The Department of National Health and Welfare published this sixty page pamphlet to answer three questions. Two of these questions are non-controversial: "What are the drug laws?" and "How are these laws implemented?". As a brief summary of the Food and Drugs Act (FDA) and the Narcotic Control Act (NCA), the pamphlet provides a useful overview for non-lawyers interested in these two statutes. If it went no further there would be little reason to review it for a legally sophisticated audience. But it does go further by attempting to answer a third very controversial question, namely "Why have drug laws?". In trying to justify every provision in the two statutes the authors descend into propaganda, falsehood and error. This point deserves comment.

The Department's essential justification is that Canada's drug laws were enacted to promote public safety. No evidence is cited to bolster any of the consumer protection claims and no mention is made of the extensive research demonstrating that public safety was rarely a motivating force behind much of Canada's drug legislation.

Why does Canada prohibit "narcotics"? Supposedly, "their psychotropic effects and addictive properties have led to stringent restrictions on their availability". In fact, the authors have the causal sequence backwards. First, the drugs were prohibited and then government cast around for a plausible justification, finding it in grossly exaggerated claims about dangerousness. Hundreds of scientists and researchers report that the drugs classified as narcotics are no more addictive or psychotropic than alcohol, tobacco, caffeine or diazepam. In the glossary, "narcotic" is defined as a "drug that in moderate doses dulls the senses, relieves pain and induces sleep, but which has a high potential for addiction and abuse". While this description fits alcohol, Valium and the barbiturates, which are not classed as "narcotics", it clearly does not fit cocaine, which is a stimulant, nor does it fit marijuana, which almost all authorities agree has a low potential for addiction and abuse. Historians report that Canada's narcotics laws,

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2 P. 16.
4 P. 58.
like parallel United States’ efforts, were enacted not for public safety but to impede Chinese immigration, repress oriental culture, protect white manufacturers and grant special privileges to medical professionals. Later, in the 1930s, marijuana was designated a narcotic by parliamentarians who knew virtually nothing about the drug.

The pamphlet makes equally specious claims in defence of the Food and Drugs Act. Restricted drugs, like LSD, are implicitly identified as the only substances with “hallucinogenic properties”. This is not true. It is also asserted that the substances listed in Schedule H “have no recognized medicinal use and are dangerous”. The reasoning here is dangerously circular. Before their use was prohibited, almost all the illicit and restricted drugs were used medicinally. Such medicinal use ceased, however, once government started criminalizing users and prosecuting physicians. Recent American cases involving the medical necessity defence illustrate that some physicians will testify to the therapeutic properties of drugs that officially have “no recognized medicinal use”. One wonders why the Canadian government is dictating to physicians which drugs they can “recognize”? As Thomas Szasz observes, this is theology, not public health.

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8 P. 16.


10 P. 10.


12 See R. v. Gordon (1928), 49 C.C.C. 272 (Calgary Dist. Ct.). After 1925 an amendment to the Opium and Narcotic Act made unlawful prescription an indictable offence punishable by a minimum three-month imprisonment. R.S.C. 1923, c. 22, s. 5.


The FDA also creates a category of drugs available by prescription only. The justification: "The main reasons for requiring additional control for these drugs are the need for professional direction and supervision in their use and in some cases their potential for abuse and misuse." A recent review of the literature on mandatory prescription laws reveals that such laws do not offer additional protection to the public and were enacted under pressure from medical societies intent on gaining financial and professional advantage. When Parliament created this drug category in 1940 the need for compulsory medical supervision was not demonstrated and since then no evidence has appeared to justify such supervision.

Under both Acts advertising certain drugs to the "general public" is prohibited. As usual, the authors claim that advertising restrictions were enacted "for the protection of the lay public". No evidence is offered in support of this claim, which is not surprising given that the available data tends to show that "ethical" advertising restrictions, whether in law, medicine or elsewhere, result in higher prices and professional hegemony, not public protection.

The pamphlet proffers a number of other dubious, self-serving justifications, all of which raise the same question. Either the authors are ignorant of the academic literature on their topic or, worse, they know what scientists are saying but are directed or choose to ignore a mountain of evidence that conflicts with their rosy little picture of enlightened legislators assisting altruistic health professionals to protect the otherwise helpless, hapless consumer.

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17 P. 32.
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