Medical Cannabis and Recreational Marijuana: Patient Perceptions, Stigma, and Gender During a Time of Emerging Legalization

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MEDICAL CANNABIS AND RECREATIONAL MARIJUANA: PATIENT PERCEPTIONS, STIGMA, AND GENDER DURING A TIME OF EMERGING LEGALIZATION

by

Matt Reid

A dissertation submitted to the Graduate College in partial fulfillment of the requirements for the degree of Doctor of Philosophy Sociology Western Michigan University April 2020

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Marijuana’s status as an illegal drug has been redefined over the previous three decades. Despite Michigan and 32 other states having comprehensive medical cannabis programs, both academics and laypeople commonly present the medicalization of marijuana as an intermediary phase or proxy for fully legalized recreational use. While some evidence exists to support this position, this framework marginalizes the struggles and experiences of patients who have found relief through their therapeutic use of cannabis. As such, the goal of this study is to re-center the voices of cannabis patients in academic conversations of cannabis as medicine.

My study is unique in that it is the first qualitative investigation of cannabis patients in Michigan, and since Michigan legalized adult-use (recreational) marijuana in 2018, my study is also the first to document patient experiences in a post-prohibition state. The research questions that guided my descriptive qualitative inquiry revolved around the areas of medicalization, normalization, and gender. The primary method utilized in my study was five semi-structured focus groups of medical cannabis patients (n=21) where the groups were asked to reflect upon their histories, current struggles, and their anticipations of the future. To expand the perspectives analyzed in my research, I also performed observations at several cannabis businesses and events (n=6), and I conducted semi-structured interviews with key informants (n=9) in Michigan’s
medical cannabis community, including dispensary owners, caregivers, activists, industry advocates, and a certifying physician.

This descriptive study expands our sociological understanding of medicalization, normalization, gender as experienced by medical cannabis. Results indicate patients prefer the current “alternative medicalization” of cannabis where their medicine is legitimized and made accessible outside of biomedical institutions. Patients in my study recounted intolerance and ultimatums to stop using cannabis by health care professionals, and they loathed how physicians pushed pharmaceuticals while criticizing cannabis medicines. Furthermore, since patients in my study continued to experience a range of social and structural stigmas, my results call into question claims that marijuana is normalized in American society. Indeed, these sweeping assertions of normalization may have been made from positions of race, gender, class, and/or generational privilege. Finally, both men and women in my study reported gender-specific stigmas over their use of medical cannabis, though men who use cannabis may more readily break with our culture’s hegemonic construction of masculinity.
ACKNOWLEDGMENTS

I am indebted to my friends, family, colleagues, and society for making my studies possible, bearable, and worthwhile. Moreover, I would like to thank my excellent dissertation committee for their support and feedback throughout my research. Additional thanks to my key informants and focus group participants, as well as to those who worked to make cannabis available as a medicine in Michigan. I am also particularly grateful for boys, Benjy and Rocky, who helped keep my lap warm as I wrote this document. Finally, much is owed to my mother, Janet, and my father, Mike. They made it possible for me to experience the academic version of the American Dream as a first-generation college student who achieved a doctoral degree.

Matt Reid
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CHAPTER I

INTRODUCTION

Marijuana’s status as an illegal drug has been largely redefined over the previous two decades. As of the writing of this study, 33 states have approved marijuana for medical use and 11 states have moved to legalize recreational use. Though the laws regulating consumption and sales vary by state, each exists within a broader legal climate of federal prohibition. California was the first state to authorize medicinal use in 1996 and critics have continually raised skepticism over whether such policies are deceptive legal loopholes. Both academics and laypeople commonly claim the medicalization of marijuana is an intermediary phase or proxy for fully legalized recreational use. While some evidence exists to support this position, this framework marginalizes the struggles and experiences of patients who have found relief through their therapeutic use of cannabis. The goal of this study is to re-center the perspectives of cannabis patients in the academic conversation of cannabis as medicine.

Legalization is steadily happening on a state-by-state basis, with Michigan voters passing a ballot measure in 2018 to permit the sale and use of recreational marijuana. My dissertation examines the experiences and perceptions of medical cannabis patients during a time of emerging legalization. We are in a unique moment where a medical cannabis system is established in Michigan while a young recreational industry is blossoming. What will happen to cannabis as a medicine once recreational marijuana becomes widely available? Only 11 states and Canada have undergone this transformation, and while data is surely still emerging, the voices of patients during this transition have not been collected or analyzed by social scientists. Furthermore, while many studies have examined medical and recreational cannabis through a
wide variety of standpoints, no research on these topics has been conducted where the researcher identifies as a patient. With this research and my insider knowledge, I hope to give voice to the community of patients during this period of state-by-state marijuana reform.

Gender has also been largely ignored by social scientists studying these issues though much can be gained through a feminist analysis of cannabis culture. My observations lead me to believe the commercialized cannabis culture will cater to hegemonic masculinity with sexist tactics like those used by the alcohol industry. These inequalities may reflect our broader patriarchal culture, but unlike most other sectors, legitimate cannabis businesses are relatively new. Since these new businesses do not have a history of entrenched male-dominated power structures, this could be an opportune moment for women and gender minorities to claim equal space in the emerging industry. Some evidence indicates this is happening, but there are also concerns that legalization will only result in consolidation under male-controlled corporations. Cannabis may be the next billion-dollar industry, but the people who appear poised to benefit the most are the familiar white men in suits with deep pockets.

This is historically interesting because cannabis was legalized for medical use by a social movement that shared similar values and membership to the women’s health care movement of the 1960s-1990s. This movement fought for access to medicine outside of disempowering medical institutions, the right to utilize non-professional care providers, and sought to restore trust in natural remedies. Cannabis was one of these alternative therapies and those working in the medical cannabis movement of the 1990s prioritized patient wellbeing over economic gain. Indeed, the original activists often provided free medicine to those who could benefit, especially those in the late stages of AIDS or cancer. Yet social rhetoric surrounding cannabis seems to have shifted from an emphasis on care and relief to a focus on business and profit. Very soon, we
may see the gendering of cannabis culture and its associated stakeholders become more masculinized, more feminized, or perhaps even less gendered altogether.

The purpose of this study is to explore the community of medical cannabis patients during a time of emerging recreational legalization. My research began with semi-structured interviews with key organizational actors in Michigan’s medical cannabis community and continued with observations of several field sites. This data was used in conducting focus groups of registered patients in southwest Michigan, and the groups were asked to reflect on their histories, current struggles, as well as their anticipations of the future. For the purposes of this study, medical cannabis patients were defined as those registered in Michigan’s Medical Marihuana Program (MMMP).

This descriptive study expands our sociological understanding of medicalization, normalization, gender as experienced by medical cannabis patients through documenting group-level knowledge, something other researchers have so far neglected through their exclusive use of survey and interview methods. Results from my research may be of interest to those who serve the medical cannabis community as well as to the policymakers who shape regulations surrounding both medical and recreational cannabis. I hope to contribute evidence that supports cannabis’s construction as a medicine, and my work may help the health care community better understand the perspective of cannabis patients. This research may also be empowering to patients who participated in my focus groups as support networks and opportunities to meet other patients are scarce in the State of Michigan. Merely coming together to discuss medical cannabis may prove to be an encouraging and illuminating moment in the lives of individual patients.
Research Questions

The research questions that guide this descriptive qualitative inquiry are:

(RQ1) How does the medical cannabis community feel about the normative status of medical cannabis in this moment of emerging recreational legalization? And, what challenges do patients face in their social and professional lives?

(RQ2) How do medical cannabis patients view the legalization of recreational marijuana? And, do patients think medical cannabis will survive once marijuana is fully legalized?

(RQ3) How does gender shape the experiences of medical cannabis patients? And, how might hegemonic gender roles be adhered to or challenged by cannabis patients?

These questions anchored my subsequent data collection, analysis, and reporting of my research. The questions are purposely broad and are flexible enough to produce engaging focus group prompts. I tried to craft these in a manner that covers the central themes I investigated since I began my proposal by reviewing and summarizing the literature on this topic. After I read through most peer-reviewed articles published on medical and recreational cannabis in the social sciences, I honed my inquiry deeper into several issues that sparked my interest. These are discussed and briefly connected to social theory in the next section.

Theoretical Frameworks

Many studies on cannabis approach the topic through one dimension, typically treating it as either a recreational drug or medicinal plant. In doing so, they usually adopt the framework of normalization for the former and medicalization for the latter. These trends are each discussed in detail throughout my dissertation, but my overarching point is that scholars acknowledge one or
the other, rarely both. Normalization implies stigmas related to cannabis have become insignificant or vanished altogether. If cannabis use has become normalized, medical patients and recreational users should not be concerned about negative evaluations from others. Medicalization implies that a substance is accepted by, and defined through, medical authorities. However, patient activists medicalized cannabis in spite of resistance from medical, political, and legal institutions. Its status as a medicine appears to be uneven and much controversy still remains. Most interestingly, some speculate if medical cannabis will survive once recreational marijuana is fully legalized. In other words, does the normalization of cannabis threaten its medicalization? These two trends are co-occurring and are often juxtaposed to criminalization rather than each other.

In addition to the theoretical frameworks of normalization and medicalization, I believe considering gender dynamics can yield valuable insight into the cannabis community. Social scientists have yet to meaningfully interrogate gender in their investigations of either recreational or medical cannabis. The scant existing research on the topics typically frames gender through the obsolete perspective of sex differences rather than seeing gender as a social accomplishment. Furthermore, since male privilege often conceals how men do gender by framing masculinity as the cultural default, I draw from the masculinities literature when interpreting my data. Existing evidence suggests medical cannabis permits men to eschew some hegemonic traits of masculinity through aligning their identity with therapeutic substance use as opposed to competitive substance use (e.g., binge drinking). Examining how femininities manifest within the medical cannabis subculture is also interesting as women are increasingly taking part in the community. As such, my analysis of gender pays particular attention to how gender roles mediate the use of medical cannabis, and perhaps how hegemonic gender scripts are transformed
when they intersect with the use of medical cannabis. Since the medicalization of cannabis diverges much from our society’s dominant biomedical model, my attention to gender in this study is primarily in relation to cannabis use rather than medicine in general.

In the following sections, I offer a review of academic and popular literature pertaining to both medical and recreational cannabis. Where possible, I have indicated gaps in the knowledge base as well as some disagreements between studies. It is most fruitful to begin with an overview of “blurred boundaries”, a concept describing how medical and recreational use blend together in often indistinguishable ways. This leads to an overview of stigma concerning cannabis use, and I offer a look into how cannabis activists resist stigmatizing forces. I will then discuss how normalization and medicalization are occurring simultaneously but not necessarily harmoniously, followed by a synopsis of the controversy on cannabis pharmaceuticals. Afterward, I analyze how gender has been examined in relation to cannabis use while paying attention to how masculinities manifest in cannabis culture. Following this, I discuss the methods researchers have used to explore these topics and then explain the methods used in this study. Finally, there are three analysis chapters where I discuss my findings before I summarize and conclude my study.

A final note-- Appendix A provides an overview of cannabis’ long and nuanced social history within the United States. Appendix B concerns cannabis in the state of Michigan while considering how other states have managed to regulate medical and recreational systems. I provide these to contextualize my research as well as to educate those unfamiliar with cannabis’ place in our society. A dictionary with detailed descriptions of key terms can also be found in Appendix C.
CHAPTER II

CANNABIS IN SOCIETY

To begin my investigation of medical cannabis in a post-prohibition state, it is necessary to address the debate surrounding whether cannabis is a normalized or stigmatized substance. There is no consensus here aside from how cannabis has become more normalized overtime, but are we at a point where we can say it has been completely normalized? Much of the uncertainty on cannabis normalization appears to stem from divergent understandings of what cannabis is. As such, this chapter explains how the cannabis plant has been imbued with contrasting meanings stemming from medical, recreational, political, criminal, spiritual, and entrepreneurial definitions. I begin with a discussion on the difficulties of classifying cannabis as either a recreational drug or therapeutic medicine. I then discuss social stigma and stereotypes related to cannabis use, whether recreational or medical. Finally, I provide an overview of the normalization hypothesis and the controversy surrounding cannabis going mainstream. These topics are essential for understanding how cannabis has been constructed as a medicine, a topic discussed in detail in the next chapter.

Blurred Boundaries

Cannabis has a multiplicity of uses along medical, recreational, spiritual, and commercial dimensions. These uses often blur together, resulting in competing and inconsistent meanings attached to the same plant (Bostwick 2012). One prominent theme in the literature is that of blurred boundaries, a term referring to the unclear line between medicine and recreational
intoxicant (Ryan & Sharts-Hopko 2017; Reinarman et al. 2011; Ogborne et al. 2000). There is a significant overlap between medical and recreational uses of cannabis, and people who use cannabis for medical purposes also use their medicine in recreational fashions (Satterlund, Lee & Moore 2015; Bostwick 2012). For example, Page and Verhoef (2006) found some MS patients occasionally medicated with their friends who recreationally use marijuana. Yet this does not necessarily mean the patients had situationally switched to a purely recreational mindset. Even within the same social setting, medical users may use less cannabis than recreational users as the prior tend to medicate until the desired effect is reached rather than in pursuit of becoming “stoned” (Bostwick 2012). Either way, “much drug use does not fit into two neat boxes, medical and nonmedical, but rather exists on a continuum where one shades into the other as patients’ purposes shift the suit situational exigencies in their health and their daily lives” (Reinarman et al. 2011:134). This chapter will explore the issue of blurred boundaries and the variety of meanings ascribed to plants in the genus Cannabis.

To reconstruct cannabis as a medicine rather than a recreational drug, patients often downplay the euphoria they experience from using their medicine (Chapkis 2007). This is a prevalent tactic as framing cannabis exclusively as a medicine counters the dominant public perception of cannabis as a pleasurable drug. Yet some medical cannabis scholars such as Lester Grinspoon (1999) take the position that it would be wrong to view cannabis as only a medicine. It has therapeutic properties but also appears to enhance the overall quality of life and promote enjoyment in one’s activities: “Cannabis use simply cannot be made to conform to the boundaries established by present medical institutions” (Grinspoon 1999:155). It can simultaneously be a source of relief, pleasure, prophecy, profit, and so much more.
Wendy Chapkis (2007) reached a similar conclusion in her study of medical cannabis patients with terminal illnesses. Changes in consciousness can increase wellbeing for those whose attention is dominated by bodily pain and depressive states stemming from illness. The euphoria experienced from consuming cannabis shifts one’s focus away from misery, often towards a more present-oriented state: “Few joys are as pure or profound as relief from suffering” (Newhart & Dolphin 2019:159). The high could also be interpreted as a convenient sign that the medicine is working. Either way, patients claim cannabis and its associated high allows them to engage in more activities and may even increase productivity (Chapkis 2007). In sum, medical cannabis patients enjoy the high in the same way recreational users do, and this inconsistent style of use poses problems for those hoping to classify the plant as either a therapy or intoxicant. Therefore, attention to the context of use is arguably more important than cannabis use itself or the resulting effects. For example, medical patients are more likely to use cannabis alone and without the desire to enhance fun or sociality (Newhart & Dolphin 2019). They may also restrict their use of medical cannabis to times when their discomfort interferes with their ability to perform their daily routine or when pain prevents one from sleeping through the night.

Aside from the context of how cannabis is used, different chemical compounds found within cannabis plants produce different bodily effects. The two major cannabinoids are widely abbreviated THC and CBD, though numerous subtypes of each exist. Tetrahydrocannabinol (THC) is psychoactive and is responsible for most of the intoxication experienced by consuming cannabis. It would be wrong, however, to think of THC as being medically worthless. Not only can changes in consciousness be life-preserving for those in chronic pain, but THC also acts as an appetite stimulant, anti-emetic, and helps with muscle spasms, sleeping difficulties, and more (Frye 2018). Cannabidiol (CBD) is non-psychoactive and is almost exclusively constructed as
medically valuable (rather than recreationally desirable). CBD can help with bodily pain, inflammation, seizures, and much more. All cannabinoids are processed in the body by the endocannabinoid system of neurotransmitters and specialized cellular receptors. Indeed, many claims makers like to point out our bodies have literally evolved to receive the unique compounds found in cannabis. This system is further explored in Chapter 3, and a dictionary with more information on cannabinoids has been provided as an appendix.

Medical cannabis patients are a diverse group and cannabis itself is more nuanced than commonly thought. The lack of uniformity necessary for adequate classification has also been noted by scholars studying recreational marijuana. Osborne and Fogel (2008) found Canadians used recreational marijuana for two seemingly contradictory reasons: to relax by “tuning out” the world and to concentrate by “tuning into” the world. These reasons largely depended on the social context and the user’s motives. Those who worked in occupations with high demands for emotional labor found their marijuana use to be relaxing, as did people with busy schedules. One single mother who worked full time and attended school part-time said: “I find that I don’t have time for ‘real’ recreation, so my recreation is to smoke a joint, lay in bed and read a book. Smoking weed is my meditation, my relaxation, my therapy, and my hobby all wrapped in one neat little white paper” (Osborne & Fogel 2008:549). Though this person is classified as a recreational marijuana user, the way she describes her use clearly illuminates some health-promoting qualities. Similarly, cannabis patients in Colorado interviewed by Newhart and Dolphin (2019) reported “microdosing” during the day in order to remain focused, and they occasionally consumed more of their medicine as a “treat” in the contexts of relaxation or social smoking.
Such narratives blur the boundaries between recreational intoxicant and therapeutic medicine. While our culture seems to enjoy mutually exclusive categories, we may be better off seeing cannabis as a “tool” that can be used for a variety of purposes (Lucas 2009). Utility helps structure meaning, and owing to the plant’s plurality of uses, there exists a panoply of terms describing the plant itself, its effects, and the people who consume it.

Terminology

Participants interviewed by Satterlund and colleagues (2015) say there are two kinds of substances and two types of consumers: The plant is either framed as “cannabis” to convey its use as a legal medicine or it is framed as “marijuana”, “pot” or “weed” to describe its use as an illegal drug. Likewise, there are two contrasting identities of cannabis users: the legitimate identity as a patient and the illegitimate identity as a drug user. Moreover, “[t]hese two substances and these two identities slide over each other in uncomfortable ways” (Satterlund et al. 2015:10). Similar findings were uncovered elsewhere, such as a study with cannabis patients in Canada where participants were keen on descriptive terminology (Athey, Boyd & Cohen 2017). Even though their sample insisted researchers use the term “medical patient” over “medical user”, the research team still adopts the later terminology to fit better with their analytical framework based on Howard Becker’s work on deviant drug careers (Athey et al. 2017:229).

While there is no consensus among experts, patients, or scientists, the trend appears to be using “cannabis” when referring to a medicine and “marijuana” when referring to a drug (Newhart & Dolphin 2019). Potter et al. (2011) say “marijuana” is often used explicitly for
describing herbal forms of the drug,\(^1\) while “cannabis” is much broader as it encompasses everything from the plant, its resins, and its derivatives. However, others use “cannabis” and “marijuana” interchangeably (Chapkis & Webb 2008). Bureaucratic identities further complicate things. While the terminology is still evolving, “medical marijuana” is often used to denote patients who participate in an official medical marijuana program while “therapeutic cannabis” is commonly used to describe health-related use among those not registered in a state-sponsored program (Fischer et al. 2015).

In this study, I have made efforts to use “cannabis” when referring to medicine or the plant in general. More specifically, I use “marijuana” when referring to recreational drug use unless discussing formal polices using the term. From my personal observations, patients in Michigan’s “Medical Marihuana Program” (MMMP) have expressed resentment over the state’s choice of terminology with many preferring “cannabis” be used instead. This is not only an issue of semantics because perceived synonyms may have divergent political and cultural meanings. In a recent analysis of keywords in academic articles, Seeber and Stott (2019) found 60% of “marijuana” articles were of negative (anti-drug) sentiment compared to 49% of “cannabis” articles. They suspect this is because “marijuana” has been the preferred term for criminologists while “cannabis” is more commonly used by medical researchers. Interestingly, the use of the word “cannabis” is growing, overtaking the frequency of “marijuana” in academic publications in 2008 (Seeber & Stott 2019).

“Marijuana” is also a term more popular in the United States than abroad (Seeber & Stott 2019), and as you may have already noticed with the MMMP, its spelling has changed over time.

\(^1\) Specifically, “marijuana” is the flower (or bud) produced by female cannabis plants. This is the only part of the plant which produces psychoactive THC. For more information on terminology and cannabis in general, see the annotated dictionary as Appendix C.
Unfortunately, this modern spelling with a “j” is believed to be rooted in the xenophobic business practices of William Randolph Hearst, a newspaper tycoon in the early twentieth century. Hearst had invested heavily in northwestern forestry companies and wanted American newspapers to abandon their tradition of printing on hemp-based paper. *Hemp* is a term for cannabis plants with minimal (practically zero) levels of THC, often grown by farmers for industrial purposes (Wesheit 2011). Tapping into anti-Mexican sentiments was one way to tarnish the reputation of hemp, and Hearst instructed his own newspapers to switch from the common terminology of hemp, cannabis, or marihuana to the more Spanish-looking marijuana (Gahlinger 2004). Anti-drug crusaders of the era quickly realized the new spelling could help their missions as well. In December 2018, Michigan officials switched from spelling “marihuana” as codified in the 1937 federal Marihuana Tax Act to the common spelling of “marijuana” (Biolchini 2018). This change only affects official communications and not the titles of state programs, bills, or laws.

The divide between “marijuana” and “cannabis” illustrates some of the tension resulting from different constructions of the same plant. Terminology should ideally be as specific as possible, but as I have already discussed, the constructed boundaries between the medicine and the drug overlap significantly. One radical way to approach the issue of blurred boundaries is to see all cannabis use as having some degree of medical or therapeutic value (Newhart & Dolphin 2019). An interesting study from Canada found teens who use cannabis recreationally often do so in natural spaces such as woods, providing them with fresh air and exercise. The teens frequently described their ventures outdoors as restorative, a type of “liberating rupture from the busyness, noise and pressures of their usual routines” (Moffat, Johnson & Shoveller 2009:89-90). As such, the findings from this study provide tantalizing evidence that even recreational use
of marijuana may often border on therapeutic use. Moreover, a survey of 236 medical students in Colorado found students who used cannabis recreationally in the past were more likely to endorse its therapeutic properties for prospective patients (Chan et al. 2016). We know there is something innately therapeutic within cannabis, but perhaps this is also true within the manner of how cannabis is consumed. Researchers have documented how cannabis is interpreted as something that needs to be shared with friends, and socialization certainly has health-promoting qualities (Sandberg 2012; Zimmerman & Wieder 1977; Becker 1973/1963).

Nevertheless, our imperfect categorization of cannabis use has been used as evidence against cannabis’ medical value, especially since most patients have used recreationally prior to obtaining medical certifications. While many patients report abstaining for years before seeking cannabis for medicinal purposes, many also report using cannabis throughout their adult lives (Newhart & Dolphin 2019; Athey et al. 2017; Reinarman et al. 2011; Ogborne et al. 2000). As we shall see, this is just one of the many reasons some are skeptical of cannabis’ therapeutic value, as no other medicine appears to be intrinsically pleasurable for the patient. Some researchers have even found that the plant itself is not stigmatized so much as the intoxicating effects (Pedersen & Sandberg 2013; Chapkis 2007). Historian John Charles Chasteen (2016) says: “[M]arijuana’s euphoriant qualities, the basis of its recreational appeal, worry many religious people, because the euphoria seems unearned and, therefore, immoral. The objection that medical marijuana users will feel better partly because they are high is essentially moralistic. It accompanies the worry that marijuana users are disrespecting traditional models” (136-137).

This concern over intoxication is not new as clinical publications on cannabis treatments between 1839 to 1937 often focused on methods to reduce intoxicating side effects, favoring alcohol extracts with less THC when compared to inhaled smoke (Lochte et al. 2017; Dahl &
Those who use cannabis for therapeutic reasons in Denmark say “medical cannabis” is defined as use primarily for relief, with any other effects being secondary or somewhat unavoidable (Dahl & Frank 2011). There is also the problem of treating cannabis as a singular, uniform plant. For example, Brand and Zhao (2017) argue cannabis used in ancient Chinese medicine had less psychoactive properties than modern cannabis. Not only did the Chinese have different breeds of cannabis plants than we do today, they primarily utilized the plant’s fibers and seeds, both of which contain minimal amounts of psychoactive THC.

While blurred boundaries is an interesting concept to be further explored in this study, it complicates the creation of a cohesive literature review. For the most part, scholars have studied recreational users and medical patients separately. Furthermore, research on medical cannabis patients tends to be restricted to areas with permissible medical use, though people still use cannabis for medical purposes in areas without medical cannabis laws. While they are not officially recognized as medical cannabis patients, little else separates these users from card-carrying patients in regions with medical cannabis policies. Yet it is possible that policy may create differences between patients in areas with and without a medical cannabis infrastructure. For example, in places without a legitimate cannabis industry, patients may rely on an unregulated black market largely accustomed to recreational buyers.

Blurred boundaries also manifest in the divergent frameworks used by social scientists, with some exploring the normalization of cannabis and others exploring the medicalization of cannabis. Proponents of normalization often advocate for decriminalization while proponents of medicalization often advance a general framework of harm reduction. Evidence supports that both trends are happening simultaneously but not necessarily harmoniously as one trend may represent a threat to the other. For example, recreational marijuana is potentially problematic for
cannabis’ status within biomedicine since the profession relies on maintaining strict boundaries between what is and what is not a legitimate medicine (Newhart & Dolphin 2019). Yet before I review normalization or medicalization, I must explicate the social stigmas associated with using cannabis. Understanding the role of stigma allows one to appreciate better the ways cannabis is being both normalized and medicalized.

Stigma and Stereotypes

In his exploration of the deep history of cannabis throughout the world, John Charles Chasteen concludes it has been a substance associated with outsiders in every society. Until the latter part of the twentieth century, cannabis was “used by the poor, by the marginal, by the chronically ill, by the artistically and philosophically and spiritually inclined, by seekers after the meaning of life, and by social and religious nonconformists of various stripes” (Chasteen 2016:137). Stated otherwise, cannabis is a substance historically used by the marginalized whereas alcohol has held a relatively privileged place throughout global history. The universal deviant status of cannabis likely stems from a variety of social factors, but one lesson is clear—all across the world, social groups who used cannabis were not considered a part of respectable society. Moreover, as is documented in Appendix A, these groups tended to be racial and ethnic minorities.

In the social sciences, research on disgraced identities stems from the work of sociologist Erving Goffman and his influential book, Stigma: Notes of the Management of Spoiled Identity.

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2 Even in India, cannabis was consumed primarily by religious visionaries who intentionally distanced themselves from mainstream society. The exception to this was the seasonal drinking of bhang, a beverage made with cannabis leaf paste and mixed with milk and spices. The drink was consumed in celebratory occasions, notably by the members of the upper caste. However, consumption of cannabis by the lower castes was frowned upon, perhaps because they typically smoked the flowering tops of the plant called ganja (Lawrence 2019; Chasteen 2016).
Loosely defined, stigma is a term describing a part of the self that is socially devalued to where it becomes morally offensive. This aspect can be a physical abnormality, faults of an individual’s character, or membership in a distasteful group. Either way, the “undesired differentness” (5) negatively distinguishes the individual from normal individuals in a society (Goffman 1963). This negative evaluation goes beyond individual sentiments and is a form of shared cultural knowledge, often making the stigmatized targets of socially-acceptable prejudice and discrimination. This part of my dissertation will explore the different types of stigma in relation to both medical and recreational cannabis use. I also review strategies identified by other researchers on how the stigmatized cope with or resist social stigma.

Stigma has become a popular concept in sociology and has been investigated in the contexts of mental illness, deviant sexualities, drug abuse, religious affiliation, and much more. As other scholars have built on Goffman’s foundational work, five defining features of stigma have so far been identified (Herek 2004). These include the endurance of stigmatizing features within individuals; the socially constructed meanings of the stigmatizing feature; the negative evaluation of the stigmatizing feature by society; the tendency of the feature to become a master status, engulfing the entire identity of a person; and the oppression of stigmatized groups through the restriction of power, resources, and social rights. One striking finding from Satterlund and colleagues (2015) was that many cannabis patients used the word “stigma” unprompted by the interviewer. The use of this word was consistent with how it is used in the social sciences, indicating the participants had an accurate understanding of the nature of stigma. They knew marijuana was viewed negatively by society and that their own history as a past recreational user would result in judgment from others.
Contemporary conceptualizations of stigma are more attentive to socio-cultural contexts and variations in experience (Livingston & Boyd 2010). For example, the stigma of being a cannabis user may be differentially applied and experienced between social classes, races, and genders. Those with social privileges are often able to conceal their stigmas better or resist stigmatizing labels becoming their master status. Furthermore, stigma may result from unequal power relations where privileged groups devalue the identity, lifestyle, and existence of groups with less social power (Herek 2007). The important thing here is that prejudices directed towards a target group become shared cultural knowledge and exist outside of individual attitudes and actions (Herek 2007; Goffman 1963). Since privileged groups wield more social power and cultural influence, they may have a more considerable say in what becomes a widely accepted cultural attitude. Stigmas also vary in their source. Michael Hammer (2015) says, “Medical marijuana is a rare issue where social, medical, and political stigmas intersect” (286). In other words, our negative attitudes towards the medical use of marijuana stem from a combination of overlapping institutional forces. Stigma also interacts on multiple analytical levels with researchers differentiating between structural, social, and internalized stigma.

*Structural stigma* operates on the macro level and results from institutional policies and procedures that oppress non-normal people (Livingston & Boyd 2010; Herek, Gillis & Cogan 2009; Corrigan, Watson & Barr 2006). Patrick Corrigan and colleagues (2005) define structural stigma as institutional policies that restrict rights and diminish the life opportunities of people with stigmatized identities. Examples of this include state legislation that restricts firearm ownership and parental rights of people with mental illness (Corrigan et al. 2005). Likewise, many states have laws that forbid felons from participating in some parts of public life even after they serve their time. Anti-sodomy laws are also an example of structural stigma as these were
once used to justify the discriminatory treatment of gays and lesbians (Herek 2007).

“Criminalizing activities render them deviant, and it is generally assumed within society that there is a good reason for this status” (Bottorff et al. 2013:8). Structural stigma can also be ideological wherein cultural attitudes work to privilege one group at the expense of others. An example of this is heterosexism, a cultural default that presumes everyone to be heterosexual while problematizing visible sexual minorities as abnormal and inferior (Herek et al. 2009; Herek 2007).

I ideology and institutional policy work together to create structural prejudices that disadvantage stigmatized groups. Most importantly, these macro-level forces create the context for stigmatizing actions and beliefs within groups and individuals. As applied to cannabis, some structural sources of stigma include laws criminalizing cannabis, policies banning cannabis and cannabis users in the workplace as well as (public) housing, school programs where cannabis is taught to be a dangerous drug, and organizational views that problematize cannabis, such as those found within Child Protective Services or the medical profession.

On a societal level, the degree of perceived dangers or immortality posed by the stigmatized varies over time and between groups, as does the degree of perceived blame (Lloyd 2013). We are said to have a uniquely Puritanical culture where pleasure and intoxication are stigmatized, and so too are the tools to achieve these states (DeAngelo 2015; Reinarman 1994). This general drug stigma can crystallize into specific drug stigmas (Lloyd 2013), as is the case with “stoners” and “potheads”. The stigma of drugs is also one in which the individual is blamed for their irresponsible decisions and poor choices, framing drug-related stigmas as warranted or deserved (Lloyd 2013). Some may perceive marijuana users to be making a poor lifestyle choice,
much like obese people (Satterlund et al. 2015). Regardless of their exact manifestations, structural stigmas inform how individuals and groups view the stigmatized.

Social stigma works on the meso level and describes how groups endorse cultural stereotypes that disadvantage stigmatized people (Livingston & Boyd 2010). There is some disagreement between scholars on the exact terminology used at this analytical level. Patrick Corrigan and colleagues (2006) call this public stigma, whereas Herek and colleagues (2009) call this enacted stigma. Regardless, this type of stigma is overt and manifests in both group and individual actions, epithets, shunning, ostracism, discrimination, and violence towards the stigmatized group (Herek 2007). Additionally, Michael Hammer (2015) provides evidence that informal norms on the cultural level impact state and local policy decisions, as when a cannabis-intolerant community votes to block (medical) marijuana reform or ban marijuana businesses within the community.

This type of enacted stigma can also be directed towards those who associate with the stigmatized group, resulting in what Goffman (1963) called courtesy stigma. This occurs when an individual is stigmatized for who they associate with rather than their own group affiliations or behaviors. For example, health care workers who treat AIDS patients may be socially distanced by their peers in much of the same way as someone suffering from AIDS. Courtesy stigma is also present in a study of straight teenagers with LGB (lesbian, gay, bisexual) siblings where Amy Brainer (2015) found the teens were frequently accused of being homosexual by their peers. Even though the teens interviewed were straight, their heterosexuality was called into question by their peers for having an openly LGB sibling. Using similar reasoning, a courtesy stigma may also be applied by non-cannabis users who have friends or family whose cannabis use is publicly known. The group association is what is targeted rather than something about the
individual or their behaviors. In fact, recent organizational research revealed cannabis stigmas are often transferred to businesses associated with the cannabis industry, such as law offices, accounting firms, and public relations agencies (Lashley & Pollock 2019).

At the individual level, stigma can be felt, internalized, or both. *Felt stigma* results from the awareness that an identity is culturally devalued and can result in anticipatory behavior to avoid negative interactions (Herek et al. 2009; Herek 2007). Felt stigma causes behavioral adjustments in both the stigmatized and normative groups. In the context of heterosexism, both heterosexual and non-heterosexuals may avoid gender nonconforming behavior and deviant sexual expressions in order to avoid the label of a stigmatized sexual identity (Herek et al. 2009; Pascoe 2007). David Karp (2006) documented the stresses of felt stigma on the romantic lives of patients taking antidepressants. He found patients worried about adverse reactions when first disclosing their medication regiments to new love interests, often obsessing over when and how to disclose such information. A couple of Karp’s participants even described concealing their medicine cabinets once new relationships blossomed into spending nights together. However, felt stigma does not necessarily have to be internalized as it results from the mere knowledge that an identity carries negative social consequences.

Felt stigma may lead to *enacted stigma* when an individual is motivated to publicly prove they are not part of a stigmatized group. For example, C.J. Pascoe (2007) found that teenage boys routinely rebuke homosexuality in order to reaffirm their heterosexuality to others. Using “fag” as an insult (an example of enacted stigma) signals to others that one is not a fag, even if the target of the abuse has nothing to do with homosexuality (Pascoe 2007). Anticipating rejection from others, both cannabis users and non-users may avoid cannabis culture, individuals known to consume cannabis, and anything else that may raise suspicions of cannabis use.
Research by Corrigan et al. (2006) proposes a similar model using the language of stereotypes instead of stigma. They call public stigma *stereotype awareness* in that people know negative attitudes towards some identities exist within society. After becoming aware of these negative evaluations, an individual may start to endorse such beliefs through *stereotype agreement*. If this occurs and the individual applies devalued cultural stereotypes onto themselves, it may result in decreases in self-esteem and self-efficacy (Corrigan et al. 2006). This is also known as *internalized stigma* and results when individuals come to believe in the cultural stereotypes surrounding a stigmatized identity (Livingston & Boyd 2010). Both the stigmatized and normative groups may internalize cultural stigmas, resulting in *self-stigma* in the former and *prejudice* in the later (Herek et al. 2009; Herek 2007). Anti-homosexual prejudices can be accepted by heterosexuals and manifest as personal biases towards non-heterosexual people. The same negative attitudes can also be accepted by non-heterosexuals and manifest as internalized homophobia, internalized heterosexism, and internalized homonegativity (Herek 2007). All of these result in self-directed prejudice by stigmatized individuals as they internalize society’s negative evaluation of their identity (Herek et al. 2009). However, Corrigan et al. (2006) note that not all people who are aware of or endorse cultural stigmas will internalize such stigmas, and this resistance protects their self-esteem and self-efficacy.

This internalization of stigma is distinct from an isolated individual attitude, as stigma constitutes shared cultural knowledge that benefits some groups at the expense of others. Furthermore, how an individual acquires a stigmatizing label is not uniform and depends on the specifics of the situation. For example, Gregory Herek (2004) accurately points out that homosexual behavior may be dismissed if it only occurs in adolescence, under the influence of alcohol or drugs, or within the confines of a sex-segregated institution like prisons. Anecdotally,
the same is true with marijuana. Bill Clinton avoided the stoner label by claiming he tried marijuana only once and did not inhale. Intermittent marijuana use during one’s teenage years may be forgiven if the individual ceases use at some point before adulthood. The stoner label can also be avoided by saying one only smoked when they were drunk, by claiming they mistook a joint for a cigarette, or that they unknowingly once ate food infused with cannabis. You may also not think someone is a stoner if they admitted to using marijuana while on vacation in Jamaica, Amsterdam, or another location with a well-known cannabis culture. In all these cases, marijuana use is seen as incidental and not characteristic of the individual.³

Making matters more complicated, stigmas vary in their degree of public visibility. Goffman (1963) termed visible stigmas *discrediting* and non-visible stigmas as *discredible*. Since the latter is concealable, an individual is only devalued once their stigma becomes known to others. People with non-visible stigmas routinely manage the extent to which others are aware of their stigma (Herek 2004; Goffman 1963). This is a strategy that protects the self on the one hand but may also diminish self-esteem and self-efficacy on the other. For example, Herek and colleagues (2009) found negative self-perceptions were significantly lower among LGB individuals who were out to family and friends compared to LGB individuals who merely believed their family and friends knew their closeted sexual identity. This reduction of self-stigma is highest for those who had explicit conversations about their sexual identity (Herek et al. 2009). As such, while keeping a stigmatized identity a secret may protect against negative reactions from others, it may also damage one’s sense of self and mental health. After all, our

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³ The endurance of stigmas also varies on the organizational level, with researchers differentiating between event stigmas and category stigmas. *Event stigmas* result from occurrences like bankruptcies or lawsuits which often fade from the public’s memory over time. *Category stigmas*, also referred to as *core stigmas*, result from an organization’s identity or central operational attributes where the very nature of the business is stigmatized. For example, core stigma is problematic for enterprises such as sex toy retailers, weapons manufacturers, and cannabis businesses (Lashley & Pollock 2019).
sense of self is partly formed by those who we find emotionally important. We internalize the expectations and opinions of others, creating “a chorus of voices that shape our internal conversations about who we are, what we ought to feel, and how we should act” (Karp 2006:126).

**Resistance and Empowerment**

Since stigma results in lasting social disgrace, the term is increasingly used in a manner of advocacy to describe the prejudice and discrimination experienced by stigmatized peoples (Lloyd 2013; Bayer 2008). Empowerment is particularly important here as the stigmatized face a vicious cycle of compounding disadvantages. Stigmas are associated with lower levels of hope, self-efficacy, self-esteem, social support, and quality of life (Livingston & Boyd 2010). The stigma of being a medical cannabis patient can lead to chronic stress and social isolation (Satterlund et al. 2015). For example, their health may also suffer as a result of underutilizing health care services out of the fear of disapproving health care providers. There is a tendency for medical professionals to spend time analyzing the patient’s moral fiber and addictive potential rather than the patient’s underlying illness. This takes time away from meaningful care and discourages patients from being honest with their care providers (Bottorff et al. 2013). Dubin and colleagues (2017) suspect there may be a mismatch between physicians’ formal curriculum, which emphasizes stigma reduction, and the hidden curriculum, which implicitly reproduces anti-marijuana attitudes. Furthermore, when patients forgo medical cannabis over concerns of stigma, they may experience unnecessary pain, suffering, and unwarranted stress (Ryan & Sharts-Hopko 2017). “Medicine can only be effective if it is taken, and stigma and lack of acceptability can interfere with compliance and safe access” (Rudski 2014:318).
A 2013 qualitative study by Bottorff and colleagues identified three sources of stigma directed towards medical cannabis patients. The first of these was negative views of cannabis as a recreational drug where larger society constructed patients as “potheads” or “stoners” (Bottorff et al. 2013). Patients reported that friends and family members questioned the legitimacy of their illness and choice of medication, often not believing cannabis had any medicinal benefits. This lack of trust manifested in enacted stigma wherein others explicitly doubted the severity of a patient’s illness and motives for cannabis use. Perceived stigma also forced patients to conceal their cannabis use from their social networks, withdraw from disapproving family and friends, and sometimes even relocate to another area (Bottorff et al. 2013).

The second source of stigma found by Bottorff et al. (2013) was illegal activity surrounding cannabis use whereby patients are viewed as engaging in illicit drug activity. Some patients found comfort in having a state-issued medical card since such cards distinguish patients from illegal recreational users. Other users, however, feared a centralized database of patient information could be abused by authorities with one participant saying, “[B]efore I was anonymous and I think I was in a better position” (Bottorff et al. 2013:5). Patients who cultivated their own medicine were suspected of being drug dealers and reported repeated harassment by police, landlords, and housing authorities for those in state-subsidized housing. Women also have the added stigma of being labeled negligent mothers if it was known they consume marijuana, a well-founded fear in light of child protective services intervening in the homes of families who use medical cannabis (Reinarman et al. 2011).

The third and final source of stigma identified by Bottorff et al. (2013) was using cannabis in the context of layered vulnerabilities or how medical cannabis use can be entangled
in a web of other marginalized identities. Patients often suffer from a marginalized or controversial disorder, such as fibromyalgia, HIV/AIDS, or mental illness. Those in poverty, as well as gender and sexual minorities, may already be framed as “problem patients” by the larger medical establishment with the addition of cannabis use further adding to their social devaluation (Bottorff et al. 2013). Perhaps another term this source of stigma could be intersectional stigma. Intersectionality acknowledges our lives are not experienced one identity at a time, but instead we experience a simultaneous plurality of social privileges and oppressions (Collins & Bilge 2016). Layered vulnerabilities are particularly sensitive in the United States with its history of socially constructed drug scares. Recurring moral panics related to drugs are often accompanied by ideologically constructed enemies, such as immigrants or countercultural youth. Sociologist Craig Reinarman calls drugs “richly functional scapegoats” (1994:165) for social fears rooted in racism, xenophobia, classism, ageism, and more.

How can we resist or combat stigmatizing forces? From a psychological standpoint, self-stigma can be reduced through one of two general strategies (Mittal et al. 2012). The first strategy is to alter stigmatizing beliefs and attitudes in an individual through practices such as cognitive restructuring and psychoeducation. The second strategy, which is gaining popularity among stigma experts, is one of mindful acceptance. This latter approach does not challenge stigmatizing forces or stereotypical thinking, but instead aims to make the individual more comfortable with their current self. Mindful acceptance can enhance a patient’s overall self-esteem, empowerment, and help-seeking behavior (Mittal et al. 2012). Outside of clinical practice, contact with stigmatized people has also been shown to reduce internalized stigma within both stigmatized and non-stigmatized populations (Herek 2007). Positive interactions with the stigmatized can be beneficial for everyone involved.
Yet the most effective stigma reduction strategy may be in changing societal beliefs and attitudes (Herek et al. 2009). If stigma is conceptualized as being a top-down model wherein individuals internalize negative cultural stereotypes, it makes sense to enact destigmatizing changes on the structural, cultural, and organizational levels. Part of the stigma towards medical cannabis patients comes from the ambiguous state of the medicine, something that is both illegal and therapeutic. Changes in drug policy may help shift our cultural framework surrounding cannabis by stopping institutional messages aimed at presenting users as morally deficient, criminal, or psychologically ill (Hathaway et al. 2011). Structural changes can be accomplished through legal reform, but also through educating medical practitioners and publicly addressing the consequences of cannabis’ criminalization (Bottorff et al. 2013). Legalization will not eliminate the stigma surrounding cannabis, but it will re-classify medical users as normal, law-abiding citizens. However, the legacy of stigma will still differentially impact those with less social privileges. A good example of this can be found in a statement by Anqunette Sarfoh, a former news anchor who quit her job to open a medical cannabis dispensary in Detroit. Sarfoh reflects on the challenges in recruiting diverse staff in a story reported by Kathleen Gray (2019):

> In our community, cannabis use has been stigmatized, because of how the legal impacts have affected our community… In [white] communities, kids can go in a cornfield and smoke a joint and go on about their lives. But in our communities, what happens when you’re caught, your future is gone. And so for the longest time, you just don’t even touch it and you grow up knowing that it could ruin your life (Anqunette Sarfoh quoted in Gray 2019).

Even after cannabis is legalized, the trauma resulting from prohibition will continue to exist as will entrenched anti-cannabis ideologies. Participants in several studies thought much of the stigma surrounding cannabis use is a result of societal ignorance or deliberate misinformation (Satterlund et al. 2015; Hathaway, Comeau, & Erickson 2011). Changing institutional messages about cannabis would be a good place to start, but the general public’s perception of drug use is
also shaped by the media, their personal experiences, and their surrounding environments. Environments that facilitate contact between the public and the stigmatized can change negative attitudes, relying on the principle that with familiarity comes empathy (Lloyd 2013; Herek 2007). As such, while some patients may prefer nondescript cannabis facilities (Satterlund et al. 2015), reducing the visibility of such locations may adversely impact public perceptions of medical cannabis users.

Conspicuous medical cannabis services could reduce some social stigma, but the quasi-legal industry faces strict regulations on permissible public outreach and advertising⁴. Even Facebook has a corporate policy prohibiting paid advertisements about cannabis and actively suppresses cannabis-related information. In fact, a company trying to promote a cannabis educational seminar is currently suing Facebook for this very reason. Cannaramic Media, Inc. charges that “the Facebook algorithm systematically removes, bans and limits not only the promotion, but also the sharing of information related to legal cannabis, the industry, legalization, social equity and medical uses of marijuana, even though the plant is now legal in 33 states, the District of Columbia, several U.S. territories, and dozens of countries around the world” (Hasse 2019). Until this type of blanket censorship ends, the current public relations strategy will remain one where cannabis entrepreneurs are active in politics and encourage (positive) news reporting on the industry (Kilmer & MacCoun 2017).

