this subject remains generally controversial among experts and authorities. Medical use of marihuana has many supporters, professional and lay, particularly for use in cases of intractable pain such as cancer, but also detractors who raise legitimate grounds for challenging its safety and health benefits. Given the conflicting medical opinions, scientific controversy and safety concerns, all the more reason for a judge requiring compliance with rules and regulations established for the legal purchase of medical marijuana.

[184] No such evidence was before me. I decline to make an award for medical marihuana.
7.1.5

In *Hollyer v. Gaston*, 2016 BCSC 1401, the plaintiff did produce sufficient expert evidence to support her claim for medical marijuana as a cost of future care, but at a much reduced amount than the $162,489 sum advanced by her counsel. Gerow J. held at para. 136,

> [136] Ms. Hollyer seeks an award for the future cost of medical marihuana in the amount of $162,489. Mr. Gaston argues that there is no evidence suggesting that long-term use of medical marijuana is medically justified or reasonable in this case. Mr. Gaston submits the sum of $5,000 is a reasonable assessment of the costs of Ms. Hollyer’s future use of medical marihuana, Robaxacet and occasional use of Advil and Tylenol.

> [137] I agree there is no recommendation that Ms. Hollyer continue to use medical marihuana for life. Dr. Caillier has recommended Ms. Hollyer use medical marihuana oil to help with sleep. However, Ms. Hollyer has only been using it for the last couple of months and has noted some side effects. There is no evidence that Ms. Hollyer will be using medical marihuana for the duration of her life. Having considered the evidence, I am of the view that an award of $5,000 for supplies, including Robaxacet, medical marihuana and over the counter pain medication is appropriate.

Finally, consider *Datoc v. Raj*, 2013 BCSC 308, where the plaintiff failed to produce any expert witness who supported his use of medical marijuana, yet the plaintiff still advanced a claim $200 per month for its use under the heading of future care costs, to a total lump sum of $20,000. The plaintiff testified that he saw a naturopath and obtained a prescription for medical marijuana to relieve his pain. He said that it assisted him to sleep, and that it prevented “panic attacks”.

However, on this relative paucity of evidence, Sigurdson J. dismissed the plaintiff’s claim at para.120, holding,

> The evidence does not support the claim that medical marijuana is reasonably necessary: see *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.). As such, I award nothing for the cost of future care.

### III. Reimbursement for Medical Marijuana Costs Under ICBC Part 7 Benefits

As we have seen, there are precedents in BC where courts have awarded a Plaintiff the costs associated with acquiring medical marijuana pursuant to a tort claim. Another issue that arises if the tort claim relates to a motor vehicle accident in British Columbia is whether the Insurance Corporation of British Columbia (ICBC) have the capacity through Part VII no-fault benefits to pay for medical marijuana to assist a plaintiff’s recovery from a motor vehicle accident.

In respect of entitlement to Part 7 benefits, mandatory medical benefits would have to fall under s.88 of the *Insurance (Vehicle) Regulation*, B.C. Reg. 447/83. These mandatory benefits are enumerated under s.88(1) as follows:

> (1) Where an insured is injured in an accident for which benefits are provided under this Part, the corporation shall, subject to subsections (5) and (6), pay as benefits all reasonable expenses incurred by the insured as a result of the injury for necessary medical, surgical, dental, hospital, ambulance or professional nursing services, or for necessary physical therapy, chiropractic treatment, occupational therapy or speech therapy or for prosthesis or orthosis.

Alternatively, if a particular treatment does not fall within the scope of mandatory payments, then ICBC is permitted to pay out discretionary benefits under s.88(2)(f) as follows:
(1) Where, in the opinion of the corporation’s medical adviser, provision of any one or more of the following is likely to promote the rehabilitation of an insured who is injured in an accident for which benefits are provided under this Part, the corporation may provide any one or more of the following:

... 

(f) funds for any other costs the corporation in its sole discretion agrees to pay.


To date, there are no reported decisions where a plaintiff has compelled ICBC to pay for medical marijuana treatment as a component of Part 7 benefits. And it may well prove difficult for a plaintiff’s counsel to obtain such a decision. Cases dealing with ICBC’s mandatory Part 7 payments under s.88(1) are showing a restrictive interpretation of the enumerated categories of mandatory payment.

For example, Raguin (Litigation guardian of) v. ICBC, 2011 BCCA 482, is a leading case dealing with determination of disputed treatments and the scope of mandatory payments covered by s.88(1). In Raguin, the Court of Appeal dealt with the plaintiff’s claim that massage therapy ought to be covered as a mandatory Part 7 benefit, since it is a form of “physical therapy” as specifically enumerated under s.88(1) of the Regulation.

