marijuana patients. And the second thing is preparing both their production capacity and human resources to be able to position themselves in recreational marijuana."

Of course, one needn't rely purely on speculation to anticipate how legalization will affect the medical cannabis industry. In Colorado, the sale of marijuana became legal on Jan. 1, 2014, and recreational sales began exceeding medical sales by August of the same year. Despite higher costs, recreational marijuana continues to outpace medical cannabis in sales growth in Colorado, and some analysts predict that the state will eventually combine the two markets under one set of regulations and tax rate. There have also been calls in Oregon to combine the recreational and medical markets to "avoid expensive duplication in legal sales settings and complication in tracking potentially more than one supply chain." — Roger Collier, *CMAJ*

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Accessibility to physician offices a "significant problem"

You might think that doctors' offices, of all places, would be among the most accessible facilities for people with disabilities that limit mobility. Yet, despite provincial disability acts that call for health care accessibility for all, that isn't always the case.

"Accessibility to physician offices is a significant problem in Canada," Craig Bauman, project manager of the Mobility Clinic, said in an email. "Often what physicians consider accessible does not fulfill best practices."

The Mobility Clinic was developed by the Centre for Family Medicine Family Health Team in Kitchener, Ontario, to enhance access to primary care for patients with mobility impairments. The clinic's physical space was designed with accessibility in mind, providing plenty of space for wheelchairs to manoeuver, accessible parking and bathrooms, a wheelchair scale and an examination room that includes a height-adjustable table and a ceiling lift.

"Although there are sometimes limitations to structural changes that can be made given the existing physical environment, leaseholder agreements, or financial constraints, simple strategies such as installing grab bars, ensuring appropriate waiting room space and chairs, and informing staff of patient needs can help improve accessibility," members of the health team wrote in *Canadian Family Physician*.

Accessibility to medical facilities for people with disabilities is also an issue in the United States. One study of access to subspecialists, published in the *Annals of Internal Medicine*, found that 22% of the 256 facilities surveyed in four US cities could not accommodate a fictional patient with obesity and hemiparesis who used a wheelchair and could not self-transfer to an examination table.

A May 2014 article in the *New England Journal of Medicine* noted that, despite federal acts in the US that mandate accessibility for people with disabilities, "research has shown that patients with disabilities may be transferred in an unsafe manner onto examination tables and other equipment, receive less preventative care and fewer examinations, and report longer waits to see subspecialists."

Improving physical access to health care environments, the paper states, would include ensuring elevators are functional, hallways are clear, buildings can be easily entered, bathrooms are accessible, examination tables are height-adjustable, specialized equipment is available for diagnostic imaging and other procedures, and policies and procedures are in place to promote accessibility.

According to Dr. Tara Lagu, first author of both US papers, there is a combination of factors that contribute to poor accessibility. One is that physicians are not trained in medical school or residency on how to provide access to care for people with disabilities.

"This lack of knowledge is in turn transferred to the clinical and administrative staff of those physicians' practices," Lagu, a research scientist at the Center for Quality of Care Research in Springfield, Massachusetts, said in an email. "Because there is not clear direction from the practice leaders [the physicians], there is an assumption by the clinical and administrative staff that accommodating these patients is not a priority."

Another issue is that some physicians who are knowledgeable on the topic still appear hesitant to make changes, likely because of a perception that it will be too expensive and benefit only a few patients. According to Lagu, however, buying something like an accessible table could also be useful in treating elderly patients, women near the end of pregnancy and patients too sick to climb onto a regular examination table.

The lack of consequences for failing to accommodate patients with disabilities is also a problem, said Lagu. The only way to punish inaccessible practices in the US is through lawsuits, which tend to be expensive, undesirable to patients and not always successful. Lagu and her colleagues have argued for systemic changes, such as removing accreditation or stopping government payments to inaccessible practices. "Of course, this is a controversial suggestion that is likely to be unpopular with physicians."

In Canada, accessibility to health care is a provincial issue. In Alberta, it's covered under the Alberta Human Rights Act. British Columbia has an initiative called Accessibility 2024, which purports to make BC the "most progressive province in Canada for people with disabilities by 2024." In Ontario, the Accessibility for Ontarians with Disabilities Act sets out accessibility requirements.

The College of Physicians and Surgeons of Ontario directed *CMAJ* to its Professional Obligations and Human Rights policy. Physicians should take "reasonable steps to accommodate the need of existing patients, or those seeking to become patients, where a disability or other personal circumstance may impede or limit their access to care," states the policy, while noting that doctors "do not have to accommodate beyond the point of undue hardship, where excessive cost, health or safety concerns would result." — Roger Collier, *CMAJ*

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