The operational structure of medical cannabis facilities access may also impact social stigma. Amanda Reiman (2008) details two different models of medical cannabis facilities, the pharmacy model and the social club model. The pharmacy model is how facilities in most states, 

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⁴ A company called MedMen based in California has been advertising on the Howard Stern Show for several years. They may be allowed to do this because SiriusXM Satellite Radio is a paid subscription service and exempt from some of the regulations on content over public airwaves. Interestingly, the commercial emphasizes how the company is professional and medically-focused, so customers shouldn’t worry about stigma and stereotypes.
as well as Michigan, operate, characterized by the narrow mission of offering medicine for purchase. This model is often administered in a top-down manner where laws dictate permissible conduct and sales (Reiman 2008). The social club model, on the other hand, is built from a bottom-up approach where patient needs are the starting point. This was the model pioneered by Dennis Person, who in 1992 started the first medical cannabis buyers club in California, largely serving patients with AIDS (Reiman 2008; Grinspoon 1999; Feldman & Mandel 1998). The defining characteristics of the social club model are the ability to consume medicine on-site and service integration. These dispensaries not only sell medicine, but they also function as community centers where patients develop social bonds and exchange information (Nicholls-Lee 2019; Feldman & Mandel 1998). There may be support groups for specific populations (e.g., veterans and gender-specific groups) as well as programs such as art classes, bingo, movie nights, excursions, and even doggy daycare. The idea is to facilitate social support among patients while allowing the use of medication at the same time, “to infuse a feeling of support and comfort into the client population served” (Reiman 2008:40).

With medical cannabis carrying a social stigma, these social clubs may help protect against some of the ostracization and mental health consequences that come with being a patient. They provide a compassionate community designed to address the physical, mental, and social needs of patients. Interestingly, similar forms of social support have been documented among other groups including graduate students who smoke marijuana within the social context of marijuana prohibition. While the graduate students in Emily Garner’s (2016) phenomenological study spoke about how society oppresses their non-medical use of marijuana, they also spoke about a mutual sense of community that comes with knowing other users. One student described

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5 Alaska became the first state to permit “social marijuana use” in April 2019. Dispensaries can apply for a license to run a cannabis lounge section in their facilities for adults ages 21 and up. This is in a recreational context, though.
their smoking friends as their support system while another discussed the bonding that results from smoking with professors, an act that helps break down institutional status differences. In other words, the mutual sense of secrecy associated with smoking marijuana may help users develop meaningful social bonds. Knowing other academic marijuana users validated the graduate students’ sense of self, as knowing other high achievers who smoked allowed them to know their lofty goals were possible (Garner 2016). These underground smoking circles may serve as protective and beneficial networks for graduate students in the often-alienating academic community.

In lieu of radical social or structural change, individuals must learn to cope with or resist stigmatizing forces. Bottorff et al. (2013) identify four coping strategies used by medical cannabis patients, including: concealing their cannabis use, convincing others of cannabis’ benefits, using cannabis responsibly, and engaging in political action to defend their right to use cannabis as a medicine. The first of these, concealing cannabis use, connects back to the discredible nature of marijuana consumption. Being a medical cannabis patient comes with a concealable stigma which causes patients to take precautionary measures about others knowing their patient status. While most people taking prescribed medications keep it a secret from others, there is something unique about prescribed cannabis and its illicit nature (Satterlund et al. 2015). The strategy of keeping cannabis use undercover is best exemplified by a 55-year-old woman who said: “Keep your mouth shut, grow it, use it, don’t tell anybody, don’t even tell your family, don’t tell our friends, keep it to yourself and save your own life” (Bottorff et al. 2013:6). Other strategies for secrecy included using incense, changing clothes after smoking, and keeping vigilant about who else could be watching. Relatedly, research on medical cannabis cultivators discovered many workers use “cover stories” when conversing with strangers or community
outsiders. These individuals often say they work in a related occupation or generically express they are small business owners (Adelman 2013). Satterlund and colleagues (2015) also found patients would also refrain from commenting on marijuana-related issues when they arose in everyday conversations. However, an irony exists when this tactic is used within the current bureaucratic system of medical cannabis. In order to become a medical cannabis patient, individuals are made identifiable through state registries and medical evaluations by physicians (Newhart & Dolphin 2019).

The second coping strategy patients use is to confront the stigma by convincing others of cannabis’ benefits through education and candid discussion. One patent took pride in transforming her once-disapproving mother into a “full on cannabis granny” (Bottorff et al. 2013:7). These conversations are necessary in a social context where marijuana use is associated with addiction, laziness, crime, and other social ills. In other words, popular thinking says marijuana use is incompatible with conventional roles and responsibilities (Hathaway et al. 2011). The task of changing these sentiments falls largely on patients though recreational marijuana enterprises may also help in this regard. A study of cannabis tourism in Colorado found the industry consciously tries to challenge perceptions of deviance through maintaining a professional appearance and conveying the latest scientific research on cannabis to their guests (Keul & Eisenhauer 2019). However, these public-facing and polished cannabis experts are using proven tactics borrowed from early medical cannabis activists.

Thirdly, medical cannabis users also stress the importance of using cannabis responsibly and in an appropriate, respectful manner. Some expressed resentment towards recreational users, who they perceived as irresponsible and detrimental to cannabis’ public image (Bottorff et al. 2013). It is common for cannabis users to use disidentifiers (Goffman 1963) wherein individuals
explicitly reduce their involvement in the drug trade and/or avoid other drugs or drug users. These disidentifiers help defend the user from deviant labels associated with the drug. When cannabis users take defensive positions regarding their use, it’s often a good sign they are attempting to avoid stigma (Sandberg 2012). Patients can prevent some stigma by making it known to others that their cannabis use is for medical purposes as opposed to recreational purposes (Ryan & Sharts-Hopko 2017; Satterlund et al. 2015; Bottorff et al. 2013). Michael Hammer (2015) notes that the word “medical” as a qualifier has had some success in shifting cultural attitudes towards marijuana from a dangerous drug to a legitimate medicine. More fascinating, though, is that recreational marijuana users also look down on people who misuse or abuse cannabis, effectively stigmatizing heavy users much like non-users would (Hathaway et al. 2011). Many of the recreational users emphasize the need to retain control over their marijuana use, moderate their consumption, and express a lack of interest in stronger forms of the drug. These findings build on Hathaway’s (2004) suggestion that much of self-regulation and self-censorship is done to avoid the risky label, as risk-avoidance is now deeply connected to morality.

The fourth and final strategy to manage cannabis-related stigma is engaging in political action by becoming a cannabis activist and advocating for the right to use cannabis as a medication (Bottorff et al. 2013). Many medical cannabis patients exhibit tertiary deviance, defined as deviants who fight to change social stigma related to their identity. Primary deviance is characterized by denial, secondary deviance is categorized as acceptance, but tertiary deviance is characterized by advocacy and mobilization (Adler & Adler 2016/1994; Becker 1973/1963). Goffman (1963) described how empowered individuals may become public representatives for their stigma, a situation we now see with celebrities sharing their stories of addiction, mental
illness, and other discredible traits (Lloyd 2013). Sandberg (2012) described how Norwegian cannabis users employed “bravado” to boast about the benefits of cannabis, such as how it enhances creativity and is therefore used by prestigious people. This bravado allows users to frame cannabis as normalized while downplaying undesirable side effects (Sandberg 2012). It should also be noted here that individuals have the agentic ability to resist stigmatizing messages from society. Research has shown people who have experienced stigma may be less willing to stigmatize others (Herek 2004). Finally, stigma does not necessarily lower self-esteem because people have a capacity for cognitive resistance and may fight against the moral judgments of others (Bayer 2008).

The classic literature on stigma emerged from clinical studies but now social scientists who study stigma often do so from a perspective of advocacy. This is because stigmas are often imposed by the powerful onto those with less social power, constituting a classic form of oppression (Lloyd 2013; Bayer 2008). However, non-elites may also be complicit as they police and enforce social stigmas as if they were following orders from those with social power. People like labels, and being labeled as normal (i.e., non-stigmatized) may be partly accomplished by directing stigmas away from the self and on to others. However, while many would argue we have a moral responsibility to defend those with less social power, a contrasting perspective acknowledges that stigma can bring about positive changes for the whole of society. Stigma has long been used as a means of social control wherein the public is discouraged from partaking in damaging behaviors such as illicit drug use (Ahern, Stuber & Galea 2006). This principle of deterrence through stigma has been successfully deployed against tobacco.

Anti-tobacco campaigns of the 1970s successfully denormalized public smoking by directing stigma towards smokers. This was facilitated by framing smoking as an environmental
health hazard as opposed to merely a personal health problem. However, while strong evidence existed for the latter, there was little scientific evidence at the time connecting smoking to public health risks like second-hand smoke (Bayer 2008). Philippe Lucas (2009) also notes how bureaucracies rely on moral justifications when the available scientific evidence does not support their position, and this was the case with both marijuana prohibition and public tobacco smoking. The push to frame smoking as an undesirable anti-social behavior continues to this day, and Bayer (2008) suggests it may be more effective in curbing smoking than other anti-tobacco policies like consumption taxes. Increasing the price of tobacco products disproportionately burdens those at the bottom of the socioeconomic ladder while stigmatizing tobacco use cuts across class lines. The only problem with applying these ideas to marijuana consumption is that smoking marijuana in public has rarely been a problem. As other scholars have noted, most smoke marijuana in private spaces and practice an etiquette of seclusion (Johnson et al. 2008).

Nonetheless, there are reasons we should be cautious of imposing stigmas as a means of deterrence. While stigmas impact all social groups (Bayer 2008), those with social privileges often have more power to resist being labeled as deviant or a greater ability to conceal their devalued identity. For example, our culture stereotypically associates marijuana use within minority groups (e.g., immigrants and communities of color) when facts point to higher use of marijuana among white people (Garner 2016). Likewise, stigmas obscure facts by emphasizing immorality over logical reasoning. I would also add to this that when we link marijuana use to deviants, reckless youth, and addicts, we increase the stigma and consequences for normative professionals who use the same substance. Furthermore, while stigma may help to deter drug use, it also results in dire physical and mental health complications among the stigmatized population (Ahern et al. 2006). Stigmatized people may respond with anger, self-imposed
isolation, or attempts to conceal their identity, all of which are associated with negative mental health outcomes. Institutional discrimination also results in lower physical health as drug users are treated as problematic by the medical establishment (Ahern et al. 2006). A final concern with socially-beneficial stigmatizing is that once a stigma is established, it is very difficult to change or remove. Normalizing a stigma requires a significant cultural shift often occurring over many years.

Normalization

The reasons people use substances are varied, complex, and change over time, yet we still tend to develop and apply one-dimensional theories of drug use. In doing so, we form inaccurate conclusions that commonly lead to inappropriate policies (Osborne and Fogel 2008). For example, those who argue marijuana is a normalized drug may frame the substance through a recreational perspective that neutralizes medical or spiritual uses as crafty recreational use. Similarly, those who argue cannabis is a medicine may also neglect the pleasurable qualities of the substance and how healthy people use the substance for fun. In either case, differential constructions of the substance are ignored in favor of a cohesive theory which may be appealingly simple but conceals contrasting explanations.

The normalization hypothesis is prominent in both criminological and sociological literature (Duff et al 2012; Sandberg 2012) and suggests that the moral boundaries surrounding marijuana have been redrawn to accommodate non-abusive use. Critics have argued this is an oversimplification wherein social contexts are ignored, as social tolerance towards marijuana is based on a variety of factors (Hathaway 2004). Nevertheless, more people are enjoying marijuana today than ever before. In 2017, nearly 15% of American adults reported using
marijuana in the past year (Keyhani et al. 2018). Despite the growing popularity of marijuana use, increased consumption is only one part of the normalization process.

Another key dimension of normalization is the reduction or elimination of social stigma. *Normalization theory* came from studies on disability and has since been used as an interpretive tool for how marijuana is becoming an ordinary intoxicant in society, largely starting in the 1990s (Sandberg 2012). This is distinct from *neutralization theory* which sees deviant drug users as attempting to manage a stigma because they are invested in mainstream society. Likewise, Erving Goffman (1963) distinguished between *normification*, which describes how deviants assimilate into society by attempting to pass as normal, and *normalization*, which describes the societal transformation wherein a once-deviant identity becomes accepted by others. While normification essentially attempts to conceal deviance, some scholars have argued normification has facilitated cannabis normalization. Lau et al. (2015) say cannabis users help normalize cannabis through normifying harm reduction techniques like self-regulation and not using at work. Such strategies help users pass as normally functioning in their everyday lives, but this claim fails to consider medical patients who may need to medicate in order to optimally function through their daily routines. It is also reminiscent of the closet in the LGBTQ community, something that oppresses the individual and diminishes the group’s visible presence in society.

Nonetheless, normalization theory applied to marijuana would assume there is no longer a stigma associated with being a marijuana user (Sandberg 2012; Parker, Williams & Aldridge 2002; Goffman 1963). While the stigma of marijuana use appears to have diminished, there is little evidence that such stigma has entirely disappeared. Some scholars argue the social stigma surrounding marijuana use now only applies to irresponsible use (Duff et al. 2012; Hathaway et al. 2011; Jarvinen & Demant 2011). Moderate recreational use has become normalized while
excessive and/or dependent use is still problematized as drug abuse. A “normal marijuana user” is one who practices self-control, discretion, and moderation (Duff et al. 2012). Similar sentiments have been found among medical cannabis patients who routinely emphasize the need for responsible use, often balancing symptom management with self-imposed limits on consumption during the workday (Newhart & Dolphin 2019). Hathaway and colleagues (2011) say, “A sense of normalcy is preserved by avoiding attributions and behaviors seen as risky, and thereby the associated stigma” (456). Therefore, the residual stigma of marijuana may function to discourage risky use of marijuana, as “participants routinely insisted that this stigma had more to do with the circumstances of [marijuana] consumption than with the act itself” (Duff et al. 2012:281).

Even though marijuana use may be becoming more normalized, the fact that most users remain guarded about their use suggests we still have a social structure or culture (or both) in which cannabis is stigmatized. This is particularly true for women who use cannabis because they are judged more negatively by others and therefore take extra steps to remain discreet: “Because marijuana is often seen as a masculine activity, a normalised marijuana using image is unavailable to many women” (Mostaghim 2019:64). The gendered dynamics of cannabis will be discussed thoroughly in Chapter 4, but the point is raised here because normalization is an uneven process along the lines of gender, race, social class, and generation. Indeed, marijuana may be more normalized for those with elite statuses including musicians, athletes, and other celebrities. These individuals were relatively immune from the “othering” endemic in Canadian newspaper articles on marijuana use where Haines-Saah et al. (2014) uncovered a “tendency to use a person’s race, class, or other irrelevant characteristics to position him or her as different, problematic, or ‘other’” (55). Nonetheless, it appears being a marijuana user no longer denotes a
master status and has instead become just another aspect of a person’s life (Jarvinen & Ravn 2014; Sandberg 2012; Hathaway et al. 2011). Yet since the stigma of reefer madness still endures, recreational users practice self-regulation and self-censorship when it comes to their own consumption (Johnson et al. 2008).

While many researchers have pointed to lingering stigma to argue against normalization, a pair of Norwegian researchers claim normalization is problematic because a distinct marijuana subculture still exists despite marijuana use becoming more widespread (Pedersen 2014; Pedersen & Sandberg 2013; Sandberg 2012). Subcultures may be conceptualized as specific groups of people, but Sandberg (2012) argues subcultures should be defined by rituals, stories, and symbols. Cannabis or marijuana subcultures, for example, are characterized by a shared symbolic universe where users are acculturated to smoking rituals and construct meanings related to the plant that oppose conventional meanings. This subculture has also been characterized by a mutual emphasis on embodied pleasures and sensual experiences (Keul & Eisenhauer 2019). Furthermore, participants in the subculture share values that emphasize naturalness and authenticity (Sandberg 2012; Shukla 2006; Zimmerman & Wieder 1977), a feature also found by Canadian researchers studying teens who smoke marijuana (Moffat, Johnson, & Shoveller 2009).

Though increased use of a substance among the population is often cited to be part of normalization, Sandberg (2012) finds that marijuana users in Norway still view the drug as oppositional and a symbolic marker of difference. This does not mean to suggest that this subculture has been static over the past several decades, but rather that users still classify themselves as existing apart from the mainstream (Sandberg 2012). Not all scholars agree with this conclusion, though. A study of adult marijuana users in Canada found most perceived
cannabis to be mainstream rather than confined to a subculture or alternative lifestyle (Duff et al. 2012). Yet this cannabis subculture has been described in the United States with ethnographic research documenting regional differences between west coast and east coast marijuana users (Johnson et al. 2008). More importantly, these subcultures have historically been a powerful counter to the interests of U.S. drug policy and enforcement.

Subcultures can also be commodified as the rise of cannabis tourism in Colorado, as described by Keul and Eisenhauer (2019), exemplifies the continued existence of a distinct cannabis culture. Cannabis tourism not only promotes cannabis consumption, but it also immerses visitors in the cannabis universe through a bus tour of the industry. With expert guides acting as cultural interpreters, visitors are transported to locations like dispensaries, growing operations, glass blowers and paraphernalia makers, and even restaurants that offer selected food pairings to accompany specific strains. Along this journey, visitors are encouraged to observe the facilities, indulge in the smell of growing plants, taste the variety of cannabis strains, experiment with different methods of consumption, learn about classic and innovative smoking rituals, and experience the unique effects of each cannabis strain they consume. Furthermore, visitors often share stories of cannabis and prohibition in their home states (Keul & Eisenhauer 2019), something perhaps akin to folktales or myth-making. As one may have noticed, the cannabis tourism industry resembles the model adopted by Napa Valley vineyards, though regulations limit the conglomereration of different cannabis facilities on one site (hence the need to drive to multiple destinations).

This brings us to another part of the normalization debate where cannabis normalization is seen as contextual since users navigate social settings of both normalized and stigmatized cannabis use (Lau et al. 2015:11). While no one denies that perceptions of cannabis vary
between social settings, we should question the utility of applying the concept of normalization on a situational basis. Afterall, isn’t every deviant activity more or less normal depending on the setting? Cannabis consumption is normal during the dispensary bus tour described above, just like nudity is normal at a nude beach or in the private confines of one’s home. This is why normalization should be understood as occurring on the societal and/or cultural levels. We have seen some degree of cultural accommodation concerning cannabis, but we have yet to move beyond the stigmas and structural penalties that have been elements in our society for so long.

The debate surrounding marijuana normalization is ongoing and much work still needs to be done in the area. For example, most of the literature on marijuana normalization focuses on the macro, rather than micro, levels of analysis (Duff et al. 2012). We have little understanding of how social groups or individuals come to change their views on marijuana, though we have some evidence that institutional change requires activism and patience. Normalization arguments also need to account for how different social groups perceive marijuana, as Erickson and Hathaway (2010) believe normalized marijuana use is largely a youth phenomenon. Indeed, the argument that cannabis is normalized came from longitudinal research on UK teenagers in the 1990s (Pennay & Measham 2016; Parker, Williams & Aldridge 2002). This assertion continues to live on perhaps because most empirical studies on marijuana use trends focus on youth populations (Duff et al. 2012). Nonetheless, 43% of full-time college students reported using cannabis in 2018 (Schulenberg et al. 2019), a figure that far eclipses the percentage of adults who have done so. Since these young adults will be our future leaders, it is common to assume we have achieved normalization already.

In fact, this is how many narratives on marijuana normalization proceed. They typically begin with the rediscovery of marijuana on the part of the counter culture of the 1960s. These
young people desired liberation from the conservative status quo of the era and approached psychedelics as tools to free the mind from traditional ways of thinking. As this hip generation grew older, they claimed positions of social power in government, law enforcement, business, medicine, and more. This model of social change is known as cohort replacement, where younger generations replace the older generation as leaders in society. Opinion polls are an insightful way to appreciate this process of change as those ages 65 and up are the only age demographic where the majority oppose legalization (DeAngelo 2015). Other scholars have also found that age is one of the most powerful predictors of support for marijuana legalization (Elder & Greene 2019). As we work our way down the age groups, support for legalization increases making it only a matter of time until legalization and normalization are realized.

The above model of social change works well in civil democracies, but it is fundamentally limited. For one, social power is never so easily surrendered, and those in power may fix the system so it cannot be coopted by newcomers. Anti-cannabis ideology has been ingrained into how law enforcement operates, how drug research is funded, and how educational systems treat cannabis. Moreover, cohort replacement is disempowering as it conceives social change as something that will happen in the future, but not something that can happen right now. Nowhere was this more atrocious than in the PR campaign of “it gets better”, a message that was supposed to reassure LGBT youth that their harassment would one day come to an end. When would this better time come? No one knows, but the message had the tacit implication to begrudgingly accept heterosexist oppression until it does. The same issue is present with narratives saying social and legal cannabis reform is eminent because of generational change.

Activism and civic engagement are also effective forces of social change, and they do not require waiting until positions of influence are vacated. Largely beginning in the 1990s, a social
movement formed in California which politically medicalized cannabis, and this framework of cannabis as medicine has since spread elsewhere. This is discussed more in the next chapter, but the point is raised here because we need to account for medicalization’s role in the normalization process. Scholars have yet to integrate these two trends which is understandable given that studies on marijuana normalization and cannabis medicalization target different populations and thus come away with different conclusions. Harm reduction studies with medical cannabis users often focus on those who are most exposed to institutional oppression, such as seriously-ill patients who medicate with cannabis frequently. While such research is valuable, the emphasis on a small segment of the population neglects a significantly more substantial part of the population, like recreational marijuana users, who also experience some level of risk (Erickson & Hathaway 2010). Studies that provide evidence for the normalization of marijuana use may also become counterproductive to the mission of medical cannabis. As researchers find more and more evidence for marijuana becoming a normalized substance in modern society, conservative anti-drug forces may renew their efforts to prevent the legalization of marijuana by targeting the emergence of medical cannabis. This backlash to normalization’s (scientific) publicity may perpetuate the institutional oppression of high-risk patients (Erickson & Hathaway 2010).

Conclusion

The debate continues whether cannabis is becoming normalized or has already become normalized. Those who claim cannabis has reached a normative status in society point to growing use among the population as well as changes in the law. Those who claim cannabis has yet to be normalized point to a subculture where cannabis is seen as an oppositional to mainstream values, how recreational users and medical patients still feel the need for secrecy,
and how the medicalization of cannabis is an ongoing process. Some of their arguments suggest that if cannabis loses its social stigma, there would no longer be a need for medicalization. This debate is explored more in the next chapter.

CHAPTER III

THE INCOMPLETE MEDICALIZATION OF CANNABIS

This chapter explicates research on how cannabis came to be constructed as a medicine in a social environment where it is classified as a prohibited substance. Since this is an area with a rich history, this chapter primarily examines academic studies related to medicalization, health movements, pharmaceuticalization, and debates on cannabis’ place within or outside of mainstream medicine. For an overview of the social history of medical cannabis, please reference Appendix A.

I begin by defining what medicalization means and then move into a discussion of how medical cannabis is received by our dominant model of medicine, otherwise referred to as allopathic or mainstream medicine. As I will show, health care professionals have had mixed reactions to the medicalization of cannabis. I then move into a discussion of pharmaceutical developments and the intense disdain cannabis patients have towards the pharmaceutical industry. Following this is a summary of the skepticism and debates surrounding cannabis’ use as a medicine, and why some believe medical cannabis will disappear in the near future.

Medicalization

Loosely defined, the term *medicalization* implies the extension of medical authority onto a deviant behavior (Newhart & Dolphin 2019; Pedersen 2015; Pedersen & Sandberg 2013;
This change does not remove stigma or normalize a behavior but shifts the default reaction from condemnation to situational sympathy (Fischer, Kuganesan & Room 2015). It is important to note that cannabis is more therapeutic than it is curative. Patients use it to relieve the symptoms of their illness rather than in hopes of curing themselves of illness (Dahl & Frank 2011; Chapkis 2007). Indeed, our perceptions about whether cannabis is an acceptable medicine are influenced by how the cannabis is consumed as well as the underlying condition being treated. For example, Jeffrey Rudski (2014) found that people find cannabis to be more acceptable for people with terminal illness rather than as a tool to ameliorate negative side effects of therapeutic treatments (e.g., cancer drugs, antibiotics, allergy medicines). The same study also found that cigarettes and water pipes (i.e. bongs) were more stigmatized than consumption through pills or oral suspensions (Rudski 2014).

Cannabis was used as food, fiber, sacrament, and medicine long before it was used as a recreational drug. The earliest reference in Greek literature occurs in the fifth century BCE when it was observed the Scythians heated cannabis seeds as part of their death ritual (Butrica 2002). Cannabis seeds were also widely consumed by Greeks though it was not until 65 CE where records show the seeds could be used as a treatment for nocturnal emissions⁶. Evidence of cannabis in Chinese medicine stretches back roughly 1,800 years (Brand & Zhao 2017), and this is surprising because cannabis in Western medicine was not popularized until the 1840s before declining in the early Twentieth century (Dahl & Frank 2011). Cannabis entrepreneur Steven DeAngelo (2015) believes the decline of cannabis patent medicines is mostly attributable to the

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⁶ Butrica (2002) extensively documents how the ancient Greeks prescribed large quantities of cannabis seeds to “dry the semen” in men and boys who “suffered” from nocturnal emissions (wet dreams). Less common preparations of cannabis included using the leaves to dress wounds, a preparation of dried leaves for nosebleeds, and liquid infusions of cannabis seeds for ear infections. It is doubtful these preparations made an individual intoxicated since THC is found only in the plant’s flower and needs to be heated to be absorbed into the body. Nonetheless, several accounts of cannabis concoctions “seizing the head” are found in ancient Greek texts. though Butrica concludes the Greeks clearly did not consider it an intoxicating substance on par with alcohol.
production of the hypodermic syringe in 1858 and the availability of more potent, water-soluble
painkillers like cocaine, heroin, and morphine. Since cannabinoids are fat-soluble and not water-
soluble, cannabis was unsuitable for the new hypodermic syringes favored by doctors of the era.
Similarly, Patricia Frye, M.D. (2018) believes the popularization of pills (aka tablets) in the
nineteenth century made cannabis medicines, mostly available in tinctures, less attractive to
physicians desiring consistent dosages.

In the United States, the (re)medicalization of cannabis largely began in the 1990s with
patient activism in California as well as the discovery of the endocannabinoid system, even
though cannabis as a folk medicine has roots extending to ancient times (Newhart & Dolphin
2019; Ryan & Sharts-Hopko 2017; Rendon 2012; Chapkis & Webb 2008; Gahlinger 2004). California
was the first state to permit medical cannabis in 1996, and since then, 33 states have followed
their lead. Wendy Chapkis and Richard Webb (2008) believe the surge of patient
activism in the 1990s is partly related to a “social movement spillover” from the women’s health
and AIDS-rights movements. The subsequent medical cannabis was based mainly in California
and spearheaded by a man named Dennis Perone, who helped craft the medical cannabis ballot
initiative and opened the country’s first buyers club. His Oakland-based Cannabis Buyers Club
model was adopted by many others, including the Berkeley Patients Group, the Cannabis Action
Network, the Oakland Cannabis Buyers Cooperative, and Californian Helping Alleviate Medical
Problems (DeAngelo 2015). These buyers clubs required membership, provided physician
certifications, and collectivized cannabis distribution as opposed to offering it for
commercialized sales. There was also the Woman’s Alliance for Medical Marijuana (WAMM), a
buyers club and community organization profiled by Chapkis and Webb (2008). WAMM never
asked for payment for the medicine they dispensed, only asking (but not requiring) members
volunteer to help with cultivation and preparation. Moreover, cannabis clubs were also hot spots for activism focused on political cannabis reform.

Yet cannabis is still a Schedule I controlled substance on the federal level resulting in its absolute prohibition throughout the United States. Unlike other countries such as the Netherlands, the United States does not officially distinguish “hard” and “soft” drugs, and instead uses a five-level categorization scheme where all Schedule I substances are deemed equally problematic. Since federal law trumps state law, this medicalization process has been a hard-fought battle with patients and care providers frequently subjected to federal raids and prison sentences (Chapkis & Webb 2008). Nearly every buyers club was raided and shut down by the DEA, some on multiple occasions. In the eyes of the federal government, these patients are no different than the narcotics traffickers and drug abusers who fill federal prisons. Despite strong support from biomedical research, patients must still navigate hostile layers of bureaucracy when it comes to their medicine. They faced resistance at every turn from political, legal, medical, and financial institutions. This is why the medicalization of cannabis is best understood as a grassroots, patient-led movement (Chapkis & Webb 2008).

Incomplete Medicalization

The concept of medicalization has largely been advanced through the work of medical sociologist Peter Conrad. His original use of the term focuses on the process transforming social problems into medical issues, usually in terms of disorders, diseases, and syndromes (Conrad 2007, 2005, 1992, 1979; Conrad & Barker 2010; Conrad & Leiter 2004; Conrad & Schneider
1992/1980). This has been done with deviant identities like homosexuality and drug addiction, as well as with unavoidable life processes like aging and social anxiety. In all cases, the formerly non-medical problem becomes defined and described using a medical framework that invites medical intervention. “Medicalization narrows the definition of health and widens the definition of sickness” (Conrad & Leiter 2005:171) by treating life’s imperfections or poor social situations as treatable conditions.

Medicalization is best understood as occurring to varying degrees as “remnants of a previous definition may cloud the picture” (Conrad 2007:6), like when criminal definitions coexist with medical definitions of cannabis. It is for this reason that Newhart and Dolphin (2019) argue cannabis is incompletely medicalized. Cannabis is defined medically, but it is also defined criminally, recreationally, capitalistically, spiritually, and beyond. As the hegemony of the criminal definition breaks down, these other definitions may find themselves more and more at odds with one another. Medicalization is not only concerned with the expansion of medical jurisdiction, but it is also realized through “the cultural acceptance of medical categorization” (Newhart & Dolphin 2019:12). It should also be noted that the medical profession does not have sole ownership of medical rhetoric and vocabulary (Conrad 1979). Interests outside of medicine may appropriate medical language and medical evidence as they strive to establish social legitimacy (Conrad & Schneider 1992/1980). These non-medical interests may be successful in medicalizing something within the popular imagination, but collaboration with medical authorities is needed to medicalize something in practice (Conrad 1992). This is another reason

Writing in 1980, Peter Conrad and Joseph Schneider make a curious prediction: “It is interesting to speculate whether the decriminalization of marijuana, gambling, and prostitution would lead to medicalization. It is likely that with marijuana and gambling, ‘compulsive’ and excessive indulgence would be defined as ‘sick’; with prostitution, medical certification might be required, as is presently the case in several European countries” (Conrad & Schneider 1992/1980:254). It seems marijuana was medicalized before it was decriminalized, and that this medicalization may have played a significant role in lessening the grip of its criminalization.
why Newhart and Dolphin (2019) say the medicalization of cannabis has been partial for it has yet to be institutionalized within mainstream medical practice.

When something becomes fully medicalized, social discourse shifts in a manner where previous constructions are largely forgotten. Since this has not yet happened with cannabis, it another piece of evidence that cannabis is incompletely rather than fully medicalized (Newhart & Dolphin 2019). Parts of our collective conscience still frame marijuana as a party drug or criminalized substance, and these constructions compete with medical frameworks for dominance when defining the plant. Additionally, access to cannabis is not entirely controlled by medical instructions, and individuals may consider non-medical reasons for becoming a patient, namely enhanced legal protections (Newhart & Dolphin 2019). The researchers ultimately purpose cannabis is best understood to be a part of complementary and alternative medicines (CAM). This federally unregulated category includes therapies treated with skepticism by mainstream biomedicine even though they may have widespread popular support as well as some scientific evidence supporting their efficacy. Other forms of CAM include chiropractic care, herbal supplements, meditation, and acupuncture. It is common for individuals to turn to CAM when standard biomedical therapies have not produced any meaningful benefits (Newhart & Dolphin 2019; Brenton & Elliott 2014).

When medicalization is successful, it extends the sick role onto deviant identities thereby reducing individual blame and social stigma (Conrad 2007; Conrad & Schneider 1992/1980). Drug addiction is an excellent example of this, with many now advocating for an approach of harm reduction as opposed to heightened enforcement and harsher penalties. However, this sympathy is unevenly applied to addicts as Rebecca Tiger (2017) demonstrates in her analysis of the current opioid epidemic. Addiction in wealthier, whiter communities is commonly met with
calls for mercy and rehabilitation. Addiction in poorer communities, on the other hand, is commonly met with a type of punitive social Darwinism; to let addicts die or, at the very least, to lock addicts up (Tiger 2017). This could be because many drug scares and drug laws are constructed to control populations deemed problematic by those with social power. For example, the infamous 100:1 rule concerning sentencing for crack compared to powdered cocaine disproportionately penalized people of color for using a cheaper version of the same drug as their wealthier, whiter counterparts. As such, it would not be surprising if medical cannabis is tolerated less when it is used among the working class or among people of color.

Part of this double standard is due to the competing forces of medical and legal social control, and how medicalization disproportionately serves the interests of those with social power (Conrad & Barker 2010). This pattern is also evident in Peter Conrad and Joseph Schneider’s (1992/1980) history of heroin addiction. Heroin went from being a non-problematized remedy when it was first introduced by the pharmaceutical company Bayer in 1898, to medicalized through physician supervision when its addictive qualities became apparent. Heroin was subsequently de-medicalized through the hegemony of a criminal designation established by the Harrison Narcotics Act of 1914. Eventually, heroin would be re-medicalized with the advent of methadone maintenance and its renewed popularity among the middle class. “This is not to say that criminal designations of addiction disappeared. Rather, claimsmakers were promoting a medical designation of addiction that would challenge, and ultimately coexist with, law-enforcement agencies' criminal approach” (Conrad & Schneider 1992/1980:132).

This is all to say that medicalization is a multidimensional process that extends beyond the domain of biomedicine. In the case of cannabis, it “involves cultural, institutional, and
interactional changes in response to these altered definitions. To accomplish this requires collective actions and risks taken by patients, doctors, researchers, and stakeholders in government” (Newhart & Dolphin 2019:30). Furthermore, while medicalization is a powerful force in modern technological societies, it is rarely total in scope and can be reversed. For example, masturbation has been de-medicalized and is now infrequently defined in medical terms. Similar transformations have occurred with disability and homosexuality, both of which are now primarily framed through the discourses of civil rights and social acceptance (Conrad 2007).

International research also provides interesting lessons in the medicalization of cannabis. There is no medical cannabis program in Norway, but some of the recreational users interviewed by Pedersen and Sandberg (2013) were analytically classified as “medical activists” because they distinguished their use as medical and many actively worked to reform Norway’s drug laws. The researchers note how this group had an impressive research-based knowledge of the therapeutic effects of cannabis, some of whom created networks to share the latest cannabis research. Furthermore, these medical activists often utilized the language of the medical system in attempts to legitimize their use to medical professionals while simultaneously distancing themselves from recreational drug users (Pedersen & Sandberg 2013). These findings are similar to those of other researchers who find medical cardholders get most of their knowledge outside of mainstream medical authorities (Athey et al. 2017; O’Brien 2013). In fact, medical cannabis is commonly positioned in opposition to mainstream allopathic medicine, and patients are very suspicious of the pill-pushing physicians who critique their use of natural medicine (Newhart & Dolphin 2019; Lau et al. 2015b). Medical cannabis patients in Michigan surveyed by Kruger and Kruger (2019) report considerably more trust in medical cannabis than in mainstream healthcare.
Many also do not discuss their use of medical cannabis with their regular healthcare providers. Overall, there appears to be widespread distrust of mainstream medicine among medical cannabis patients.

**Cannabis as Controversial in Mainstream Medicine**

Medicalization often results from collective action as opposed to a top-down medical colonization of new problems. Patients may mobilize with sympathetic professionals, lay advocates, and pharmaceutical companies to politicize their illnesses by demanding recognition as sufferers of a medical condition. Conrad (2005) even argues the engines of medicalization are shifting from the medical profession to expert patients, insurance companies, and biotechnology. Moreover, individuals are increasingly thought of as patients overseen by a medical authority and increasingly thought of as consumers who can be targeted with marketing campaigns. A buyer-driven system is emerging that challenges the traditional role of physicians as the sole authoritative gatekeepers of medical services (Conrad & Leiter 2004). Though medical cannabis is often positioned as oppositional to pharmaceutical corporate interests, the two forces appear to empower lay individuals as opposed to mainstream medical authorities.

Rebecca A. Penn (2014) argues the medicalization of cannabis is best understood through the lens of an embodied health movement (EHM). EHM5s have three characteristics: (1) activists frame their organizing efforts and critique of the biomedical system through the experiences of their biological bodies, (2) they seek biomedical support for their illness claims by challenging what counts as scientific evidence, and (3) activist-experts collaborate with biomedical authorities for research, funding, and expanded access (Penn 2014; Brown et al. 2004). Each of these characteristics are elaborated on below.
Rather than being constructed around a disease category like other EHM (see Brown et al. 2004), medical cannabis patients constructed a collective identity around their therapeutic use of cannabis and struggles for legal access, social legitimacy, and biomedical recognition. Using medical cannabis is embodied because instead of relying on standard scientific and medical models of treatment, medical cannabis users primarily draw upon their lived bodily experiences where their use of cannabis brings meaningful comfort. Furthermore, the identity of being a cannabis patient arises from a “lack of institutional support for medical cannabis from the government, law enforcement, scientific bodies, and health professionals, and the criminalization of medical cannabis patients” (Penn 2014:374). The patient identity helps establish a new discursive frame where users are seen as deserving of compassion and care as opposed to condemnation for using a stigmatized substance.

EHMs also challenge the process of biomedical knowledge which privileges randomized controlled clinical trials. While the medical cannabis movement does not seek to discredit RCTs, they seek to expand what is considered empirical evidence by valuing qualitative and/or anecdotal evidence (Penn 2014). Medical cannabis patients also tend to rely on subjective definitions of health and wellness (Newhart & Dolphin 2019) as opposed to those based on objective, authoritative data like clinical studies. “EHM activists often judge science based on intimate, firsthand knowledge of their bodies and illnesses” (Brown et al. 2004:56), and most of the evidence on cannabis’ efficacy comes from self-report studies or clinical observations. These studies are also typically performed by sympathetic professionals who personally believe cannabis should be available for medical purposes (Penn 2014).

Since the medical cannabis movement developed its own scientific knowledge base without much institutional support, those who have worked to advance our understanding of
medical cannabis have become cognitive and cultural authorities on the issue. “Even if activists
do not get to participate in the research enterprise, they often realize that their movement’s
success will be defined in terms of scientific advances, or in terms of transformation of scientific
processes” (Brown et al. 2004: 57). As such, the medical cannabis movement has produced
scores of “activist-experts” who collaborate with researchers, health professionals, and
policymakers. Working as individuals or collectively as organizations (e.g., Patients of Our
Time, Americans For Safe Access, and the American Cannabis Nurses Association), they seek
policy reform, research funding, and enhanced professional education regarding cannabis.

Research has firmly established the utility and benefits of using cannabis in conjunction
with other therapies (Frye 2018; Abrams et al. 2011), but not all health professionals are
enthusiastic about the medicalization of cannabis. Overall, medical use of cannabis tends to be an
individualized routine as opposed to the institutionalized regiments of care found within
mainstream biomedicine (Newhart & Dolphin 2019). Unlike a prescription with directions for
use, dosages, and possible side effects, cannabis patients receive little to no guidance from a
physician after obtaining their medical cannabis certification. The patient is ultimately
responsible for deciding upon the type, quantity, and potency of their cannabis medicines, as
well as establishing their own medication regiment. Indeed, finding the optimal strain type and
medication routine is often achieved through self-experimentation with multiple products or
strain types. Since certifying physicians typically only see the patient every year or so for
program renewals, this could be an area where mainstream health care providers can offer
valuable support. Victorson et al. (2019) found cannabis patients trust their regular physicians
but that patients were also dissatisfied with the limited knowledge their physicians had on
medical cannabis. Improving physician education on cannabis medicines is important because
patients were uncomfortable with “having to get information about [medical cannabis] from untrustworthy and unreliable sources, such as the internet, dispensaries and their peers” (7).

Likewise, some are critical of cannabis’ status as a state-endorsed therapy rather than a scientifically-supported or physician-endorsed therapy. While substantial evidence exists supporting cannabis’ efficacy for some conditions like chronic pain and muscle spasticity, state-qualifying conditions for medical cannabis include many wherein efficacy has yet to be empirically established (Choo, Feldstein & Lovejoy 2016). Physicians also find it unsettling that state medical cannabis laws were passed without much physician input (Kondrad & Reid 2013). It should be noted, though, that physician input may be more valuable when it comes to specific regulatory decisions. If doctors do not embrace cannabis reform, they may miss an opportunity to provide feedback on regulatory policies. For example, there is much concern about appealing to children through the packaging and marketing of cannabis products. As cannabis may impede cognitive development when used by youth, physicians should have an interest in advising lawmakers on safer cannabis sales (Nathan, Clark & Elders 2017).

Some doctors have even cautioned against medicalizing cannabis because many users smoke the plant rather than use oral or inhaled cannabinoid pharmaceuticals (Jones & Hathaway 2008; Kahan & Srivastava 2007). However, patients with severe illness may not worry about the harm of smoking because their illness has a more significant impact on their overall health (Page & Verhoef 2006). There also appears to be more satisfaction with smoking medicine among the community of patients. A survey of 1429 cannabis patients in Washington found nearly 85% prefer inhalation over other methods of ingestion (Sexton et al. 2016). Indeed, the therapeutic effects of cannabis vary depending on the type of cannabis being consumed as well as the route of administration.
Smoking cannabis results in a more rapid, intense absorption of cannabinoids than does ingestion (Elikottil, Gupta & Gupta 2009). Cannabis users have also reported that the effects of smoking and eating cannabis feel different (Ogborne et al. 2000), which may explain why some patients continue to smoke the plant despite the risks associated with smoking. Other studies have found patients describing edibles as being too difficult to accurately dose, increasing the risk of undesirable side effects (O’Connell & Bou-Matar 2007). Their concerns are well-grounded. Of 75 edible medical cannabis products from California and Washington tested by Vandrey et al. (2015), only 17% were accurately labeled. Over half of the products tested had significantly less THC than the product advertised. Fortunately, in the event too much cannabis is consumed, the person simply has to wait until their body metabolizes the cannabinoids (Frye 2018), though products now exist which claim to mitigate the effects. Edibles also cost substantially more money when compared to smoking raw plant material. A participant in an exploratory study by Ogborne et al. (2000) noted that eating cannabis-infused foods is more expensive than smoking, and my anecdotal observations confirm this.

The medicalization of cannabis has also affected the role of health care providers. Medical cannabis inverts the typical model of prescribed medicine wherein control is largely held by the physician (Newhart & Dolphin 2019; Zolotov et al. 2016; Bostwick 2012; Nussbaum, Boyer & Kondrad 2011). Jones and Hathaway (2008) go as far as saying “marijuana represents a challenge to allopathic medicine inasmuch as it enables patients to wrest control of their symptom relief from established medical practitioners” (170). In the United States,

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8 Aside from fraud or error, another possible reason for the discrepancy in edibles is expressed by Laurie Wolf in the Netflix series Rotten (Season 2, Episode 6): “When you’re deciding to try making edibles, [consistency] is the most critical thing to consider. What you’re making has to be the same. You know, 5,000 of them have to have the exact same potency or pretty close. We did a spiced nut mix, but there were five different kinds of nuts that all have different sizes and all have different textures. The pecans absorbed and held in between their little lines more THC than the peanuts did. So, we just kind of gave up because I have no idea how we could infuse that in order to have every batch be homogenous” (2019, 24:20-25:10).
prescriptions for cannabis are technically illegal, so doctors may only recommend cannabis to their patients (Cohen 2010). Physicians “certify” that patients have a qualifying medical condition for a state’s medical cannabis program and may only “recommend” cannabis as opposed to “prescribe” cannabis (Sideris et al. 2018). One consequence of this is the actual dose and regiment of cannabis is determined by the patient themselves rather than mandated by a physician (Bostwick 2012). Some have criticized this arrangement as it narrows the doctor-patient relationship to a mere recommendation, whereas nearly every other medical intervention requires frequent physician monitoring and assessment of treatment (Kondrad & Reid 2013; Nussbaum, Boyer & Kondrad 2011). However, patients interviewed by Michelle Newhart had an interesting view of this required doctor-patient relationship. While none objected to the requirements, many expressed “the doctor’s recommendation was less about medical advice and more about meeting system obligations” (Newhart & Dolphin 2019:107). Patients are aware of the efficacy and safety of cannabis, and many use their medicine in self-directed manners to suit their immediate needs.

Scant physician oversight does not totally leave patients without expert guidance and support. Staff members at cannabis dispensaries, commonly known as “budtenders”, are the public face of the industry and, in many ways, mediate experiences patients have with their medicine. Fortunately, most dispensary staff make product recommendations that are consistent with empirical evidence on therapeutic effects (Haug et al. 2016). Budtenders often receive training, many are patients themselves, and interactions with returning patients allow them to gauge the efficacy of previously purchased products. However, there is almost no research on patient trust in budtenders aside from a brief conference presentation by Jennifer Rineer and Nicholas Peiper (2017). By surveying the perceived degree of trust budtenders had with their
patients, the researchers found training did not increase patient trust and that years of experience as a budtender actually decreased patient trust. The only factor that raised patient trust was the budtender’s personality, particularly their openness in discussing medical cannabis with the patient (Rineer & Peiper 2017). This finding is similar to a study on clinics of alternative medicine where trust was partly established by a practitioner’s verbal and nonverbal communication skills (Pedersen, Hansen, and Grunenberg 2016).