After conducting a complete historical review of the previous versions of s.88 of the Regulation, which previously included a requirement that the insured’s physician prescribe the treatment at issue, the court held at para.44,

While not determinative of the issue before us, it appears that the trend in the legislation is toward specific enumeration of the type of mandatory benefits that can be covered and limitation of the role of the insured’s physician regarding what type of service may be necessary.

At para.58, the Court of Appeal held,

While the Regulation does not refer specifically to massage therapy in s. 88(1), I am of the view that, when all of the relevant provisions in the Regulation are read together with the Health Professions Act and its related Regulations, physical therapy may properly be interpreted as including massage therapy. To be payable under s. 88(1), the other requirements must be met as stated in the section; that is: “[w]here an insured is injured in an accident for which benefits are provided under this Part, the corporation shall ... pay as benefits all reasonable expenses incurred by the insured as a result of the injury for ... necessary physical therapy . ...”

In Park v. Targonski, 2015 BCSC 1531, Fitch J. considered Raguin, and observed at para.32,

As I read Raguin, a cautious approach is being counselled to classifying services, not specifically enumerated in s. 88(1) of the Regulation, as benefits ICBC is obligated to pay an insured (see, to like effect, the observations of Fitzpatrick J. in McDonald v. Insurance Corp. of British Columbia, 2014 BCSC 2155 at para. 95). Nonetheless, the Court in Raguin held that massage therapy was a mandatory service included within the meaning of “physical therapy” despite not being
specifically set out in the provision. The result flowed from the fact that both the
dictionary definition of “physical therapy”, and the definition of that phrase used
in the related regulatory scheme, include massage therapy.

Given the tenor of the case law, while it may be possible to argue that medical marijuana falls within
the scope of “necessary medical … services”, and is therefore mandatory for ICBC to pay as a Part 7 benefit under s.88(1) like any other prescription drug, such an argument will probably be hotly contested by ICBC.

Some further guidance might be found in decisions from other jurisdictions, where the construction
of other insurance policies was at issue, to determine whether their scope included payment for an
insured’s medical marijuana.

Consider the example of the Ontario Labour Arbitration Board decision in *Hamilton (City) v. Hamilton Professional Fire Fighters’ Ass. (Robillard Grievance)*, [2016] O.L.A.A. No.129, where the
union filed a grievance on behalf of a firefighter, relating to a claim for payment under a group
benefit insurance plan administered by Manulife. The union claimed that the firefighter’s spouse
was entitled to be reimbursed under the insurance plan, for her prescription for medical marijuana.
The union raised a number of arguments that may be instructive for litigation concerning medical
marijuana under ICBC’s Part 7 benefit scheme.

In *Hamilton (City)*, the arbitrator conducted a thorough review of the legislative history and
significant court decisions that provide the current legal framework for medical marijuana. In
particular, at para.14, he noted that:

\[
\text{Health Canada, through the Food and Drugs Act [RSC 1985, c F-27] (FDA) and the Food and Drug Regulations (FDR), sets out the general framework for the authorization of drugs for sale in Canada. If Heath Canada, upon reviewing and testing the submitted evidence of the drug manufacturer, is of the view that the overall benefits of the drug outweigh its risks, the product will be authorized for sale in Canada and be designated with a DIN.}
\]

Manulife and the employer had required that all prescription drugs submitted for reimbursement
would have a “DIN” associated with them. The union argued that such a requirement was merely
procedural, and it should not disentitle claimants from reimbursement under the policy. But in
reply, the employer asserted that a DIN could never be ascribed to marijuana since it remains a
controlled substance under the *Controlled Drugs and Substances Act (CDSA)*, and therefore it
could never be a drug which could generally receive approval by Health Canada under the *FDR*. In
the employer’s view, the failure of the claimant to provide a DIN was fatal to the claim.

In beginning his analysis of the parties’ submissions, the arbitrator observed at para.35 that the
firefighter’s spouse had provided a “medical document”, as defined under the *MMPR*, from both a
purposive and substantive perspective could be viewed as the equivalent of a prescription.

However, the arbitrator dismissed the union’s grievance, and held at para.38,

\[
[38] \text{In my view, a review of the relevant collective agreement language as a whole, suggests that the parties clearly contemplated that eligibility for reimbursement was premised on the drug in question being approved by Heath Canada as a drug under the FDR, thereby having a DIN assigned, as well as being purchased by a prescription issued by a medical doctor. Further to this point, it should not be overlooked that the parties expressly defined the available drug benefit coverage in terms of "prescription drugs". And while, as suggested, a "medical document" pursuant to the provisions of the MMPR, from both a purposive and substantive perspective very much mirrors a prescription; it is clearly not a "prescription".}
\]
More importantly, the parties have expressly mandated that any claim for reimbursement of a drug expense must include the particular drug’s DIN. That requirement, in my view, is not simply procedural in nature but a mandatory element of any claim; acting as verification that the drug for which reimbursement is being sought is an approved drug under the FDR. Specifically, the reference to a mandatory inclusion of a DIN in any submitted claim can be seen as confirmatory of the parties’ intention that the only drugs that warranted reimbursement were drugs that have been subjected to the testing associated with the Health Canada approval process, for the purposes of the FDR. Stated in a slightly different manner, the express stipulation that a DIN be provided when submitting a claim, suggests that the parties contemplated a particular “stamp of approval” of Health Canada was being sought; not only that the drug has been authorized for sale in Canada but confirmation that the drug has been approved by Health Canada under the provisions of the FDR.