The lack of expert guidance at medical cannabis dispensaries is concern enough to where states such as Minnesota and Pennsylvania require dispensaries to have an onsite pharmacist or licensed medical professional. Other states may simply require these medical professionals to be on call, but Michigan has no such requirements. “More than half the states with medical cannabis allow budtenders to help patients choose products to address anything from back pain to chemotherapy side effects” (Roubein 2019, paragraph 6). Yet it appears that having suboptimal medically-focused dispensaries is better than a cannabis marketplace monopolized by dispensaries catering to recreational users. Medical users in the Netherlands express disappointment in the country’s preferred model of retail coffee shops because the staff is not trained in medicinal uses of cannabis (Nicholls-Lee 2019). This may be due to how the coffee shops cater their business to tourists rather than locals, as they can make more money with the former. Moreover, cannabis patients in Canada report a preference for dispensaries specifically focused on providing cannabis for therapeutic purposes. These medically-focused dispensaries commonly feature a variety of strain and product options along with staff knowledgeable of cannabis’ efficacy for various ailments (Capler et al. 2017). In Michigan, some medical cannabis dispensaries offer private consultations with a budtender where a patient can discuss their needs without being overheard by others. I have even seen a dispensary which has a physician stop in
once a month where they are available to answer questions rather than to certify patients for the MMMP (which is illegal to do in a dispensary).

Perhaps the largest source of unease among physicians in the U.S. and Canada is in their legal role as gatekeepers to cannabis since it is their recommendations that authorize patient use (Fischer et al. 2015). Doctors are dissatisfied with deceptive patients who utilize scarce clinician services as a ticket to accessing the medical cannabis market. While legal scholars (Cohen 2010) and some medical researchers (Choo et al. 2016; Zolotov et al. 2016) have called for greater regulations and physician oversight of medical cannabis, this does not appear to be a popular argument among the health care community nor the community of patients. Patricia Frye, M.D. (2018) says the quick, in-and-out visits with a certifying physician are optimal for patients who have prior experience with cannabis and uncomplicated medical histories. They will still have the opportunity to ask questions and may learn more about cannabis’ medical efficacy, but extensive testing or consultations are not needed for this group. On the other hand, Frye (2018) advises patients with complex medical histories to consider seeing a cannabis specialist who can provide them with individualized information. These appointments may be more protracted and more expensive, but it is crucial to evaluate how one’s existing medication regimen, cardiovascular status, and/or mental health will be affected by cannabis.

A final source of unease pertains to physician financial interest in medical cannabis facilities (Nussbaum et al. 2011). Though most state laws forbid recommending physicians from having stakes in cannabis enterprises, many dispensaries advertise their ability to secure quick physician approvals for new patients. A survey of 520 family physicians in Colorado found just

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9 Frye (2018) offers little to designate between the two types of certifying physicians. She says clinics with multiple locations often provide the quick in-and-out visits whereas independently-owned clinics typically have a physician who will spend more time with the patient. Her major piece of advice is to call and ask how much time a typical visit takes.
10% supported the state’s existing dispensary business model despite most having favorable views regarding cannabis’ therapeutic properties (Kondrad & Reid 2013). They took issue with the system’s lax gatekeeping for individuals pursuing medical cannabis certifications as well as the lack of an ongoing relationship between certifying physicians and their patients.

Other medical professionals are against medical cannabis policies because the consumption of cannabis is highly skewed among registered patients. Miller and Oberbarschiedt (2017) claim current medical cannabis initiatives allow heavy users to continue their addiction. They say most of the cannabis in both medical and legal states is consumed by daily (or near-daily) users, not “responsible adults” looking for occasional recreation or relief. The fear here is that big marijuana businesses will thrive by exploiting heavy users, much like the tobacco and alcohol industries (Miller & Oberbarschiedt 2017). Their argument has merit as other researchers have found there are small but significant differences between studying cannabis users and studying cannabis consumption (Burns et al. 2013). When we examine the specific measure of past-month use days (as opposed to the number of individuals using cannabis), we find heavy users account for a large share of the total use. Yet one group accounts for most heavy use: those ages 50 and up. Their use days nearly tripled between 2002 and 2012, while the use days for every other age group remained relatively stable (Burns et al. 2013). Perhaps this is due to more age-related illness within this group, especially conditions associated with chronic pain.

Concern has also been raised over “doctor mills”, or physicians who certify large numbers of patients without extensive evaluations or adequate medical proof. According to Nussbaum and colleagues (2011), 49% of the 128,698 registered patients in Colorado were certified by just 15 physicians in the decade following the enactment of the state’s medical
cannabis law. It has also been found that physicians with a high-volume of recommendations are more likely to qualify patients based on the catch-all category of chronic, severe pain compared to family physicians with a low-volume of recommendations (Kondrad & Reid 2013).

There are several problems with the concept of doctor mills. To begin, physicians report having little familiarity with the medical benefits of cannabis, which may explain why many do not directly suggest cannabis to their patients (Sideris et al. 2018). Most medical schools do not teach about the endocannabinoid system or anything to do with cannabinoids in general (DeAngelo 2015). A majority (71%) of New York State physicians support cannabis use for medical purposes, and many are willing to refer patients to doctors who specialize in medical cannabis. A similar finding was uncovered in patient interviews by Newhart and Dolphin (2019) where over half of their sample reported discussing medical cannabis with their regular physician, but over 80% ended up getting certified through a specialty physician. Regular physicians opt to not recommend cannabis themselves due to their limited area of medical specialty and the illicit federal status of the drug (Sideris et al. 2018). Furthermore, physicians who recommend cannabis to their patients become subject to intrusive state oversight and risk significant repercussions should any discrepancies in paperwork emerge. Medical licenses may be revoked, the certifying physician may face jail time or career-ending fines, and their reputation becomes tarnished in an industry dominated by powerful pharmaceutical companies (Newhart & Dolphin 2019). It is for these reasons that many certifying physicians perceive intangible rewards from their work as opposed to the money or professional prestige associated with a career in biomedicine.

As for the catch-all category of chronic pain, it is perhaps more fruitful to consider the narrow list of approved conditions for medical cannabis in each state. A recent survey by Kruger
and Kruger (2019) found four of the most common ailments reported among Michigan medical cannabis patients are not specifically included in the list of qualifying conditions. These include general pain, back problems, depression or bipolar disorder, and headaches or migraines. Since their conditions are not recognized as qualifying for medical cannabis by the state, their certified condition must be listed as severe, chronic pain. Despite this practice receiving some criticism, “off-label” uses of prescriptions have long been utilized by medical practitioners. Our current system requires that all prescribed drugs be approved for specific medical conditions, though doctors have the ability to prescribe drugs for non-approved conditions (Newhart & Dolphin 2019). As such, the concern over off-label uses of cannabis can appear as double standard when compared with the off-label uses of pharmaceutical drugs. These inconsistent standards of efficacy are explored in the next section of this chapter.

(Anti)Pharmaceuticalization

Surveys of patients find many use cannabis as an alternative to or means of reducing pharmaceutical prescriptions, most commonly those for opioid painkillers (Kruger & Kruger 2019; Boehnke, Litinas & Clauw 2016; Sexton et al. 2016; Zaller et al. 2015). Moreover, 30% of patients surveyed by Kruger and Kruger (2019) claimed their primary health provider was unaware of their use of medical cannabis. The same survey found patients prefer cannabis over pharmaceuticals in terms of effectiveness, side effects, safety, addictiveness, availability, and cost. In this section, I detail why patients chose cannabis over traditional options as well as controversies surrounding pharmaceutical cannabis products.

Travis Satterlund and colleagues (2015) identified three interesting reasons why patients prefer herbal medicine over pharmaceutical cannabis products. First, there is the fact that plant-
based marijuana is “natural” and perceived to be safer than synthetic chemicals. Interviews done by Joan Bottorff and colleagues (2011) reveal patients frame cannabis as a means to break free of the toxic “trial and error” cycle of pharmaceutical therapies. Cannabis not only offers physical relief but also relief from the frustrating sequence of failed prescriptions with unpleasant side effects. Many patients blame such side effects on the toxicity of pharmaceutical medications, and many fear becoming “overtoxified” (Bottorff et al. 2011:773). Even if cannabis brings them little relief, it lacks the side effects, risk of dependency, and synthetic ingredients of pharmaceuticals. It also allows one to retain more personal control over their medicine since one could stop using at any moment without going into withdrawal (Newhart & Dolphion 2019).

Secondly, many patients viewed pharmaceutical companies with contempt and cynicism (Satterlund et al. 2015). Colorado patients interviewed by Newhart and Dolphin (2019) were deeply offended by the ability of big pharma to peddle dangerous drugs for profit while suppressing medical research and development concerning cannabis. Overall, patients seem to harbor resentment towards the pharmaceutical industry. The medical activists in Norway interviewed by Pedersen and Sandberg described the side effects of prescription drugs in “rich and living language” (2013:22), and this is something I have anecdotally observed among medical cannabis patients in the United States. Cannabis patients tend to have horror stories of impairment, disability, addiction, and debt stemming from their previously prescribed medications. Patients are well aware of the industry’s unscrupulous business practices, and many loathe the industry’s abilities to profit from “toxic” substances or drugs with concerning side effects (Newhart & Dolphin 2019; Victorson et al. 2019; Lau et al. 2015; Satterlund et al. 2015; Pedersen & Sandberg 2013).
Finally, framing pharmaceutical products as “somewhat evil” allowed patients to rationalize their cannabis use as relatively benign, safe, and relatively normal (Satterlund et al. 2015:8). This perspective also allows the patients to minimize self-stigma and negative perceptions about their personal use (Pedersen 2015). A survey of physicians in New York State found the majority of (84%) believed opioids were more dangerous than cannabis (Sideris et al. 2018). As I will discuss later in this section, cannabis may be the safest medicine known to humankind. Therapeutic use stretches back millennia with no deaths, overdoses, or permanent side effects. Yet we have only recently begun to understand cannabis through pharmacological science.

**Synthesizing Cannabis**

When the endocannabinoid system was discovered by science in 1996, it clarified the biological processes of consuming cannabis-based compounds. This discovery allowed researchers to understand how cannabinoids like THC and CBD are processed by the human body. In fact, the body has specialized cell receptors specifically built to receive cannabinoids.\(^{10}\) In this way, cannabis as a folk remedy is similar to opium or ephedra, as each was used for therapeutic purposes long before their distinct mechanisms were detailed by scientists (Bostwick 2012).

Medical researchers have so far distinguished three types of cannabis compounds or cannabinoids, though there may be more (Bostwick 2012; Elikottil et al. 2009). The first are *endocannabinoids*, the natural chemicals produced by the human body and function as

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\(^{10}\) Cannabinoid receptors have not been found in the brain stem, the region of the nervous system responsible for regulating involuntary functions like respiration and circulation. Perhaps this is why it is impossible to overdose on cannabis as excessive amounts will perhaps be psychologically, but not physically, worrisome (Frye 2019).
neurotransmitters. Our bodies even produce minimal levels of certain cannabinoids independent of one’s consumption of cannabis. These endogenously-produced cannabinoids help achieve a stable internal environment, or homeostasis, as we move through fluctuating external environments (Frye 2019; DeAngelo 2015). The second are **phytocannabinoids** which encompass the hundreds of compounds found in the cannabis plant, such as THC, CBD, and many others. The third and final form are the **synthetic cannabinoids** which include pharmaceuticals and other laboratory-made substances resembling naturally-derived botanical cannabinoids (Bostwick 2012). Scientists have even genetically engineered yeast to produce cannabinoid precursors, the basic building materials needed to create more-complex compounds like THC and CBD (Brodwin 2019).

Pharmaceutical advancements have made some worry that modern chemistry may be able to isolate and manufacture the more-potent compounds present in cannabis, much like that of cocaine from the coca leaf (Grinspoon 1999). Yet while several synthetic forms of cannabis exist, nothing comes close to the therapeutic power of whole-plant medicine. The oldest synthetic cannabinoid is known by the brand name Marinol (**dronabinol**) and has been legally prescribed for nearly 30 years. Since Marinol is essentially synthetic THC, some scholars have noted the irony of prescribing the plant’s most psychoactive substance in place of the natural plant itself (Chapkis & Webb 2008; Chapkis 2007). Cesamet (**nabilone**) is also a synthetic cannabinoid that mimics THC but may be even more potent (Lochte et al. 2017). Another pharmaceutical product is known as Sativex (**nabiximols**) which is derived directly from botanical cannabis and is currently undergoing FDA trials in the United States (Rendon 2012; Chapkis & Webb 2008). Sativex comes in the form of a sublingual spray and contains a 1:1 ratio of THC to CBD which reportedly does not make the patient high. A final pharmaceutical known
as Epidiolex was recently approved by the FDA for children with seizures, but this is nothing more than pharmaceutical-grade CBD (cannabidiol). Since they are each botanical extracts, “generic” versions of Sativex and Epidiolex can be made at home or purchased from most dispensaries.

Attempts to purify cannabinoids have been less than impressive so far, with most patients who use synthetic cannabis preferring to smoke the natural plant instead (Webb & Webb 2014; Grinspoon 1999). Part of the problem with synthetic cannabinoids is that while many active compounds are present in raw cannabis plant material, pharmaceutical drugs approved in the United States must isolate only one of these compounds (Elikott et al. 2009; Grinspoon 1999). Furthermore, pharmaceutical products are significantly more expensive and less effective than the botanical cannabis available to medical cannabis patients (Chapkis & Webb 2008; Ogborne, et al. 2000). The hundreds of unique compounds in the natural cannabis plant work in synergy to produce effects greater than the sum of isolated compounds, a phenomenon some have dubbed “the entourage effect” (Frye 2018; Rendon 2012).

Natural marijuana with its many chemical compounds cannot be evaluated by the standard FDA approval process (Grinspoon 1999). Patients seem to enjoy this aspect of cannabis; that “whole plant medicine” it cannot be claimed and exploited by pharmaceutical companies. Some claim the pharmaceutical industry is well aware of cannabis’ efficacy but widely supports continued criminalization over the fear of losing control over current treatment options (Chapkis & Webb 2008). Incidentally, the federal prohibition of cannabis may be one of the few things keeping pharmaceutical giants at bay. The current system of state-approved medical cannabis is ultimately federally prohibited, and as such, beyond the reach of globalized

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11 Commenting on the inability of the FDA to evaluate cannabis, one medical scientist interviewed on 60 Minutes (October 2019) called cannabis a “messy” drug.
corporate profits. This is a large part of why cannabis was medicalized through patient activism without much help from medical institutions or pharmaceutical companies (Pedersen & Sandberg 2013; Chapkis & Webb 2008). Outside of patient activism, there were also developments in cannabis cultivation that helped cannabis’ medical potential.

**Improving Cannabis**

Jim Rendon (2012) is a freelance business writer and though he does not explicitly connect the dots, he identifies several developments that facilitated the medicalization of cannabis, and these have not yet been mentioned in the academic literature. Before the twenty-first century, the marijuana available to consumers was often of suspect quality. There was virtually no supply of potent, pure, optimally-grown medicine available for patients. Individual consumers would have to take their chances and trust whatever source they could find, but most did not mind if what they purchased was less than immaculate. That began to change with the publication of *High Times*, a drug culture magazine launched in 1974. Not only did the magazine have literature on cannabis, it included *Playboy*-like centerfolds of magnified marijuana. As consumer desire shifted towards more exquisite buds, the indoor growing revolution of the 1980s and 1990s made top-tier product accessible (Rendon 2012).

Growing cannabis outdoors is risky since the crop can be damaged by rain, wind, insects, and more. So, when the federal government began cracking down on outdoor grows in the 1980s, it’s arguable the quality of cannabis improved as growers moved their cultivation inside (Rendon 2012, Pollan 2001). Cannabis grown indoors produces denser, more-potent buds that are often visually-perfect. Every variable can be controlled indoors from the light, humidity, ventilation, and plant nutrients. Growers even compete to grow the best cannabis by experimenting with
different combinations of these elements. They also share their results and strategies over the Internet, disseminating knowledge on message boards and websites (Rendon 2012). This all fueled rapid improvements to quality around the same time the patient-led medical cannabis movement was occurring. Put simply, *High Times*, indoor growing, and the Internet helped raise the quality of marijuana to something more on par with what we would expect from a medicine—something potent, pure, and produced in conjunction with other experts.\(^{12}\) Despite progress made in the quality of cannabis medicine over the past several decades, some still believe the pharmaceutical industry will bring benefits to medical cannabis patients.

**Pharmaceuticalization**

One facet of medicalization is *pharmaceuticalization*, or the “translation or transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical intervention” (Williams, Martin & Gabe 2011:711). This often manifests in pharmaceutical drugs being promoted for small nuisances or to improve human performance (e.g., nootropics). Examples of pharmaceutically-constructed diseases include chronic dry eyes, restless leg syndrome, female sexual dysfunction, low testosterone, ADHD, and high cholesterol in anyone over 30 years old. While people may experience these conditions situationally, or while these conditions may be largely attributable to natural aging, the pharmaceutical industry markets them as treatable ailments. This effectively allows individuals to form an identity as someone who suffers from X. While this process is dynamic and reversible, it has created

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\(^{12}\) While “lamp-grown” (indoor) cannabis may achieve museum-quality levels, it takes a significant toll on the environment through high electrical demands. This is why Steve DeAngelo (2015) has consciously decided to rename cannabis grown outdoors as “SunGrown”. After his California dispensary shifted to this terminology in conjunction with an environmentally-focused ad campaign, sales of SunGrown cannabis jumped from 4% to around 30% of his total business.
consumer groups of patients who mobilize around and defend their diagnoses and prescribed medications (Williams et al. 2011). Simply stated, pharmaceuticalization provides patients with an identity based on their consumption of specific pharmaceutical drugs. It also legitimizes their suffering while providing them with a tool to address their health problems. More often than not, these drugs are designed to manage biomedical risk factors in overall healthy patients.

Though Joseph Dumit (2012) does not explicitly use the term pharmaceuticalization, his critical analysis of the pharmaceutical industry illuminates how it came to dominate biomedicine. The most important element is that the industry began to shift our cultural definition of health towards one of risk management and risk reduction. In other words, health is not simply being free from illness, it is a quest to minimize biomedical risk factors like high cholesterol and high blood pressure. The industry even established mass risk levels used to identify when someone may “benefit” from pharmaceutical intervention. In conjunction with the new emphasis on health risks, there was also the rise of clinical drug trials and the privileging of this type of research on the part of the FDA. This coalesces with direct to consumer drug advertisements which the FDA began to liberally permit in 1999 following an overhaul of the agency’s guidelines. Before the 1999 broadcasting rules, prescription advertisements had to state all possible side effects. After the new rules, drugmakers could simply direct consumers to a published magazine advertisement if they wanted to learn more about the drug’s side effects. All of this was explicitly planned with the aim of growing the number of prescription medicines in our lives (Dumit 2012). The more people who use prescriptions and the longer each person relies on them, the more money the industry will make.

The pharmaceutical industry has also flooded the biomedical knowledge base with research based on clinical trials and other corporate-sponsored drug studies. Clinical drug trials
have become the gold standard in how regulators approve drugs, but they are only good at answering very specific questions (e.g., was there a difference between the control group and the experimental group). Much of the available scientific facts about health now come from the pharmaceutical industry, and these facts almost always support industry products and practices (Dumit 2012). More disturbing is how the FDA began to rely exclusively on clinical trials to evaluate the safety and efficacy of new drugs. The FDA has the most respected regulatory standards in the world, but it also oversees the largest market in the world. With profits being so high, there is a significant incentive to deceive regulators or cheat the regulatory system. One of the ways pharmaceutical companies accomplish this is by withholding unsuccessful clinical trials from the public. Even though the FDA requests to see unsuccessful trials, these are never made public knowledge, and the drug will be approved so long as two clinical trials were successful (Dumit 2012). This means a drug could have had two clinical trials where it was shown to be safe and effective, but it could also have numerous clinical trials where the same drug was shown to dangerous or ineffective.

Another dimension to pharmaceuticalization is the creation of patient identities based on risk factors and drug therapies. This often results in expert patient agendas aimed at the right of choice regarding their medications (Williams et al. 2011; Conrad 2005). Expert patients are the “idealized product of the past fifty years of pharmaceutical marketing” (Dumit 2012:184). They embrace a definition of health as a reduction of risk factors, they keep up to date on their own biomedical risk numbers, and they actively seek information on new risks and treatments. Expert patients also demand access to the latest clinically-proven therapies even if such therapies have not yet undergone regulatory evaluation. This often manifests in the form of patient activism aimed at securing the right to try experimental or non-FDA-approved therapies (Williams et al.
Research critical of pharmaceutical lobbying practices has also documented the industry’s work in weakening regulatory requirements designed to protect patients from ineffective and harmful drugs (Light, Lexchin & Darrow 2013; Dumit 2012). It is no wonder, then, that most new drugs approved since the 1970s have little advantage over the existing pharmacopeia, and that true pharmaceutical innovation has been static or declining. The industry likes to take the easy route of re-marketing old drugs for new uses, or re-introducing old drugs that are different but not more effective (Light et al. 2013; Dumit 2012; Williams et al. 2011; Chapkis & Webb 2008).

Despite the conceptual inappropriateness of considering cannabis pharmaceuticalized, it appears the medicalization of cannabis was also facilitated by the pharmaceutical industry. GW Pharmaceuticals is the company that invented Sativex, the prescription medication made from cannabis plant extracts. To get the medication approved in the United States and abroad, the company conducted numerous scientific studies on the medication’s efficacy. These studies have since been used by medical cannabis activists as evidence to support medicalizing cannabis, but GW Pharmaceuticals does not like this. GW claims there is a significant difference between smoked cannabis and Sativex, and even though the two substances have the same basic active compounds (THC and CBD). Many patients think of GW Pharmaceuticals as “the Monsanto of cannabis” (Rendon 2012:180). They worry the company will monopolize cannabis for corporate profit through attacking the decentralized networks of growers who supply most of the medical cannabis used by patients today. However, the company undoubtedly helps the medical cannabis movement by providing standardization and research (Rendon 2012). It should be noted, though, that the company was formed in 1998, two years after a medical cannabis movement had already
succeeded in California. Perhaps it may be better to view this as the pharmaceutical industry appropriating cannabis activism in their quest for more prescription drugs and higher profits.

Fortunately, cannabis may be one of the least toxic substances known to the modern pharmacopeia. It is safer than any over-the-counter pain remedy and has a longer history of pharmacological use than any modern medicine (Frye 2018; Webb & Webb 2014; Grinspoon 1999). Administrative judge Francis Young of the Drug Enforcement Administration even concluded a person would have to smoke 1500 pounds of pure marijuana in 15 minutes for it to be lethal (DEA 1988). The safe track record of cannabis poses serious problems for medical researchers like Choo and colleagues (2016) who caution against renewed interest in medical cannabis by comparing it to physician enthusiasm over opioid painkillers around the turn of the twenty-first century. While opioid addiction and overdose has become a major social problem, a lethal overdose of THC has never been reported in humans (Bostwick 2012). There are also no consequential symptoms of withdrawal from suddenly ceasing cannabis use, and many patients are regularly forced to do so when traveling (Webb & Webb 2014). Likewise, “[cannabis] has no known long-term health consequences other than possible effects on memory and cognition in heavy users who start at a young age” (Fyre 2018:15). Other researchers have found both medical and recreational cannabis users practice harm reduction techniques to mitigate potential health effects. Lau et al. (2015a) found users may switch to vaporizers to avoid the consequences of inhaling smoke and they may self-regulate their consumption in order to avoid building cannabinoid tolerance. Similarly, patients may restrict their cannabis use to times when their discomfort becomes unbearable, and some report taking breaks from cannabis medicine when/if

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13 Some states like Michigan accept out-of-state medical cards so patients can purchase medicine while traveling. Carrying cannabis through an airport is a federal crime even in states which have legalized medical and recreational use. Illinois has even placed “last chance” marijuana disposal bins at airports throughout the state.
their circumstances improve (Newhart & Dolphin 2019). As such, many patients see no reason for cannabis-based prescription drugs or synthetic cannabinoids. The overwhelming desire of patients appears to be the right to use whole plant medicines grown outside of pharmaceutical or medical control.

**Connoisseurship**

Researchers have documented how cannabis was medicalized primarily through the work of patients as opposed to medical, state, or corporate institutions (Pedersen & Sandberg 2013; Chapkis & Webb 2008). Pharmaceuticalization is not inevitable, and patient activism may both assist and threaten the industry’s grasp on professionalized medicine. Patients emphatically do not want big pharma encroaching upon the medicine they love so dearly. One interesting form of resistance to the pharmaceuticalization of cannabis has been through *connoisseurship* (Newhart & Dolphin 2019; Lawrence 2019). Biomedical logic demands standardization and uniformity, but strain diversity and freedom of choice are deeply valued in the cannabis subculture (Capler et al. 2017). The number of developed strains is somewhere in the hundreds (if not thousands) while dispensaries routinely carry 10 to 20 varieties, and sometimes more. Each has its distinct properties and effects attributable to its unique profile of cannabinoids and terpenes. Perhaps the best description of this comes from journalist Michael Pollan who says each strain of cannabis and each method of consumption has a “specific *psychological texture* of its high” (2001:150, emphasis mine).

Traditionally, varietals of cannabis were placed in a binary spectrum of *C. sativa* which produces an uplifting, mentally-stimulating effect, and *C. indica* which produces a sedating, bodily effect. The current focus seems to be increased attention to a strain’s terpene profile,
something largely ascertainable by smell. *Terpenes* are aromatic essential oils found in all plants though cannabis has one of the most diverse terpene profiles in the plant kingdom with over 260 different terpenes identified thus far (Lawrence 2019; Frye 2018). Indeed, the scent of cannabis is a powerful hallmark of the plant. Michael Pollan acutely describes the smell of indoor cannabis cultivation rooms as “[s]weaty, vegetal, and sulfurous” like “a locker room in the Amazon” (2001:136). Taking this metaphor a step further, terpenes are like the various perfumes and body sprays used in today’s locker rooms. They add another layer to the scent of the room, but in the case of cannabis, they also mediate the plant’s effects. A connoisseur can sensually distinguish between strains conducive to stimulation and those which promote relaxation. There are also a plethora of colors, tastes, and methods of consumption that further diversify the modern cannabis marketplace. There are even organic options for consumers wary of pesticides, though the organic label is not policed by an organization like the USDA. Likewise, pesticides appear to be of little concern in the medical cannabis community because of cultivation standards and mandated product testing\(^\text{14}\). All of this stands in opposition to the flattening goals of pharmaceuticalization.

Connoisseurship is also evident in how cannabis is sold and consumed. Jim Rendon describes California dispensaries as displaying cannabis and cannabis products with “the kind of fetishized care reserved for expensive jewelry or custom-made suits” (2012:31). He notes the trend towards brightly lit atmospheres with high ceilings and wood-framed, glass display cases. There are even specialized magnifying jars with slide-off-tops that allow customers to smell buds before purchase. I have even witnessed budtenders slowly and gently place purchased buds in a

\(^{14}\) Some states like Michigan require testing for pesticides, fungicides, and heavy metals before cannabis can be sold in retail dispensaries.
take-home container using chopsticks (as opposed to just dumping it in). This level of care is appreciated but appears wholly unnecessary and is often time-consuming.

Another example of connoisseurship can be found in a new book on cannabis etiquette written by Lizzie Post, the granddaughter of the famed etiquette writer Emily Post. Among other things, the book describes the proper way to curate a home cannabis bar with a wide selection of strains, equipment, edibles, and other products. In order to please one’s “ganja guests”, Post (2019) recommends strains be labeled with names, cannabinoid levels, terpene profiles, and strain effects, such as whether it’s uplifting or sedating. If one wanted to learn more about this diversity, an awe-inspiring overview of cannabis strains can be found in the “Explore Strains” section of Leafly.com. Or one could consult an “interpener” trained by the Trichome Institute. They created the term *interpening* by combining the words “interpreting” and “terpenes”, and define it as “the art and science of the cannabis sommelier; evaluating flower for total quality control, psychotropic effects, and variety type designation” (Trichome Institute 2019). The worlds of wine, craft beer, cheese, and coffee all have their discerning experts, and now cannabis does too.

While pharmaceuticals are known for their standardization and purity, the cannabis community has its own quality control facilitates known as testing labs. The first testing lab opened in California in 2008 and this type of service has flourished ever since (Michigan currently has four licensed “safety compliance” facilities). These businesses screen cannabis for contaminants like mold, pests, and chemicals as well as provide accurate levels of cannabinoids like THC and CBD. This information enabled cannabis growers to practice a type of self-regulation in regards to the purity and potency of their products (Rendon 2012). Michigan even requires that all medical cannabis sold in dispensaries be tested and verified by an independent
These labs also provide essential services to growers, such as genetic testing and cross-fertilization. Testing for genetics has proved to be immensely valuable since growers no longer have to wait until a plant matures to analyze its qualities (Rendon 2012). Efficient DNA testing has greatly increased the speed at which new strains are developed, and this, in turn, has likely facilitated connoisseurship among consumers. Such developments and enthusiasm over this natural medicine are not unique to cannabis, though.

Medical Skepticism and Conflict

It has been noted that medicalization may be used as more of a strategy for criticizing the dominant punitive approach to drugs rather than out of a deep belief in the efficacy of the hyped medical benefits (Conrad & Schneider 1992/1980). Indeed, many media figures, politicians, and academics have portrayed medical cannabis as a means of deceiving a prohibitionist government into allowing some marijuana use. However, these claims are often unsubstantiated beyond anecdotal evidence (Kilmer & MacCoun 2017; DeAngelo 2015).

People who advocate against permissible use of medical cannabis sometimes point to the problems of medicalizing by popular vote (Choo et al. 2016; Cohen 2010). Their argument is that all other prescribed medicines must pass rigorous regulatory standards and that marijuana has not yet met these standards. Therefore, states that pass medical cannabis programs sidestep important regulatory agencies such as the FDA. Furthermore, cannabis has a better safety record than nearly every other medicine including widely-used over the counter pain remedies, with zero fatal overdoses in known history (Frye 2018; Webb & Webb 2014; Bostwick 2012;
Grinspoon 1999). This also means that the plant is safer than alcohol and caffeine, both of which are drugs celebrated in American society.

Alas, the metaphors of a stalking horse or trojan horse are commonly used when describing medical cannabis. Fischer and colleagues (2015) call it a “sneaky sidedoor” (p.185), a means of legalization through medicalization. Open-ended comments on a survey of 520 family physicians in Colorado also reveal many believe medical cannabis is largely used as a form of legal protection for healthy people with recreational intentions (Kondrad & Reid 2013). Other scholars have said legalizing recreational cannabis will “reduce the strategic use of medical cannabis laws as a stepping-stone to the legalization of recreational use” (Hall & Lanskey 2016:1770). Media pundits frequently amplify these narratives by pointing out they have seen young, fit, and healthy-looking people use the medical cannabis system. Steve DeAngelo even calls this the “Able-Bodied Young Man (ABYM) theory” since he has heard it so frequently when debating medical cannabis (2015:55). This tactic is used to question the legitimacy of medical cannabis even though not all illnesses are visible. Not only do many individuals attempt to conceal their sickness, but the ABYM theory also obscures the millions of veterans who suffer from post-traumatic stress disorder. Most of these ABYM accusations come from law enforcement, politicians, and conservative media figures who have little direct experience with medical cannabis or patients (DeAngelo 2015).

What about the people who deceptively become patients to continue buying and consuming marijuana legally? Perhaps we should avoid treating marijuana as a value-laden dichotomy between medical and recreational use (Athey et al. 2017). In other words, the recreational use of medical cannabis does not nullify the possibility that the person is receiving some health benefits. This duality appears to be understood by medical experts. Recreational
legalization in Colorado made medical students in the state more likely to recommend cannabis than previous laws permitting medical use only (Chan et al. 2016). If medical cannabis is merely a ruse, then wouldn’t recreational legalization nullify physician recommendations for cannabis? This finding may be a result of diminished legal repercussions faced by both doctors and patients, but it is certainly not the abandonment of medical cannabis as many anticipated.

While many have raised skepticism over medical cannabis policies, the body of social scientific research is filled with data from patients who overwhelmingly speak of life-supporting results. Study after study imparts patient enthusiasm for their medicine and a deep conviction in the therapeutic value of cannabis. It seems odd to me that this sizable group of people and their place in the debate have been largely ignored by skeptics of medical cannabis. Pundits, bureaucrats, and scholars sometimes speak of medical cannabis as a system exclusively used by perfectly healthy people looking to get stoned. Even stranger is the presumption that the end goal of medical cannabis programs is full-scale legalization. It ultimately stereotypes patients as a homogenous group of pleasure-seeking marijuana enthusiasts. However, no one has analyzed how cannabis patients view recreational legalization. If medicalization was merely an intermediary phase on the road to full legalization, then cannabis patients should welcome policies that increase access for all. Yet sentiments seem to be more complicated.

The patient experience is different in areas without accessible medical cannabis infrastructure. There is no tradition of medical cannabis in Norway and researchers have found some users feel pressure to constantly reaffirm the medical value of their cannabis use (Pedersen & Sandberg 2013). Since they do not want to be perceived as pleasure-seeking, recreational users, they made intentional efforts to reduce their association with cannabis subculture: “Any identity that endorses recreational cannabis use and traditional cannabis culture jeopardises the
identity frame of the medical cannabis movement and risks the medical cannabis cause being seen as ‘just another way’ to legalise cannabis” (Pedersen & Sandberg 2013:26). On the other hand, in the United States, the symbols of the cannabis subculture have been adopted by the medical cannabis industry: tie-dye, Rasta, marijuana-leaf iconography, and much more.

Yet even when medical cannabis use is legitimated by state and medical authorities, patients still feel the need to socially distinguish themselves from illicit recreational users (Athey et al. 2017). Michelle Newhart and William Dolphin (2019) found patients in Colorado prefer a clear system boundary between medical and recreational cannabis. They were overall supportive of recreational uses, but they were also invested in their identity as a patient along with the medical system of cannabis access. Among other things, being a “patient” grants one access to the medically-focused system as opposed to recreational dispensaries, it may protect against sanctions from employers or authorities, and it helps reframe the individual’s cannabis use as therapeutic rather than pleasure-oriented. Yet the researchers’ data collection ended before Colorado legalized recreational cannabis in 2012. Does this identity work still exist in areas where both recreational and medical cannabis are available? To my knowledge, no one has studied cannabis patient sentiments in a post-prohibition state. My research attempts to answer that question because Michigan is one of the few areas where medical and recreational sales will exist side by side.

In States that have legalized recreational marijuana, the existing medical marijuana industry has played a major role in crafting regulatory guidelines (Room 2013). For example, Patrick K. O’Brien (2013) describes medical marijuana as a form of neoliberal state control. The state has realized that enforcing cannabis prohibition through law enforcement has been an uphill battle and has chosen instead to set strict regulations that are largely enforced by medical
dispensaries. Much of this decision may be based on the premise of capital gain through taxation and less public expenditures of policing marijuana use (Kilmer & MacCoun 2017). This shift to a legal market has also made the marijuana community visible and thus identifiable by state authorities. Since operating in the shadows is arguably less efficient than operating a site of legal commerce, those who buy and sell marijuana can now be monitored by the state (O’Brien 2013).

Even if the intent of medical marijuana policies was not focused on recreational legalization, such programs have played a significant role in facilitating the legalization of recreation use through defining deviance down (Adler & Adler 1994/2016). As marijuana users crept out of the shadows, the general public was able to see that normal, and even prestigious people use marijuana: “The dispensary system… placed marijuana into the normative system of community life, distancing it from previous associations with an underground market of criminals” (O’Brien 2013:438). Furthermore, cultivators experienced in growing medical cannabis enjoy a head start in the recreational industry as both utilize the same plants and cultivation practices (Weisheit 2011). It seems logical growers will welcome a recreational system since it substantially expands their customer base.

**The End of Medical Cannabis?**

Currently, states with both medical and recreational cannabis typically impose fewer taxes on the production and sale of medical cannabis (Hall & Lynskey 2016). Medical cannabis businesses may also be permitted to grow more plants and offer products with higher levels of active cannabinoids. Nonetheless, the tax difference is relatively small for consumers and does not consider fees involved with registering as a patient. Depending on the degree of difference, lower taxes on medical cannabis may provide a strong economic incentive for individuals to
remain patients as opposed to recreational buyers (Fairman 2016). Interestingly, when California voters legalized recreational marijuana in 2016, the measure also imposed a 15% excise tax on both medical and recreational markets. Experts reasoned lower taxes on medical cannabis would incentivize those without legitimate medical reasons to become or remain medical patients. Since the new tax would inevitably make medicine more expensive, a sizeable minority of patients came out against the measure to legalize recreational marijuana in California. Among them was Dennis Peron, the father of the modern medical cannabis movement (McGreevy 2016).

Dissatisfaction with proposed legalization has happened before among the cannabis community. In 2010, an initiative to legalize recreational marijuana in California failed at the polls with 46.5 percent of the vote. While many factors surely contributed to the demise of Proposition 19, Jim Rendon (2012) argues one of these factors was a lack of support from the state’s medical cannabis growers. Rural farmers in Northern California have been at the forefront of advancing cannabis for decades, though often illegally. When medical cannabis took off in the state, many small-scale farmers acquired permits to grow a medical crop, but so did urban indoor growers. Growing indoors can produce larger yields and more-potent buds, and it’s arguably more profitable if done on a large scale. Rural farmers feared legalization would invite corporate interests with intents on establishing industrial indoor grows near urban areas. This would have wrecked the cannabis economy for small outdoor growers and as such, many voted against the legalization initiative (Rendon 2012). Despite this resistance, California legalized recreational marijuana six years later.

Many have hypothesized legalized recreational marijuana will cause declines in the number of cannabis patients on state medical registries. If true, Newhart and Dolphin (2019) believe this will be due to the bureaucratic barriers involved with becoming a state-certified
patient, a non-anonymous process riddled with paperwork and fees. While being a medical cannabis patient may carry some social privileges, existing and potential patients may forgo the hassle and simply buy their medicine in the more-accessible recreational marketplace. On the other hand, this state-sponsored identity may help to preserve a medical cannabis system in states with recreational marijuana. Cannabis patients have stronger ties to their identity partly because of their membership in a formalized state program. Being a card-carrying member of a community makes it more difficult to transition out of a community since it involves more than a simple shift in perspective. Cannabis patients may be too invested in their identities to simply abandon their membership status in a community (Newhart & Dolphin 2019).

While Kilmer & MacCoun (2017) argue that medicalization and legalization are intertwined, they also speculate if medical marijuana programs will survive once prohibition ends. A larger recreational industry may see medical marijuana as a source of competition for clients. Also, as research will be easier to conduct once prohibition ends, results may no longer support marijuana’s therapeutic benefits or may support the use of non-psychoactive, synthetic products over the natural medicine (Kilmer & MacCoun 2017). Part of cannabis prohibition is “federally mandated ignorance” (DeAngelo 2015:46) surrounding cannabis research, so it is likely the golden age of cannabis research is still ahead of us.

These possibilities have significant implications for medical cannabis patients. As more states move to legalize recreational marijuana use, they may also undermine the hard-fought recognition of marijuana as a legitimate medicine (Satterlund et al. 2015). Legalized use of recreational marijuana may devalue the medical distinction in the collective conscience, turning patients back into drug users. According to Wayne Hall and Michael Lynskey (2016), the legalization of recreational marijuana will result in lower prices, increased availability, enhanced
safety and quality, and more social acceptance surrounding marijuana use. If being a medical cannabis patient shielded against some of the social stigma, a more tolerant society may make that reason obsolete.

Perhaps the biggest sign of medical marijuana’s twilight is the shift in rhetoric from patient needs to economic generation via jobs and taxes (Kilmer & MacCoun 2017). Some have argued this economic imperative threatens both recreational and medical cannabis with dangers inherent in for-profit, commercialized models (Choo et al. 2016; Pardo 2014; Room 2013; Nadelmann 2007). Craig Reinarman (1994) has identified this tension between our modern culture of mass consumption and our historical roots as a temperance culture. We value self-control and abstinence, all while living in a capitalistic environment of mass-marketed temptation, indulgence, and instant gratification. The pressure to always grow sales may lead to unscrupulous advertising, dangerously potent products, widespread applications of toxic chemicals to boost yields, and other public health concerns. A recent article on “pot addicts” in The Atlantic says: “Thousands of Americans are finding their own use problematic in a climate where pot products are getting more potent, more socially acceptable to use, and yet easier to come by, not that it was particularly hard before” (Lowrey 2018). The author blames advertisements aimed at incorporating cannabis into all of life’s activities, untrained budtenders professing the safety of their products, and lax regulatory standards regarding the potency of consumer THC products. While much concern has been expressed over increased marijuana consumption among youth, these fears have yet to materialize in states with recreational marijuana (Peters & Foust 2019; Hall & Lanskey 2016).

Fears over potency are not unique to the United States. A study on small-scale cannabis growers in Belgium uncovers some negative perceptions regarding the commercial cultivation of
cannabis for sale in the world-renowned Dutch coffee shops (Decorte 2011). Interestingly, the small-scale growers take pride in producing a milder, gentler product often of superior quality. They perceive the cannabis sold in coffee shops to be stronger but also dirtier because of the chemicals used to increase yields and potency (Decorte 2011). Large-scale cultivators push their crops to unnatural levels where qualities like flavor and enjoyability are lost. A similar trend may emerge in the United States where levels of THC in cannabis have skyrocketed over the past several decades. Though scholars have critiqued the reliability of the method, seized cannabis samples in 2009 had an average THC content of 8.49%, up from 0.9% THC in 1976 (Weisheit 2011). Based on my own experiences, it is common to see THC levels exceed 20% in the medical cannabis sold in Michigan dispensaries. This is roughly five times more potent than the marijuana available in the 1960s (Rendon 2012).

Conclusion

Whether or not cannabis is or becomes medicalized depends on a complex interplay between patient demands and biomedical acceptance. For the most part, scholars have focused on either patient desires or the perspective of mainstream medicine, but rarely have these two standpoints been integrated to illuminate the medicalization of cannabis. My findings on this topic are discussed in Chapter 7 where I propose cannabis is best theorized as alternatively, rather than incompletely, medicalized.

The current backlash against cannabis appears to be aimed at potency, publicity, and profits. Market forces have taken cannabis and transformed it into a commodity where businesses compete to capture market share with extreme products. At the same time, some have argued that cannabis should be placed under biomedical control if it is to be considered medicine
in our society. This is why it is important to keep in mind that cannabis was initially medicalized through what some have termed an embodied health movement because subjective notions of patient wellness were discredited by biomedicine. “Biomedicine operates through the stability of its state-supported and institutionalized structure. Because of its dominance, the biomedical discourse has come to hold power of telling the ‘truth’ of conditions and concerns subjected to it in a social context that values rationality, objectivity and science (Sointu 2006:340). The same values are also emphasized in the economic discourse that has come to dominate debates on cannabis legalization. Could there be a common cord connecting the two?

As a feminist and a gay man, I see a strong connection to masculinity in those who support medicalizing cannabis under biomedical control as well as those who support legalization through economic imperatives. As the plant gains legitimacy in the eyes of the law, the male-dominated culture of venture capital is extending its grasp over the emerging industry. Profit may not be inherently evil, but concerns within the cannabis community appear to be over who is profiting. While cannabis is often described as the next billion-dollar industry, wealthy white men in suits seem to have positioned themselves as the primary benefactors of legalization. Likewise, should cannabis ever be completely medicalized, it would mean the plant is controlled under biomedical institutions. These institutions have long been criticized as privileging male bodies while attempting to control female bodies and neglecting women’s health in general.

But little is known about gender and cannabis use within the social sciences. Unsurprisingly, the best research on gender and cannabis comes from outside of the United States, most notably Canada and Norway. It is time to document how Americans craft gendered selves within cannabis culture, and this is explored in the next chapter of my dissertation.
CHAPTER IV

GENDER AND CANNABIS

As has been demonstrated earlier, the normalization and medicalization of cannabis tend to be masculinized—Using cannabis is more normative for men and many have called for cannabis to be controlled under paternalistic biomedical structures. With that said, this chapter will explore another other novel aspect of my dissertation, that of gender within Michigan’s medical cannabis community. Since my study will be among the first to contribute to the knowledge base of gender in relation to medical cannabis, here I provide examples from the literature on recreational marijuana, alcohol, tobacco in relation to gender. Unfortunately, much of what we know about gender and cannabis comes from anti-drug studies on youth populations. This is why I have also profiled how gender has been discussed in popular media on cannabis, particularly when it comes to women in the cannabis sector. I conclude with an overview of how scholars theorize masculinities and propose how my intended study will contribute to the dialogue.

Gender in the Academic Literature

Aside from a Norwegian study of recreational cannabis users (Dahl & Sandberg 2015) and a small Canadian study of medical cannabis patients (Bottorff et al. 2011), there has not been much meaningful research on gender and cannabis. Researchers have described variations among men and women who use cannabis, but little has been done to deeply interrogate gendered practices. This is even truer in regard to racial and ethnic dimensions of medical cannabis as nearly all studies approach the topic through a colorblind frame, perhaps because they have majority white samples and/or a white research team. More gender and race-conscious research
needs to be conducted in this area, ideally research that takes an intersectional perspective on these two forces of privilege and oppression.

We have a good understanding that methods and quantity of consumption vary between the sexes. Surveys find men use more cannabis and do so more frequently than women (Burns et al. 2013), and that women are more likely to use cannabis for specific medical purposes and often report doing so later in life (Cuttler et al. 2016). Recent statistics indicate men age 26 and older are twice as likely as women in that age group to use marijuana at least once per month (10% to 5%). This difference increases with age, as men between the ages 18 and 25 are only about a third more likely than similarly-aged women to use marijuana (24% to 18%) (SAMSA 2016).

**Sex Differences**

The most prominent framework used to analyze men and women within the world of cannabis is that of *sex differences*. This dated perspective sees gender and sex-assignment as essentially the same, and ignores processes of socialization which instill masculinity or femininity in the individual (Ferree & Hall 1996; West & Fenstermaker 1995). We know men are slightly more likely to support marijuana legalization than women (Schnabel & Sevell 2017), but without explanation these differences come across as inherent within the sexes rather than a social product attributable to gender. An analysis of state registries found two-thirds of cannabis patients are male but this ratio has been decreasing over time (Fairman 2016). The author speculates males may be early adopters of medical cannabis because of their tendency to have prior involvement with illicit recreational marijuana.
Ratios aside, sex differences in use are reportedly small but significant among recreational marijuana users, but sex differences in use are believed to be trivial among cannabis patients (Cuttler et al. 2016). Biomedical research on sex differences suggests hormonal differences between sexed bodies may explain why women are more likely to be affected by cannabis than men. Women report better subjective effects of cannabis than men, but they are also more prone to adverse reactions (Cooper & Haney 2014; Craft et al. 2013). Another interesting difference reported by Cuttler et al. (2016) is men are more likely to report a sense of enthusiasm after smoking while women are more likely to report a desire to clean. The researchers say little more about this odd desire than attributing it to women’s larger share of domestic labor. Without digging deeper into the role gender plays in cannabis culture, we may risk presenting cannabis as a tool to make the oppressive second shift marginally more enjoyable.\footnote{One of the Norwegian participants in the study by Dahl and Sandberg (2015:705) describes the opposite of this sentiment. Elisabeth (age 32) stated smoking marijuana stopped her from fussing over cleaning and tidying up. It made her laid-back to where she broke from those culturally feminine characteristics, much to the enjoyment of her partner.}

Other research on sex differences finds men and women smoke medical cannabis at near-equal rates in the Netherlands, but women are slightly more likely to medicate with recently-introduced cannabis oils (De Hoop, Heerdink & Hazekamp 2018). This may also be true in the United States as men report using more joints/blunts, concentrates, and vaporizers, whereas women report using more pipes and oral methods of ingestion such as edibles, oils, and capsules (Cuttler et al. 2016). Among people who use CBD, men are more likely to report using for general health purposes whereas women are more likely to report using to treat specific medical conditions (Corroon & Philips 2018). There are many more of these sex differences in the patient
community, but to reiterate my point, none are meaningfully analyzed within the sociology of gender.

Part of the mission of feminist sociology has been to disenchant biological assumptions concerning sex, gender, and nature (Flax 1987), as well as to establish gender as a significant organizational element in all areas of social life (Fonow & Cook 1991). It’s time this powerful perspective be applied to social research on cannabis in a way to could help break down stereotypes and promote egalitarian change (Sprague 2016). Only two studies come close to this type of gendered analysis: The Norwegian study mentioned earlier (Dahl & Sandberg 2015) and a study using interviews with 23 Canadian patients by Joan L. Bottorff and colleagues (2011). Findings from both studies are integrated throughout this chapter.

**Gendering Cannabis**

The lack of attention to gender may result from gender’s status as a variable rather than a focus in most studies, but I also suspect it may be an artifact of male-dominated samples. Most social research on both medical and recreational cannabis users is conducted on predominantly male subjects (e.g., Newhart & Dolphin 2019; Satterlund et al. 2015; Zaller et al. 2015; Belackova & Vaccaro. 2013; Reiman 2007). Even the paper with the most gendered analysis uses two male-dominated samples, one with 88 men and 12 women and the other with 18 men and seven women (Dahl & Sandberg 2015). While some studies on medical cannabis patients have good levels of gender representation (Corroon & Phillips 2018; Sexton et al. 2016; Bottorff et al. 2013), and while two studies have a majority female sample (Victorson et al. 2019; Haug et al. 2016), these studies have not analyzed how gender is performed or how gender may structure use.
Some of this gender imbalance may be justified. The recently-published study by Newhart and Dolphin (2019) had a roughly 70/30 male-female sample, but this ratio resembles the demographic composition of medical cannabis patients in Colorado. Nonetheless, women are slightly more likely than men to indicate a willingness to participate in biomedical research regarding the efficacy of cannabis for chronic pain (Bachhuber et al. 2018). Presumably, they should also be willing to discuss how femininity or being a woman shapes their use of medical cannabis, but researchers have not yet explored this. On the other hand, there is some indication there is a heightened stigma faced by women with children (Newhart & Dolphin 2019; Reinarman et al. 2011), and this stigma may inhibit mothers from participating in studies related to cannabis.

What we do know about gender and adult cannabis use largely comes from studies on recreational users in criminalized contexts. Bruce Johnson and colleagues (2008) found some modest but significant gender differences in their ethnographic study of recreational users in New York City. Male marijuana users are more likely to smoke blunts and female users are more likely to smoke joints. Men are also more likely to smoke in the morning, at work, and in public places. Women were more likely to follow civic norms regarding not smoking in public, not in the presence of children, and always in moderation. The researchers note, however, that their sample was more alike than different, though significant gendered patterns are present (Johnson et al. 2008). Furthermore, while drug use is mediated by gender, it may be more important to see drug (sub)cultures as gendered (Measham 2002). In other words, gender may be a significant organizational component within the subculture itself in addition to how gender shapes individual use.
Most of the literature on gender and marijuana comes from anti-drug studies on adolescent use. A frequently cited study partly-titled “Girls Are Retarded When They’re Stoned” (Warner, Weber & Albanes 1999) uses the separate spheres framework to analyze youth smoking as reported through sex-segregated focus groups. Slightly better is a qualitative study of adolescent marijuana use in Canada where gender is also discussed (Haines et al. 2009). Interestingly, both studies observed students were less comfortable talking about gendered practices than they were with discussing their use of illegal marijuana. The Canadian researchers realized it was difficult for students to be reflexive about gender as a social category, so they reformed their questions in a manner that asked students to reflect on the gender composition of their own smoking groups. Their overall finding was that masculinity facilitates authentic use of marijuana while femininity impedes authentic use (Haines et al. 2009). This means teenagers doing masculinity could easily accommodate marijuana into a gendered routine while teenagers performing femininity resorted to tactful marijuana smoking in order to maintain a feminine presentation of self. Interestingly, femininity was also a means of accessing marijuana since girls are largely beholden to male dealers or to their boyfriends when it comes to obtaining marijuana. While none of the girls interviewed in the study admitted to using boys for marijuana, some of the boys interviewed expressed that girls have an easier time getting marijuana owing to their sexual assets (Haines et al. 2009).

Historically, research focusing on adult women’s use of drugs often approached the issue through sex issues concerning women as prostitutes or drug-using mothers. The “mad, sad, or bad” framework was popular through the 1980s and problematized all female drug use in a manner that ignored agency or pleasure, factors only reconsidered by scholars beginning in the 1990s (Arnull & Ryder 2019; Dreher 2002, Measham 2002). This shift reflects changes in
women’s structural position within society rather than women using more drugs as a social group. For example, women who use stimulant drugs to ward off sleep may do so to extend their leisure time in a society where they are expected to work outside of the home for pay as well as at home for free (Measham 2002). Cannabis’ ability to alter time perceptions may also help overworked women find greater enjoyment in the scare leisure time they spend with children. Nonetheless, society still tends to stigmatize female intoxicant use much more than male intoxicant use: “Too much ‘fun’ is portrayed as dangerous to a young woman’s physical safety, appearance and national decorum… and by engaging in cultures of intoxication they are seen to fail to perform acceptable feminine roles” (Arnull & Ryder 2019:2).

Yet cannabis is not like other intoxicants, and there are some discrepancies related to gender and marijuana smoking in the academic literature. Young British women in their 20s interviewed by Measham (2002) perceive marijuana as more controllable than alcohol, a drug with a long legacy of inebriation and male aggression. On the other hand, focus groups of girls (ages 15-16) in Denmark find the exact opposite sentiment: Marijuana is difficult to control and unlike underage alcohol use, young people risk becoming daily users (Jarvinen & Demant 2011). These differences may be cultural and age-related, especially since the youth interviewed by the Danish researchers had the misconception that marijuana was a dangerous drug while alcohol was relatively harmless. Interestingly, when these same youth were again studied at ages 18-19, one of the girls expressed a fondness for marijuana and described it (as the boys did) as being controllable and pleasurable (Jarvinen & Demant 2011). Such findings should raise caution about generalizing research on adolescent drug use to adults.

The illegal marijuana marketplace has been described by others as more masculine than the budding legitimate cannabis industry. Purchasing marijuana from a dealer is typically done
between two men whereas legal enterprises like dispensaries are more welcoming to women (O’Brien 2013; Bottorff et al. 2011; Warner et al. 1999). For example, Canadian cannabis patients who are women are more likely to acquire cannabis through legitimate channels when compared to Canadian men who are patients (Bottorff et al. 2011). Yet just as legal establishments such as bars are highly gendered spaces (Mullen et al. 2007; Measham 2002), so too may be cannabis dispensaries.

Masculinity’s connection to the world of marijuana may facilitate access but this association comes at a cost. Psychological research on stereotypes has found males are more likely to be judged as cannabis users than females (Hirst, et al. 2018). This confirms findings by Looby and Earleywine (2010) who found reactions to cannabis stereotype threats varied by gender. The men in this study feared their status as a cannabis user would invoke prejudice by the evaluator measuring the participant’s performance on an exam. Stereotype threats occur when individuals believe they may be stereotyped by others, creating a pressure that causes the individual to adjust their appearance and/or behavior (Newhart & Dolphin 2019; Hirst, et al. 2018; Looby & Earleywine 2010). This pressure has the potential to boost one’s performance but can also result in decreased performance owing to the added psychic stress. Most of our cultural images of stoners are males, making men more vulnerable to cognitive distress over their cannabis use. Women who were exposed to stoner stereotype threats actually had slightly better cognitive performance scores than women in the control group (Looby & Earleywine 2010). This may be due to the relative lack of female stoner stereotypes, how women identify with other
social groups more closely than cannabis culture, or intrinsic motivation to disprove cultural stereotypes that have disadvantaged women for so long (Looby and Earleywine 2010).\(^{16}\)

“Stoner” was also conceptualized as masculine by high school students interviewed by Haines et al. (2009) and by college students interviewed by Mostaghim (2019). These students stated that habitual marijuana use by girls would be inauthentic and out of the norm. This resembles findings by Measham (2002) who found young adults interpret excessive intoxication as failing at femininity but succeeding at masculinity. Some of the high school girls who used marijuana frequently took pride in how it made them “just one of the guys” (Haines et al. 2009:2033). This could be due to our patriarchal culture valuing masculinity over femininity, but the researchers speculate this sentiment is due to the drug’s association with masculine leisure activities and male bonding. A more potent explanation could be that there is a gendered double standard when it comes to teenage substance use. While substance use by young men is commonly dismissed as a risky rite of passage into adulthood, substance use by young women is frequently denounced as unfeminine and dangerous (Arnull & Ryder 2019). The gendering of teenage substance use is further impacted by cultural assumptions related to race, ethnicity, social class, and more. Nonetheless, resistance to this gendered double standard was expressed by some of the Norwegian high school girls in the study by Dahl and Sandberg (2015). These girls interpreted smoking joints as a way to construct a more progressive femininity, with some likening it to a “small scale gendered rebellion” (705).

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\(^{16}\) Stoner stereotypes are also largely associated with youth and young adults (Newhart & Dolphin 2019). The stereotype exaggerates qualities like irresponsibility, laziness, and lack of experience. This is good to keep in mind because many academic studies on marijuana use are based on youth samples. Resulting data may help reinforce our cultural assumptions related to age and marijuana use, essentially confirming rather than challenging the stereotype. Furthermore, the stereotype also links adult use of marijuana to immaturity and other age-inappropriate behaviors.
Since marijuana is coded as masculine, abstaining from marijuana in high school was a sign of failed masculinity, and boys who refused to smoke were disparaged as “bitches” (Haines et al. 2009; Warner, et al. 1999). This feminizing epithet is highly reminiscent of CJ Pascoe’s book *Dude You’re A Fag* (2007), where the word fag was directed at (presumably) straight boys who did anything remotely feminine. Both “bitch” and “fag” are used to establish and reinforce a masculine hierarchy among male youth by degrading boys who act like girls. Similarly, “two-beer queer” is an epithet for young men who break with masculine tradition by consuming little or no alcohol. This label has nothing to do with one’s sexuality but rather their failure to meet hegemonic masculine norms (Peralta 2007). Yet other research on drinking patterns among young adult men finds both social context and personal history are more influential than hegemonic notions of masculinity (Mullen et al. 2007). Maturing into adult roles characterized by responsibility and independence played a significant part in this change. As such, feminizing epithets directed at boys who abstain from smoking marijuana may be largely attributable to a high school setting where peer pressure is a powerful force. Again, this fact raises issues of validity when using youth-based studies to infer gendered patterns among adults.

This masculinization of youth marijuana use may be evidence of gender hegemony in the subculture, yet it is not without resistance on the part of guys. A survey of young urban men found recreational marijuana use was negatively related to one’s endorsement of traditional masculine norms (Taggart, Brown & Kershaw 2018). In other words, men who endorse masculine status, toughness, and anti-femininity norms are less likely to use marijuana than men who fashion alternative masculinities. The researchers speculate this is due to men valuing self-control, responsibility, and accountability within disadvantaged neighborhoods.
Similar findings are evident in studies on youth marijuana use. Young girls in the focus group study by Jessica Warner and colleagues (1999) claimed marijuana reduced the inhibitions of their male peers, making the boys more sociable and kinder. Likewise, some boys interviewed by Haines et al. (2009) described marijuana use as a tool to refashion masculinity into a less aggressive, more emotionally expressive identity. One boy stated: “Weed is just a happy drug. I mean, it’s my drug of choice because it makes me happy and nothing bad happens when you smoke weed” (2033). Interestingly, while this boy connected marijuana with an alternative form of masculinity, others discussed how being “chill” while high was largely a masculine demeanor. They chastised peers who became too excited or “heaty” while smoking. In other words, the dominant expectation for those who smoke marijuana was to enact a form of masculine coolness (Haines et al. 2009).

Findings such as these tell us we should resist the tendency to polarize masculine and feminine behaviors, and instead treat drug cultures as multifaceted sites where masculinity and femininity can be constructed and challenged. Gender should be seen as an accomplishment within drug cultures rather than a biological imposition (Measham 2002; West & Fenstermaker 1995). This permits the possibility of social change within the drug subculture as well as within general ways of doing masculinity and femininity.

Alcohol, Tobacco, and Gender

Gender differences have been a popular framework in research on licit substance use. Robert Peralta (2007) found college men use stories and trophies of alcohol use as a marker of embodied masculinity. Stories of heavy drinking are told in a manner in which the individual enjoyed the experience, proving one’s ability to remain in control of their body and
consciousness. Physical proof of this masculine accomplishment can be found in the scores of empty liquor bottles proudly displayed in residences, and more recently, with social media photographs documenting heavy drinking. College women attributed this tolerance to natural biological differences and felt excess drinking on their part would be stigmatized and even dangerous (Peralta 2007). In other words, excessive drinking would detract from one’s performance of femininity. College men celebrated those who put their bodies at risk by consuming excessive amounts of alcohol and interpreted such rituals as a sign of toughness. This allows some men to relationally distance themselves from drinking styles characterized as feminine (Peralta 2007). In other words, risky drinking was one way for these men to accomplish masculinity.

Perceptions of risk may also help explain the gender gap in support for marijuana legalization. Researchers have consistently found women are somewhat less supportive of legalizing marijuana compared to men (Elder & Greene 2019). While women are generally more liberal on policy issues than men (e.g., gun control, environmental regulation, government spending on social welfare, equal rights, etc.), they also tend to be more conservative on issues with a moral dimension (e.g., pornography, school prayer, divorce, etc.). Yet Laurel Elder and Steven Greene (2019) found there is a more significant variable when explaining the gender gap over support for marijuana legalization: “the white male effect”. This effect occurs from (white) men’s willingness to embrace risk and manifests through less concern over issues like climate change and as such, perhaps more support for legalizing marijuana. In other words, when gender and race privilege coalesce, the potential risks associated with specific policies become

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17 It should also be noted that in Elder and Greene’s (2019) statistical model, gender was a far more potent predictor than race in explaining one’s support legal marijuana. When analyzed individually, both gender and race had a significant effect on attitudes towards marijuana. However, masculinity was the most powerful predictor as support did not vary significantly between white men and men of color.
less of a concern. White men are more comfortable with the current status quo of weak but risky environmental regulations, and this may also explain why white men are also more likely to support legalizing marijuana despite the uncertain risks involved in doing so (Elder & Greene 2019).

Not all men conform to traditional notions of masculinized behavior. Young British men interviewed by Mullen and colleagues (2007) reported a preference for drinking in mixed-sexed groups as opposed to the exclusively-male drinking groups of their fathers. The brewing industry itself recognizes this shift in gendered drinking patterns and has been creating products and advertisements aimed at a more diverse consumer base (Mullen et al. 2007). Yet advertisements and marketing also provide cultural discourses through which individuals can enact gendered selves. Cigarette companies exploited pre-existing gender norms in order to provide women with tobacco products in line with their performances of femininity, even though some women enjoyed how cigarette smoking challenged conventional notions of femininity (Gilbert 2007; Amos & Bostock 2006; Nichter et al. 2006). While the studies on youth tobacco smoking and marijuana smoking find much in common, it is only the later studies which show us young men breaking with hegemonic masculine codes. Alternatively, Bottorff et al. (2011) say gender differences in smoking cannabis are muted when compared to gender differences in smoking tobacco. They reason this is because the effects of smoking cannabis are more important than the smoking ritual itself. In other words, smoking cigarettes may be more socially performative than smoking cannabis since the latter is typically about getting high rather than looking cool.18

18 Steve DeAngelo (2015) hints at a possible explanation for this though he does not connect it to gender. When it comes to substances like alcohol and tobacco, marketing never focuses on the actual effects of the substance. For example, alcohol commercials never boast about the product’s ability to get you drunk or decrease your judgement. Instead, they appeal to lifestyle, coolness, sexuality, glamor, luxury, and adventure. A naive viewer may not realize the commercial is pushing a psychoactive product. My thinking here is that within these idealized images are gendered ways of consuming the substance. Since cannabis has never been mass marketed aside from
The methods used by researchers also have significant roles in shaping conclusions related to gender. One of the interesting findings from Mullen et al. (2007) is that male drinking patterns are more diverse and flexible than quantitative studies suggest. Their focus groups of young men in the UK found masculinities are being refashioned along with the changing social context of male drinking norms. Similarly, while quantitative methods uncover few gender differences among tobacco smokers, ethnographic research reveals nuances in how men and women craft gendered selves through smoking tobacco. For example, young men smoke in solitary ways while young women, who are held more accountable for their behavior, prefer smoking in groups in order to avoid some of the stigmas of engaging a masculine-coded activity (Amos & Bostock 2006; Nichter et al. 2006). Arnall and Ryder (2019) also found teenage girls were careful to balance risk and pleasure against one another in their decision to use recreational intoxicants. The most common way to hedge risk related to substance use was to pursue such pleasures in the context of a social group. None of the girls interviewed spoke of using drugs alone: “Although friends may be conduits into [alcohol and other drug] use, they are also the people who watch your back and look after you. Girls described how they look out for themselves and others, highlighting social networks that mitigate substance-related risks, strengthen social bonds, and demonstrate care” (Arnall & Ryder 2019:10). Doing deviant things in a group diminishes some of the blame each individual receives, and findings like this reveal how a gendered self is both influenced by and constructive to drug subcultures.

characterizations in popular media, it may lack culturally idealized styles of consumption. In other words, since cannabis has never been commercially connected to an attractive lifestyle, users may focus more on the effects than the messages their use sends to others.
Adults, Gender, and (Medical) Cannabis

What about gendered analyses in the context of adult medical cannabis use? Only one study focuses on the subject in an exclusive manner. Joan L. Bottorff and colleagues (2011) found medical cannabis patients described the effects of cannabis in glowing terms such as “life preserving” or a “life force” (772). Women were more likely to explicitly use this terminology than men, and women were also more likely to frame cannabis as a mood-booster or a “medicine for the mind” (773). The authors connect this culturally prescribed feminine ideals of emotional awareness and emotion work. One Canadian man in the study told the interviewer that cannabis allowed him to retain control over his body despite his sickness. Overall, men were more likely to frame cannabis as enabling self-reliance when managing their illness, often avoiding professional health care services. Women, however, were more likely to work with health care services in regard to their cannabis use and desire to reduce prescription medications. Men also disclosed how cannabis helped their mental health, but they tended to frame use as controlling one’s anger or rage. These are also both characteristic of depression related to chronic illness in men, perhaps since our culture discourages men from discussing emotions (Bottorff et al. 2011). Either way, medical cannabis helped these men manage and perhaps refashion their enactments of masculinity.

In their qualitative study of the gendering of illicit marijuana use, Scandinavian sociologists Silje Dahl and Sveinung Sandberg (2015) found that men who use marijuana typically lack celebrated cultural characteristics of masculinity (Dahl & Sandberg 2015). The effects of marijuana are often described as mellowing and therefore have been associated with a softer version of masculinity (Haines et al. 2009). Marijuana is not considered to be among the hard drugs (like opioids), and it is common to see marijuana referred to in feminine ways (e.g.,
Mary-Jane). Yet marijuana use still appears to be coded masculine as female users of the drug feel they sacrificing feminine ideals of purity (Mostaghim 2019; Dahl & Sandberg 2015).

As part of several gender differences found in Scandinavia’s underground cannabis subculture, the authors note how female users avoid extreme forms of ingesting cannabis and prefer “… a softer, milder, and more gradual form of intoxication” (2015, p.704). These women were not only concerned with being physically able to handle such intense highs, but they also worried about breaching cultural ideals of feminine moderation and control. Smoking is an embodied practice, and if we cannot maintain control over our bodies when smoking (e.g., coughing), we risk losing face in our enactments of masculinity or femininity. While female cannabis patients in Colorado reported taking small hits until the desired medical effect was reached, their common use of “small-capacity pipes or vaporizers” (Newhart & Dolphin 2019:141) may also be interpreted as an enactment of femininity.

Interestingly, innovative or “serious” smoking methods are also a part of the enactment of masculinity (Mostaghim 2019; Dahl & Sandberg 2015). Extreme new ways to get high are more favored among men than women. Just like with chugging alcohol and other quick ways to get drunk, the Scandinavian study found that “maximizing intoxication was a practice mainly reserved for men” (Dahl & Sveinung 2015, p.704). Unfortunately, the authors do not add much explanation beyond this finding though clues are found elsewhere.

Detailed analyses of gender within either the medical or recreational cannabis community has been conspicuously absent from the scientific literature. Scholars such as Sexton et al. (2016) have pointed out the preponderance of male-dominated samples in cannabis research, and Haines et al. (2009) remark there is little qualitative research on gendered cannabis use. They also call for the use of participant-driven methodologies that would allow for more personal disclosure on
sensitive topics such as gender. My dissertation answers this call by using focus groups as a research method with medical cannabis patients in southwest Michigan. Before getting into the specifics of my methodological approach, it is worthwhile to examine gender and cannabis as portrayed in non-academic literature.

Women in the Cannabis Industry

Much of the discussion surrounding gender and medical cannabis comes from media outlets as opposed to academic researchers. Additionally, as “gender” is something commonly constructed to pertain to women as opposed to men (Ferree & Hall 1996), masculinities are largely absent from popular discussions. A hallmark of social privilege is the ability to comfortably live one’s life without awareness of such privilege and with little consideration of the privileged identity. As such, it is not surprising that men and masculinities are “invisible” within the world of cannabis because their way of doing gender is the cultural default. Femininities, on the other hand, demand explanation within spaces defined as masculine or non-gendered.

Yet because the legitimate cannabis industry is still in its infancy, it lacks a history of male domination endemic in most other enterprises, especially those surrounding drugs. This could provide women with an opportunity to claim and define their own spaces within the legal cannabis world at a level on par with men. The evidence suggests this is happening to some degree though it seems unlikely the medical or recreational industry will be egalitarian or better yet, non-gendered.

A lengthy Newsweek article from 2015 lauds the increasing number of women entering the multi-billion-dollar cannabis industry with the appealing title of Women in Weed: How legal
marijuana could be the first billion-dollar industry not dominated by men (Lidz 2015). Yet the article steers clear of hard statistics on gender proportions in the industry and instead relies on case studies, the profiles of select female leaders, and the uncontextualized raw growth of women-led organizations (i.e., saying a networking group grew to over 500 members in 2 years does not tell us much about how that fact compares with broader industry trends). We also see a tendency to preserve traditional gendered occupational roles. Pink-collar professions within the industry, such as the American Cannabis Nurses Association, retain a disproportionate number of women (86% in this case), and the stereotypical female-as-caregiver role still holds true. As Genifer Murray, a scientist and owner of a cannabis testing facility in Colorado, told Newsweek: “This is a compassionate industry, for the most part, especially if you're dealing with the medical side. The medical patients need time and consideration, and women are usually the better gender for that. The industry is flat-out geared for women” (Lidz 2015, paragraph 18).

Unlike most corporate businesses, the young legal cannabis sector does not have a history of sexist barriers. Marijuana Business Daily found in a survey of 632 cannabis industry executives and professionals that women hold 36% of leadership positions within the industry (Olson 2015, paragraph 8), compared to an overall average of 22% nationwide (Pew 2015, paragraph 13). As stated by a male CEO of a cannabis company, it has “become very unfashionable very quickly to have scantily clad women repping products at [business to business] trade shows” (Lidz 2015, paragraph 28).

Specifically impressive is that high-level positions in testing labs are occupied by women 62% of the time, compared to 38% in dispensaries or retail. Yet overall, senior leadership roles are still dominated by men in nearly two-thirds of cannabis businesses (Olson 2015, paragraph 14). This 2-to-1 gender disparity is a far cry from what the overly-ambitious Newsweek article
would lead one to believe. It is also worthy to note that testing labs operate behind the scenes of the cannabis industry. Testing labs cater their services to dispensaries, growers, and manufacturers of products containing cannabis rather than patients or the public. These labs serve to verify the potency of products as well as to check for mold, pests, and other potentially toxic foreign debris. While individual consumers can certainly pay for testing services themselves, most trust their dispensary to screen products or remain unconcerned with this backstage sector of the legally-operating cannabis world.

More troubling are findings from an unpublished master’s thesis by Michele Cadigan (2018). Interviewing 30 employees at recreational dispensaries in Washington state, Cadigan found women were typically met with suspicion by customers while men were better able to position themselves as experts. Furthermore, men working in the dispensary were often promoted faster and enjoyed more privileges like first access to free merchant samples. This may explain why some of the men called the dispensary their dream job while many of the women likened the dispensary to any other retail business (aside from the unique products being sold). Cadigan (2018) also found women quit at higher rates due to the overt and covert sexism from their customers, coworkers, and bosses.

Unfortunately, the cannabis industry appears to be less of a utopia than many business reports impart. Some of the women “canna-preneurs” interviewed by Borchardt (2017) acknowledge that as the industry matures, it may be drawn towards a more male-dominated corporate structure. Yet there is active resistance to hegemonic business culture as well. Progressive, feminist, and queer voices are present in the young world of legal and medicinal cannabis. Jessica Assaf, a graduate of Harvard Business School, has a website called Cannabis
Feminist though the site content is scant and geared toward product sales. More substantial is critical feminist blogger Angela Bacca, who writes:

The stereotypical stoner has always been one of two things; the 18-24 year old privileged white male or the demonized drug addict, most often a person of color or other marginalized group. Perceptions dictate personal outcomes, and historically when white men are outed for using marijuana they still retain the capacity in the public eye to serve as President of the United States. For marginalized groups — women, people of color, different genders, religions, the poor or disabled — being outed for using marijuana is more likely than for a white male to come with devastating consequences such as abusive run-ins with law enforcement, a justice system stacked against them, incarceration, child removal, and job or home instability. This, of course, devastates whole communities everywhere around the world (Bacca 2015).

Indeed, racial disparities in the legal cannabis industry are appalling. For decades, black and brown people have been the primary victims of cannabis-related arrests and prison sentences. A Politico article states that less than 5% of legal cannabis businesses in the United States are owned by black people, while police officers in Oakland, California continue to arrest black residents nearly 20 times more often than white residents for cannabis-related violations (Blau 2018). This has effectively resulted in the gentrification of cannabis, a claim further supported by a content analysis of cannabis advertisements where experts were predominantly depicted as white males (Mabee 2019). In Michigan, licenses to operate medical cannabis

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19 Massachusetts created a Social Equity Program to give underrepresented entrepreneurs an advantage in their emerging recreational cannabis marketplace (CCC 2019). The program is supposed to aid in the licensing process for those most impacted by marijuana prohibition. In order to be eligible for the program, an individual must meet one of the following:

- Residence in an area of disproportionate impact for at least 5 of the past 10 years and an income that does not exceed 400% of the Federal Poverty Level.
- A past drug conviction and residence in Massachusetts for at least the preceding 12 months.
- Married to or the child of a person with a drug conviction and residence in Massachusetts for at least the preceding 12 months.
businesses can be denied if the applicant has a criminal record or prior bankruptcies, two factors which disproportionately exclude non-white applicants.20

Bacca’s claim about child removal has also been noted by others. The threat of Child Protective Services (CPS) appears to be a major reason for women, particularly those with young children, remaining closeted about their cannabis use. In many states, CPS openly threatens to take children away from parents who are cannabis users, even if it is medically legal (Reinhart 2014, Lidz 2015). Because of changing laws, social workers have recently called on CPS to refocus on the context of cannabis use rather than the use of cannabis itself (Stott & Gustavsson 2016). Unfortunately, changes in policy may only partially lift barriers for cannabis use among mothers. In addition to state intervention, the stigma of being considered an irresponsible parent (particularly an irresponsible mother) inhibits women from openly partaking in cannabis culture (Dahl & Sveinung 2015). Fears of negative judgment from one’s peers, coworkers, and relatives are often enough to make women with children think twice about disclosing their status as a medical patient or recreational user. This stigma effectively forces patients who are mothers of young children into a closet. There are signs of change occurring in this area, though. Analysis of 2013 Pew data found parenthood status does not affect how women or men view marijuana legalization. Furthermore, both mothers and fathers are as likely as non-parents to have used marijuana in the past year (Elder & Greene 2019).

Despite the potential of the “bad mother” stereotype, Whoopi Goldberg has become somewhat of a luminary in the industry. In 2011 she spoke with People Magazine about smoking

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20 Part of Michigan’s new recreational marijuana initiative includes a social equity plan “to promote and encourage participation in the marijuana industry by people from communities that have been disproportionately impacted by marijuana prohibition and enforcement and to positively impact those communities” (Gray 2019). However, this type of equity statement was not present in the ballot language for Michigan’s medical cannabis initiative. In fact, no demographic information is available on the 230+ medical cannabis license holders in the state though such information will be collected under the recreational licensing process.
cannabis before her 1991 Oscar win (Byrne 2011) and wrote a column for *The Cannabist* in 2014 where she divulges the wonders of her vape pen (Goldberg 2014). She has since launched a line of medicinal cannabis products designed to ease menstrual cramps under the business name Whoopi & Maya. In an interview with *Vanity Fair* in 2016, Goldberg said she was disheartened at industry leaders believing medicine for menstrual cramps was niche market:

> Hey, this niche is half the population on the earth… This seems to be people flippantly blowing you off, which is what you get whenever you start talking about cramps. [Industry leaders] weren’t thinking, how do you target this? I have grown granddaughters who have severe cramps, so I said this is what I want to work on (Whoopi Goldberg as interviewed by Ciaramella 2016).

I have seen this view of women as a “niche market” elsewhere while I have never seen men presented in such a way. In one special episode of CNBC’s *The Profit* (2017), a pair of women are twice rebuked for making a female-focused pastry infused with a small amount of cannabis oil. As written on the product’s label, one of the recommended uses was for menstrual cramps (in addition to relaxation and inflammation). The Profit (Marcus Lemonis) scolds the women by insisting their product will alienate male consumers. Later in the episode, as the women try to explain to a potential retailer their goal of appealing to other women in a market dominated by masculine products, The Profit literally interrupts and mansplains to everyone how men won’t buy the product. Ironically, the hour-long episode continually emphasizes the need to differentiate one’s business in California’s saturated cannabis marketplace.

**Masculinities**

Raewyn Connell’s theory of the *social organization of masculinity* is currently the dominant theory in the field, so much so that nearly every masculinities theorist uses or at least addresses this framework (Pascoe & Bridges 2016; Schwalbe 2014; Schrock & Schwalbe 2009).
The theory is based on a dynamic structural view of gender as a social practice. For example, Connell (1995) defines masculinity as: “simultaneously a place in gender relations, the practice through which men and women engage that place in gender, and the effects of these types of practices in bodily experience, personality, and culture” (138). The emphasis of this work is on the process, practices, and projects of gender, or as Connell eventually calls these, configurations of gender. Per this perspective, individuals commit themselves to gendered projects configured around the reproductive arena. Accordingly, the reproductive arena refers to the wider processes of the social reproduction of gender rather than the biological act of reproduction itself. The arena encompasses everything from our sexual norms, popular fashions between the sexes, gendered roles, and parenthood responsibilities (Messerschmidt 2015; Connell & Messerschmidt 2005; Connell 1995). The strength of this perspective is that gender is not isolated to a performance like the doing gender framework, but rather that gender is evident throughout social reality—from our bodies and our understanding of self to our culture and material goods.

Perhaps the most valuable thing about Connell’s theory is that it doesn’t stop at explaining the differences between men and women. It goes on to explain relations among men which becomes the crux of the theory as it is known by another name—hegemonic masculinity theory (HMT). As a gay male, I’ve always had a degree of healthy skepticism towards any theory of gender that assumed all men were essentially the same in terms of power and prestige. Many perspectives on gender assume a sense of harmony among the privileged category of men, yet relations among men are often a vicious source of inequality and conflict. Most men realize a staunch hierarchy among men whether they would openly admit to it or not. Connell’s HMT is valuable because it sees masculinity as being embedded in our culture in addition to something
enacted by individuals. It has also allowed us to study differently practiced masculinities while grounding such analyses within a common structural frame (Schwalbe 2014).

Hegemonic masculinity is the most culturally exalted form of masculinity in any given society at any given time (Connell & Messerschmidt 2005; Connell 1995). Hegemonic masculinity is constructed to legitimize patriarchy, wherein masculinity has power over femininity in society. “This is the mechanism through which every male enacting an identity as a man, whether he strives to enact hegemonic masculinity or not, is granted male privilege—cultural benefits and unearned advantages conferred by virtue of membership in the social category of men” (Ezzell 2016:188). Another way to express this is to think of what Connell (1995) terms the patriarchal dividend, which refers to the rewards all men receive from their patriarchal privilege, including power, prestige, respect, and material advantage. Some styles of masculinity benefit more from this dividend than others, but the gender hegemony enables the continuation of a patriarchal order by rewarding specific traits with authority, dominance, and power. It is not just individual men who strive to meet hegemonic ideals, but women and other men must place value in the hegemonic form as well, even if they personally reject it.

It is important to note that no single individual perfectly personifies hegemonic masculinity; rather, it is the overall framework in which we can see specific examples of dominant and subordinate forms of masculinity (Messerschmidt 2015; Connell & Messerschmidt 2005; Connell 1995). Hegemonic masculinity provides a cultural framework through which male bodies produce gendered selves. It does not describe individuals but rather ways of being. Hegemonic masculinity, in other words, is an ideal type, a value-laden category used to compare subcategories and individual enactments of masculinity (Heckman 1997). Ideal types are useful in avoiding universalism because ideal types are the products of cultures, making it necessary to
consider the culture itself in our analysis (Heckman 1997). The Western hegemonic ideal of masculinity typically incorporates the following traits: anti-femininity, control over others, control over the self, strength, rationality, toughness, competitiveness, generativity, and heterosexual prowess (Schwalbe 2014; Peralta 2007). Though these are all qualities of human beings rather than intrinsic qualities of men, our culture typically associates these qualities with what a “real man” should be. Furthermore, Connell and Messerschmidt (2005) say hegemonic masculinity may be a goal towards which many men structure their lives, but it does not necessarily result in satisfying life experiences. In fact, hegemonic masculinity may be damaging to one’s body and mental health (Ezzell 2016; Peralta 2007).\(^2\)

While men may structure their gendered expressions towards the hegemonic ideal, many also discover other ways to enact masculinity. There are also complicit, subordinated, and marginalized masculine configurations (Connell & Messerschmidt 2005; Connell 1995), and these are often lumped together under a framework termed “multiple masculinities” (Pascoe & Bridges 2016; Schwalbe 2014). I think the best way to make sense of this is to understand the concept of *cultural creativity*, a practice where individuals claim some flexibility in how their specific roles are performed: “As social actors, men and women are presented with stages and scripts not of their own choosing. What they do creatively within these roles and cultural constraints, and how originally they perform their roles, however, is not preordained” (Gutmann 2007:245). Cultural creativity emphasizes that people desire a transformation of their life situations and acknowledges their agency to do so. Many men intentionally refashion their masculinity into non-hegemonic forms. In fact, multiplying masculinities is occasionally framed

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as the antidote to social problems stemming from hegemonic masculinity (Ezzell 2016; Pascoe & Bridges 2016).

Yet rigid connotations of masculinity persist in American society, and this is particularly true for enacting masculinity on the part of people of color. Nikolas Dickerson (2018) demonstrates how the use of marijuana by black athletes creates a space for the reinforcement of *legible black masculinities*, the most legible of which is the “black criminal”. Since using marijuana is often seen as a challenge to the status quo, the other legible script of black masculinity—that of the “good black”—is no longer viable for interpreting actions taken by the athlete. Our larger society has yet to embrace black masculinities that fall outside of the tropes between “good black” and “bad black,” and as such, both “legible scripts of black masculinity objectify black men and strip them of their agency and humanity” (Dickerson 2018:390). In sum, multiplying masculinities may be easier for white people as racial stereotypes add a layer of categorical oppression to alternative masculinities performed by people of color.

Nonetheless, scholars have been busy documenting the multitude of non-hegemonic masculinities for several decades, and much diversity has been added to the scientific literature on masculine expression. But this has become somewhat of a problem as multiple masculinities collapsed into an endless array of individualized masculinities to the point where we risk deconstructing down to each individual man (Bridges & Pascoe 2016; Schwalbe 2014; Schrock & Schwalbe 2009). What is perhaps most surprising here is the pace at which marginalized masculinities have exploded in popularity among social scientists. For example, Matthew Gutmann (2007), originally writing in 1996, stressed the need to locate and focus on diverse expressions of gender within overgeneralized categories. Around a decade later, many
masculinities scholars of today think the field faces the opposite problem: an overabundance of masculine subtypes. Michael Schwalbe (2014) aptly terms this the “masculinities industry”.

My study does not seek to document a specific typology of “cannabis masculinity” or anything similar. Rather, I am interested in how men in the medical cannabis community practice their cultural creativity in defiance of hegemonic pressures. As discussed elsewhere in this chapter, some of the studies on both youth and adult marijuana use indicate men craft alternative forms of masculinity. They do not abandon social pressures to enact masculinity, but they do not strive for the ideal hegemonic form either. It seems they may buy into some hegemonic notions of masculinity while deferring others. Part of my dissertation research has been to describe multiple masculinities within the medical cannabis community, and in Chapter 8, I discuss which hegemonic notions these men support and which they refashion.

Conclusion

How gender influences medical uses of cannabis is still largely unknown. Though we have some evidence from popular media as well as scientific literature on recreational marijuana, the specific context of medical cannabis may affect gendered enactments differently. Cannabis is both a substance and a socially constructed symbol that can be a resource for the enactment of a gendered self. However, is it a symbol of femininity, masculinity, or neither? How are masculinities and femininities enacted in the medical cannabis community? Examining these issues may provide further evidence that gender is not static, but that it is continually being remade and refashioned.

This concludes my review of the scientific literature related to cannabis use in both medical and recreational contexts. My review demonstrates both breadth and depth of cannabis
history, how scholars have theorized cannabis, and where cannabis might be headed in the future. The next chapter explains the methodology of my study.
CHAPTER V

METHODS AND METHODOLOGY

This chapter explicates my methodological approach and research design. I begin by providing an overview of the methods and perspectives employed by other researchers studying the topic of cannabis. This allows me to contextualize why my research is unique and how it contributes to the knowledge base. I then move onto my experiences with medical cannabis and my research questions. Following this, I detail the methods used in my study which include key informant interviews, observations, and focus groups. Afterward, I discuss the challenges I experienced while recruiting patients and the difficulties I encountered when sampling for focus groups. Finally, I explain the strengths and limitations of my research along with ethical considerations and issues of validity. I conclude with an overview of my analytical strategy.

Contextualizing My Study

Social research on medical cannabis is limited because it exists in a liminal space, being neither totally illegal but not entirely accepted by authorities (Satterlund et al. 2015). This makes medical cannabis patients a “half hidden population” (130) whose medicine is legitimated on the state level while criminalized on the federal level (Reinarman et al. 2011). As such, relatively little is known beyond patient demographics since most studies on medical cannabis utilize surveys and produce depersonalized statistical reports. One of these demographic studies was completed in southwest Michigan (Ilgen et al., 2013) while others have sampled elsewhere in the state (Kruger & Kruger 2019; Boehnke, Litinas & Clauw 2016). Other surveys of patients have been conducted in California (Reinarman et al. 2011; O’Connell & Bou-Matar 2007; Reiman
2007), Washington (Sexton et al. 2016; Roy-Byrne et al. 2015), Rhode Island (Zaller et al. 2015), and Hawaii (Webb & Webb 2014). Demographic studies on those who use cannabis for medical purposes also come from Israel (Zolotov et al. 2016) and the United Kingdom (Ware, Adams & Guy 2005). These studies typically inquire about a respondent’s history and reasons for use, as well as methods and quantity of consumption.

Patient demographics give the impression of a unified community, but qualitative approaches reveal cannabis patients are not a homogenous group (Loflin & Earleywine 2014; Osborne & Fogel 2008; Chapkis 2007). This is why Ryan and Sharts-Hopko (2017) believe qualitative inquiry is best suited for exploring medical cannabis patients. Patient experiences are varied and diverse, being influenced by their location and state of residence, their relationships with family members and health care providers, their diagnosis, and the patient’s personal beliefs about marijuana. Qualitative studies with enrolled cannabis patients have been conducted in California (Lau et al. 2015a/2015b; Satterlund et al. 2015; Chapkis & Webb 2008), Colorado (Newhart & Dolphin 2019; O’Brien 2013), Illinois (Victorson et al. 2019; Bruce et al. 2018), and Canada (Athey et al. 2017; Bottorff et al. 2013; Page & Verhoef 2006). Significant here is that no one has used qualitative methods to investigate Michigan patients and only one study has conducted focus groups with registered cannabis patients (Victorson et al. 2019). While interviews are good for collecting individual experiences and life histories, we do not have any group-level data to tell us about patients as a community (Hollander 2004).

Since every method has its own strengths and limitations, the best use of methods is to combine them in a manner that yields additional insight into the topic under investigation (Johnson 2000). When two or more research methods are used together in a single study, scholars call this triangulation. There is some controversy surrounding this term, however. Some
say triangulation only works if we believe in an objective truth where “every method is a
different line of sight directed towards the same point” (Berg 2009:5). Likewise, Alan Bryman
(1992) says it is common to see a pairing of methods that do not enhance the validity of a study,
as the strengths and limitations of each method are not used in a complementary fashion. On the
other hand, Michael Bloor and colleagues (2001) argue triangulation simply requires the
researcher to contrast results from one method with that of another. In this way, “triangulation is
not so much about getting to the ‘truth’ but rather about finding the multiple perspectives for
knowing the social world” (Marshall & Rossman 2011:254). Triangulated methods each focus
on a shared point but illuminate said point through different means, often resulting in different
understandings. Triangulation pluralizes our vision and can be used to enhance the
confirmability, transferability, and credibility of our study (Marshall & Rossman 2011).

I have triangulated key informant interviews, site observations, and focus groups in an
attempt to pluralize the knowledges deployed in my research. Focus groups were the primary
method in this study, and my use of key informant interviewing was to get a better sense of
Michigan-specific issues as well as to refine my focus group discussion guides (Morgan 1997).
Some of the key informants also served as gate-keepers to the medical cannabis community,
helping with participant recruitment and offering their facilities for data collection (Krueger &
Casey 2009). Finally, site observations allowed me to witness action without the information
being filtered through an authority figure. The observations were also valuable for revealing
small details that helped me communicate the milieu of medical cannabis in Michigan.
Perspectives and Standpoints

Most research on cannabis is conducted under a paradigm of prohibition, risk, and abuse (Subritzky 2018; Garner 2016; Ware 2007; Hammersley & Leon 2006; Zinberg & Harding 1979). The reason for this is despite cannabis having a long history as a medicine and sacrament, it is now largely defined by the legal system as a prohibited substance (Newhart & Dolphin 2019). For example, many researchers frame their studies through a risk-dependence model, where all cannabis use is measured in relation to harm. However, the same researchers also routinely fail to control for other environmental factors that may reduce wellbeing, such as variations in the strain and purity of cannabis as well as a person’s reasons for use (Temple, Brown & Hine 2010). Not many researchers have approached cannabis from a perspective that implies use is normal, non-deviant, or non-problematic, even though cannabis use itself is generally regarded as normalized (Hammersley and Leon 2006). Qualitative studies by Osborne and Fogel (2008) and Garner (2016) come close to this, but these studies pertain to recreational use rather than medical use by patients.