In sharp contrast with the decision reached by the arbitrator in Hamilton (City), consider the very recent decision by the Nova Scotia Human Rights Board of Inquiry, Skinner v. Canadian Elevator Industry Welfare Trust Fund (Trustees of), [2017] N.S.H.R.B.I.D. No.2. In Skinner, the claimant was initially denied reimbursement for his medical marijuana on the same basis as was upheld in Hamilton (City), in that medical marijuana has not been approved by Health Canada under the FDA, and as such, it does not have a DIN. Accordingly, medical marijuana was not an approved drug under the terms of the Welfare Plan at issue, in the eyes of the employer and plan administrator.

The claimant, Skinner, filed a complaint under the Nova Scotia Human Rights Act, RSNS 1989, c 214, alleging discrimination in the provision of services on account of physical and mental disability.

In beginning his reasons for decision, the Board of Inquiry Chair noted a key distinction from Hamilton (City), at para.27, in that the Welfare Plan in Skinner did not expressly limit coverage to drugs possessing a DIN. It did not define what constitutes a “drug”, and did not limit the definition of “drug” to only “Health-Canada-approved” drugs or any other express category. Moreover, the policy language at issue did expressly cover both “drugs” and “medicines”, so arguably medical marijuana could fall within the scope of “medicine”, even if it were not classified as a “drug”.

However, the Board observed at para.31 that his comments on construction of the Welfare Plan were effectively obiter dicta since he only had jurisdiction to determine whether there had been a violation of the Human Rights Act, not jurisdiction to construe the Welfare Plan to determine whether there was a violation of the collective agreement.

Ultimately, the Board did find that there was a violation under the Human Rights Act. At para. 159, the Chair noted,

The Welfare Plan’s exclusion of medical marijuana was not designed to treat certain beneficiaries differently than others, but this exclusion had the substantive result or effect of treating the complainant differently. Whereas some beneficiaries receive coverage for their medically-necessary, prescription drugs, by special request, the complainant’s special request for a medically-necessary, prescription drug, is excluded by the plan because the drug in question has not been formally approved by Health Canada even though it can be legally prescribed.

Then at para.184, the Chair held,

In summary, the complainant has established, on a balance of probabilities that the denial of coverage for medical marijuana amounts to prima facie discrimination. Unlike other beneficiaries under the Welfare Plan, the complainant’s request for
special coverage of a medically-necessary drug, prescribed by his physician, was rejected. This non-coverage had a severely negative impact on the complainant and his family, which amounts to a disadvantage. While the initial non-coverage was only arguably "based on" the complainant’s disability, the Trustees’ subsequent denial of the complainant’s accommodation request, and decision to deny coverage on a case-by-case basis or to amend the Welfare Plan, was "based on" the complainant’s disability.

Ultimately at para. 213, the Chair ordered the Welfare Plan to immediately, forthwith, begin providing coverage of medical marijuana for the complainant, up to and including the full amount of his most recent prescription.

It remains to be seen whether ICBC can be compelled to pay for an insured’s medical marijuana pursuant to mandatory payments under Part 7 benefits. But these recent tribunal decisions, *Hamilton (City)* and *Skinner* provide guidance.

### IV. Alleged Failure to Mitigate by not Using Cannabis as Medicine

The arguments of ICBC defence counsel in a Glesby vs. MacMillian 2014 BCSC 334 provide an interesting example of just how far our society has evolved in regards to cannabis. At paragraph #69, Baird, J. finds: "I decline to find that the plaintiff failed to mitigate her losses by not taking medical cannabis." The trial judge continues: "I accept as sincere the plaintiff’s reservations about the acquisition and use of cannabis."

So here is a case where defence counsel engaged by a Provincial Crown corporation is heard to say to a Plaintiff (as a reason for declining to accept the claim for injuries): "You are not smoking your ganja, man!". My how the world has changed since I began to practice personal injury law over three decades ago!

We will need to await further developments in the law to better gauge the Court’s willingness to impose a positive obligation on Plaintiff’s to consume cannabis as a strategy for mitigation.

### V. Conclusion

With the looming changes in the legal framework for recreational cannabis, and with the evolving acceptance of marijuana as medicine, the legal framework for cannabis in personal injury law will no doubt continue to develop. We can expect further test cases regarding marijuana as a special damage and potentially testing the limits of ICBC’s Part 7 scheme.

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