The standpoint of the researcher also varies among the existing literature on medical cannabis patients. Most of the quantitative studies are disembodied in that the researcher is invisible. These studies value objectivity and neutrality but make it difficult to evaluate researcher bias or experience in the area. A powerful alternative to detached observations holds that reality is a co-construction between researchers and their participants. Known as interpretivism, this scientific paradigm claims data are created rather than discovered (Eide & Kahn 2008; Charmaz 2006). Furthermore, this perspective necessitates an acknowledgment of subjectivities; “bias” for lack of a better word. Kathy Charmaz (2006) says: “We are not passive receptacles into which data are poured… Neither observer nor observed come to a scene
untouched by the world” (15). Rather than claim we can uniformly understand an objective reality, interpretivists say we should illuminate the plurality of meanings, experiences, and realities people construct. Qualitative social research methods such as interviewing, participant observation, and focus groups allow us to appreciate the contextual nature of the data we create.

From my own exploration of the literature, there are no studies conducted where the researcher is or was a cannabis patient. Two books come close, though. Wendy Chapkis and Richard J. Webb (2008) were involved as caregivers and activists in California’s medical cannabis movement. Their book, *Dying to Get High: Marijuana as Medicine*, examines a caregiver community serving seriously ill patients at a time when authorities were still raiding medical dispensaries throughout California. Michelle Newhart and William Dolphin (2019) worked in California’s medical cannabis industry before Newhart conducted her dissertation on patients in Colorado. Their book, *The Medicalization of Marijuana: Legitimacy, Stigma, and the Patient Experience*, examines cannabis’ construction as part of complementary and alternative medicine (CAM) through the experiences of middle-aged patients collected from 2010-2012. Noteworthy is how Newhart’s data collection ended right before Colorado voted to legalize recreational use on November 6, 2012. I collected data following Michigan’s legalization on November 6, 2018, effectively picking up right where Newhart left off.

I have been a registered patient in the state of Michigan since 2014. My experiences with medical cannabis have been overwhelmingly positive, but sometime after becoming a patient, I realized that I was back in the closet. I spent the first 18 years of my life hiding my sexual orientation from others and now I had another identity that carries much stigma. Unlike my sexual orientation, this other devalued identity opens up the possibility of legal discrimination.
from employers, landlords, and more. My social location as a gay man also places me as an “outsider within” the category of masculinity. Owing to their position on the periphery of privilege, the outsider within often has a clearer view of categorical power, status, and privilege (Collins 1986).

The link between sexual orientation and marijuana goes further than just my own social position. American attitudes towards same-sex marriage and marijuana legalization have changed simultaneously, as these are strongly connected to maximizing individual liberty (Schnabel & Sevell 2017). These dual trends in public opinion have also been documented by Cameron Duff and colleagues (2012) among Canadians. Furthermore, my impression from reading many studies of marijuana normalization is that it closely resembles the narrative for marriage equality. Before same-sex couples had the right to marry, many states allowed for civil unions which granted queer couples most legal rights of marriage but without the dignity of a social institution. Medical marijuana is conceptualized much like the civil union, a type of tepid compromise between prohibition and tolerance. As the civil union may have been an intermediary step on the road to marriage equality, medical marijuana is treated by some scholars in much of the same way.

Absent from this comparison are the lived experiences and perspectives of those most impacted by cannabis policy. Cannabis is widely accepted to have therapeutic value, patient narratives speak of life-changing results, and there is an ongoing political struggle in which

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22 The “seclusion etiquette” described by Johnson et al. (2008) also reminds me of the historical changes experienced by homosexuals in our society. By largely restricting marijuana use to private settings, this norm of seclusion is primarily practiced to avoid damaging one’s reputation among their social network. These users were much more concerned about social stigma and practiced an etiquette of seclusion in order to avoid informal social controls, with Johnson et al. (2008) saying there is an informal compromise between police and cannabis users. Smoking cannabis was tolerated as long as it was out of sight, just like same-sex romance used to be.
many activists have sacrificed their freedom in the name of safe access. What do these people think of the current landscape and anticipated changes concerning cannabis in our society? Does legalized recreational marijuana help or hinder the construction of cannabis as a medicine? My dissertation research sought to answer these questions by deploying a mixture of qualitative research methods. My primary method of inquiry was focus groups of MMMP patients in southwest Michigan though I began my study conducting interviews with key informants and performing structured observations of cannabis facilities and events. Once again, the research questions that guided my inquiry were:

(RQ1) How does the medical cannabis community feel about the normative status of medical cannabis in this moment of emerging recreational legalization? And, what challenges do patients face in their social and professional lives?

(RQ2) How do medical cannabis patients view the legalization of recreational marijuana? And, do patients think medical cannabis will survive once marijuana is fully legalized?

(RQ3) How does gender shape the experiences of medical cannabis patients? And, how might hegemonic gender roles be adhered to or challenged by cannabis patients?

Being an insider within the medical cannabis community is also an asset in collecting data from patients. Several qualitative investigations discuss the role of the researcher in data collection (Newhart & Dolphin 2019, Pedersen 2015, Chapkis & Webb 2008), noting participants were eager to know about the researcher’s cannabis use and their political positions regarding cannabis legalization. In general, patients appear to be tired of having their medicine placed under the microscope in a manner that introduces doubt and where any findings can be used as evidence against their patient status. This concern is not without reason as patients fought
hard to legitimize cannabis as a medicine through what some have called a social movement (Chapkis & Webb 2008). My status as a cannabis patient was perhaps surprising but also welcomed by the patients involved in my study. Since an insider was conducting the research, patients may have felt more at ease and may have disclosed more information.

Key Informant Interviews

The key informants I was after all held public and respectable roles in Michigan’s medical cannabis community. They included dispensary owners, activists, caregivers, individuals within cannabis-related business and political networking organizations, a certifying physician in Michigan’s MMMP, and an individual working in cannabis marketing. To persuade key informants to participate in my research, I employed several strategies outlined by Andrew Shenton and Susan Hayter (2004). These included emphasizing the value of their contributions, highlighting my personal links to the medical cannabis community, answering their questions openly and honestly, and remaining receptive to any suggestions they may have. While I was not able to offer my key informants any monetary or materials incentives, previous research on cannabis growers found the growers were more concerned with intangible rewards than profits or trophies (Potter et al. 2011). I believe my key informants perceived similar nonmaterial benefits from participating in my research owing to their status within Michigan’s cannabis community.

Overall, key informants were excited to share their thoughts and experiences in the industry, and many understandably had a perspective grounded in the worlds of business and politics. One of the key informants even asked I meet them for lunch at a local brewery, and we spoke about their new business for an hour or so before agreeing to do the interview another day. Recognizing I was a broke graduate student, they even paid for my soup. In exchange for this
kindness and their involvement in my research, I shared with them some of the academic studies which compiled patient demographics. I made similar offers to the other key informants though none have yet to take my offer up.

The key informants were rather eager to be interviewed and some even suggested other notable figures to contact. I took them up on a couple of these suggestions, increasing the number of interviews from seven in my proposal to nine in my final report. One key informant declined to be interviewed because they considered themselves an outsider in the cannabis community and expressed their job was to report objective facts without personal interpretations. This was understandable, and I replaced this person with another individual who I had recently read about in a news article.

Table 1 - Key Informant Interviews

<table>
<thead>
<tr>
<th>KEY INFORMANT INTERVIEWS</th>
<th>Description</th>
<th>Date</th>
<th>Duration</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy</td>
<td>Board member for MI NORML and cannabis activist.</td>
<td>June 25</td>
<td>43 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Justin</td>
<td>Cannabis activist, dispensary co-owner, and radio host.</td>
<td>June 25</td>
<td>65 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Ramona</td>
<td>Owner of a cannabis marketing firm and public relations professional.</td>
<td>June 27</td>
<td>30 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Madison</td>
<td>Executive in the Michigan Cannabis Industry Association and cannabis lobbyist.</td>
<td>June 28</td>
<td>70 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Kayla</td>
<td>Dispensary owner in southwest Michigan</td>
<td>June 28</td>
<td>50 Minutes</td>
<td>In Person</td>
</tr>
<tr>
<td>Jackie</td>
<td>Founder of a cannabis networking association and a leader in Michigan’s chapter of Women Grow.</td>
<td>July 2</td>
<td>44 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Dr. Steven</td>
<td>A certifying physician in the MMMP and the owner of a holistic health center.</td>
<td>July 5</td>
<td>78 Minutes</td>
<td>In Person</td>
</tr>
<tr>
<td>May</td>
<td>A long-time caregiver in the MMMP.</td>
<td>August 15</td>
<td>39 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Michael</td>
<td>A long-time caregiver in the MMMP and former commercial grower.</td>
<td>August 23</td>
<td>120 Minutes</td>
<td>In Person</td>
</tr>
</tbody>
</table>
Observations

I was given permission to observe two cannabis-related facilities, and I visited each location two times, each at different times on different days. One of these facilities was a provisioning center (aka dispensary) and the other was the office of a certifying physician. My observations were structured using a field note guide included as Appendix G. However, I also followed advice from Berg (2009) and Lofland et al. (2006) where jottings are done on-site, and detailed descriptions are undertaken immediately after exiting the field. I observed these facilities for a total of roughly four hours and spent approximately the same amount of time writing detailed descriptions afterward. Care was taken to be as concrete as possible where general adjectives were avoided in favor of specific details. While mundane and thick with description, “the objective in writing fieldnotes is to get information down as efficiently, correctly, and honestly as possible” (Lofland et al. 2006:116). I also included my personal feelings and impressions since qualitative research encourages us to be sensitive to our positionality in the field as well as our emotions and biases. My detailed notes similarly include analytic comments and subjective reflections, both of which are bracketed as not to be confused with my narrative of field observations.

While I tried to observe another dispensary, I was unsuccessful at getting permission from the owner. This person did not flatly deny my request but failed to respond to my emails or phone calls. Thankfully, one of my key informants invited me to a special event they were holding which centered on patient networking and education about the state’s new regulations. This ended up being more of a business-centered event, but it was still valuable for insight into the commercial structure of Michigan’s medical cannabis program. It was also interesting
because it provided a contrast to my status as an insider in the cannabis community. I am a complete member of the group being observed, and my role at the dispensary and medical office was that of a full participant as an observer (Creswell 2013). However, I felt more like an outsider at the networking event as most of my interactions with other attendees began with them asking, “What type of business are you in”? As a social researcher, I had no use for something like a CPA, growing equipment, or secured transport services, so I felt more removed from the crowd in that social setting.

Table 2 - Observations

<table>
<thead>
<tr>
<th>OBSERVATIONS</th>
<th>Description</th>
<th>Observation 1</th>
<th>Observation 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature’s Healing</td>
<td>A provisioning center only accessible to those in the MMMP. Access limited to the waiting room as patients are taken into private rooms for sales.</td>
<td>July 5 6:00pm to 7:05pm</td>
<td>July 13 2:00pm to 3:00pm</td>
</tr>
<tr>
<td>Alternative Midwestern Medicine</td>
<td>Office of a physician who certifies patients for the MMMP in addition to offering a range of classes and hemp products. Not able to observe doctor-patient consultations.</td>
<td>July 10 10:20am to 11:30am</td>
<td>July 15 10:00am to 11:00am</td>
</tr>
<tr>
<td>MMMP Conference</td>
<td>An event for patients and caregivers in a large hotel’s conference area. There were two main rooms with one devoted to presentations and another for vendor booths.</td>
<td>July 28 1:00pm to 4:00pm</td>
<td>na</td>
</tr>
<tr>
<td>Boutique Herb (pop in)</td>
<td>An upscale dispensary chain new to the West Michigan area. I visited as a first-time patient.</td>
<td>July 6 4:00pm to 4:15pm</td>
<td>na</td>
</tr>
<tr>
<td>Kosmic Buds (pop in)</td>
<td>A new dispensary in the West Michigan area with plans of vertical integration. I visited as a first-time patient.</td>
<td>July 24 5:20pm to 5:35pm</td>
<td>na</td>
</tr>
<tr>
<td>MI Harvest Fest</td>
<td>The first public cannabis event in the area following legalization. Akin to a smaller “cannabis cup” competition.</td>
<td>October 27 3:00pm to 5:30pm</td>
<td>na</td>
</tr>
</tbody>
</table>

Though my formal observations were conducted in July 2019, I kept a similar record of observations I made in everyday life. These included billboards along highways, comments I
overheard at parties, and a major grocery store selling hydroponic nutrients. I also noticed something interesting happened over the course of my study. Several new dispensaries opened up in southwest Michigan and I visited two of them for a number of reasons: (1) I wanted to post advertisements for my focus groups, (2) I wanted to take advantage of their new patient discount, and (3) I wanted to get a sense of what each one was like. I consider my visits to these sites more personal than research-centered, but since qualitative research uses the researcher as an instrument, I wrote reflections on each of my visits afterward. I spent roughly 15 minutes at each location and call this style of observation a “pop-in”.

Being a complete member in Michigan’s medical cannabis community made these two pop-ins possible. My role at each location was a customer who happened to bring fliers for his research project. This resulted in some interesting observations, one being particularly striking. In a small town near Lake Michigan, there is a dispensary across the street from another dispensary, and these dispensaries couldn’t be more different. One of these establishments is new while the other has been operating for many years, though I had not visited before since it is out of my way. The older dispensary is rustic and quaint, similar to a local no-thrills bar, and reminds me of the dispensaries in pre-MMFLA Michigan. The newer dispensary is more like a top-tier wine cellar with modern décor, high ceilings, and a floor plan similar to an Apple store. They are also a franchise of a company with locations in cities like Las Vegas and San Francisco. What is this place doing in a rural town with an approximate population of 700 and a pre-existing dispensary? They know their status as a licensed medical facility will get them first grabs at a recreational license, and the town is one of the few municipalities in Southwest

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23 The MMFLA was implemented in 2016 and provided a pathway for cannabis businesses to legally operate by acquiring a state-issued license. Many small provisioning centers operating in the gray area of the law were forced to close because the licensing fees and requirements are too high.
Michigan which has opted in to allow medical and recreational cannabis businesses. For more information about the history of and regulations on cannabis in Michigan, see Appendix B.

Focus Groups

My five focus groups contained a total of 21 patients and lasted between 75 and 120 minutes. Focus groups are also social events where participants drive the discussion (Bloor et al. 2001). Richard Krueger and Mary Anne Casey say: “As participants answer questions, their responses spark ideas from other participants. Comments provide mental cues that trigger memories or thoughts of other participants—cues that help explore the range of perceptions” (2009:35). In this way, my research answers Garner’s (2016) call for participant-driven research on the topic of cannabis. Furthermore, my anecdotal experiences lead me to believe cannabis patients enjoy sharing their experiences with their medicine. Morgan (1997) says focus groups are ideal for topics that would make for engaging discussions among participants, and I believe the patients in my groups mostly enjoyed the chance to share their experiences and opinions with other participants.

In terms of the repertoire of qualitative research methods, both participant observation and focus groups are interested in group interactions. Unlike individual interviews, each provides direct evidence about differences between and similarities among our research participants with regards to their opinions and experiences. While the degree of naturalness is higher in participant observation than in focus groups, the later allows the researcher to control what topics come under discussion (Morgan 1997). Focus groups allow us to observe a range of opinions and feelings on specific topics selected by the researcher (Kruger & Casey 2009).
Two studies have so far used focus groups as a method to investigate recreational marijuana users. One of these was done by Haines et al. (2009) on a sample of Canadian teenagers, and the other was done by Jarvinen and Demant (2011) on a sample of Danish teenagers. The Danish focus groups were analyzed for collective images of the drug, and the focus groups tended to negotiate and compromise until a relatively uniform symbolic representation was reached. Compromise, however, is not always desirable, and my use of focus groups emphasized diversity in perspective rather than uniformity. I began each focus group with a statement welcoming the participants to disagree with one another and encouraging them to share dissimilar experiences. My research also differs from each of these former studies by using focus groups of adult medical cannabis patients.

My focus group question guide can be found in Appendix I. As suggested by Morgan (1997), I decided to use a semi-structured question guide where each group would be asked the same questions but perhaps in a different order. My reasons for doing this include a desire to maintain consistency as well as to control for my lack of experience moderating focus group discussions. Unstructured guides may be preferred by professionals, but I was more comfortable moderating from a set list of questions. However, the focus group setting is less controlled than that of individual interviewing, and too much structure may inhibit the natural flow of group interaction or turn the focus group into a question-answer group interview (Bloor et al. 2001). Subsequent questions posed to the group should appear as natural follow-ups to the discussion rather than abrupt transitions into other topics, so I occasionally rearranged the order in which some questions were asked. This was done because the group’s discussion organically journeyed into another topic on my list, and I believe my decision to continue the topical conversation
ultimately produced trustworthy answers to my research questions as per the rules of thumb by Morgan (1997).

As for the questions themselves, I tried to abide by the advice given by Krueger and Casey (2009:36-38) who say good questions should: evoke conversation, are easy to say, are clear, are short, are one-dimensional, are usually open-ended, use words the participants would use when talking about the issue, and include clear, well-thought-out directions. While these suggestions may sound counter to the complexity of scientific inquiry, simple questions tend to stimulate the most discussion and get to the core of the topic under investigation. Furthermore, my questions proceed in the manner of a funnel (Krueger & Casey 2009; Morgan 1997) where I move from general to specific questions. As suggested by others, I also used probes to keep the discussion flowing and focused on the topic at hand (Krueger & Casey 2009).

**Table 3 – Focus Groups**

<table>
<thead>
<tr>
<th>FOCUS GROUPS</th>
<th>Participants (n=21)</th>
<th>Gender</th>
<th>Race</th>
<th>Age Range</th>
<th>Duration</th>
<th>Average Years in MMMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>n=4 (6 confirmed)</td>
<td>1 Man</td>
<td>3 White</td>
<td>18 to 43</td>
<td>1 Hour, 45 Minutes</td>
<td>2.75 (1 to 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Woman</td>
<td>1 Biracial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Non-binary</td>
<td></td>
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<tr>
<td>Group 2</td>
<td>n=6 (7 confirmed)</td>
<td>3 Men</td>
<td>6 White</td>
<td>34 to 66</td>
<td>2 Hours</td>
<td>3.33 (1 to 6)</td>
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<td></td>
<td></td>
<td>2 Women</td>
<td>1 Non-binary</td>
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<tr>
<td>Group 3</td>
<td>n=2 (6 confirmed)</td>
<td>2 Men</td>
<td>1 White</td>
<td>39 to 53</td>
<td>1 Hour, 15 Minutes</td>
<td>7 (4 to 10)</td>
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<td></td>
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<td>1 Biracial</td>
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<tr>
<td>Group 4</td>
<td>n=2 (6 confirmed)</td>
<td>1 Man</td>
<td>2 White</td>
<td>32 to 41</td>
<td>1 Hour, 30 Minutes</td>
<td>5.5 (2 to 9)</td>
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<td></td>
<td></td>
<td>1 Woman</td>
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</tr>
<tr>
<td>Group 5</td>
<td>n=7 (8 confirmed)</td>
<td>4 Men</td>
<td>6 White</td>
<td>28 to 64</td>
<td>2 Hours</td>
<td>3.42 (1 to 8)</td>
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<td></td>
<td></td>
<td>3 Women</td>
<td>1 Native American</td>
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**Recruiting Participants**

As it turned out, subject recruitment was one of the most challenging parts of my study. My initial approach was placing fliers at numerous provision centers and posting messages on
cannabis-related social media pages. After over a week of doing this, I had a depressing total of five respondents complete my screening survey. My hunch was that the fliers had not been posted after I dropped them off at the dispensaries, so I made the rounds to these locations again with new fliers. I discovered I was right, and none of the six or so locations had my study’s information posted. Social media was also a relative failure as messages posted to pages or groups go unseen by the vast majority of followers. I felt somewhat angry but mostly anxious, and I knew I would have to get more creative with participant outreach or I would have to drop my plans for focus groups.

Provisioning centers (aka dispensaries) are tightly controlled spaces in Michigan. They are subject to strict regulations on who is allowed in, what is allowed to be sold, and how business can be legally conducted. Prior to the 2016 MMFLA, dispensaries were more like self-structured enterprises with no regulatory oversight but also no legitimacy in the eyes of the town or state. Owners knew their businesses could be raided at any moment, and they logically kept their physical locations simple and out of the public eye. While the MMFLA created a pathway to licensure, the first two years of the program yielded few licenses due to complications with now-defunct Michigan Medical Marihuana Licensing Board (MMMLB).

I mention this here because one of the dispensaries I intended to post fliers—and perhaps the dispensary serving the most patients in Southwest Michigan—was once forced to close for several months by the MMMLB. This facility was denied a license because the owners had previously competed in one of Michigan’s HighTimes-sponsored cannabis cups, an act that was deemed out of line for an owner of the medical cannabis provisioning center. Fortunately, the facility was later granted a medical license after the MMMLB was abolished by the new governor and replaced with the Marijuana Regulatory Agency (MRA). When I visited this
location for a second time with fliers and questions, I was told they were awaiting a response from their legal team before they would advertise my study. Since other dispensary owners immediately agreed to post my study’s information, this was likely a precautionary measure owing to that facility’s history with regulators. Since my materials were never posted, I take it that the lawyers said better safe than sorry, or that the owner simply did not want to post my fliers.

Aside from art and business information, there are no message boards or other wall postings in provisioning centers in southwest Michigan. However, they all have little areas where business cards accumulate from local realtors, mechanics, and insurance agents. Realizing this, I condensed my flier into a double-sided business card and ordered 440 of them from Walgreens for $27.92. Several days later, I returned to each dispensary with the business cards and, with the quick approval of the front desk employee, placed them in the designated area. My fliers were still not posted but I had solved my dilemma, and many of the participants in my focus groups informed me they learned about the study from picking up a business card. In fact, only two of the eight facilities I visited would end up posting my fliers, the office of a certifying physician and a testing lab with little patient traffic.

Around the same time I turned to business cards, I also started to get more aggressive with social media posts. After getting many promises but no actual help, I began commenting on statuses shared by Michigan cannabis groups as well as cannabis-related articles posted by local news organizations. I even began advertising my study on my own Facebook profile, first using a “hashtag soup” approach where I included any relevant hashtag I could imagine. I then boosted these Facebook posts by paying $20 for targeted advertising, a strategy I first learned when launching my personal website and later refined as the media editor for an academic
organization. Since Facebook does not have an option to target users with interests in cannabis, I targeted those with interests in alternative medicine and those who follow the pages of NORML and Weedmaps. Setting the audience to within a 50 miles radius of the study site helped keep the advertising applicable to southwest Michigan, and only users over 18 years old saw the advertisements. This approach reached around 2,500 people and while it is impossible to tell, I would guess 20 or so ended up completing the screening survey.

The final saving grace for my recruitment woes came unexpectedly when I received a call from a local reporter. They must have seen my comments on their cannabis-related news stories and decided to feature my study in its own special article. I honestly thought I was going to be asked to stop commenting on their posts when I began talking to the reporter, but our four-minute conversation turned into a short piece titled, “WMU student’s research probes medical marijuana patients post-legalization” (Miller 2019). After the article was published, my participant pool rose to over 50 eligible respondents.

**Sampling and Conducting Focus Groups**

Kruger and Casey (2009) say the purpose, population, and budget drive the sampling approach used in focus group studies. Recommendations for group size typically vary between 4 to 10 participants with a total of 3 to 5 groups per project, though it is strongly advised to set a target number of groups rather than a bare minimum (Morgan 1997; Berg 2009; Krueger & Casey 2009). However, these are all guidelines that are flexible to suit the unique needs of the research goals and population, though preference is given to easily identifiable groups in distinct locations. Since medical cannabis patients typically visit dispensaries and health centers, I planned to use these facilities to advertise my study. This type of purposefully selected sampling
approach lacks the representativeness of true random samples, but generalizability is not a goal of this qualitative descriptive study.

I began scheduling and inviting participants to focus groups when I had roughly 30 eligible respondents in my sample pool. The first two groups were very successful, containing four then six participants, but problems began with filling seats for the third focus group. While six individuals confirmed their attendance to the third group, only two attended. As recommended by Bloor et al. (2001), participants were sent confirmation emails upon enrolling as well as a reminder email the day of the focus group. They were also be provided with a map to the facility and the contact information of the researcher. I had also asked participants about their typical availability in my screening questionnaire, and I took care in inviting participants to groups held on days where they were available. The only way I had contact with these eligible participants was through email, and if I had to do this study again, I would ask for their phone numbers as well. Nonetheless, all planned groups had six or seven participants RSVP, and aside from the last group, all had multiple members drop out at the last minute or were absent without explanation.

David L. Morgan (1997) suggests we over-recruit by about 20% in order to make sure we have the minimum number of required participants for each group. I had a total of 70 eligible participants in my sampling pool and after my fourth focus group where only two individuals attended (though six RSVP’d), I had exhausted my patience for no-shows. There was a final group scheduled for the following week, and I began sending out batches of invitations to all 56 people in my pool who had not yet participated, including those who failed to show for prior groups. A handful of individuals responded back that they were busy, but seven eventually confirmed. One of them backed out the day before, but luckily, another person had taken my
screening survey and qualified for the study, and they were fortunately available for the next day’s focus group. All seven of these participants showed up and it was my only group with a perfect confirmed participation rate.

Scholars generally support the use of at least three or four focus groups per study though the specific requirements and goals of the study should determine the number of planned groups (Krueger & Casey 2009; Bloor et al. 2001). I used a total of five groups though two of these contained only two participants. I still classify these groups of two as focus groups because there was still a group dynamic, with participants commenting on and responding to one another. These groups took less time than the others since we moved through topics faster, but the conversational nature of the discussion still resulted in a lively exchange between participants and allowed them to raise issues not covered by my questions. This was particularly interesting with the topic of guns and marijuana as my analysis on gender will show.

I was fortunate to receive a grant from Western Michigan University’s Graduate College that allowed me to purchase gift cards worth $25 apiece to be used as participant incentives. These small payments may also function to reduce bias and the power differential between the researcher and the participants (Bloor et al. 2001). While participants in social research spend their time and energy providing data, they often receive little to no direct benefit by doing so. The researcher, on the other hand, benefits from their participants in the form of prestige and publications used towards professional advancement. As such, payments to participants help balance the benefits gained from social research, and the participants are also compensated for their time. While such payments may also incentivize participation research, some medical cannabis patients had non-tangible motivations for participating in my study. One participant refused the incentive, and others verbally expressed the money was not why they decided to
participate. As mentioned elsewhere in my dissertation, there are few spaces in southwest Michigan where cannabis patients can meet one another and discuss issues in their community.

Finally, participants in my study were informed that their involvement would not influence their access to medical cannabis or impact their status as a patient in Michigan’s Medical Marihuana Program (Zaller at al. 2015). Making this known is paramount because medical cannabis patients are not a protected class in the eyes of the law. Likewise, some patients in southwest Michigan may have purposefully abstained from my study over fears of discrimination or other possible repercussions should their identity as a cannabis patient become known to others. That is just one reason why confidentiality among other participant protections is vital to this study.

Ethics and Possible Issues

In terms of ethical standards, my research adhered to practices described in the literature as well as those used in focus groups conducted by others (Jarvinen & Demant 2011; Berg 2009; Bloor et al. 2001). Participants signed informed consent forms and were guaranteed the right to withdraw from the focus group at any point. They were also given a statement on group confidentiality that is not legally enforceable, but is designed to get participants thinking about the private nature of the information shared in the focus group. However, Morgan (1997) says groups of self-acknowledged deviants (deviants who are open to others or even proud of their deviant status) may not be too concerned about confidentiality in focus groups since such groups are the informal equivalent of their deviant subcultures. I believe this was the case with medical cannabis patients, though confidentiality statements were nonetheless signed by all participants. Likewise, the statement allows a participant to withdraw from the group should they fear for
their own confidentiality or if they believe they will be unable to keep the group’s information private (Berg 2009). I also came prepared with a list of counseling resources should any emotional distress arise. While one may be tempted to serve as therapist or life-coach, Eide and Kahn (2008) contend the ethics of care stipulate a researcher should seek alternative forms of support for participants. If we act as therapists in believing we can remedy any burdens a participant has, we may be inadvertently keeping the participant from more effective professional help. My prepared list of mental health resources may have also helped to foster a sense of care between my participants and myself.

As the discussion moderator, I maintained an atmosphere of trust, respect, and civility in each focus group. I also paid special attention to the setting of the group since this can impact disclosure and interaction. Each focus group was held in a large yoga room at a holistic health center, a site that was available and convenient for both the researcher and the participants (Morgan 1997). As suggested by experts, the group was arranged in a circle, so I did not become a focal point (Bloor et al. 2001). Likewise, I provided nametags and refreshments. Aside from a low participant turn out, no problems emerged in any of the groups. In fact, the final focus group concluded with a discussion on the lack of patient-focused organizations, and how the region once had its own subchapter of NORML. Since MI NORML operates on the east side of the state, several group members exchanged contact information in hopes of reestablishing a southwest Michigan chapter.

Establishing Validity

The paradigms of quantitative and qualitative research necessitate different evaluative standards based on their different approaches to scientific knowledge. A paradigm integrates
specific epistemological, ontological, and methodological premises (Denzin & Lincoln 2013), essentially allowing a researcher to make sense of the methods they use to investigate the social world. So how do we evaluate qualitative research? There are many different evaluative terms in the qualitative paradigm which all speak to something akin to validity. For quantitative researchers, the term *validity* is synonymous with “truth” but should always be understood as an approximation rather than an absolute (Cook & Campbell 1979). Qualitative researchers commonly frame validity as “soundness”, “credibility”, or “trustworthiness” (Marshall & Rossman 2011), and these are just a few of the many evaluative standards in the paradigm. We must resist this push for a singular gold standard that reflects the needs of the biomedical sciences, and instead extend a standard that values humanistic science (Denzin 2013; Denzin & Lincoln 2013; Torrance 2013). Some scholars even believe that disagreement on evaluative standards among qualitative researchers is a good thing. Since qualitative research is practiced by many disciplines, researchers are encouraged to be multivocal and to use less technical jargon. This increases the appeal and applicability of qualitative work, and the tensions between different evaluative standards should be seen as generative while researchers debate their usefulness (Torrance 2013).

Most simply stated, validity in qualitative research is understood as research “that is plausible, credible, trustworthy, and, therefore, defensible” (Johnson 2000:119). While there are many validation strategies that can be applied to qualitative research, our attention to specific issues will most likely be directed by the peculiarities of our research. Nevertheless, John Creswell (2013) recommends at least two strategies be used in any given qualitative study. My dissertation research emphasizes three: trustworthiness, reflexivity, and triangulated methods. The most important thing to keep in mind when evaluating qualitative research, however, is to
consider if the study contributes to our understanding of important questions, the venerable *So what?* question (Creswell 2013).

**Trustworthiness and Reliability**

Validity in focus group research is made possible by carefully explicating decisions made and procedures used in every stage of the research process (Krueger & Casey 2009). Details related to decision making allows others to trust and potentially verify our conclusions. Denzin and Lincoln (2013) argue that trust is established through transparency in qualitative research. The trustworthiness of a qualitative study is a composite concept dependent on the authenticity, believability, and applicability of our findings (Denzin & Lincoln 2013). If a reader can gauge these three things, then a study and its findings can be said to be trustworthy. Another component of trustworthiness is verifiability. Verifiable analyses are central to any research and are characterized by others reaching similar conclusions based on the same data. This essentially safeguards against the selective perception on the part of the researcher. My research has left a *trail of evidence* (Krueger & Casey 2009) in the form of transcripts, observational notes, and recordings. My project also used a structured discussion guide which enhances trustworthiness by ensuring each focus group is asked the same questions (Morgan 1997). This discussion guide has been included as an appendix, and this guide can also be used to gauge the reliability of my study. *Reliability* is achieved when others can perform the same the data collection procedures on a similar group, and if reliable, come way with similar conclusions. Since my study utilized five focus groups, a degree of reliability is present since the biases of one group cannot completely sway the results.
One of the touchier elements of my research is that of participant anonymity. Protection of subjects is standard practice in qualitative research, even though some scholars have critiqued the masking of subjects as anti-scientific and ethically dubious (Murphy & Jerolmack 2016). However, any and all cannabis use is still federally prohibited, and medical cannabis patients are not a protected class. Wendy Chapkis remarks how many of the terminally-ill patients in her sample demanded to be identified, with one saying: “This is my story, my legacy. Use my name” (Chapkis & Webb 2008:5). Some of the middle-aged patients interviewed by Newhart and Dolphin (2019) also wanted to remain identifiable, but these researchers were adamant in their use of pseudonyms for subjects, businesses, and location details. My research adhered to similar precautionary measures with my IRB insisting on pseudonyms for all participants, even well-known key informants. Since I also collected information related to occupation and health condition, minor changes to these details have been used in the written report to further protect the identity of my participants.

If we put everything on the table for our audience to judge, a degree of trustworthiness, verifiability, and reliability is arguably present in the research (Denzin 2013). The need for rich detail is arguably most important when it comes to researcher bias, an issue discussed in the next evaluative standard presented.

**Reflexivity**

Qualitative data are shaped by the researcher’s relationships with their participants, but research can still be validated through what Altheide and Johnson (2013) term *validity-as-reflexive-accounting*. This is a type of validity established by illuminating the interaction between the researcher’s perspective, the researcher’s logic, and the topic under study. Michael Bloor and colleagues (2001) note the processual nature of focus group discussions often contain
humor, irony, and are affected by the presence of the researcher. Data should be analyzed and conveyed while keeping these conversational factors in mind. Reflexivity is essentially an awareness of one’s own presence in the research, and the validity of a study can be evaluated by others when we account for ourselves (Altheide & Johnson 2013).

I have tried to account for myself and my perspective throughout this project, and I hope my biases have been transparent enough for the reader to understand my position. While I believe cannabis should be accessible for all who seek it, I do not have a personal affinity towards framing cannabis as a medicine over other constructions of the plant. I also do not use that term “bias” as a negative like it is used in positivistic epistemologies. In order to obtain consistent, truthful results, dominant models of science stress that research should be depersonalized, unbiased, and value-free. This stems from the belief in a singular, objective, and measurable reality that stands apart from the researcher’s social position (Altheide & Johnson 2013). This epistemology is more germane to quantitative research as “qualitative research is a situated activity that locates the observer in the world” (Denzin & Lincoln 2013:6). Yet when the researcher is inextricably integrated into the research, it means their biases become part of the research as well. Since we know the researcher’s positionality can never be fully erased, research can be graded along a continuum of “better” to “worse” by evaluating the researcher’s transparency through reflexivity (McCorkel & Myers 2003).

Non-reflexive writing emphasizes detached objectivity, thus concealing the relationship between the knower and known. Feminists have critiqued this as a disarming commitment to neutrality accomplished through a decentered subject (Sprague 2016; Harding 2005). This style of presenting research removes perspective, human feeling, and subjectivity. As stated by C. Wright Mills (1959), “[the positivistic] way of presenting work does not use any voice of any
man. Such writing is not a ‘voice’ at all. It is an autonomous sound. It is a prose manufactured by a machine” (220-221). This lack of voice comes from the masculinist assumption that humans could be liberated from the irrational forces of the human body (Sprague 2016). Our histories, biases, and perspectives are framed as obstacles rather than forces that shape our experiences of reality. “Qualitative research requires a mutual standpoint, researcher to participant, human being to human being” (Eide & Kahn 2008:199).

Qualitative sociology owes much to feminist sociology, which says that knowledge is perspectival and produced from multiple standpoints (Smith 1974). This makes knowledge situated and communally constructed, an insight from standpoint theory, originally a “method for naming the oppression of women grounded in the truth of women’s lives” (Heckman 1997:356). One’s standpoint is anchored in the everyday world rather than in some abstract situation. Furthermore, some scholars believe oppressed standpoints tend to be more objective than privileged standpoints (Harding 1991). For example, my identity as a gay man may grant me more insight into masculinities owing to my position on the margins of male privilege, a similar idea of the “outsider within” (Collins 1986). Since Connell’s (1985) theory of hegemonic masculinity includes heterosexuality as a core component of the masculine ideal type, gay men are marginalized by default.

Moreover, situating knowledge from a standpoint makes objectivity practical, as something that can be validated by multiple, different standpoints. Standard objectivity via neutrality is irresponsible because it is unlocatable and thus is unable to be called into question. By being unaccountable, hegemonic objectivity is a “conquering gaze from nowhere” (Haraway 1988:581). Since standpoint epistemology establishes that all knowledge is perspectival, it requires researchers to explicate the social locations from which knowledge is produced,
discovered, and/or interpreted (McCorkel & Myers 2003). *Strong objectivity* can thus be achieved by exposing oneself to the same rigorous criticality as we do our subjects in research, a process called *strong reflexivity* (Harding 1991).

In contrast to strong reflexivity, weaker forms of reflexivity only provide vapid statements of the researcher’s identity, motivations (if mentioned at all), and experiences in the field. What strong reflexivity does is make our own unknown assumptions visible to an outside observer. Strong objectivity is achieved when a reader can weigh the researcher’s impact on any knowledge brought to scientific attention (Harding 1991). More basically expressed, standard objectivity eliminates the researcher from the analysis by emphasizing the elimination of bias. Strong objectivity positions the researcher as central to the analysis by emphasizing transparency (Harding 2005;1991). Furthermore, strong objectivity makes the researcher locatable and therefore accountable (Haraway 1988). This partial, locatable, critical knowledge can sustain shared conversations about the viability of its truth and usefulness. Likewise, strong objectivity identifies how a researcher flavors their research questions, methodological approach, and ultimate conclusions. There are no universal standards to follow, and methodological decisions are often made on a situational basis. The key to this process is not to detail one’s biographical history, but to analyze how positionality shapes researcher-subject relationships (McCorkel & Myers 2003). My hope is that I have accomplished that throughout this report.

**Triangulation**

I have triangulated key informant interviews, site observations, and focus groups in my research on medical cannabis patients. My decision to do this was to pluralize the perspectives contained in my data rather than to compensate for the specific limitations of each method. That
A positivistic approach to triangulation is rooted in the belief of an objective target or logical validation (Bryman 1992), whereas my use of triangulation is to have the three methods inform one another. Key informants had expert knowledge of Michigan’s cannabis environment while focus group participants had firsthand experiences in that environment. Overall, the focus groups did not mirror the information received by key informants, and my goal was not to unify these two perspectives. My goal has been to richly describe the current state of medical cannabis and to communicate the contrasting experiences among and between patients, professionals, and myself. For example, key informants largely came from the business world and spoke from an economically centered perspective. They were also asked different questions related to their different roles in the industry, and most of these questions would have been irrelevant to patients in my focus groups.

The interpretivist position holds that there is no absolute, independent truth, and we should not assume that triangulation deepens our vision (Charmaz 2006). Once again, the goal is a diversity of visions to achieve a more nuanced understanding of the topic at hand. However, it is necessary to consider the merits and limitations of my primary method. David L. Morgan (1997) says the strengths and weaknesses of focus groups are somewhat of a compromise between those of interviewing and participant observation. In particular, focus groups are a useful means to collect data regarding participants’ attitudes towards others. Bruce Berg (2009) says surveys or interviews are better in collecting information related to the self, but focus groups allow us to unearth group sentiments regarding other groups. My research falls within these recommendations, as I am interested in how medical cannabis patients perceive their social context, gendered behavior, and recreational uses of marijuana.
Other strengths of focus groups include the moderator’s ability to explore unanticipated topics as they emerge in group discussion, the ability to use simple sampling strategies, and a reduction in power between the moderator and the participants (Berg 2009). Focus groups also demand less active involvement from the researcher to elicit information since other group members may naturally do so. Likewise, focus groups have a high degree of external validity (i.e., generalizability) since elicited conversations mirror natural conversations participants have in their everyday lives (Hollander 2004). Nonetheless, a method by itself does not automatically yield any insight (Charmaz 2006). We must analyze, interpret, and connect our findings to theory.

Limitations of focus groups include the fact that some participants contribute more than others, and their dominance can skew group-level representations. This concern for over-disclosure can be somewhat mitigated by assembling groups of strangers, as I have done here (Bloor et al. 2001). Focus groups also tend to inhibit the expression of extreme or unpopular views which are more commonly disclosed in individual interviews (Jarvinen & Demant 2011). There is also the problem of oversharing, particularly on the part of men. This phenomenon is commonly known as mansplaining, though within the world of market research, it is known as the “peacock effect” (Kruger & Casey 2009). Other limitations of focus groups include the need to be brief with participant answers, resulting in less depth to the information shared. We also need to be cognizant that data reflect group opinions, rather than individual opinions, and that the moderator’s skills significantly affect the quality of data obtained (Berg 2009).

Some scholars stipulate focus group data should only be used to make statements about group-level attitudes (Berg 2009; Hollander 2004), but David Morgan (1997) says it is also possible to use individual participants as units of analysis. In other words, focus groups allow us
to use individuals as a unit of analysis as long as we are careful to contextualize the data within the group. While the group certainly influences what individuals express, the group is also composed of individuals with unique thoughts, feelings, and perspectives. Both the group and each individual must be understood as mutually constructive. Nonetheless, I have avoided interpreting body language unless in extreme or notable circumstances. I am not a psychologist, and gestures or other expressions are easily misinterpreted in focus group environments (Krueger & Casey 2009).

Analytical Procedures

Like all stages of focus group research, the purpose of the research drives the analysis (Krueger & Casey 2009). The audio from both the key informant interviews and focus groups was transcribed by the researcher for readability, an imperfect style that favors efficiency above detailed preservation of unvarnished human speech (Bloor et al. 2001). In other words, I removed most of the numerous *Uhs* and *You Knows*. These transcripts and my field notes would later be analyzed using qualitative coding software.

My analysis of focus group data was systematic and rigorous where statements were coded for theoretical and emergent themes. Unexpected topics emerged in this process like concerns related to gun ownership and occupational immobility. I informally began analysis upon transcription where I indexed themes via brief notes when something significant was expressed (Bloor et al. 2001). Formal analysis began with segmenting data into broad themes (or nodes) related to medicalization, normalization, and gender. My structured question guide eased this process since some consistency was created by asking the same questions in mostly the same order to each group (Krueger & Casey 2009). I used the program NVivo to organize my data and
then started to refine codes within the three broad categories mentioned above. For example, the
category of “gender” was then further segmented into themes related to masculinity, femininity,
or general statements on gender. The subtheme of masculinity was then organized between
statements indicative of hegemonic, alternative, or general masculinities. I iteratively continued
this process until I felt I could no longer meaningfully divide subthemes. There were also many
codes unrelated to my research questions, primarily those related to Michigan regulations and
specific products, and while these do not inform my subsequent analysis, they may be useful for
future research projects.

My final report is written in a manner that balances direct quotations and researcher
discussion. David Morgan (1997) encourages the use of “well-chosen” quotations that link “the
importance of the topic and vividness of the example” (p.64). Both my analysis and written
report have been careful to keep the context of statements intact, and one way of assuring this is
to use longer direct quotes (Bloor et al. 2001). Using direct quotations from the focus groups also
helps to establish interpretive validity, or the degree of accuracy behind meanings communicated
and understood in the research (Johnson 2000). I have also been careful to avoid numerical
comparisons between the groups as suggested by Kruger and Casey (2009). Since my sample
size is too small, and discussions may be skewed by over or under sharing, I am unable to
adequately infer percentages from my focus groups to the larger population of medical cannabis
patients. Modifiers like “some”, “many”, “a few”, or “most” have been used to characterize
group perceptions.
Conclusion

More qualitative research on medical cannabis patients is needed to enrich our understanding of this diverse and understudied group. As such, my use of focus groups, key informant interviews, and observations should contribute rich information to the literature on this population. What did I find? Chapter 6 discusses how patients experience stigma and how such experiences trouble claims that cannabis is normalized. Chapter 7 concerns the medicalization of cannabis, and my results indicate that patients prefer the current model of cannabis as a non-institutionalized medicine. Finally, Chapter 8 details some of the ways gender shapes experiences within the medical cannabis community. Overall, the following analysis chapters help restore nuance and complexity to our understanding of medical cannabis patients, and I connect my results to existing studies throughout each chapter.
CHAPTER VI

CANNABIS STIGMAS IN A POST-PROHIBITION STATE

When scholars approach the topic of cannabis normalization, they typically point to statistics that show more people are accepting of and using cannabis more than ever before (Mostaghim 2019; Satterlund et al. 2015; Jarvinen & Ravn 2014; Sandberg 2012; Duff et al. 2012; Hathaway et al. 2011; Jarvinen & Demant 2011; Erickson & Hathaway 2010). However, patients in my focus groups do not think we have yet to normalize cannabis in our society. While our society is undoubtedly becoming more tolerant, the stigma associated with cannabis still haunts their lives. This chapter explores how patients experience stigma in a post-prohibition state. The research questions that guide my analysis are: How does the medical cannabis community feel about the status of medical cannabis in this moment of emerging recreational legalization? And, what challenges do patients face in their social and professional lives?

Overall, patients feel less constrained regarding their medicine now that it is gradually becoming legal for adult users. I begin this chapter with an overview of how macro level, structural stigmas have diminished, though the uneven process of legalization still presents challenges to patients, many of whom still feel their medicine carries a non-normative status. Afterward, I examine how social stigmas, or those operating in the meso levels of society, impose powerful limitations on the social and professional lives of cannabis patients. It is also in this meso level that we see how the normalization of cannabis is mediated by factors like employment status, gender, and race. In fact, since my focus groups lacked racial diversity, this chapter of my analysis (and the others) are primarily based on the experiences of white people.
Finally, I discuss how my findings problematize linear narratives of normalization, and how patient activism may still be necessary for a legal state.

**Structural Stigmas**

Structural stigmas stem from the macro levels of society and include laws prohibiting cannabis as well as widely shared anti-cannabis cultural attitudes (Livingston & Boyd 2010; Herek, Gillis & Cogan 2009; Corrigan, Watson & Barr 2006). It is on this level that patients in my focus groups feel the most progress has been made. As states began to permit medical than recreational cannabis use, many of my participants were relieved they no longer had to worry about criminal penalties. Some of them, like Greg from Focus Group 2, no longer feared persecution, but the freedom of the post-prohibition world did not extend to other areas of his life:

Moderator: By a quick show of hands, whose family members know about their medical cannabis use?

*everybody raises hands*

Greg: That's a general statement. Because it could be 1 person or 100.

Moderator: Right, but we are open to at least some people in our family.

Greg: Yeah, I'm just open to my wife.

Moderator: No one else?

Greg: Nope. Because it's none of their business.

Wanda: Didn't you say that you got the medical card to be more out?

Greg: Not that I'm running around telling people, but the card made it legal.

Wanda: Oh, so in terms of cops and stuff...

Greg: Yep. As I said, I spent 51 years in the shadows but I'm legal now.
Many of the patients in my focus groups cited legality as easing their fears and reducing the level of concealment they practiced in terms of their cannabis use. Though Greg was not opening up to anyone aside from his wife, several patients said it eased their familial concerns as their families were more concerned about the illegality of their medicine as opposed to other concerns associated with cannabis. However, since legality has spread on a state-by-state basis, and as regulations impose new challenges on the patient community, freedom from persecution was experienced contextually and situationally. For example, patients in Focus Group 1 said the uneven status of cannabis between states restricts their ability to travel, or at least make it impossible to travel without worry:

Moderator: What do we think the future of medical cannabis will look like?

Avery: Hopefully it will be national by then instead of state because it is a real pain. Like, I have to travel a bit because my dad lives in Arizona and my sister lives in Ohio, so traveling is a nightmare.

Sophia: And that is why I stay home because I'm afraid I cannot take my medicine with me or I won't be able to get it while I am gone.

Jimmy: I have the same concern. I've gone to a conference before for research and stuff…

Sophia: How many days, do you remember?

Jimmy: I was helping organize it, so I was there for almost a week and a half, it was really long… ya… I bought a pack of cigarettes because I was so stressed.

Sophia: Right?! It's not even like you're planning to sell it, you just want to make sure you're good while you are gone.

Avery: Not like you're being mischievous or whatever.

Sophia: Yeah, I would just want to take my meds with me so I can have a good time. And I'll be discreet with it, but I think it does keep me home a lot. I thought of going on cruises or even taking a trip to Chicago, but o my gosh…

Currently, all medical and recreational cannabis sold within legal states must remain in that state as federal prohibition makes it illegal to send cannabis across state lines, even if it is between legal states. Likewise, since airports and postal services are regulated by the federal
government, no cannabis can be brought through TSA or shipped to one’s destination. This makes travel uneasy for patients as they must illegally sneak their medicine past authorities, or restrict their travel to states with accessible dispensaries. Fortunately, some medical states allow dispensaries to recognize out-of-state medical cannabis cards. Michigan is one of these states, and while I was observing patients in a dispensary, a woman visiting from Hawaii came in. After a quick bartender-esq check of her card, she was able to purchase her medicine. The staff later informed me they have an online tool they can use to further scrutinize suspicious-looking cards, also noting that out-of-state cards have become common at their dispensary.

The federal prohibition of cannabis creates problems for patients seeking to travel beyond their state borders, but even within legal states like Michigan, some patients still feel criminalized over whether they are in compliance with stringent regulations. Deborah, from Focus Group 5, still worries about criminal penalties whenever she visits a dispensary:

Deborah: It’s like being a kid in the candy store. But driving out there, though, I'm looking all around for narcs hiding somewhere. I'm looking like, where are they? Where are they watching? And honestly, I did exactly like they told me. I opened up the trunk of the car and threw it way back there so I can't reach it. I did exactly what the law said... But it is awesome that in my lifetime, to be able to see this industry open up and to be able to talk about it openly...

Having medical cannabis within one’s reach while driving is a criminal offense in Michigan, and for a long time, it was advised patients transport their medicine within a locked box inside of their trunk. This is similar to laws on how firearms are transported though cannabis has never killed anyone, and laws are laxer regarding the transportation of alcohol, a far more intoxicating substance. Similar to Deborah, Alexander from Focus Group 4 still feels the lack of social cannabis spaces makes the culture surrounding cannabis use seem criminal. He used to visit social clubs but never felt secure:
Alexander: Michigan used to have plenty of clubs and compassion clubs, and lounges where you could use meds. There was one in Lansing, for example, but all of these places were illegal.

Audrey: Like it still felt like you were doing something wrong?

Alexander: That's exactly it.

Interestingly, feelings of insecurity were also evident at a legal harvest festival I visited in the Fall of 2019. This was one of the first public cannabis events to be held in southwest Michigan since it was legalized nearly one year ago. Open to everyone over age 21, medical cardholders received discounted admission to the event which featured around 40 vendors selling flower, edibles, concentrates, and more. Smoking or consuming openly was allowed since the organizers had secured the necessary permits, and the organizers also served as security staff for the event. To my knowledge, no problems ever arose, but I overheard several attendees express that caution was needed when leaving the event. One said officers in the area were “not friendly” towards cannabis culture while he encouraged an attendee to drive carefully.

Finally, caregivers in the state’s medical system cited legal compliance as a major source of stress in their lives. I interviewed two caregivers who had each been supplying patients with medicine for nearly 10 years, and they each had numerous run-ins with law enforcement. For example, May and her husband began growing as caregivers in 2008 after the passage of the MMMP, and several of her patients weaponized law enforcement when the caregiver relationship fell apart:

May: We had several [patients] that we had to drop. Just because, to be honest, it's the legality of it. Two of our patients in the very beginning thought that we were cheating them, and they turned us into the police. I don't know if the state actually was involved, but the county and the city that we live in showed up at our house with Child Protective Services. We had to prove everything but we were good. We were fine. We were legal. They investigated all of their wrongful claims, but there was never an instances of us breaking the rules, you know. So they thanked me and they apologized, and we all came to the conclusion that it was just basically like a hate thing. They were jealous basically. They were mad and they thought we did something wrong, but we didn't. They thought
they could get us in trouble because they weren't getting what they thought they deserved, I guess. Because caregivers, depending on how established they are, some of them offer free medication. They offer different things to get someone to sign up, you know. And a caregiver puts all of their time and all of their money into growing the product, and then the patient thinks that they’re entitled to something free.

Despite cannabis being a relatively easy-to-grow weed, getting it to produce flowers that are pure and potent is a challenge. This may be why only a handful of patients in my focus groups have tried growing their own medicine. Caregivers can spend tens of thousands on equipment and electricity bills for indoor grow operations often exceed a thousand per month. May also considers tending to her crop as a full-time job and claimed she does not know any serious growers who are able to work in addition to being a caregiver. While some caregivers may occasionally provide their patients with free medicine, most expect a fee that is typically lower than what a dispensary would charge. Despite “free medicine” being somewhat of a rarity in Michigan, patients receive a variety of benefits from having a caregiver, including consistent access to high-quality medicine, having caregivers grow specific strains, and a relationship more personal than those forged through retail dispensaries.

Social Stigmas

While structural sources of stigma may be diminishing, patients have seen little progress in social sources of stigma. Social stigmas operate within the meso level of society and can include group-related sentiments, organizational policies, and cultural stereotypes (Mortensen et al. 2019; Hammer 2015; Livingston & Boyd 2010; Herek et al. 2009; Corrigan et al. 2006). For example, media representations of cannabis users can reproduce social stigmas, and patients in my focus groups desired to see more non-problematic depictions of the medical cannabis community. Overall, my participants thought the visibility of cannabis was increasing and that
news reporting on the topic had improved. Patients in Focus Group 5, for example, valued objective reporting, even over reporting that was intentionally pro-cannabis:

Moderator: So, we just raised the topic of the media. How do we think the media portrays cannabis nowadays?

Jackie: The media hasn't dropped the stigma.

Austin: I think it might depend on which state you're from. You know, in Indiana it is always a topic, constantly, because every state around them is starting to legalize other than Kentucky. And they've even okayed cannabis growth, you know, as far as hemp type growth. So, Indiana just finally legalized hemp growth again, in the state. So, you know, it'll be interesting, but I think that's kind of where people see things from. It's a state that's built on Eli Lilly, Roche, and pharmaceuticals, and they will protect their belief that pharmaceuticals are the way...

Deborah: They talk about it. But I don't know which way Channel Three slants it yet...

Doug: Yeah, it's just they say the words. I mean, you can generally feel the slant when they're going one way or the other. And I think they're just passing it on...

Damien: I don't either.

Briana: Which is kind of how you want your news sources to be. You don't want them to pick one way or the other. You want them to be unbiased.

Deborah & Damien: Right.

Doug: I'm constantly reading articles every day. And every time I open up Google to search something, usually one of the top three articles is something about marijuana somewhere. So, I mean, it's definitely being talked about, with some good and some bad. It just depends on where it's at and what's going on. I've seen articles where people were mad because a dispensary was opening near a school. You know what I mean?

The political orientation of media outlets has been shown to influence how they portray marijuana in news stories. Mortensen and colleagues (2019) found neutral media outlets deployed the least marijuana stereotypes when compared to liberal or conservative outlets, the latter of which utilized the most. Yet while reporting on the topic was thought to be less stigmatizing than before, patients in my focus groups were also critical of news coverage which used terms like “pot shop” in describing medical cannabis provisioning centers, and many believed too much attention was granted to opponents of legalized cannabis. Like Doug above,
Focus Group 2 was critical of news coverage on the possibility of children purchasing adult-use cannabis from retail locations despite this never happening before in other legal states. Patients were also keen on crime reporting where officers or the reporter mention that cannabis may have been in the wrongdoer's system. This can be somewhat of a double standard since pharmaceutical drugs with more severe side effects are never treated with the same scrutiny.

Though participants acknowledged film and television representations of cannabis users had diversified, many also took issue with the predominance of stoner stereotypes. The Netflix show *Disjointed* was brought up in three of the focus groups, and while some patients enjoyed the show’s comedic focus on a medical cannabis dispensary, participants in Focus Group 2 were offended by the show’s stereotyping of cannabis patients:

Moderator: What do we think in terms of the media’s portrayal of cannabis?
Wanda: It's being discussed more but they're not doing a good job portraying it.
Sean: The media will mess anything up if you give them the chance.
Moderator: How are they messing it up?
Irene: They stick to the stereotypes.
Wanda: Exactly. Even the medical shows.
Irene: Yeah like *Disjointed*!
Wanda: Right! *Disjointed* was supposed to be about medical marijuana facility and they were all typical stoners.
Andrew: Yeah, I couldn't even make it through the first episode.
Wanda: I thought it was hilarious but it's not medical in any way.
Andrew: I was offended. I worked in and then I managed a dispensary, and I was offended.

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24 A similar problem has occurred around Halloween for the past several years. Media reports featuring police officers warn parents about the possibility of their children receiving THC infused trick or treat candy. However, there is no evidence this has ever happened.
Wanda: Well, remember also that I'm only a year-and-a-half into this so to me it was hilarious.

Some patients in my focus groups acknowledged media stereotypes of cannabis users were also shaped by gender and race. There is even evidence for this as a content analysis of Canadian newspaper articles revealed normalized marijuana is masculinized and racialized (Haines-Saah et al. 2014). Relative to men and whites, the use of marijuana by women and racial minorities is more stigmatized. Audrey from Focus Group 5 said women who use marijuana on-screen are traditionally presented as sexually permissive or involved in prostitution. Jimmy from Focus Group 1 said that while he has seen respectable white characters use cannabis, characters of color who use cannabis are often involved in criminal subcultures like gangs. Overall, participants desired media representations that reflected their diverse lived experiences rather than traditional stoner stereotypes. Patients also wanted cannabis to be more visible in the media, preferably where it is talked about openly and honestly. In other words, they wish for social censorship on the topic to be removed. This is why Doug from Focus Group 5 was disheartened when he saw *High Times* magazine was by request-only at a local bookstore (like pornographic magazines) despite periodicals on alcohol being placed out in the open.

Like prior research, social stigmas also caused cannabis patients to limit public knowledge of their use of medicine (Newhart & Dolphin 2019; Satterlund et al. 2015; Bottorff et al. 2013). Participants in my focus groups feared negative reactions from their families, communities, and group affiliations. However, some participants, like Gavin from Focus Group 3 and Alexander from Focus Group 4, were very blatant about their use of medical cannabis. Alexander had stopped worrying about what his clothes smell like following legalization (though he also said he was recently asked to leave a restaurant for smelling like cannabis), and Gavin took the bold move of informing his neighbors and church community upon receiving his card.
He considered himself to be an advocate for cannabis medicines, and since he had a criminal record, he wanted to make sure everyone knew he uses legally.

While many patients would educate their friends and family members on the medical benefits of cannabis, Gavin and Alexander are the exceptions to the overall pattern as most of my participants remained guarded about their personal use of medical cannabis. Many participants in my focus groups were afraid of being “outed” by their friends or family members, like Jimmy from Focus Group 1 who hid his patient status from his younger siblings. Similarly, some participants in Focus Group 2 feared their use of cannabis would be leaked by their children:

Greg: The social stigma is just so predominant that you don't talk about it in church, and you don't talk about it in school, and you don't let anybody know.

Darlene: I think it depends on where you're at.

Irene: I think that if they have a problem with it, then they just don't say anything to me. Like my kids will be at school and they'll be doing their whole “don't do drugs” lecture, and my kids will be like, wait a minute... and they're like challenging the teacher. And I'm a teacher myself. So they're like, where are your kids coming up with this stuff? And I'm like, oh, me. I can use cannabis or I can be walking around on 80 mg of oxycodone.

Greg: Or not walking around...

[group says “right”]

Irene: Yeah, or have to use a wheelchair and I don't want to do that.

Wanda: Well, she touched on the school issue and I thought that was interesting because I just enrolled my kids in a Montessori School. I didn't think that anybody would be against it there, but the principal had mentioned that somebody had picked up their children after hotboxing in their car...

Andrew: That’s different...

Irene: Ya, that’s not cool.

Wanda: ...so we got on the subject of cannabis and I said that hey, well, I do use it, but no way would I ever do something like that... but yeah [laughs]. I guess my kids’ teacher and even the principal all know, and I think they're all on board with it, which I am glad because I didn't want my kids outing me either.
For several participants in my focus groups, revealing their cannabis use to family members resulted in being distanced or shunned. Sean and Darlene, both from Focus Group 2, felt their relations with their parents had deteriorated upon disclosing their patient status. Sean had not spoken to his father in years because of cannabis and Darlene felt unsupported by her parents, a feeling amplified by their embracement of her alcoholic brother. Similarly, Sophia from Focus Group 1 had purposefully ignored one side of her family for many years since they were adamantly against her use of medical cannabis. Most patients had a supportive family, but for many it was a gradual process of getting family members to accept cannabis as a medicine. Fortunately for some, liked Briana from Focus Group 5, the new adult-use laws facilitated familial acceptance:

Briana: My mom was probably the only family member that knew from the beginning up until, I would honestly say, probably until it went recreational. With my dad, I might have told him before that, but it just kind of came up one day in conversation and I was pretty much over hiding it from him. So, I just pulled out my card one day and handed it to him and was like, you can’t really say anything to me. I’m 30 years old, I’m a successful person, I hold a job, and everything I have is paid for. So, I'm like, you know, that stigma is not there, at least with me. I don't think anybody on my mom's side of the family knows, but none of them live around here so it's not like I ever see them. And then I think my dad's side of the family kind of knows now just because I've been a little bit more open talking about it when they've brought it up at family functions, about the recreational side of it. So, they know I at least know enough about marijuana that I think they probably have an idea, but I've never came out and confirmed it.

While the majority of patients in my focus groups still limited public knowledge of their medical cannabis use, many were also tired of practicing discretionary measures. Since cannabis in Michigan is now legal for anyone to consume in private confines, patients like Deborah and Doug from Focus Group 5 did not worry about pesky neighbors anymore. This is not to say, however, that their neighbors welcomed their cannabis use:

Deborah: My neighbors know... They live next to me, so they know. But there's also a stigma in that, you know. Even at my age, there’s people that are older than me and they don't appreciate having cannabis around. But fuck ‘em, I don't care. It's legal now.
Doug: As a matter of fact, I have a lady that moved in downstairs from me… So, I had a pretty lengthy talk with her and even after I explained to her all the things going on with me and the medical reason why I need it, she still just didn't get it. She is very... and she'll complain every time she thinks I'm smoking. I can't even make a batch of edibles without her complaining... But I don't care. And I think she gave up at this point.

Landlords in Michigan can prohibit general smoking in apartments as well as growing, but they cannot prohibit cannabis itself or non-smoking methods of consumption. Nonetheless, consumption cannot be publicly visible\textsuperscript{25}, and this created problems for patients like Sophia from Focus Group 1 who simply dreamed of being able to medicate while relaxing on her patio.

Employment Concerns and Occupational Immobility

The most consequential sources of social stigma for patients in my focus groups were from the medical profession and employers. Patients described being given an ultimatum from medical professionals to choose between either cannabis or conventional treatments. Policies like pain contracts prohibit patients from using cannabis while being prescribed pain killers, and some patients described receiving anti-cannabis lectures from their physicians. These medical sources of stigma are discussed more in the next chapter, but sometimes they intersect with stigmas from employers. Darlene from Focus Group 2 works in the medical field, and while her experiences with cannabis stigma come from a variety of sources, she fears for her professional identity:

Darlene: Hi. I'm Darlene and I've been patient for a little over two years, but it took me three years to work up to it [laughs].

Greg: Why?

Darlene: Why? Because the stigma.

\textsuperscript{25} Perhaps the weirdest manifestation of the ban on visible cannabis consumption can be found in boating laws. In the summer of 2019, the Michigan Coast Guard informed boaters that they may only smoke cannabis inside their boat’s cabin. This is ironic given the concerns about smoking any substance in an enclosed space, while at the same time, the large distance between boats on the water makes second hand smoke unlikely.
Sean: I heard that a lot.

Darlene: And I just wasn't sure, so I did a lot of research. But ya, it took a while to get over the stigma of it.

Sean: Yeah, the stigma and the stereotypes just ruin it for people.

Darlene: Right, because I still participate in the professional world and it’s… it's something to be concerned about to some degree.

About three-fourths of the participants in my focus groups were employed full time, part time, or worked odd jobs or within the gig economy. Fortunately, most of them had found a source of income that allowed them to use medical cannabis outside of work, though many experienced challenges with drug-free workplaces. Despite cannabis being legal for those ages 21 and up in Michigan, employers can still refuse to hire or fire those who screen positive for cannabinoids. Some of the participants in my focus groups, and a couple of the people I interviewed as key informants, described taking a period of absence from their medicine when attempting to get a new job. Like Irene from Focus Group 2, they all loathed that period of abstinence, and other patients like Andrew refused to go without their medication:

   Irene: I had several employers who did everything they could to not have me go in for drug testing. One of them was finally like, okay, I've done everything I can and it's your fourth promotion in three years, so you have to go...

   Andrew: Oh yeah, I totally forgot! When I first moved to Michigan I had a very similar thing happen…

   Irene: Yeah this was a Friday afternoon and they asked if I thought I could go Monday morning and live through the weekend without using cannabis. I was like, yeah, sure but you're probably not going to want to be around me.

   Andrew: I had told my former employer because when I first moved here, I was in an industry that was not cannabis-friendly at all…

   Greg: Were you a cop?

   [group laughs]

   Andrew: No, but similar. I had told my employer, this is how I function and this is how I do it, and he was 100% okay with it. I even went to the lab and got tested, and I had even
gotten promoted to assistant manager. Then the ATF released a statement regarding their position on cannabis, and this was maybe 2 or 3 years ago, and so this freaked out my employer a little bit. So he made me choose between the job or cannabis.

Irene: I choose life.

Andrew: Exactly.

Sean: Right. Don't give me the option because it's an easy choice.

Wanda: I would never choose a job over this freedom again. That is why I am self-employed because I won't do it.

Patients may need to medicate often and some of my participants who held jobs were comfortable talking about the regimens they do before or during work. All of them who disclosed such practices claimed it had no effect on, or even enhanced, their work performance.

For example, the following is a continuation of the above discussion from Focus Group 2:

Andrew: I just started my current job which is selling aquariums, and it's awesome. But I had been going to this place for years for my fish and only recently found out that they needed some help. The manager had known me as a cannabis user and enthusiast, and when calling me to tell me that I had gotten the job, she said, I just want you to know that you can't come to work high. And I said, okay. [group laughs]. But I was thinking, well, you've never seen me not high, so...

Greg: Like that would be a problem (sarcasm).

Wanda: [laughing] What else are you going to say to that though?

Irene: Yeah, like, how would they even know the difference? And when you are in pain you don't get a high from it. You get normal.

Sean: Most of the people that I run around with, they wouldn't know any difference if I was high or not. Because when I leave the house I'm usually smoked up, you know?

Andrew: Right. They wouldn't know. And I'm also not leaving the house unless I'm… in a proper mindset.

Similarly, Alexander from Focus Group 4 introduced himself this way:

Alexander: My name is Alexander. I've been a patient for four years now. And my favorite way to medicate is smoke a joint. And to me cannabis is a way of life. It's there in the morning, it's there at night. helps me get up and want to actually go to work, to actually do the things I need to do during the day.
Other participants described being tactful with how they medicated in the context of work. Some used edibles before or during their shifts since these are more discrete than smoking, and some even self-censored their social media feeds so that their employer would not become suspicious. Overall, patients did not problematize cannabis and work, though they knew this sentiment was not widely shared in society. Some patients were even critical of drug testing in high-risk professions, like the gentlemen in Focus Group 3:

Wade: I don't know if folks should be high if they're working on heavy machinery. But then again, how can you tell? Maybe they had done it a couple nights before? Or maybe they just did it 10 minutes before? So that's going to be another dicey thing. Every year there's a fight like that.

Gavin: Talking about heavy equipment, I think there really needs to be a study specifically on that type of thing. Because how do we know what has been going on all these years without us even thinking about it? Because I know that I've been smoking since I was a teenager and my driving record is clean. So, I have a hard time believing that it adversely affects us to the extent that they would like us to believe. I mean, I might stop a little earlier at a stoplight. But I'm not going to have that road rage like the alcoholic or even a sober person might have.

Though I did not ask about patients’ sentiments regarding drug tests, no one expressed they thought drug tests were ever necessary for cannabinoids. Others supported drug tests for other substances, like those in Focus Group 5, which also had two people who were open about their use of medication to their employers:

Damien: It'll be interesting to see what a lot of the companies do as far as drug testing now, especially for new employees now that cannabis is legal...

Jackie: At least a handful have dropped the marijuana off of their screening panels. They're just testing for all the stuff they should be testing for.

Moderator: For those of you that do work, are you open about being a patient at work? [Only Austin and Doug say yes].

Deborah: I just don't trust them, so I keep it under my hand.

Damien: Whatever the company is politically... The company I work for is very Republican and I keep my mouth shut.
Austin: I supervise security at a cannabis processing company. There's the understanding that there's no reason for you to be stoned or messed up, you know. I believe in medicating, and if you need to do something to keep you in a functioning state, I understand that. But to sit and smoke a blunt or whatever, or just smelling like it, I don't think that's something that security should be doing. But I mean, there's nothing we have to sign or pass or anything else. I don’t smoke marijuana on the job but it is beautiful smelling it every day [group laughs].

Doug: The only reason I say I'm honest is just because of my job. Otherwise, I think it just depends on where you work or your environment. I work for a home repair service. My boss is located about an hour away, and as long as I do my job and I don't have any complaints about me, then he’s okay with it. I don't go in front of customers smelling like weed. But my boss knows because every time he sees me, I'm usually medicated. Because a lot of times, when I have to go meet him in his region or whatever, I might smoke one before I see him. So, when I get there, I might smell like it or... be high. And I tell him that I just got done medicating because that was my only break. So, I just think it depends on your work environment.

Considerations of medical cannabis use in the workplace are important because Lau et al. (2015a) claim users help normalize cannabis through normifying harm reduction techniques like avoiding use at work. Such measures help users pass as normally functioning in their everyday lives, but the medical cannabis patients in my study trouble this claim. As we have seen, patients in my focus groups secretly medicated before or during work, and several others expressed they wished they had the ability to do so. These individuals described feeling and acting normal following medicating, but they knew this style of using cannabis would be interpreted as drug abuse in their workplaces. While the normifying practice of concealment may help cannabis patients avoid employment repercussions, it ultimately places them in a closet akin to sexual minorities. With that said, staying closeted did not facilitate social acceptance of queer people; it may have even perpetuated their social oppression. As such, normification per Lau et al. (2015a) may not facilitate normalization and is rather used as a tactic to protect the self in the face of a hostile social structure.

My final finding on the intersection of cannabis stigmas and employment manifests when patients feel stuck in their current occupation, a phenomenon I call occupational immobility.
Since many employers drug test new employees or conduct random drug screenings, several patients in my study expressed they were with their current employer only because they thought no other line of work would accept their medical cannabis use. For example, Wanda from Focus Group 3 relied on the gig economy because they did not think a regular job would accommodate their use of medical cannabis. Similarly, Sophia from Focus Group 1 would do odd jobs such as cleaning houses, though she recently found seasonal work as a part-time house cleaner:

Sophia: Normally I smoke before I go to work. I just recently got a job where I'm doing cleaning and they were advertising for employees all over the place, so I told them that every two hours I'm going to need a smoke break. They know me and I can keep going, and I'm a heck of a worker but I know what I need. So, my jobs are kind of short and sweet, and they're usually a couple hours at a time. I also take care of my mom and I'm usually there for four hours, but before I go in I take a little smoke break. Now if I was working at Taco Bell it would be another story. That's why I've always avoided those kinds of jobs where I know I wouldn't be able to get away to do it.

These two patients and others were not only wary of drug screenings but also needed the chance to medicate every so often. Medicating while on break may be a solution but drug-free workplaces make doing so difficult, and even if they tried to do so secretly, that would once again lead to an omnipresent fear of what might happen if the boss found out. Audrey from Focus Group 4 lived with that fear until she discovered a company policy that gave her immunity for prescribed medications:

Audrey: I have my work and I don't want to get hurt and for them to be like, well, you don't have a card for it. And just because it's legal recreationally doesn't mean it's legal at work. One of the reasons I got my card is because in the handbook it said you need a prescription for your medication and that is the only way. And I was like, I have this card and it is just like a prescription. It's just like, you know, Norco. I was the first person at my job to use my medical card while I was hurt. That was really scary because I had worked there for nine years. You know, I could have lost my job after being injured.

Alexander: It's good that they were flexible with that to where it was for marijuana too instead of just pills…

Audrey: Right and they didn't say that. They just said it was prescriptions. I'm like, Okay, I have a prescription. I got hurt. You guys can change the handbook afterwards, but right
now... And that's another reason why I have stayed there for another two years is because they recognize my card and it's hard to get a job with having cannabis in your system.

While Audrey did not loathe her current job, she thought she could do better as a licensed veterinary technician, an occupation in much demand. Additionally, she also stated her coworkers eventually learned she was a cannabis patient, and ever since she believed some have treated her differently. The conversation from Focus Group 4 on employment continued for some time, and while Alexander’s employer was accepting of his cannabis use, Alexander thought his medicine ultimately stifled his career prospects. Perhaps this is why Alexander had appeared to internalize the stoner stereotype to where he thought cannabis users were less motivated than others (Livingston & Boyd 2010; Herek 2007):

Moderator: Is there a difference between guys who use cannabis and guys who don’t?

Alexander: Guys I know that smoke cannabis aren't the most motivated individuals. Guys I know that don't smoke are very motivated and have achieved higher life goals.

Moderator: What do you mean by motivation and life goals?

Alexander: Just making more money. That's very much what it boils down to. They were able to stay motivated to get that good job where a person like me had to settle for the dead-end job that accepts my marijuana use.

Audrey: Yeah, well I have a boyfriend that uses cannabis and he's been very motivated.

Alexander: Well, even if he has a good job now it's still a dead-end job because he will never be the boss or CEO...

Audrey: He will be the boss because it's his family’s business that he's working at. But before that he was a manager elsewhere and then decided to go work for his family because he would have a better career. Like, he'll be the owner one day, you know? So that's nice for him. I have had boyfriends who had dead-end jobs. But then again, if they... Like, I'm stuck in the job where I'm at. I want to get a different job but it's really hard because I don't want to stop smoking. And I want places to recognize my card, so until then, I'm stuck where I'm at... Like, if you could get a different job that recognized your card, would you do something different?

Alexander: Definitely.

Audrey: You have talent that's there that they don't recognize because of your card, because you smoke, you know?... My main issue is that nobody really recognizes it like
they should. I can smoke and come back to work unlike the girl that went out and took a frickin’ Valium and then came back into work. Because I'm not going to pass out in the chair while she might.

While headlines typically portray the cannabis industry as brimming with opportunity, the social stigma associated with cannabis is still so strong that public leaders act against the economic interests of their communities to prohibit taxable cannabis commerce. Patients in my study were amazed at how many municipalities have opted-out of the medical or recreational cannabis market. As of November 2019, 80% of Michigan’s municipalities have banned recreational cannabis businesses, including Detroit (Carmody 2019). This prohibition of cannabis businesses may be caused by social stigma, but it also helps to reproduce such stigmas by eliminating visible cannabis spaces. It also reduces opportunities for patients to become gainfully employed in an industry they love, especially for those who do not drive or live far from the nearest licensed business. Focus Group 5 thought such preemptive measures made little sense in a deindustrializing state like Michigan:

Deborah: I think because pot has been considered bad for so long, that all the little birds in Michigan now are blocking all these stores and these facilities. They're just shooting themselves in the foot. I think this would be an awesome industry to welcome into your village, community, or town.

Damien: I agree.

Austin: It's going to bring hundreds if not thousands of jobs into just this area. Maybe even more. So how can it not be beneficial? I mean, that's about how many GM jobs were lost at one time. And they're going to be good paying jobs too.

Doug: And not only that, but when I saw that there was a job fair, I was like that something's serious... For real, there was a job fair the other week... It was a 420 job fair. I've never seen one of those before so that means there's something coming.

Deborah: Yeah, I think so too.

Several cannabis job fairs have been held in southwest Michigan over the first year of the adult-use market, and all were heavily attended. Perhaps it would be good practice if these
businesses gave preference to medical patients, especially since their patronage of the state’s licensed medical businesses has partially helped pave the way for the emerging recreational industry. Since the state requires applicants for adult-use licenses to have operated for at least one year as a medically licensed business, patients as a customer base have literally made soon-to-be licensed adult-use stores possible. The same is true with the other types of licensed businesses—growers, processors, transporters, and testing labs. While it is unknown how many of the current employees at such businesses are patients, my informal observations of cannabis job postings lead me to believe not all of them are patients, as many postings say “no medical card required”.

Normalization as Colorblind

Historically, cannabis use on the part of racial and ethnic minority groups served as the impetus for prohibition and tough penalties (see Appendix A). Moreover, despite rates of drug use being similar across racial lines, drug enforcement in communities of color is significantly more severe than enforcement in which communities (Alexander 2010). For a whole host of reasons from racism to implicit biases, society generally problematizes drug use when the user lacks white privilege. As such, the stigma associated with cannabis use is also mediated by race, and several of my participants were keen to point this out. When I asked questions about gender, participants in two focus groups mentioned they felt cannabis was more racialized than gendered. For example, Jimmy from Focus Group 1, who is a white man, took issue with the gentrification of the industry:

Jimmy: I'm worried about the continued gentrification of the industry because it is increasingly becoming white-washed in a way, and even culturally speaking. That makes me nervous because here we have something that was the War on Drugs and cannabis used to be a taboo topic or sin or something like that. But now it's kind of being
celebrated among a lot of rich white people who are like, *let's revitalize this city or this neighborhood or whatever by opening a dispensary or a growing warehouse or something.*

Indeed, many of Michigan’s licensed cannabis businesses are owned and operated by white people with deep pockets. One of the key informants I interviewed was very critical of Michigan’s social equity program which is supposed to reduce licensing barriers in communities most impacted by the war on drugs. Madison, who is a woman of color, explained to me that since the scope of the legitimate cannabis industry has never been measured, we do not have an adequate means to judge what is equitable. She also criticized the state’s colorblind approach to the social equity program since eligibility is based on zip code because Michigan prohibits racial/ethnic information being used in the state bureaucracy. Madison was also very attentive to the sentiments within communities of color, something that she worked to improve when adult-use cannabis was on Michigan ballot:

Madison: During the campaign I was advocating for Proposal 1 and the Detroit NAACP was in opposition to Proposal 1, which is the only proposal they opposed. At one NAACP meeting the speakers for the other two proposals would get up and do their thing, but I was the only one who had any opposition. So during these discussions at a lot of African-American forums, I was acutely aware that there was so much misinformation being given about what the plant was, and because we have a history... an emotional history of over incarceration associated with the plant, it was a very touchy topic. When I would try to talk about how it is a plant with medical benefits people would say: *No, this is something that is going to send people to jail.* They do not even perceive it as a medical tool, and this is compounded by the fact that there was a marketing campaign that was done by Healthy and Productive Michigan who is in conjunction with the NAACP, that said this is crack weed and this is the return of the crack epidemic (they even had T shirts with this).

Resistance to legalization within communities of color is understandable when considering the relative absence of racial justice from the mainstream legalization conversation. Steven Bender (2016) argues that campaigns to legalize medical and recreational cannabis have so far failed to focus on racial equity despite the enforcement of prohibition being largely racialized. With the exception of Washington D.C., racial justice was rarely mentioned as a
reason why cannabis should be legal for medical or adult use. In fact, when race was brought into the pro-legalization debate, it was often in the form of disdain for Latin American drug cartels. With this racialized menace in mind, “voters may have been making the choice between their perception of shady cartels of color controlling the illicit market, and of more trusted white business owners and local government profiting from marijuana consumption” (Bender 2016:694).

People of color are not only underrepresented in legal cannabis commercial sectors, they also face disproportionate challenges when consuming cannabis, even in legal states (Vitiello 2019; Bender 2016). Price is one concern as regulated retail dispensaries are more expensive than the unregulated illicit market. Since dispensaries test their products for purity, the appeal of affordable black-market marijuana may have health consequences for poorer consumers who are more likely to be racial minorities. There are also legal consequences for such transactions since the sale of marijuana is restricted to licensed entities in states with medical and recreational laws (Bender 2016).

Likewise, racial profiling survives in a legalization regime, and since people of color are more likely to be pulled over than their white peers, they may have disproportionate enforcement of no-THC diving laws. The same problem is also applicable to possession of marijuana by those under age 21 as well as the public consumption of marijuana, both of which carry financial and/or criminal penalties in legal states (Vitiello 2019). In post-prohibition Colorado, arrests for public consumption for blacks are about double those for whites, and arrest rates for Colorado schoolchildren are even more racially disproportionate than before legalization (Bender 2016).
The lingering “emotional history of over-incarceration” (to use Madison’s words) was also identified by several of the patients in my focus groups. Austin from Focus Group 5 explains why his wife is against legalization:

Austin: My wife is not recreationally believing that, you know, that there should be marijuana. She thinks it should be medically used only. But she's a black woman who has watched her nephews be locked up for having it on them.

Similarly, Sophia from Focus Group 1, who is biracial, did not take kindly to her college-aged son openly using cannabis following legalization in November 2018. She explained how she did not want him using it in her subsidized apartment as she fears eviction, and sternly cautioned him to be discrete since police maintain a noticeable presence in her neighborhood. This has been observed elsewhere as people of color also face more controls on their behavior through private contracts in states with legal cannabis (Bender 2016). Employers may still drug test workers for cannabis, but drug testing is most prevalent in low-wage professions more likely occupied by racial minorities. The same is true with residential leases where landlords can evict a tenant for smoking marijuana, and sometimes even for possession of cannabis products on the premises. Sophia was perhaps more aware of these potential consequences owing to her prior involvement with the criminal justice system over her use of cannabis before becoming a patient:

Sophia: I said the best thing about medical cannabis is avoiding jail, prison, or fines. I don't want to go to jail, I don't want to go to prison, and I don't want to pay any more fines. So that's probably the best.

Even though cannabis is now legal in Michigan, the state has yet to act to expunge prior offenses and prisoners are still incarcerated for non-violent marijuana offenses. Finally, a comment made by an acquaintance I met speaks volumes on the racialized normalization of cannabis. As I was explaining my research to others at an Independence Day BBQ, a woman of color commented: “I don’t think it will ever be legal for me”. Indeed, a content analysis of Colorado news reporting found legalization did not result in a normalized depiction of minority
cannabis users. When criminal or stoner stereotypes were used by the media, they were more likely to feature racial minorities than white people (Mortensen et al. 2019). As such, if we make the sweeping claim that marijuana is normalized, we may be doing so from a colorblind position of racial privilege.

**Progress and Improvements**

As I have shown throughout this chapter, my research indicates we should be cautious of making blanket statements like “cannabis is normalized”. In terms of stigma and social disapproval, patients and key informants agreed that while things have improved, we are not yet in a culture where cannabis is seen as normal. More simply put, the legalization of cannabis is not the same as the normalization of cannabis, and we are still fighting a cultural battle for acceptance. However, the legalization of cannabis has helped to reduce associated stigmas and may even reduce internalized stigmas within cannabis patients. Sophia from Focus Group 1 credits the new legality of cannabis with easing her concerns over being in the wrong:

Moderator: In your opinions, what separates medical marijuana from recreational marijuana?

Sophia: In my opinion, it's the word.

Moderator: Just the word?

Sophia: Sometimes and I'll tell you why. When I was younger, I thought it was more recreational. But now when I look back on it, I feel like it was more therapeutic, or something to help me through tough times. I used to feel bad when I smoked, like *oh my god I'm addicted to marijuana*, you know what I'm saying? Because people told me that and I heard it. But in my mind it's not a bad thing, it's awesome. So them passing the law really relaxed my mind on that bit of it. I don't feel like such a bad guy anymore.

The federal prohibition of cannabis was frequently cited as being a cause for continued stigma, as were the entrenched prejudices in older generations who were taught that marijuana is a dangerous drug. In fact, many of my key informants and focus groups participants were
optimistic that things will get better once the older generation dies off. Those who expressed this often did so with glee in large part because their experiences with older anti-cannabis people were demoralizing. Patients and key informants would attempt to educate them and clarify their misconceptions, but all too often these older people did not want to listen. Justin, who worked on the legalization campaign in Michigan, explains this well:

Justin: Everybody knows what cannabis is but most people have an incorrect perception of it. I shouldn't even say most people because I think that tide is turning. So mainly the discussion when we go out and do our things as activists, advocates, and business people is more of what cannabis is not then what cannabis is. We're trying to overcome objections and things like that… Generations of people were told cannabis is bad, they hardly ever looked into it, and they just internalized it. The most credible sources in the world-- my parents, my teachers, and the police around me-- are all telling me it's bad. So there's no point of even challenging or getting through this, or even being skeptical or critical of it. They just accept it and internalize it without thinking twice.

While we wait for the natural cycle of cohort replacement to bring into power a more accepting generation, other structural and social changes may also help to normalize cannabis in society. Participants in my focus groups thought the proliferation of CBD products has helped to destigmatize cannabis, and some described getting their skeptical family or friends to start experimenting with CBD therapies. Hemp-based CBD medicines are widely available now thanks to Congress’ descheduling of industrial hemp from the Controlled Substances Act in 2018. The fact that Family Video now advertises their line of CBD products was something humorously mentioned in four of my focus groups.

Additionally, the media has been improving their representations of medical cannabis and cannabis users. While patients think more progress can be made, they valued the occasional objective news report as well as scientific reporting on cannabis research. Several patients in my focus groups cited Dr. Sanjay Gupta of CNN as an example of cannabis reporting done correctly, and a couple of patients even used his series to educate their family members on cannabis’
medical benefits. Darlene from Focus Group 2 used the documentaries to change her son’s negative perspective on cannabis, as did Andrew from the same focus group with his parents:

Darlene: I have a teenager and he was very against cannabis. We did Boy Scouts and everything as he grew up, and they are very anti-drug, so it took me awhile to get him to understand because he was almost 14 when I became a patient. I didn't tell him at first because I couldn't figure out exactly how to approach him on that. Since he had grown up watching his uncle struggle with alcohol and stuff, he was very against self-medication and things. So, it took a lot to get him to understand, and in all honesty that CNN documentary… I taped it and had him watch it with me so he could ask questions as we went along, and that's how I changed mindset. Now he's open to more herbal supplements and things whereas he used to not even take an Aspirin for headaches. Now he's looking at things from a more natural standpoint and is more open-minded about it.

Finally, another piece of evidence that society is becoming more accepting of cannabis may be found in emergency situations regarding cannabis consumption. Several focus groups commented on the increases in hospital visits associated with cannabis, the vast majority of which occur when an adult consumes too much THC or when a child accidentally eats an edible. However, patients were quick to point out that the increased visibility of these incidents is likely due to people being honest. For example, three patients in my focus groups recounted a situation where their dog had gotten a hold of their medicine, and with the exception of Deborah from Focus Group 5, they were immediately forthcoming to the vet:

Deborah: I come from a generation where you lied about that for so long. But now to tell somebody the truth, it's just a gut reaction... In fact, our dog ate a little nug for the first time and I didn't know what happened to her. She was just lying there, she wouldn’t get up, and when I picked her up, she peed all down the front of me. So, we hop in the car and took her to the doggie emergency room, and the little lady comes out and she says [laughs], Is there any chance that there's cannabis in the house? And I'm like, No. No. You know, I'm like automatically lying because that's the mode I've been in for so long. And my husband grabbed her outside of the door and said, Yeah, there's a chance, and I'm like, Yeah, you're right. And they just told us to take her home and let her sleep it off.
Conclusion

Like research by Satterlund and colleagues (2015), participants in my study usually mentioned the word stigma before I did so as the focus group moderator. Furthermore, cannabis patients were keenly attentive to stigmatizing forces at the macro, meso, and micro levels in our society. While patients agreed progress had been made at the macro level, primarily in that laws criminalizing cannabis have been removed throughout the state, they saw only mild changes to cannabis stigmas within the other dimensions in our society. Moreover, since patients still experienced cannabis stigmas in many areas of their lives, we should be cautious of claims that cannabis has achieved a normative status, even in a legal state like Michigan.

The normalization hypothesis suggests our moral code now accepts non-abusive, non-risky forms of cannabis use (Jarvinen & Ravn 2014; Duff et al 2012; Sandberg 2012; Hathaway et al. 2011; Jarvinen & Demant 2011). However, the experiences of patients in my focus groups trouble such sweeping claims. Even though cannabis may be more normalized than even a decade ago, the fact that patients face discrimination and remain guarded about their use suggests we still have a social structure or culture (or both) in which cannabis carries a stigma. Duff and colleagues (2012) use the term “residual stigma” when referring to cannabis stigmas in a more accepting society, but my research suggests the word “residual” may be premature.

Like previous studies, my results suggest social approval of cannabis is mediated by a variety of factors like age, gender, and race (Hammer 2015; Bottorff et al. 2013; Reinarman et al. 2011; Hathaway 2004). Anti-cannabis ideologies may have crystalized within older generations, hampering the ability of older patients to feel at ease within cannabis culture, and perhaps causing some of my participants to look favorably upon the inevitable process of cohort replacement. Similar to other research, my findings suggest cannabis use by white people may be
less stigmatized than cannabis use among other racial and ethnic groups (Dickerson 2018; Lewis & Proffitt 2012). This inequality may be amplified as whites continue to dominate the legal cannabis marketplace, a process made easier by their relative reprieve from the war on drugs that has de vested communities of color.

Most significantly, institutions, organizations, and groups still stigmatize cannabis, even within legal states. Often found in the form of zero-tolerance policies, these structural stig mas (Corrigan et al. 2005) make patients worry about being out of compliance with numerous regulations, imparting the impression that society problematizes their medicine. This fear can manifest when police or state agents, like CPS, are called to investigate medical cannabis patients. Similarly, little has changed in our Puritanical culture which stigmatizes intoxication (DeAngelo 2015; Reinarman 1994), even though cannabis patients say their medicine makes them feel “normal” as opposed to “high”. Participants in my study often stated they spent significant amounts of time educating others on the wide variety of cannabis medicines, but since most Americans are unfamiliar with cannabis (Lloyd 2013), they face an uphill battle in dislodging ingrained cultural stereotypes about cannabis and cannabis users.

At the intersection between the macro and meso levels, institutions like the media, politics, and the economy still problematize cannabis. Cannabis patients are frustrated with the lack of diversity as the media often sticks to classic stereotypes like stoners and potheads. Basically, the media still amplifies anti-cannabis messages (Reinarman 1994), as do political actions taken at the local level (Hammer 2015). When municipalities opt-out of cannabis businesses, it sends the message that cannabis is problematic.

Employment policies operate in a similar manner, and it was rare for patients in my focus groups to feel secure and/or happy at their places of work. As states cede control over cannabis
to the regulated dispensary system (O’Brien 2013), they may also be passing on the source of structural cannabis stigmas to employers. In other words, while criminal penalties are no longer a consequence of cannabis use, employment penalties now accomplish a similar deterrence effect. More importantly, anti-cannabis workplace policies condemn all cannabis use, not just risky or abusive use (Duff et al. 2012; Hathaway et al. 2011; Jarvinen & Demant 2011)\textsuperscript{26}. Even with employers who do not drug test, patient accounts suggest their use of cannabis results in suspicion among others in the workplace. Everyone in the workforce has job-related stress, but imagine if part of that stress was related to a medicine that has enabled you to work without life-limiting pain or deleterious side effects. Changes to organizational policy or employment laws are necessary for cannabis patients to thrive in their careers. No one should live in fear of being fired over using a beneficial substance, and no one should be denied a position for their medical regimen.

In sum, the lived reality of being a cannabis patient in a post-prohibition society is not the same as being a cannabis patient in a society where cannabis is normalized. Legalization has certainly helped to destigmatize cannabis use, but we have yet to achieve a social environment where cannabis use no longer carries penalties. After all, the deviant label is not wholly controlled by the legal system as various social intuitions, groups, and actors apply the label to individuals and behaviors (Becker 1973/1963). Whether the sanctions come from one’s family, employer, or community, patients still feel that their medicine is problematized. As a result, they may face legal discrimination or shunning, and many still conceal their use of medical cannabis in a manner similar to when it was illegal. Likewise, increases in use statistics appear to be a poor barometer of social acceptance. Even though more people are enjoying cannabis today than

\textsuperscript{26} In December 2019, U-Haul announced it will be implementing a nicotine-free workplace policy. While existing employees are not affected, the company will not hire new employees who screen positive for nicotine in any form.
ever before, they do so under the persistent possibility of social sanctions from someone or something.

If we want to create a social context where cannabis is normalized, we need to become conscious of social and structural stigmas stemming from non-state entities. Deviance as a precursor to stigma is perhaps best seen as “the product of a process which involves responses of others to the behavior… Deviance is not a quality that lies in behavior itself, but in the interaction between the person who commits an act and those who respond to it” (Becker 1973/1963:14). The disapproving reactions by health care providers, employers, and family members associated with the patients in my study signal cannabis still carries a deviant identity. Even today, the “worst consequences, social and individual, seem to arise from how nonusers react to users” (Becker 1973/1963:200).

The media, employers, and local politics can improve how they treat cannabis and cannabis users, even if new-found acceptance applies exclusively to cannabis patients first. If legalizing medical cannabis has been the first step on the path to total decriminalization, maybe the normalization of medical cannabis (in particular) will be an effective way to facilitate the complete normalization of cannabis in our society. There is some evidence this has been happening—the media has been doing a better job at profiling cannabis patients in a non-stigmatizing fashion, some employers make exceptions for employees who are registered in the state’s medical cannabis program, and some municipalities may allow medical cannabis business but not those serving an adult-use market. It will be interesting to examine how these policies evolve in the future, but in the meanwhile, we should be careful of equating legalization and popularization with normalization. Since cannabis patients still experience significant personal and professional challenges related to their use of medicine, it is a stretch to claim we are in a
post-stigmatized society. The status of cannabis as a medicine is explored in the next chapter of my analysis.
CHAPTER VII

THE ALTERNATIVE MEDICALIZATION OF CANNABIS

This chapter of my analysis considers patient perceptions about the future of medical cannabis. The research questions that guide this analysis are: How do medical cannabis patients view the legalization of recreational marijuana? And, do patients think medical cannabis will survive once marijuana is fully legalized? Overall, patients favored the legalization of adult marijuana use, and many welcomed the ease at which cannabis can be discussed in a post-prohibition environment. To this effect, my data suggests that legalization facilitates medical uses of cannabis as non-users become curious about the benefits of the now-legalized plant. Likewise, while patients in my focus groups thought legalization would reduce social stigmas and institutional consequences, they believed maintaining their state-sponsored patient status would be an additional layer of protection in a society where cannabis has yet to be normalized. Moreover, patients are optimistic about the future of medical cannabis, and while their perceptions are nuanced, they enjoy the current system of medical cannabis being regulated by the state.

In this chapter, I begin by examining how patients support legalization since they think of it as expanding access to cannabis medicines. Afterward, I show that patients favor the current structure of medical cannabis where it exists outside of, but not in opposition to, mainstream medicine. The next section reveals this sentiment may stem from the fact that mainstream medicine does not welcome an alternatively medicalized model of cannabis, and patients feel as if they are given ultimatums from traditional health care providers. Since mainstream medicine is rather intolerant of cannabis medicines, I then move into a discussion on how patients stick with
cannabis as opposed to obeying mandates from their physicians, and in large part, this is because cannabis gives them superior relief without the side effects. Finally, I explore patient sentiments towards pharmaceutical interest in cannabis, which can be described as anything except for positive. While it may seem as if patients are unsupportive of the medicalization of cannabis, the discussion of my findings reveals patients think medical cannabis will thrive in the future, but it will do so as something that is medicalized outside of dominant medical institutions.

Legalization Stimulates Medical Interest

As my previous chapter has argued, participants in my research did not think cannabis was normalized yet, but they were optimistic about the future. Interestingly, they were also optimistic about the future of medical cannabis specifically. While some fear their medicine would be coopted by corrupt pharmaceutical companies or paternalistic physicians, my participants agreed that the legalization of adult-use cannabis will result in more people seeking cannabis for therapeutic purposes.

Perhaps the most notable effect legalization had was facilitating honest conversations about cannabis and its medical properties. Patients in my focus groups stated that they commonly educated curious others on the medical benefits of cannabis. When I would ask how people react upon discovering a participant was a cannabis patient, the overwhelming majority stated something akin to this discussion from Focus Group 2:

Moderator: In general, how do people react when they find out you’re a cannabis patient?

Irene: They are very inquisitive. They tend to have a lot of questions for me and most of them say things like, wow, I never would have thought that do you use cannabis.

Sean: Yeah most of them don't understand that CBD and marijuana is the same thing as a hemp plant and stuff like that. So, a lot of people don't know and you have to fill in the blanks a little bit so they understand it a little bit more.
Darlene: I think there was just a general lack of education out there. That's why I say that the documentaries and stuff are helpful.

Patients pride themselves as being knowledgeable on medical cannabis, and many claimed they convinced friends or family members to try cannabis medicines. Since legalization has made cannabis accessible to anyone over age 21, it is reasonable to think that more people will experiment in hopes of finding relief. This is counter to the thinking of many scholars who believe medical cannabis will fade from discourse in a post-prohibition world (Kilmer & MacCoun 2017; Hall & Lanskey 2016; Fischer et al. 2015; Cohen 2010). If anything, medically-focused users may not feel the need to enroll in a state-sponsored program, and perhaps patient registries will become a thing of the past. However, that is not likely to happen in the foreseeable future as all but two patients in my focus groups plan to renew their medical cards. Canada’s medical cannabis program has grown since the country legalized cannabis last year (Health Canada 2019), and the biggest reason for this may be that structural stigmas and structural penalties have been removed. People may feel more comfortable seeking cannabis for medical purposes, and this is something Dr. Steven has noticed in his practice:

Dr. Steven: [Following legalization], we have seen more and more older patients who are on the edge philosophically or socially, or for whatever reason they are on the edge about it. They see that it is available everywhere now and they want to see what they can do for themselves medically. They come in and they have a lot of questions and they do not have a lot of experience, and they benefit a lot from what we have to offer, especially in terms of experience. So, I think that it is good for the medical side, even if just philosophically.

Michigan’s medical cannabis system had grown steadily for 10 years before voters legalized adult-use in 2018. Like California and Colorado, regulators in Michigan plan on maintaining separate administrative systems and supply chains, though each may be more alike than different. Perhaps the most meaningful distinction is that patients in Michigan will have access to products with higher levels of THC, and they are exempt from the 10% excise tax.
When I asked what separates medical from recreational cannabis, patients and key informants responded in largely bureaucratic terms. For example, Randy has worked as a patient advocate in Michigan for many years and has experience working with politicians and regulators. He interpreted my question from the perspective of the legal system:

**Interviewer:** So, what is the difference between recreational marijuana and medical cannabis?

**Randy:** None. The only difference between recreational marijuana and medical cannabis is whose hand it happens to be in. If I have a medical card, then all the cannabis I possess is assumed by the law to be for medical purposes. Now if I don't have that medical card, then I don't have any of those presumptions. That would be considered recreational cannabis even if I acquired it from the same source. It's all about who owns it.

Cannabis is highly regulated in Michigan and elsewhere, and bureaucratic oversight may be the first distinction on key informants’ minds. Patients also acknowledged the difference between medical and recreational is largely something that exists on paper, but they were more likely to think of individual intent and social perceptions. Focus Group 2 explain it this way:

**Moderator:** What do we think separates medical marijuana from recreational marijuana?

**Andrew:** How the person is using it.

**Irene:** Intent...

**Darlene:** I like that word intent.

**Irene:** ...Other than that there is no difference.

**Sean:** Perception, the way people look at it too. How we view it as a society.

**Irene:** I've noticed a difference in quality. There can be differences in the chemicals that they use and also having it tested or not tested makes a difference, especially when you're sensitive to certain chemicals.

**Andrew:** But I don't think that defines medical or recreational.

**Wanda:** Yeah because you could do both in organic grows. It's the same thing really.

**Andrew:** I feel like eventually the growers should be licensed and clean. But the difference is that it's sold through this door and it's medical here, and recreational over there. So that's kind of how I feel the system works.
Few participants explained the difference in terms of the overall health of the user. Like other research (Newhart & Dolphin 2019), patients may have recognized that the context of use is more important because individuals with health conditions may occasionally use in more social fashions. Only one patient in my focus groups thought that there were no differences between medical cannabis and recreational cannabis. Alexander from Focus Group 4 did not negate the therapeutic potential of cannabis, but he believed that since anyone could justify their use as medical, the differences between intent were null:

Moderator: In the future, do you think there will still be medical cannabis?

Audrey: I think so because there is a lot of medical uses for it. It’s not just for fun, you know. Like when I crushed my finger recently and instead of taking pain pills, I was actually taking my edibles. And it helped so much. I mean, I got my finger crushed and I was prescribed Norco, and I still can't move my finger. But you know, I do my edibles a lot more now because I am in more pain.

Alexander: And I disagree. I think it'll just be the same. There is no added benefit from recreational marijuana or medical marijuana. It has all got the same chemicals in it and it's the same effect.

Audrey: But what about all the kids that are doing it, like using it for medical purposes? They wouldn't be able to do it if it was all like that. You know, like the kids with seizures, and they need a lot for seizures. It’s more of an extract but still...

Alexander: I mean, I hope they would keep that... In my opinion, everybody's hurting in a certain way. You can call it medical marijuana for anything, like daily life. Everybody wakes up and we have tooth pain, body aches, or whatever. Everybody experiences that.

Though Alexander presents medical definitions of cannabis as meaningless, the majority of patients in my focus groups and key informants believed all cannabis use had a medical meaning. Even if the difference between medical and recreational users or intentions was small, they acknowledged recreational users were receiving some therapeutic benefits. The most extreme version of this sentiment can be expressed as “all use is medical”, an infamous phrase attributed to California activist Denis Peron. However, there is nuance here as evidenced in
statements made by three of my key informants. Justin, who worked on Michigan’s adult-use campaign, says cannabis is inherently medical because humans have an endocannabinoid system:

Interviewer: Is there a difference between medical and recreational cannabis?

Justin: There is but it's subtle. For example, let's say there's a legalized retail store... are you going to go in there and buy a CBD oil suppository to have fun? Probably not. But every time somebody goes to use cannabis for fun, they're getting some sort of medical benefit from it, in my opinion. You have an endocannabinoid system and you're feeding it.

Evidence, while emerging, suggests the endocannabinoid system helps maintain homeostasis in the body as we experience ever-shifting external and internal environments (Frye 2018; Bostwick 2012). In other words, “all use is medical” because your body will respond to cannabis in beneficial ways. Similarly, Madison works to promote cannabis business opportunities in communities of color. She compares cannabis to foods that have health-promoting properties:

Madison: Honestly, I think that all cannabis use has medicinal properties whether you intend it to or not. But intent is also a big factor because it will encourage you to seek out different forms, variations, and ingestion methods, and these vary greatly. What I mean is cannabis is beneficial as a topical ointment or cream even if it has a very high THC level. Because of the way it is absorbed through the skin, it will not have a psychoactive effect. Therefore, it is always extremely beneficial. However, if you consumed burned flower or a concentrate, or even an edible, those ingestion methods will have greatly different reactions on the body. Even when I go speak to a crowd of people and some people have negative views around the plant, I use this analogy of ginger ale. It's known that if you have an upset stomach you can ease it with ginger ale, but intrinsically nothing is different about the ginger ale if you're consuming it as a medicine or in an ice cream sundae. And the same is true with this plant.

Like ginger with gingerol and perhaps wine with antioxidants, Madison suggests “all use is medical” because cannabis contains health-promoting compounds. A third reason why cannabis is inherently medical was expressed to me by Dr. Steven, a certifying physician in the state’s medical cannabis program for over a decade. He acknowledges the legal distinction between medical and recreational users, as well as the balancing role of the endocannabinoid
system, but also adds that cannabis will benefit anyone by restoring their attention to the present moment:

Dr. Steven: I think there is a lot of overlap. There are legal definitions to medical and recreational, so let's do that first. Clearly, a lot of people who became medical patients started using recreationally and illegally before they came in the door. And because it was illegal, it was defined as recreational. But the reality is, a lot of people that call their use recreational, legal or illegal, were using medically already. The things that people tend to use cannabis the most for are chronic conditions, whether it’s pain, anxiety, or sleeplessness. Cannabis is really interesting physiologically and it has a balancing role in the body, or the endocannabinoid system does, and we live in a culture that is constantly being tagged out of balance. There is a Native American term koyaanisqatsi that means “life out of balance”. It's essentially when life and everything around you is keeping you so off-balance that your life becomes more problematic than happy. Ultimately, we all want to be happy and we want our friends and family to be happy. If we're honest with ourselves, we like to be happy. And if we're really honest, we'd like to be happy all the time. But it really doesn't work that way. When you have a body that bugs you all the time or psychological condition that's like sand under the skin, you're uncomfortable and your mind goes into problem solving mode. I hurt-- Why? How do I get rid of it? This really takes your focus off of the things that may be more enjoyable to think about, like your family or your spiritual work, whatever it happens to be. So again, I think there is a lot of overlap… I find that marijuana creates kind of a meditative experience, and what I see is that a lot of people who were never into meditation or weren’t feeling all that spiritually connected at all, it’s almost like a crack in the door. There’s another way of feeling, there’s another way of being mentally that is not quite so problematic. And it actually starts to get them sort of interested in meditation and a lot of people ask me how to get started. If marijuana didn’t do anything but that, to create this kind of impulse towards mindfulness, if it only did that, I would be thrilled about it. But it does way more than that.

Dr. Steven’s use of Native American terminology to explain a theory of balance is not surprising given his office is filled with symbols of Eastern philosophy—Hindu sculptures, posters on chakra alignment, and quotes from yogi gurus. Nevertheless, I find his explanation of cannabis’ efficacy to be impactful since I practice mindfulness meditation myself. There is something to be said about cannabis’ ability to refocus our attention on the present moment, and several of the other participants in my study spoke of how cannabis allows them to better focus on their work and daily tasks.
Consistent with previous research on cannabis patients, many of the patients in my focus groups began using cannabis in a recreational fashion through the black market but later began to appreciate the therapeutic qualities (Newhart & Dolphin 2019; O’Brien 2013). Though their mindset shifted over their course of the cannabis career, the majority of them now define cannabis through predominantly medical terms. Jackie from Focus Group 5 illustrates this change of meaning in her introduction to the group:

Jackie: I’m Jackie and I’ve been medicating for about 25 years. When I started it was definitely recreational. That’s how it was introduced to me. But it didn’t take very long to realize that it had its benefits and it was a medicine. So, I’ve probably been a cardholder for about three years now. My preferred method would definitely be my beautiful little bong that I’ve had for like 16 years. It’s an amazing piece and it just... I don’t know, I can’t part with it. I don’t like joints that much. I do use concentrates and I make my own edibles. I’m actually going into business, selling edibles, and I’m making basically the same topical that [another group member uses]. I’m still in the beginning stages of that, but my edibles are very much loved among everybody that tried them so far. So I’m really excited about my new venture. Cancer patients just love them, so it’s awesome. And that’s exactly what I wrote down on the card: that cannabis is a medicine to me. Absolutely it’s a medicine first and foremost.

While Jackie hoped to turn her passion for making cannabis edibles into a small business, she primarily ascribed medical meanings to the plant even in a post-prohibition state. While some in the medical cannabis community have expressed their dissatisfaction with legalization for numerous reasons (see Appendix B), participants in my focus groups did not see legalized recreational use as detracting from the medical status of cannabis. In fact, none of my participants were against legalization or the concept of recreational cannabis, and the overwhelming majority planned to continue participating in Michigan’s medical marijuana program. Only two participants in my focus groups said they did not plan to renew their cards once the adult-use dispensaries opened, but the rest acknowledged the card would still be worthwhile in a state like Michigan. Participants in Focus Group 2, for example, liked the status and access brought by the card:
Darlene: I'd like to think that you wouldn't need a card 20 years from now. That you would be able to go and just seek the treatment that you need.

Wanda: I'm okay with needing a card.

Andrew: I'm with you. I like the distinction.

Wanda: If they want to require a card, that's fine. But I want insurance to pay for my medicine.

Darlene: I guess when I say that, I would like it to be more available. What I mean is that I would like it to be available to people who need it medically…

At the very least, having a medical cannabis card distinguishes one apart from society’s dominant view of cannabis users as hedonistic and, depending on the state, criminals. It may also help the individual reframe their use of cannabis as justified for medical reasons in a society that commonly applies the frameworks of drug abuse and addiction to marijuana. Perhaps this is why while Darlene dreamed of a day when the card would no longer be needed, she planned to renew hers for the foreseeable future. Some patients, such as Irene, had experience visiting states with both medical and adult-use cannabis facilities. In such cases, they remember little difference between options on the medical and adult-use sides, though medical cardholders pay less through lower taxation rates. Briana and Jackie from Focus Group 5 likened the difference to being a VIP:

Briana: I guess I don't really see a huge difference for medical patients versus recreational, like once they start establishing more regulations and laws on the recreational aspect of it. I was just in Vegas last week and they are a recreational and medical state. And really the only difference that I could see from being out there was that if you're a medical card holder, you just pay less. You still get all of the same access to all of the same stuff. You still can go in at the same time with somebody who is a med card holder versus just somebody who's buying from the recreational side. You just pay less taxes.

Jackie: Also, they kind of treat you more like a VIP. You have your own special lines and they're usually shorter than the recreational lines because you are a medical card holder.

Briana: Yep. But other than that, I mean, your options are still very much in the same.
Patients in my focus groups seemed to perceive the card as granting them enhanced status and expanded access in a post-prohibition state\(^{27}\). While Briana noticed little to no difference among products in Las Vegas, Michigan allows more potent edibles and concentrates to be sold to medical patients compared to recreational consumers. Other patients noted that having a card will allow them to purchase more products per dispensary visit, but this is not exactly true as both medical and recreational customers are limited to 2.5 ounces of flower per day. No one in my study mentioned ever hitting the purchasing limit, but it is conceivable that in states as large as Michigan, patients may decide to buy in bulk if they live far away from a dispensary. Similarly, having a card meant guaranteed access to cannabis as the emerging recreational market shifts the business landscape.

Even though it did not affect them, many patients were frustrated with the slow rollout of recreational businesses, and some patients feared the emerging recreational market would attract the ire of law enforcement. For example, Audrey from Focus Group 4 had been a patient since the dawn of the MMMP and she remembers multitudes of raids on medical dispensaries throughout the 10 years of the program. This resulted in her having inconsistent access to her medicine as she frequently had to find new dispensaries upon her favorite dispensaries being shut down. While law enforcement has been more tolerant of the licensed medical dispensaries after the regulations established by the 2016 MMFLA, Audrey and others fear a similar pattern will result with the new recreational dispensaries.

\(^{27}\) The comparison to being treated like a VIP or someone with a superior status was also mentioned in an interview with Jackie who had moved from Colorado to Michigan several years ago. Jackie now runs a cannabis networking association in Michigan and publishes a cannabis magazine, and she likened the divide between the markets in terms of medical connoisseurs and recreational rookies: “It’s going to be awesome to watch how Michigan’s market evolves because we have a lot of educated consumers. We have 300,000 patients, a lot of people are educated on what they want already, and then recreational opens the door to all these rookie consumers to start trying it out”. The idea of connoisseurship, which stands in opposition to pharmaceuticalization, is explored more in Chapter 3.
Product options and access aside, a more significant reason for maintaining one’s status as a cannabis patient was a sense of increased protections. Several patients thought medical cannabis would be cleaner than recreational cannabis, but this is a misnomer because the testing standards are the same for each system. Other protective reasons for maintaining the card may also be misnomers, but these are ultimately situational. For example, four patients in my focus groups cited CPS as a reason for maintaining their cards since they each had young children at home. The current policy of CPS appears to be treating marijuana use as grounds for child removal only if it prevents parents from safely taking care of a child, and this is evaluated on a case by case basis. However, having a card may sway an agent to exercise their discretion and dismiss the parent’s cannabis use, and the same is true with the criminal justice system. Two of my participants had criminal records, and both thought of having a card as another layer of protection from the criminal justice system, even in a legal state. Furthermore, two other patients mentioned that their employers had drug-free workplace policies complete with random drug tests. While employers can still terminate employees for using cannabis in most legal states, and while there are no legal protections in Michigan for patients should they be drugged screened, each of these patients had employers who accepted their use of medical cannabis.

The most pressing concern among patients in my focus groups involved the medical profession. Several patients described that their doctors would still prescribe them pain medication since they were registered cannabis patients, but this appeared to be an exception to the rule. Pain contracts and mainstream medicine as a whole often mandate patients to choose between either cannabis or conventional treatments, and this controversial ultimatum is discussed in the next section of this chapter. Finally, while none of my participants mentioned this, it is possible that patients will maintain their cards to grow more plants. Michigan’s adult-use law
allows a household to grow up to 12 plants, and since the medical system also permits up to 12 plants, this may mean patients can technically grow 24 if they follow the strict regulations. However, this has yet to be clarified in court or by regulators.

Cannabis as Alternatively Medicalized

As the medical cannabis community believes medical meanings attached to cannabis will continue in a post-prohibition state, it is worthy to consider nuances within these sentiments. Existing research on medical cannabis suggests that it is “incompletely medicalized” in that biomedicine has yet to establish hegemony in how cannabis is defined (Newhart & Dolphin 2019). However, patients in my focus groups do not wish for cannabis to become completely medicalized as this would mean the plant is exclusively controlled by medical institutions. Perhaps this is because cannabis was medicalized through a grassroots, patient-led movement (Penn 2014; Chapkis & Webb 2008), but my research also indicates patients are dissatisfied with the structure of mainstream medicine. Instead of “doctors orders” and profitable synthetic compounds, many patients expressed their support for the current model of medical cannabis.

The following exchange is from Focus Group 2:

Andrew: For me, the best thing about medical cannabis is that it signifies a shift in how we treat ourselves and our medical knowledge.

Moderator: Huh… What do you mean by that?

Andrew: So, no business can succeed without money being its main concern. So with the business of treating ourselves or going to the doctor, like many things, it could have been done differently and it could have been done better as far as our medical history goes. I mean, over-drugging and things like that…

Darlene: Also under-drugging… Followed by over-drugging.

Andrew: Right. And this is a more natural way to help ourselves and to treat ourselves than with pills and other things.
Wanda: And it is getting people to look at their own situations instead of just relying entirely on their doctors for everything. Now they are researching their own things and finding out what works for them.

Sean: You have to be your own advocate.

Being in control of one’s own medicine was a significant factor in their support for the current medical model of cannabis. Similar to Newhart & Dolphin (2019) and Lau et al. (2015b), patients in my study appreciated the self-directed nature of their medicine as opposed to the institutionalized regiments of care found within mainstream biomedicine. Briana from Focus Group 5, and Gavin and Wade from Focus Group 3, all exemplify this preference for being free from strict physician supervision:

Briana: For the best thing about medical cannabis, I wrote you have an array of options. It's a solution that is more natural. But I'd say the biggest one for me is that I'm the one with the control. I don't have a doctor telling me you have to take this at a certain time every day, with or without food. Or that it's going to cause 30 worse side effects than what you're treating. So, I'm the one that has the control of when and how much.

... 

Gavin: One of the main things about cannabis, especially now that it's legal, is you regulate and control it as opposed to a doctor. And I'm all for doctors. I mean, they went to school and everything. But only you know what you need when you need it. And it's hard to tell that to some doctor or other authority. You know, I believe in the old apothecary stuff. Really, like, you can learn from people that have knowledge and you know your body better than anybody else does.

Wade: I totally agree with that one right there.

Personal control, independence, and accessibility were all frequently cited as advantages to the current model of medical cannabis. The versatility of cannabis was also cited as an advantage over mainstream medicine, as were the variety of cannabis medicines. Lengthy lists of state-approved conditions for medical cannabis programs are often criticized for being too liberal, but patients attest that cannabis helps with numerous medical conditions. Likewise, patients have learned that cannabis is not a singular, uniform medicine, but rather exists in
diverse forms with often different effects. The following is from Focus Group 2 in response to my question about advice for new medical cardholders:

Moderator: What advice would we have for somebody who has just received their medical card?

Irene: Do your research.

Wanda: Try everything in the dispensary.

Darlene: Do your research and document or journal how you feel.

Irene: And don't just go to one place for your research. Do what they actually taught you in the old days in school. Read everything you can get your hands on and form an opinion for yourself.

Andrew: Yep and everybody's body is different so they handle cannabis differently. So, see what works for you.

Irene: Right and you have to keep on trying too. Like if one thing doesn't work for you, don't give up because you should try the other 300 kinds to see if any of those work.

The individualized effects of cannabis and the need to keep on trying different cannabis medicines were frequently cited by focus group participants and key informants alike. Though I did not directly ask, no one complained that a product or strain was ineffective, though everyone had their preferred method of delivery. Darlene’s comment above—the need to document personal effects—was echoed by the certifying physician I interviewed, and one new dispensary I observed even provides patients with a logbook for that very purpose.

What works for one person may not work as well for another, but everyone agreed that some form or regiment of cannabis medicine could work for anyone. Dr. Steven best explains this:

Dr. Steven: [New patients] should experiment and try a lot of different things in small amounts. They should also take notes and come back and see me so we can talk about it. A lot of it has to do with changing your mindset about it. They're used to getting a medication where the doctor says, *take this number of these on this schedule and you get a refill*. That's not how cannabis works. It's far from a one-size-fits-all type thing. It varies with your physiology, your stage of life, and how you structure your day, like
whether you have a job or are busy. But there are so many forms and varieties that you can almost tailor it to anybody's lifestyle.

Participant sentiments stand in opposition to the critique that medical cannabis models do not have enough physician oversight (Nussbaum, Boyer & Kondrad 2011). In fact, some patients in my focus groups remarked that the requirement of physician certification was too onerous. This does not mean that they objected to having to seek a physician certification, but rather that the proof of need requirements was too burdensome. In order to become a cannabis patient, one must seek a recommendation from a physician participating in MMMP, but different physicians demand different amounts of paperwork. About half of my focus group participants report supplying their physician with an extensive file detailing their condition while the other half reported their physician needed little, if any, medical proof. Regardless of the proof required, all of them appreciated these medical professionals expanding access to cannabis. The points above are contained in this conversation from Focus Group 5:

Damien: I'll tell you, it was not easy getting my medical marijuana card. They wanted every piece of information from every doctor I had ever seen. And then it still took a month.

Austin: Ya, until you go to a High Times event or something like that, you know, one of the Cannabis Cup things where they've got a doctor on site giving six-minute interviews...

Briana: I'm not going to lie, when I got my medical card, it probably was not from a legit doctor...

Doug: Me too.

Briana: Ya, like you go in and you pay them money, and they sat down and talk to you, but you don't have to provide doctor records.

Damien: Two years ago, they wanted everything in the world from me.

Doug: Yeah, mine was three years ago, but I provided nothing...

Briana: But once you are a patient, you don't need the extensive paperwork every time you renew. You don't have to go through all of that again. They basically just mark down what they marked on the previous time, and they push it on through
Damien: Ya, they just want their $75 renewal fee.

Austin: Now with the recreational rules, that's what it should be. They shouldn't even be asking questions at this point in time anyway. You know, it doesn't matter now that it’s legal. I'm still paying you the fees and whatnot, and I'm exercising my right to come to you. But you know, it's gotten to that point where some doctors like [Damien’s] stick by the rules, and others are just trying to help people get something that they feel should be available to everybody in the first place.

It is important to keep in mind that most licensed physicians do not participate in the state’s cannabis program, and some medical institutions like hospitals prohibit staff from recommending cannabis. While patients had differing experiences with certifying physicians regarding the initial approval process, all had favorable views of physicians who participated in the MMMP. This is significant since our society’s dominant model of medicine problematizes cannabis, sometimes to the point of withholding care.

Allopathic Intolerance

While patients enjoy medicating on their own terms, they also wish that biomedicine would become more accepting of their medicine and care regimens. This is significant because medical cannabis is largely theorized to be a linear continuum where the plant is moving into the domain of biomedicine (Newhart & Dolphin 2019, Frye 2018). But my research suggests patients value cannabis’ status as existing outside of this construction, perhaps where the two models of medicine coexist. Though patients in my focus groups did not see state-endorsed models of medical cannabis standing in opposition to institutionalized medicine, patient accounts suggest institutionalized medicine might.

Overall, patients were frustrated with how traditional health care providers viewed cannabis. This frustration manifested in two ways, the first of which is where doctors were
scorned for ignoring cannabis as a possible treatment. As Focus Group 1 was discussing media portrayals of cannabis, Sophia interjected with an observation:

Sophia: Can I bring something up that's kind of been weighing on me? And I don't know if this is one of your questions or if it might not be... But I just started recently watching TV again and I see a lot of these commercials that make me feel bad, like the sick kids in the Saint Jude's Children's Hospital. Like, you're a research hospital, so can you just open your mind to cannabis? Just open your mind and open your doors. I think the parents would have wanted you to do that. Jesus would have wanted you to do that. It scares the crap out of me that if one of my kids or one of my grandkids gets sick, that they are going to have to do chemotherapy, and chemo is going to kill them. You know what I'm saying? So that still really bothers me. I want access to medication that is not going to kill me or kill my family.

There is limited evidence that cannabinoids may be useful in treating cancer and we are far from any definitive proof on the matter. As such, Sophia’s comment may be best interpreted as advocating for more research on cannabis and cancer (Saint Jude’s is a research hospital) as well as the use of cannabis medicines to reduce suffering. Since “[m]edical cannabis use could be considered as oppositional to ‘mainstream’ healthcare, which relies heavily on pharmaceuticals” (Lau et al. 2015b:17), I think Sophia is simply implying they should look into this unconventional medicine. Indeed, advocates for cannabis medicines have primarily sought to expand access to cannabis as a source of relief rather than a tool to cure disease (see Appendix A). Nonetheless, other studies have found cannabis users deploy bravado (Sandberg 2012) to reposition a culturally devalued substance into something positive. The “bravado of subcultural discourse” (p.380) boastfully exaggerates positive elements of cannabis and is often used to counter social stigmas.

Patients also resent physicians who disapprove of medical cannabis. While several patients in my study were able to find physicians who supported their use of medical cannabis, the majority had the opposite experience. This is an excerpt from Focus Group 1 which illuminates patient frustrations with medical professionals:
Moderator: Has anybody here ever experienced any negative reactions based on being a patient?

Bailey: O yeah, I have by other doctors.

[Everyone in the group immediately signals their agreement]

Sophia: I told my doctor off!

Avery: When I was going to get my card, my doctor strongly advised against it.

Jimmy: Mine did too and I was seeing a psychiatrist at the university I was attending. They said I shouldn't do that and that they wouldn't prescribe me my medication for ADD if I smoke cannabis.

Bailey: Yes. Psych doctors, in particular, I have found in my experience are really against it.

Jimmy: Yeah, and I didn’t have the courage to tell my doctors that I use marijuana so I used hypotheticals. I was very specific and told them I was considering trying marijuana even though I had already been using it. And they were like, **well, you can’t do that because then I can't prescribe you your medicine.** But the weird thing is that when I went to see a general practitioner at the same university and I told them the same hypothetical situation, they were like, **okay that's great. If it helps you, that's great.** I do think this doctor was very progressive though.

Patients wanted mainstream medicine to respect their use of cannabis, but all too often their interactions with and treatments from medical professionals were disappointing. This may be due to the fact that the endocannabinoid system and cannabis are not commonly covered in medical schools (Sideris et al. 2018; DeAngelo 2015). Indeed, Victorson et al. (2019) found cannabis patients trust their regular physicians but were dissatisfied with the limited knowledge their physicians had on medical cannabis.

Perhaps this is why the cannabis patients in my study tended to be knowledgeable in the areas of health and medicine, especially when it came to drugs which helped their conditions. Like previous research, the patients in my study gained much of their knowledge from outside of mainstream medical authorities (Victorson et al. 2019; Athey et al. 2017; O’Brien 2013; Pedersen & Sandberg 2013). They developed extensive medical knowledge through years of trial
and error with surgeries, prescription drugs, and other treatments. What they know about medical cannabis came from personal experiences, the medical cannabis community, and self-directed research. Unfortunately, sometimes this knowledge of “what works” made doctors question their motives for requesting certain pain relievers. Being a cannabis patient may have also influenced doctors’ decisions to withhold certain drugs, even when undergoing surgery, as evidenced in this discussion from Focus Group 2:

Moderator: Has anyone ever experienced any negative reactions after someone finds out you are a patient?

Wanda: From doctors. But usually you can tell whether or not they are going to be okay with it based on how they talk to you from the beginning. My doctors have been pretty good, but I have heard from a lot of people that they cannot get their prescription pain medicines because they use cannabis. Even though the prescriptions work a little bit, the cannabis makes all their pain go away. But not without the prescriptions, they need both. And they have to pick one or another because their doctors won't allow both.

Sean: The only negative I've ever had with it was at the VA. I went to have my surgery and they wouldn't give me demerol even though I was in so much pain, because they said I was a druggie…

Irene: A drug seeker.

Sean: Yeah and I was like, seriously?! Because I smoke marijuana?!! And this was the only thing that helped my pain, other than serious pain, was demerol. You know? That was my only other pain relief and they just brow beat me every time I went in there.

Wanda: Yeah if you tell them the name of a medicine that works, you're automatically a drug seeker.

Moderator: That's an interesting observation. So if you know something by name, they're not going to give it to you?

Sean: It's true. It's very true.

Wanda: They want to go through their procedures.

Irene: Especially if they say, well, what if we try this? And I go, well, why don’t you look at my file first? That's where I've gotten to now. Whatever they gave me last time, it didn't work great.

Sean: And then when you tell them what you've been through and stuff like that, they look at you and they're like, Okay. We're still going to do this my way.
Wanda: Usually if they take the time to sit and listen they're good, but…

Darlene: I've been told working in the medical field that we should be actively trying to dismiss a patient if we find out they use cannabis.

Sean: Oh wow. I believe it.

Darlene: Because they don't want the liabilities in their minds that go along with…

Wanda: What liabilities? Like paying closer attention when you're under anesthesia? Because what really else is there, and you should be paying close attention anyway.

Andrew: Money.

Greg: It's just a complete misperception about the effects of marijuana and what it does to your body.

Darlene: In a lot of their minds, cannabis is still a gateway drug and if you happen to need the combination of cannabis and an opioid, or really any kind of pain med…

Andrew: Yeah. I would have to use opioids when the pain would get really bad but I would always do so with cannabis. Especially when you want to stop using those pain meds, the withdrawals and everything, cannabis makes it easier to work through that and stops me from wanting to take more pills.

Darlene: But in a lot of doctors' minds, that would make someone a drug-seeking patient and qualify them for dismissal.

Resistance to medical cannabis on the part of doctors has been documented elsewhere.

Some of the cannabis users interviewed by Lau et al (2015b) described backlash from healthcare providers for choosing to substitute cannabis for painkillers. These individuals were dismayed by their doctors’ preference for riskier pharmaceuticals and this may have damaged the trust integral in biomedical doctor-patient relationships. “Substitution highlights users’ self-determination—the right of individuals to decide which treatments or substance is most effective and least harmful” (Lau et al. 2015:658). Yet the paternalistic nature of biomedicine seems to frown upon empowered patients, especially if the patient has opted to use an unconventional therapy.

The more profound frustration cannabis patients had with mainstream medicine was the ultimatum to choose between cannabis or traditional pain medications. The subject of pain contracts came up in three of the five focus groups, and these contracts have become increasingly
popular in the wake of the current opioid crisis. Many physicians require patients to sign the contract in order to receive pain killers, but the contract often contains a mandate to remain drug-free, meaning cannabis-free. Patients also expressed resentment at the way pain contracts intruded upon their lives and set structured regiments on when pain medicine can be taken. The following conversation is from Focus Group 2 after Irene mentions she had to switch doctors because of the pain contract requirement:

Sean: Yeah, I never had a pain contract.
Darlene: I was the person that used to make you sign the pain contract.
Moderator: What is the pain contract?
Irene: Oh God. They are ridiculous. You have to pee in a cup at random and then they check your levels. The one that they wanted me to sign said to show up within an hour of getting the call with my prescription. And my doctor's office is an hour drive. So, I was like, *wait a minute*... You want me to have to leave work, which the reason I take the pills is so I can keep functioning and working, and then you want me to drive an hour? The contract also says that I can't carry my prescription with me because if it gets stolen, then I am responsible. So that means I would have to go home first, which is another 20 minutes out of the way, get the prescription, and then drive an hour to the office. I would already be over that 60 minute time limit. I'm like, *do I have any drug felonies? Do I have any charges?* And of course I don't, so I told them I'm not signing it.
Wanda: They made me sign one after my surgery and I laughed because I didn't even fill the prescription. They gave me oxy which doesn't do anything for me, so why would I fill it?
Sean: I would never sign one of those. I would have laughed at them and walked out.
Darlene: It was hard to have people sign those because you could tell that people needed it, whatever the drug is. And they make you abide by a pill count, and if you're off by just one freaking pill... and who doesn’t make mistakes... you're in violation of the contract.
Wanda: I always drop them on the floor and everything, and if it goes under the sink or something, you're screwed.
Greg: Same.
Darlene: Or if there was just one day where you needed one extra tablet…
Irene: Or even if you needed to cut that one in half to take an extra half or something.
Darlene: And we have patients that we know have filled their prescription at five different pharmacies on the same day. That's the person you need to watch out for, not the person who lost two pills in a couple month period. This is not the same kind of grievance.

Wanda: And you know what? The people who want to get their pills illegally are going to find ways to do it anyway regardless of what they make us sign.

Darlene: It just makes them so skeptical. And then when you start throwing laws on top of it, which could happen with marijuana… They're easing laws right now but they're also going to bring back and impose new rules on top of it…

Greg: Yep.

Irene: They always said that you have to choose between one or the other. You can use your narcotics or you can use your marijuana, but you cannot use both since we won't write a script. And I was like, wait a minute… if you're on a prescription for something, are you ever giving someone just one prescription? Or are you writing somebody a prescription for pain, and then also a muscle relaxer, or are you also prescribing something for their stomach, or something for this, that, or the other thing? So how is it an either-or? They have no way of knowing if they complement each other. One medicine might even make the other one more effective. But my current doctor was like, here is your prescription for pain meds, and don't panic, but you're going to have to go downstairs and sign a pain contract. But this is my last day here and I have already prepared your paperwork for transfer to my new office, so even if you don't sign the contract downstairs, you can still get your medicine tomorrow. That's why I drive an extra hour to go see this doctor.

Pain contracts (or pain management agreement plans [PMAP]) have become a popular mechanism to surveil patients being prescribed narcotic medications. In Michigan, pain contracts are recommended in the quasi-regulatory guidelines for the prescription of controlled substances, but these guidelines are not legally binding (Davis n.d.). Daniel Cobaugh and colleagues (2014) say: “The intent of the PMAP is to provide full disclosure of the risks and benefits of opioid therapy and institutional policies with regard to ongoing regular pain assessment, random urine drug screening, and the use of a single opioid prescriber group and pharmacy” (1550). There are no standard criteria for pain contracts, but a popular sample from the American Academy of Pain Medicine specifically mentions marijuana use as a violation of the agreement (see Sample n.d.).
There is dissent in the biomedical community regarding the necessity and rational of pain contracts. Buchman and Ho (2014) note these contracts rarely contain themes about the goals of care, and that such contracts place the onus of trustworthiness on the patient rather than the physician: “Some providers may assume irrationality and attribute to these patients a credibility deficit regarding their knowledge of their bodies, their experiences with medications and both licit and illicit drugs, and their reports of pain and suffering. In this way, opioid contracts may send the clarion message that the physician does not trust the patient” (675). Despite placing burdens on the individual patient, Rager and Schwartz (2017) argue such contracts are ethically justified because they address a public health need to control opioid abuse. Nonetheless, there is limited evidence on the effectiveness of pain contracts in deterring opioid abuse (Rager & Schwartz 2017; Buchman & Ho 2014).

Jackie and Doug from Focus Group 5 had a similar experience with pain contracts:

Jackie: There are also a lot of medications that your doctor will not and cannot prescribe you if they know that you're using cannabis. I have to sign agreements to get my pain relievers because there are some things that even the cannabis doesn't totally relieve. But to get my pain relievers for extreme headaches and things like that, I have to sign an agreement, which I obviously break. It's the only way that my doctor will prescribe me the meds that I need, so I have to lie.

Doug: There was a couple medications that I turned down because they told me I had to sign a waiver.

Patients want mainstream medicine to honor their use of cannabis as medicine in conjunction with standard treatments, but mainstream medicine often presents them with an ultimatum. However, patients do not want to choose between one or the other because the combination of allopathic and alternative medicine yields the best results. It is also interesting how the popular imagination suspects many cannabis patients lie to get their medical cards, but Jackie’s account suggests many patients might be forced to lie in order to get treatment from regular healthcare providers. Perhaps this is why many of the patients surveyed by Kruger and
Kruger (2019) do not discuss their use of medical cannabis with their regular physicians. They know mainstream medicine considers prescriptions and cannabis to be incompatible, so withholding information is necessary to receive the care one requires. Yet if forced to choose, my data suggests patients prefer medical cannabis to standard pharmaceuticals for a number of reasons.

Relief without Side Effects

The above discussion has shown that cannabis patients enjoy how their medicine is self-directed, individualized, and versatile. However, they do not want cannabis to be completely absorbed into society’s dominant model of medicine, and at the same time, they are alienated from traditional medical providers. Since state-level medical cannabis policies have allowed this alternative model of medicine to exist alongside mainstream medicine, patients want access to both styles of care. This duality is preferred because medical cannabis may offer patients something that prescription medicines, the primary tools of the modern allopath, do not. Whereas the allopathic approach attempts to mitigate problems and restore normative functioning, cannabis is seen as going a step further. The comments made by the members of Focus Group 1 touch on the strengths of the current medical cannabis system as well as the benefits of cannabis itself:

Jimmy: I would say the best thing about medical cannabis is ease of access and that I can develop a treatment plan that works best for me.

Avery: I would say the best thing about medical cannabis is that it gives people access to things that would help them function where they wouldn't have been able to otherwise.

Becca: I said generally that the best thing about medical cannabis is that it saves lives. Either literally or it gives people enough relief so they can function and have a life.

Sophia: Yeah, so they can live instead of just exist, and there’s a major difference.
Indeed, patients described cannabis as promoting quality of life, as enhancing pleasure while living with illness, and as something that restores vitality. Irene and Wanda from Focus Group 2 each have incurable chronic conditions, and they also describe cannabis as something that goes beyond restoring normal functioning:

Irene: You can call me Irene and I've been a patient for almost 30 years, so long before it was legal by any means. For me cannabis is how I'm able to thrive in day-to-day life instead of just surviving and making it through every day. I have two complicated genetic disorders that result in several dislocations on a daily basis…

Wanda: My name is Wanda and to me cannabis is freedom. I'm stuck in my body in a similar way to another participant, and it is a painful cage without cannabis. I was also in a car accident a little over two years ago and I hadn't smoked or used cannabis in any form before that. I'm a brand-new patient and I used to be vehemently against it. My mother was a drug addict so I just lumped cannabis in with all the other thing she did. I said I would never touch any of it until I did and it changed my life. I'm not pain free all the time, but I am more than before, so it's a miracle, it really is.

The relief provided by cannabis is amplified when it is compared to traditional treatment options. Many patients in the focus groups had devastating experiences stemming from pharmaceutical drugs and surgical procedures. While cannabis did not completely solve their health problems, it offered more effective relief without life-limiting side effects. Many participants liked how cannabis kept their personality intact whereas pharmaceutical medications disconnected their emotions. Deborah, from Focus Group 5, introduced herself in the following way:

Deborah: My name is Deborah and I had my license for two years, but I was using cannabis way before then. I'm sixty so I've been using it for a while for anxiety and then after I had thyroid cancer, I got muscle cramps really bad. Cannabis helped that too. Of course I tried pharmaceuticals first, for anxiety as well, but they make me not me. And so I got sick of it. And then after you become tolerant to the level that they give you, they jack it up and then you're less and less you. But on cannabis I can function, I can still be a wife and a mother and work… And to me, cannabis is a possible natural solution to a medical issue. I don't want to take pills.
Likewise, this particularly illuminating response comes from Sophia in Focus Group 1 when asked to complete the sentence, *To me, cannabis is...*

Sophia: I said, to me cannabis is minimal pain. I was diagnosed with some type of degenerative junk in my back a few years ago and I have like a curvature and some other stuff going on. I really want to be active, but I've tried pain meds and they make me sleep and feel weird to where I just can't function. So, I'm living like a functional life, where I'm able to go places and do things and enjoy my family, rather than sleeping and feeling weird all the time. And I feel like it's a gift from Mother Earth, so I am grateful for it. I feel like it is here for us and we should appreciate it and it should be shared. Like, I can live with this and the side effects are not going to kill me unlike a lot of other meds. And I was on a lot of meds. I was on a high blood pressure medicine, I was on one for acid reflux, and I was on antidepressants for a while. But I got to the point where I didn't even cry anymore, and I was like this isn't me or how I want to be. So for the past five to seven years I've been smoking strictly and enjoying life.

In fact, some patients stated that cannabis replaced multiple prescriptions, especially those for psychiatric conditions, rather than just those for pain management. Indeed, others have noted cannabis patients may use medical cannabis as an alternative to prescription drugs, as a way to taper off prescription drugs, or as a compliment to prescription drugs (Bruce et al. 2018). Like previous research, patients in my focus groups had horror stories about their experiences with pharmaceuticals (Newhart & Dolphion 2019; Satterlund et al. 2015; Bottorff et al. 2011; Chapkis & Webb 2008). Bailey’s story is particularly powerful in that cannabis saved her from a toxic cycle of prescriptions which may have amplified her suicide ideation:

Bailey: My name is Bailey and my pronouns are they and them. And I said cannabis is a civilization creator. Because without hemp I do not think we would be where we are, but that's another topic. For me, personally, it is a lifesaver and what I talk about might be triggering so I don't know if it's okay… *Group assures them it's okay*... Well, I've been a patient for six years and my qualifying condition is pain associated with PMDD. But before that I had mental health issues and I was suicidal since I was a preteen. So I said cannabis is a lifesaver because I truly believe that I would have succeeded in an attempt if I didn't have it because I would have overdosed on pills. And that's what the doctor wants to give you, so I found a non-lethal thing that helps.

Both Sophia and Bailey from Focus Group 1 had been diagnosed with premenstrual dysphoric disorder (PMDD), a condition that causes severe depression, anxiety, or irritability
leading up to menstruation. Each of them also found more relief with cannabis than any prescription they have tried, perhaps because cannabis does not dull their sense of self or creative capacities:

Sophia: I always ask my doctors if they rely on what they learned in school or if they continue to learn. I remember seeing this one doctor and I think she was like ready to get rid of me, and even after medical marijuana passed, I told her I felt like I was self-medicating with cannabis. It was for PMDD and I was flipping out on my poor kids. She was like, well, you're a phenomenal woman so we're going to prescribe this for you and you won't even need marijuana anymore... [Bailey, who also has PMDD, laughs]... Yeah, so I at least tried it but I realize that the medicine was not for me. I had gone to funerals and I didn't cry, and that was not me. I didn't like it.

Bailey: So it shut off your emotions too much?

Sophia: Basically, yeah. Oh my goodness, it was so weird. I felt like I wasn't going to get me back. My creativity was gone and it was not worth it to me.

Avery: Before I smoked marijuana that was one of my biggest fears. I had depression and anxiety since as long as I can remember, and in 4th grade I can remember harming myself because I didn't know how to cope. But I never wanted to get medication because I had heard it shuts off your feelings. I am also a very creative person and since pills can shut off your creativity, and I didn't want to do that. So marijuana helps me where other meds cannot.

Other patients like Wade from Focus Group 3 commented on how cannabis relieved their pain without numbing their physical sensation. This enabled them to perform normal tasks while avoiding further injury caused by overexertion. But for the vast majority of the patients in the focus groups, the best thing about medical cannabis was an escape from pills with undesirable side effects. The following is from Focus Group 5:

Austin: The best thing about medical cannabis is that it is available.

Deborah: The best thing for me is no more pills.

Doug: That's basically what I said. I can take one medication instead of a million pills.

Deborah: A million pills with a million different side effects.

Damien: I said basically the same thing. It seems like it solves a lot more medical problems and doesn't cause as many medical problems.
Deborah: I'm looking forward to hearing the disclaimer on pot when they come up with that, because you know they will. It'll be interesting to see what exactly they deem as a downside.

Is being “high” a side effect? Only two of my participants expressed that the psychological intoxication was occasionally undesirable. However, those participants also noted there are other cannabis products available that provide pain relief without the high such as CBD and THC-A. Most focus group participants appreciated how cannabis shifted their perception with Greg from Focus Group 2 calling the high “an added benefit”. The two men in Focus Group 3 agree:

Moderator: What is the best thing about medical cannabis?
Wade: I would say the best thing is the relief and, like, the calming effect...
Gavin: No side effects.
Wade: Yeah, I haven't seen one side effect personally.
Gavin: And allegedly, there have been no deaths from it. But you can get killed from an aspirin...
Moderator: What would you say to the people who would say that getting high is a side effect?
Gavin: Well, is getting high a side effect or a benefit? That's a personal perspective [Wade agrees]. But I would say that it is that core issue in you that that determines it. Like, why are you drinking a beer after work? If you work heavy construction, you come home and you drink a beer... and I'm not talking about get drunk... But you have a beer or two and kick back. Is that a side effect? Or is that just enjoying life?

The high provided by cannabis may also lead to an added benefit not commonly associated with prescription medications. Patients in the focus groups talked about cannabis’ pro-social properties, whether it be through reducing social anxiety or forging common bonds. It’s availability as a recreational substance now facilitates the latter, potentially providing patients with life-affirming social ties. Friendships were included with the “best parts” of medical cannabis in Focus Group 1:
Bailey: I think marijuana brings people together, all different types of people. And that's my favorite part right there because I love different people.

Avery: It’s one of the best ways to meet people.

Sophia: Heck yeah! It's fun because you never know someone’s story and they're usually pretty cool. I just feel a connection for some reason. When I know someone else smokes, I'm like, _dude we are there._

Avery: The barriers come down a little bit. And I know this is a different topic than what we're on but with my anxiety and PTSD, in certain situations cannabis helps me calm down too. So smoking is like the best way to get to know someone because I'm not super anxious.

Sophia: Exactly.

Avery: And we can both kind of relax and chill.

To my knowledge, there are no support groups for medical cannabis patients in southwest Michigan. There are no patient associations and outside of brief visits to dispensaries where medicating on site is prohibited, no places to socialize and share experiences. Legalizing cannabis for adult use may expand the social network of cannabis patients and the locations at which patients feel at home. However, legalization is not without its drawbacks as cannabis patients fear their medicine will become scarcer as the market adjusts to recreational consumers. Yet this concern is minuscule when compared to another threat identified in all of the focus groups—Big Pharma.

**Big Pharma**

Pharmaceutical companies have been tepidly researching cannabis medicines since the late 1970s and so far, none of the resulting drugs have been more effective than whole plant cannabis medicines. Nonetheless, some politicians, medical authorities, and pharmaceutical companies have positioned themselves in opposition to state medical cannabis programs because several cannabis-like pharmaceutical options exist for those living with chronic illness or...
managing terminal diseases like cancer or AIDS. Indeed, part of the reason the federal
government ceased using natural cannabis for the (now defunct) Investigational New Drug
Program program was that *Marinol* had become available on the prescription market (see
Appendix A). Not only are *Marinol* and other pharmaceutical cannabinoid drugs less effective
than natural cannabis, they are inaccessible for individuals without health insurance, significant
finances, or the ability to navigate the health care bureaucracy.

The overwhelming majority of patients in my focus groups and key informant interviews
were pessimistic about pharmaceutical companies becoming further involved with cannabis
medicines. In fact, the only positive comments about pharmaceutical developments were in terms
of research and increased understanding of cannabinoids. The ability of pharmaceutical
companies to conduct extensive studies came up in Focus Group 4:

Moderator: Since we think pharmaceutical companies are going to get involved, is that
going to be positive or negative?

Audrey: Negative.

Alexander: I think positive.

Audrey: I think it will just make it more corporate and prices go up higher, even though
it's medical, you know? And like insulin, they can set their own price, so...

Moderator: Good comparison. Alexander, how's it going to be positive?

Alexander: These companies have the money to put in for research where a caregiver,
such as myself, does not. These people have billions of dollars at their disposal. Why
wouldn't they research better quality, better potency? I mean, just over the last 10 years
we've come to a fuller understanding of marijuana.

Audrey: There's already people studying it though. Like people over in California, they
got lots of people studying it and have done lots of studies.

Alexander: Definitely. And that became possible after legalizing it. They can't begin to
study something that's illegal.

Several patients in my focus groups expressed their desire for retail pharmacies like
Walgreens to sell cannabis medicines, but they did so out of hope the medicines would be
available over the counter (without a prescription). Only one participant noted that they desired prescription cannabis medicines, but this was because they assumed medical insurance would cover the cost. Yet every one was in agreement that “Big Pharma” would negatively impact medical cannabis, and their fears centered around restricted access in the name of profit while degrading the plant. Focus Group 1 raised the specter of pharmaceutical corruption before I had chance to ask about it:

   Bailey: Something I'm worried about is Big Pharma.

   [everyone immediately agrees]

   Jimmy: Yes, I was just about to say that too.

   Sophia: Yeah me too because it's going to happen.

   Moderator: What do you mean by Big Pharma?

   Bailey: Like how it will be their brand, pre-rolled with additives in it maybe. And sure, there could be like a Marlboro brand for recreational, but I'm just worried about them taking over the industry so individual growers can't really participate in the medical aspect, and then just changing things around.

   Avery: Big Pharma will make it just another medication instead of this helpful herb that we use.

   Jimmy: What I'm assuming will happen is that there will be different strains that will be patented. Like what we see with Monsanto with the different kinds of seeds.

   Sophia: And they jacked those seeds up too, didn't they? I mean it started off sounding good but now it's like killing the bees and all kinds of bad stuff is happening.

   Since patients knew their use of cannabis allowed them to transition off or reduce pharmaceutical medicines, they feared Big Pharma would attempt to reduce access to cannabis or try to claim cannabis for themselves. Focus Group 5 was aware that the pharmaceutical companies responsible for the opioid crises have histories of opposing medical and recreational legalization:

   Damien: With the big controversy about opioids, Big Pharma has got to make up that money someplace, right? They have to, and what's the logical way for them to do it?
Cannabis. You're already seeing studies where cannabis is taking the place of opioids for a lot of people.

Deborah: Yeah, it's a natural alternative.

Damien: Right, so what's big pharma thinking? You know, they're putting a big bust on us for doing opioids. We really need to claim this new industry for ourselves, like really fast and make it big.

Austin: Right, before they can get a chance to privatize it.

The discussions above show that while cannabis patients recognize the benefits from pharmaceutical innovation, they are concerned over big businesses restricting access to natural cannabis medicines. Key informants had similar concerns but two of them, each of whom worked on drafting Michigan’s adult-use legislation, believed the right to grow was well established in Michigan. Nonetheless, state regulators recently changed the rules so caregivers could no longer sell directly to licensed medical or adult-use dispensaries. Caregiver-grown medicine had sustained Michigan’s medical cannabis system for over a decade with little complaint on behalf of patients. The recent changes to the caregiver rules overwhelmingly benefit corporations who invest significant sums in up-scale retail dispensaries and grow sites capable of mass production. While everyone in Michigan has the right to grow 12 plants, it may only be a matter of time until big businesses like pharmaceutical companies seek to curtail this home-grown competition. If this happens, the diversity of cannabis strains and products may be lost to the flattening effect of mass production. This would hamper the connoisseurship (see Chapter 3) that has enabled patients to experiment with the wide array of cannabis medicines.

Conclusion

Will medical cannabis systems survive in the post-prohibition world? Patients in my focus groups believe they will and even desire a distinct medical cannabis system to be maintained. They also acknowledge the power of corporate-sponsored research into the efficacy
of cannabis medicines, and while they hope mainstream medicines become more accommodating of medical cannabis, patient sentiments appear to be against the total institutionalization of cannabis within biomedicine. This fact has implications for how we theorize the medicalization of cannabis. The most recent research into this area calls cannabis “incompletely medicalized”, presuming that it is headed into the realm of biomedicine where medical authorities will become the gatekeepers of cannabis medicines (Newhart & Dolphin 2019). Though the medical profession is slowly warming up to the idea of treating cannabis as a medicine, the patients who actually rely on the plant do not wish to see it totally medicalized.

Instead of “incompletely medicalized”, it may be more fruitful to consider cannabis as “alternatively medicalized”. Overall, cannabis patients favor the current system of cannabis being medicalized by the state (and society) where their status as a patient is legitimated outside of medical institutions. This allows them to claim a patient label without placing themselves under intrusive medical control, a status made more appealing by the current authoritative nature of mainstream medicine. Nonetheless, patients in my study wanted their regular health care providers to respect their use of medical cannabis, perhaps envisioning a system where mainstream medicine and cannabis medicine cooperatively coexist to best address patient needs. After all, medical cannabis has been theorized to be part of complementary and alternative medicine or CAM (Newhart & Dolphin 2019; Subritzky 2018; Chapkis & Webb 2008) where it is used to enhance wellbeing in the context of chronic illness. Chronic illness differs from disease in that it refers to the subjective experience of the suffering individual rather than an objective, visible entity (Mizrachi et al. 2005). Likewise, wellbeing transcends physiological health and is often used as “an implicit critique of the ways in which biomedical knowledge has traditionally constructed the passive patient” (Sointu 2006:346). While health is conceptualized
as the absence of disease, wellbeing describes feeling good, satisfaction with life, and positive functioning. Indeed, those who pursue CAM are often active, empowered, and knowledgeable agents in their quest for a subjective sense of wellbeing (Brenton & Elliott 2014; Penn 2014; Sointu 2006).

One problem with the alternative medicalization of cannabis will be its acceptance within the biomedical community. Historically, biomedicine earned its prestige and dominance by actively suppressing folk medicines, natural remedies, and traditional health care services typically offered by women (midwifery, for example) (Ehrenreich & English 1978/2005). While biomedicine created a firm boundary between their scientific approach to medicine and every other approach to healing, the coexistence of biomedicine with CAM has been documented before.

Mizrachi and colleagues (2005) conceptualize three stages of how biomedicine operates alongside alternative medicines. Medical cannabis is perhaps best placed in the cautious approval stage where it is perceived as valuable for its placebo effect since the “hard-core logic of bioscience” (26) has yet to extract the precise mechanism the treatment has on the body. While this is better than the negation stage where alternative medicine is excluded from biomedical discourse, medical cannabis has yet to reach the reconciliation stage where it is integrated into biomedicine. Yet even if this were to happen, reconciled alternative medicines are restricted to the area of illness rather than disease (Mizrachi et al. 2005). As such, reconciling medical cannabis with our dominant biomedical system may be beneficial to those suffering from chronic illness. Cannabis patients would be able to access biomedical services when needed while continuing their use of a natural remedy which helps them cope with persistent pain and discomfort.
Complementary and alternative medicines generally emphasize holism and empowerment, and people often turn to CAM “because they distrust biomedicine or are unhappy with their lack of control in traditional medical settings” (Brenton & Elliott 2014:91). Cannabis has allowed them to claim some self-control over their conditions and treatment plans, and the relative freedom from healthcare supervision allows them to use their medicine without judgment or bureaucratic consequences like those found in pain contracts. Though some medical researchers have called for greater physician oversight of medical cannabis (Choo et al. 2016; Zolotov et al. 2016; Nussbaum, Boyer & Kondrad 2011), cannabis patients see such supervision as undesirable and unnecessary. We must also keep in mind that there is a difference between supervision and guidance. Victorson and colleagues (2019) discovered cannabis patients desire more professional information regarding product options and effective medication regiments, but like patients in my focus groups, they did not state they wanted medical cannabis available by prescription. Perhaps Michigan should consider following other states which mandate a health care professional be available for consultations in medical cannabis dispensaries.

This study also adds to Conrad’s (2005) argument that the engines of medicalization are shifting to interests outside of the medical profession, namely expert patients (see also Conrad & Barker 2010 and Conrad & Leiter 2004). However, these expert patients are not the product of pharmaceutical advertising or other corporate interests. Instead, they are the product of a system that had shunned them and their choice of medicine for the past several decades. When we theorize cannabis as incompletely medicalized, we neglect the fact the many patients appear to disdain the complete medicalization of cannabis. Since cannabis was medicalized by patients rather than medical authorities, it might be wise to place patient interests first and foremost in how we conceptualize this topic. If we do that, the word “incomplete” carries a grave
consequence when considering medicalization. Instead of a linear continuum where cannabis is moving towards total medicalization, patients desire an alternative medicalization of the plant. They appreciate the current way the plant is medicalized, and while the current state-sponsored system of medical cannabis is far from perfect, it appears more desirable than the familiar system of routine doctors’ appointments and medicine by prescription.

Others have noted the benefits of switching non-toxic and non-addictive medicines from prescription (RX) to over-the-counter (OTC). Chang et al. (2016) say such RX-to-OTC switches save a consumer time, money, and the discomfort of having to discuss their personal lives with relative strangers. While not without the potential of misuse, when smoking-cessation aids like nicotine gum and patches became available OTC, their use among smokers more than doubled within a year (Shiffman & Sweeney 2008). Perhaps a similar phenomenon may occur if medical cannabis becomes more widely available. As has been noted throughout this study, many medical cannabis patients eventually reduce the number of prescription drugs they consume, most notably opioid pain killers. The Consumer Healthcare Products Association (n.d.) claims OTC nicotine cessation products have a $2 billion public health benefit each year. Meanwhile, the health care costs of the opioid crisis alone were estimated at $60.4 billion in 2018 with a total cost to the economy of $179.4 billion (Davenport, Weaver & Caverly 2019). If medical cannabis helps just a fraction of prescription opioid users to reduce, cease, or abstain from those highly addictive medications, the economic savings would be enough to justify increased access to medical cannabis. Yet while economics may prove to be a powerful argument for medical cannabis, we should avoid placing this imperative above patient needs and their desire to “thrive,” in the words of one of my participants, while living with chronic illness.
CHAPTER VIII

GENDER IN THE MEDICAL CANNABIS COMMUNITY

This final chapter of my analysis will describe some of the ways gender manifests in the medical cannabis community. As little research has been done in this area, my investigation of the issue is broad and should serve as a useful starting point for future inquiries. The research questions that guided my questioning of participants and analysis are: How does gender shape the experiences of medical cannabis patients? And, how might hegemonic gender roles be adhered to or challenged by cannabis patients? I begin by discussing some of the difficulties with asking about gender while illuminating how parental status typically brought about a nuanced conversation on the topic. I then detail how gender dynamics, primarily the gender division of labor, manifests among cannabis entrepreneurs and business practices. Following this, I describe how gender roles operate within the cannabis community. The next section concerns how cannabis stigmas and stereotypes are mediated by gender, an interesting area where both women and men report gender-specific devaluations over their use of cannabis medicine. Finally, I reveal how cannabis may facilitate or attract non-hegemonic enactments of masculinity.

Probing about Gender

The first task I gave focus group participants was to complete the following sentence: “To me, cannabis is…” . The responses between men and women were more similar than different, but men’s responses were more diverse. Women tended to describe cannabis in exclusively medical frames such as “minimal pain,” “relief,” and a natural alternative to synthetic medicines.
Men used these descriptors as well, but they also described cannabis as “an old friend”, “a way of life”, and as a plant created by God. Unlike findings by Bottorff et al. (2011), two men and one non-binary participant in my focus groups called cannabis a “lifesaver” whereas no women used such a term. Interestingly, the three non-binary participants in my focus groups also described cannabis in terms not used by men or women, as “freedom,” “a civilization creator,” and “a potentially useful substance.” Finally, as my previous chapter demonstrates, participants often framed medical cannabis as enabling self-reliance or restoring personal control over their medical regiments. This was a theme common among participants of all gender identities in my study whereas prior research found men were more likely to frame cannabis in such a way (Bottorff et al. 2011).

Differences between what is expressed by participants in a study may be useful to analyze gender, but asking them directly about the topic was my preferred approach. Nevertheless, probing about gender in the focus groups was more difficult than I anticipated. Like the youth focus groups conducted by Haines and colleagues (2009) and Warner and colleagues (1999), the adult participants in my focus groups appeared hesitant to discuss gender in relation to cannabis. I suspect this is because gender is something many people take for granted, and cisgender privilege may function to make gender appear natural. After all, a hallmark of social privilege is relative freedom from thought on the privileged category, so gender may not be something my participants thought about often. When I asked about gender, many participants interpreted my questions in biological terms as seen in this exchange from Focus Group 2:

Moderator: Is there a difference between men and women who use cannabis?
Andrew: There are suppositories that women can use that men can’t.
Wanda: You can use them too. Just not in the same hole.
Andrew: That's what I mean. As a man who does not have a vagina, I cannot use a cannabis suppository that way.

Wanda: You can use it anally and it works similarly.

Andrew: Right and I have used them.

Sean: I didn't know they have suppositories. No kidding...

Andrew: Yep they do. But for me that's the only difference.

I often had to use numerous probes to get focus group participants and key informants to think about gender differences. Restating the question in various ways sometimes helped spark a discussion on gender, but after some time mulling over their thoughts, most participants began to mention subtle differences until something significant got the conversation going. As seen in a continuation of the discussion from Focus Group 2, this was sometimes parental status:

Wanda: I just don't know if this can be put in terms of gender…

Andrew: Yeah I'm having a tough time with the gender questions.

Irene: Yeah it's hard.

Moderator: That's okay, it's fine...

Wanda: I just don't see it being a gender issue.

Andrew: Unless it has to do with having a child. Under those circumstances, I think, 100%, women get screwed more.

Wanda: Oh yeah, you shouldn't smoke around your kids and things like that.

Irene: That's actually why I got my card.

Moderator: Is that different for fathers though?

Wanda: Yeah, they can smoke wherever they want.

[group in agreement]

Andrew: Right. If the kids not with you, it's like, let's step out in the garage and smoke since the kid is with the wife. As long as he is not supposed to have the kid in his possession, then technically he is allowed to smoke. Not that I agree with that, but…
Wanda: Since the women are supposed to take care of the children, you're not allowed to be inebriated. But the dads can do whatever they want.

Irene: My old mother-in-law said that her daughter was never coming over my house again because I was a drug addict...

Wanda: Yeah, like it's unsafe [sarcasm], and you hear that from families…

Participants were more aware of gender when thinking about parents who use medical cannabis, and they primarily constructed mothers as the primary caretakers of children. Irene’s comment above illustrates this as mothers who used medical cannabis may be seen as neglecting to care for children in the home. This concern has also been documented elsewhere (Newhart & Dolphin 2019; Dahl & Sveinung 2015; Haines-Saah et al. 2014; Reinarman et al. 2011), but unique here is the relative tolerance given to fathers who medicate in the garage. This specific space for men to escape the judgment of poor parenting was mentioned in three of the focus groups. After all, the garage is constructed as a masculine space and one typically free from meddling children. Perhaps this should cause us to question why women are not afforded a similar private retreat in the traditional American home.

Despite patients being aware that mothers may face harsh judgment for using cannabis, three women in my focus groups expressed they thought cannabis made them a better mother. Irene from Focus Group 2 and Sophia from Focus Group 1 claimed their use of medical cannabis allowed them to exercise more patience when it came to raising children. Similarly, Deborah from Focus Group 5 described abstaining from alcohol when she began self-medicating with cannabis decades ago, an important feat given that alcoholism runs in her family. Nonetheless, the fear of being seen as a negligent mother was a concern for many of the women in my focus groups, and these gender-based stigmas are explored more later in this chapter. Before I detail how gender mediates stigma, it is worthy to examine how the changing legal status of cannabis
has impacted gender representations in cannabis culture. The best place to begin is by analysis of gender in the cannabis industry.

Organizing Gender in the Cannabis Industry

For the most part, when participants in my study described gender in relation to medical cannabis, they tended to do so in traditional ways. There are many exceptions that are discussed later in this chapter, but the hegemony of gender roles has certainly seeped into the medical cannabis community. These traditional gender roles manifest in a variety of ways and sometimes mirror the gender dynamics found in other areas of our society. Doug and Briana from Focus Group 5, for example, described a traditional division of labor when it comes to growers and processors:

Doug: I find more women doing more of the baking, the edibles, and things like that...

Briana: The cannabis butters...

Doug: Yeah I was gonna say the creams and stuff like that, women do those more. And I think it has to do with... um... how things are looked at in life.

Briana: Gender roles in society, yeah.

Doug: Typically, women are made more or the kitchen and you know, certain things, and men are made for certain things. And that's how I think it does follow through with a lot of things. I've noticed with my caregivers, even though I talk to a female, she does all the edibles and the oils and all that stuff while he strictly does the growing.

Briana: Yeah. I think some of it too is that I think guys might just be more interested in that kind of work, like the farming aspect of it.

A similar division of labor was found by Alisha Adelman (2013) in her master’s thesis on gender dynamics among marijuana cultivators in California’s Golden Triangle. Men primarily took responsibility for the growing the family’s crops while women prepared the marijuana market. Likewise, Cadigan (2018) found employees working in cannabis dispensaries are often
arranged in ways where men are positioned as experts while women are placed in supporting roles. Focus Group 1 also thought employees in dispensaries are often arranged in gendered ways where men drive the hard business while women provide support:

Avery: [The dispensary] is still like a bro’s club.

Jimmy: Agreed. Whenever I walk into a dispensary, I feel like there is this bro mentality.

Sophia: In the front and the back?

Moderator: What do you mean by bro mentality?

Avery: They have like the women in the front and the bros in the back.

Jimmy: Yeah, there's usually a woman there as the front desk receptionist and she checks you in and stuff… And it's hard because I'm a queer man and I always feel uncomfortable talking to straight men and it's hard to explain. But I'm uncomfortable about it because there might be some sort of homophobia thing going on or something, but it's also because I can see straight through this mask they put on…

Sophia: Ya…

Jimmy: Am I right? [group expresses their agreement] … there's like these tough straight hetero cis-gendered men who are like, [in deep voice] yeah let me go get this, blah blah blah. And I’m like, yeah, man, whatever…

Bailey: It's like they're always after the sale and they don't want to connect with you if that makes sense

Jimmy: Yeah, and then with the women helping people at the dispensary, I feel like… I don't know, like they either try to fit in with the boys, with the mentality that the men are carrying on, or it defaults back to that front desk, how may I help you…

The gendered organization of cannabis businesses was also mentioned by several of my key informants. Hegemonic masculinity is partly characterized by risk tolerance, and when it comes to establishing a dispensary, there are a lot of risks. Yet as the industry becomes more established, some of the risks, especially the legal risks, disappear. This was the thinking of one of my key informants who established her dispensary shortly after the MMFLA passed in 2016. This regulatory passage provided cannabis businesses with licenses and legitimacy in the eyes of the state:
Kayla: A lot of times the female perspective is a little bit more calculated and thought through, which ends up taking more time. So I think in the cannabis industry we are going to see a decent female representation, and there already is in a lot of aspects, but it will continue to develop as time goes on. I think that women are probably going to take more of a strategic approach, to wait and see if this makes sense… a more sensible approach than I took [laughs].

While Kayla still sees much risk in operating a licensed dispensary, her statement is significant when contrasted to how a male dispensary owner describes his decision making.

Justin and his friends lost their insurance business in the wake of the 2008 financial crisis, around the same time Michigan voters approved medical cannabis in the state. There was no licensing system available at the time, so businesses operated in a gray area and were often tacitly allowed to operate by local authorities:

Justin: So we're sitting in a situation, we're looking for something to do, we have a building and this law passes in the city with over 80% of the vote. So we look at it, and we say fuck, well in California they started doing it. I do a little bit of legal research and I see [the medical cannabis law is only an] affirmative defense28 in Michigan. And that's all they did it off of. But the California law not only had affirmative defense but also a licensing component to it. So we're like, fuck, we can do this, let's do it! We didn't bother consulting any lawyers or anything like that, or if we did it was by specific questions, and we got going. If we hadn't done that, other people would have done it in their own way. But I think it was good how we did it. We worked transparently with the local government and we got going.”

Justin’s account of his business venture appears to be anything but “calculated and thought through”. He continued to describe how he eventually learned the ins and outs of running an unlicensed dispensary through responding to challenges rather than planning for challenges. Fortunately, his business was successful and was eventually able to secure a license when that option became available after 2016. His experience may be the exception as many unlicensed dispensaries in pre-MMFLA Michigan failed due to raids, political issues, and/or not

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28 “Affirmative Defense” was a common way to make medical uses of cannabis legal for patients registered in a state medical cannabis program. These policies did not amend state laws on marijuana use and they did not make it legal to sell medical cannabis. They simply provided patients a legally valid defense for use in court should the patient be arrested and charged with a marijuana-related offense.
being able to secure a license after one was needed. As such, this masculine embracement of risks associated with running a dispensary may have helped Justin and others start their dispensary at a time where both success and legality were far from certain.

This is not to say the initial masculinization of medical cannabis retail dispensaries was entirely positive. Some of the drawbacks to the “fuck, we can do this, let’s do it” approach include becoming entangled with an unregulated supply chain, exposing oneself and one’s associates to legal risk, and the omnipresent possibility that the dispensary could be shut down at any time. This might result in patients not being able to access medicine until they find a new source, a relative rarity in southwest Michigan for the first decade of the state’s medical cannabis program.

The above reasons and more are why Kayla, the dispensary owner previously quoted, speculated that the quasi-legal status of the industry affects gender dynamics. However, she is optimistic about the future and believes the growing focus on quality business practices will weed out some of the problematic aspects associated with masculinized competition. For example, she thinks the future will be more patient-centered instead of product-centered:

Kayla: There is this huge gender disparity between what was happening in what we call the gray market and what is happening now in the legal market. I think that over time we will see a phase-out of a lot of the grey market mentality. But I think the grey market piece was very male-dominated, very macho, and kind of... harsh? I would say harsh, at least more so than what we will see in the legal market. I don't think we will see a lot of people post about how they are great growers and how they grow the best product so much as we will see people talk about how they are good business people. And this is a business. It is a business where I can help people, or maybe they are waiting for the rec market, but it is a business where I can make good financial decisions where previously in the grey market it was a little bit more about “let me show you how good I am”... “let me show you how good of a product I can grow, how good of an extract I can make”. I think it is more of a “let me show you how good I am” type of thing, not so much of a business perspective. Hence the cannabis cups and how much they want to show you all of the awards they won, and how they have the best strain. Well, in business, yeah, that can play a part, but it is not the focus.
The illegal nature of the industry has undoubtedly facilitated a gender gap in business owners. Nonetheless, while women are gaining a strong foothold in this new multi-billion dollar sector, we need to wary of at least two things.

The first is that as big money interests come into the picture, they may facilitate a masculinized corporate culture endemic throughout society. This was a fear expressed by the women “canna-preneurs” interviewed by Borchardt (2017), and unfortunately, this already appears to be happening. In 2015, Marijuana Business Daily found 36% of industry leadership roles were held by women, perhaps because the burgeoning legitimate sector had no glass ceiling to break29. By 2017, that figure had reduced to 27%, possibly indicating a glass ceiling is being established as male-dominated investment firms enter the scene. Amy Margolis runs a business accelerator program for female cannabis entrepreneurs, and she is quoted as saying: “I don’t think there’s any doubt that as traditional capital starts to come into this space, starts to overwhelm the space, we are seeing women either pushed out or unable to get funding… Men seem to control funding overall, and they would prefer to fund men” (Harris 2019, paragraph 3).

This need for significant sums of investment capital is partly a product of onerous state regulations. In Michigan, for example, applicants for a cannabis business license must have capitalization of at least $150,000 for a small grow operation (100 plants), $500,000 for a large grow operation (2000 plants), and $300,000 for a provisioning center or a processor license. This disadvantages women and minorities who are more likely than (white) men to lack the required bankroll or borrowing ability.

The once-illegal nature of the cannabis industry may have worked to privilege men who developed businesses, as their embracement of risk might have resulted in financial rewards as

29 Compared to 22% to 25% across every other industry (see Olson 2015, paragraph 9)
well as a head start in the licensed industry. Steep capitalization requirements also privilege this group, and now that the state has a social equity program that can reduce those requirements by half (or more) for certain populations, this leveling of the playing field may provoke hostility in those who do not want more fair competition.

Gender Roles in Cannabis Culture

The above section and more hint that the hegemonic gender structure has found its way into the new world of legal cannabis. Perhaps it is too early to tell if legalization will help or hinder gender equity in the new industry, but what about the larger cannabis community? The certifying physician I interviewed thought much of the masculinization of the community was a result of prohibition. These comments came up in the context of strain names which impart masculine associations like “AK47” and “Alaska Thunder Fuck”:

Dr. Steven: There is that “hey dude” flavor in the community that kind of carried over from when it was illegal. The naming also kind of carried over from when it was illegal, and they used to name heroin batches too. I think it's kind of progressed. It's kind of cute, like a name like green crack. I do hate that name. But people don't seem to get too hung up on that.

Overall, patients in my focus groups did not seem to get hung up on masculinized or feminized products. Most patients appear to be able to see through marketing tactics, both in terms of gender and beyond. They knew which products they preferred regardless of branding or target audience, likely because the effects are more important than the image the product conveyed, a finding also noted by Bottorff and colleagues (2013) in their comparison of tobacco and marijuana smokers. Some men talked about buying topical creams, some women discussed their preference for blunts, but most commonly, my participants mentioned using products not widely associated with a gender category. One group had an interesting observation regarding CBD products that are now widely available throughout the country:
Greg: When it comes to the marketing and the packaging of the CBD products, that's not aimed towards me…

Moderator: What do you mean?

Wanda: [laughs] Ya, this is girl bait [raises her colorful, slim can of CBD infused soda]. Greg: Exactly. That’s right.

Wanda: It's cute, it's in simple packaging…

Greg: Yep, and you were in marketing.

Darlene: It doesn't scream CBD...

Greg: It's subtle.

Irene: It's subtler and marketed towards women for sure.

Greg: Design, artwork, colors… all those things determine marketability.

[Darlene takes out a Mary’s edible product in a white packaging]

Darlene: Would you buy that?

[G signals Yes]

Andrew: Well, that's not marketed towards either women or men.

Darlene: No, but it's called Mary's.

Andrew: But that's because the company is called Mary's Medicinals. But it's still a very gender-neutral packaging. They are historically a company that has been doing well because they rely on the quality of their product.

[Group agrees]

While “gender-appropriate” products seemed of little importance, an area where hegemonic gender roles were visible concerned the growing of cannabis, something largely constructed to be a masculine endeavor. Not only does growing carry the risks of financial loss and hostile neighbors, but it also involves hard work and science skills, each of which are culturally coded as masculine. The following is from Focus Group 5:

Moderator: Why do we think it's gendered with the growing?

[Several say I don't know]

Briana: I know for me, personally, I am not a science person...
Jackie: It's hard work, I know that...

Briana: ...Like, I don't know if I would be able to because it's sciencey. I mean, I can grow a flower, but it dies a couple times and it needs water.

Jackie: ...There's a lot of physical labor involved too.

Briana: That too. And there are steps to the process. At one point I had a caregiver, though I don't anymore, but I saw his grow set up and I mean, it's time-consuming. It is basically a full-time job for yourself on top of... I mean, it really does increase your electricity and your water bills. And the smell is really strong. So, you know, it just depends on how you live, and if you have the opportunity to grow that.

Deborah: That's what made us stop growing because it didn't make any sense to spend more. The electricity was just ridiculous and then you to get the smell thing. We had a tenant in our basement, you know. Everything was closed up tight, but still...

Briana: And then all the materials that it takes. It can be costly.

Deborah: And that's what we found. It just wasn't worth it when it's available elsewhere.

Austin: You can do it outdoors and you can get a good crop without getting stuck with a high priced bill. But most people don't think that's what they're paying for. I mean, you're paying a lot more than you think. You're losing time, you're losing money...

Deborah: Yeah. And you have to worry about what happens when the electricity goes out...

Austin: ...Right. And the other worry is that if somebody smells it outside of your house, what's gonna happen? Especially having a family...

I also interviewed two caregivers, and each said that they have seen more men than women becoming involved with growing. There are no statistics available on gender in this area, but my observations support the existence of this gender gap. For example, the many grow shops around Michigan are typically staffed by men, and the grower-focused Facebook groups have a majority male membership. Yet while men may be over-represented among cannabis growers in Michigan, it does not necessarily mean they are better at cultivation. Michael has

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30 “Grow shops” are hydroponic supply shops. They sell everything one needs to grow cannabis indoors except the seeds or plants. This includes lights, nutrients, soil mixes, grow tents, and much more. While the grow shops are set up for general plant growing supplies, it’s obvious they structure their business around growing cannabis.
been involved in growing since the MMMP launched in 2008, and he has held multiple roles as a grow shop employee, caregiver, commercial grower, and business owner:

Michael: Women are better growers than men. I might be better at carrying water and doing manual shit, but women are way better at growing cannabis than men. There’s not many of them, and they’re like fucking unicorns when you see one. If a woman walked into a grow shop, people’s heads would explode, and I bet she would get proposed to on the spot… It’s a white male dominated industry, but what I have found is that women do not have egos, and they seem to be a little more in tune, caring, patient, detail-oriented… everything stereotypically associated with femininity. But the biggest thing is that they don’t have the egos that men do. Women will listen to your suggestions on growing. They may disagree, and they may have an argument or a debate, but that’s good and shows sound reasoning. Men, on the other hand, will go, “You don’t know what you’re talking about, bro”.

There may also be good news here as I estimated the gender ratio of all attendees around 60/40 at a recent Harvest Cup in southwest Michigan. There were also no “hot girls” representing products at this post-prohibition cannabis event (Lidz 2015), and I hope this is from changes in culture rather than differences in venue. Three years ago when I attended a larger cannabis cup competition hosted by a major magazine, scantily-clad women were abound to hand out information and samples from all sorts of cannabis businesses. This was also noted by Duke in Focus Group 5 who has worked as a grower for the last five years:

Moderator: Do we think cannabis culture does a better job of appealing to one gender or the other?

Duke: I've seen more men in the growing industry though it's been growing for women. But like, for the longest time, women were only allowed in High Times if they had bikinis on. But I think they're stopping that...

Briana: I would agree with you on that. If you're talking about the grow aspect, it is probably more gendered towards men. But I think users in general, I think it's pretty even.

Dissatisfaction with the subordination and objectification of women was brought up in several focus groups. For example, Focus Group 1 had already talked about unequal gender roles
in dispensaries where women are largely confined to the front desk. They were also concerned about the sexualization of women:

Bailey: On the subject of women stereotypes, I don't know if I can think of any right now, but what comes to mind is in the cannabis industry there is the problem of the sexualization of women…

[everyone empathetically agrees]

Jimmy: O my god, yes…

Sophia: I've noticed. What are they doing now, like beer commercial type stuff?

Bailey: Oh yeah pretty much, girls in the bikinis and stuff…

Focus Group 2 also expressed their dissatisfaction with the sexual objectification of women working in the industry. I had noticed one participant in this group wanted to express something about gender before the conversation shifted to families and stigma:

Moderator: Andrew, you were going to say something a minute ago…

Andrew: Just that I still think there is this exploitation of women’s sexuality in the cannabis business, and I don't see the same for men.

Wanda: Oh I have noticed that! The women in dispensaries wear very low-cut shirts...

Andrew: Well, even in advertising... And I would be the first one to not go to a dispensary because… I don't want to say that there shouldn’t be women bud tending, but when women are bud tending, or when anybody who is bud tending is put out to display themselves…

Irene: Almost like Hooters mentality?

Andrew: Yes. And I disagree with that style. Even when it comes to the 420 thing... I don't think that is conducive to the movement. I know a lot of doctors offices that advertise in the back of magazines… I could just be remembering mostly Los Angeles, but… It is definitely sexualizing this industry.

Irene: Well, it's the same for like anything. Automotive, beer, construction, you know… no woman that actually works on their car is doing it in their bikini. You're just not going to.

Wanda: But this is almost the first time that we can have advertisements for cannabis, so where do you go with that? You go to what works.
Sean: And that's certainly an eye-catcher.

Greg: Like a topless car wash.

Overall, patients in my focus groups were conscious of how the cannabis community is perceived by outsiders. Andrew did not like the “420 thing” which is associated with the stoner stereotype. In the cannabis subculture, April 20th and/or 4:20pm are times to get high, though the “420” descriptor can also encapsulate the range of symbols and actions associated with excessive marijuana use. He also raised the issue of businesses sexualizing their female employees to gain a competitive edge, something that may happen in dispensaries though I believe it is more common with “brand ambassadors” at cannabis events. Other studies have documented this problem of sexualizing women in cannabis retail. When Michele Cadigan (2018) interviewed employees at recreational dispensaries, she found women quit at significantly higher rates due to sexism from their bosses, coworkers, and even customers. Once again, increasing the representation of women in the industry may help in this regard. As more women become dispensary owners, growers, and managers in the industry, sexualized female sales tactics may not only become less effective, but empowered women in the community may also become more of a go-to image for female cannabis users in general. Hopefully, the cannabis industry will move beyond these sexist practices as it becomes more solidified in mainstream culture. After all, stereotypes and stigmas related to the gender of cannabis users are still popular in our collective conscience (Mortensen et al. 2019; Haines-Saah et al. 2014).

Gender, Stigma, and Stereotypes

As I have already demonstrated in Chapter 7, patients still navigate a range of cannabis stigmas in their daily lives. Though things have been improving, the fact that stigmas remain a
powerful force trouble claims that cannabis is normalized. But how might stigmas interact with gender to differentially shape the experiences of men and women who use cannabis?

Overall, my key informants and focus group participants agreed that women face more judgment for anything they’re doing. Ramona, who specializes in medical cannabis public relations, told me she thought “women are more sensitive to the stigma”, and the four other women I interviewed as key informants agreed. In fact, two of these key informants remarked they knew other women who hid their use of cannabis from their husbands. No such statements were expressed by the men I interviewed, and all of my focus group participants expressed their families knew of their use of medical cannabis (even if their family was disapproving). Perhaps this is why several of my interviewees and focus group participants thought women favored more discrete cannabis products. For example, Madison, who helps promote cannabis business opportunities in communities of color, thought women were more tactful in their consumption:

Madison: At the recent High Times Cannabis Cup, one woman took first, second, and third place. So women definitely have the ability to do this. I think male consumption is much more public, though. I don't think men consume at a much greater rate than women; I just think that they can do it more freely. And I think that women's consumption is much more disguised through things like edibles or things that look dainty, things that are still consumption but things that are not necessarily perceived as consuming cannabis. It's consumption if I roll a cone, and it's also consumption if I eat some infused mints, but you didn't know that I ate infused mints. So I think that's where there are some differences.

These observations of gendered consumption practices were noted by others in my study and resemble findings where extreme consumption methods (dabbing, blunts, etc.) were primarily practiced by men (Mostaghim 2019; Newhart & Dolphin 2019; Dahl & Sandberg 2015). Just like downing copious amounts of alcohol to prove one’s masculine toughness and competency (Arnull & Ryder 2019; Peralta 2007; Measham 2002), the conspicuous public consumption of cannabis may be interpreted as an enactment of masculinity. Typically, the more smoke one inhales or the larger the smoking device, the more potent the effect.
Another possible explanation for the relative ease at which men consume cannabis in public may be due to the media. Most of our cultural images of stoners are men (Mostaghim 2019; Bacca 2015; Looby & Earleywine 2010), a fact noted by many participants in my study. Even though stoners are commonly conceptualized as masculine, male privilege may facilitate men’s identification with these playful stereotypes. After all, men are granted social authority on account of their gender alone, while women consciously try to achieve empowered statuses. Perhaps this why Madison and two other key informants had issues with “stoner chicks” in the media:

Madison: I think that the only images of consumption that people saw were kind of like stoner chicks. And that stoner chicks have this kind of air-headed mentality, and I don't think that most empowered women align with that. It also could potentially be because women are mothers, and there is a different set of expectations and responsibilities that comes with that. And also marketing too, because they provide a lot of the images we see.

These three key informants mentioned they thought media representations of women cannabis users were unrelatable, a sentiment also shared in two of my focus groups. Women in these groups discussed how female characters who used cannabis were traditionally depicted as engaging in other criminal activity, particularly prostitution. This is not necessarily a new theme either as Susan Boyd (2009) found anti-marijuana propaganda films often portrayed women who use marijuana as more criminal and more interested in drugs than their male peers. Things may be improving here, though, as Audrey from Focus Group 4 likes how modern representations are more diverse:

Moderator: Do you think [the media] shows cannabis as more of a normative thing?
Alexander: I think so…
Audrey: I like seeing more ladies that smoke. Cause you didn't use to see that before, you know? I mean, if they were, they were always the ones snorting coke and giving head in the movies [laughs]. Not the ones that were funny and otherwise normal.
As cannabis becomes more accepted in polite society, perhaps gender-based cannabis representations will continue to evolve in the media. Alternatively, two women in my focus groups remarked that they appreciated how cannabis challenges traditional constructions of femininity. Sophia from Focus Group 1 did not care about the discreetness of her consumption, and even mentioned how cannabis facilitated her break with emphasized femininity:

Sophia: I don't wear dresses very often, and I don't paint my toenails, and I don't wear makeup, you know what I'm saying? I'm hairy in places that I probably shouldn't be [laughs]. But I'm okay with it. I realize that I'm a female, but I don't feel like I need to play a certain role. So maybe me drinking Hennessy straight out of the bottle or smoking blunts makes me look a little more manly, but I'm okay with it. Like men act that way and not women, but again, I'm okay with it and comfortable with it.

One may be tempted to say women are more stigmatized than men for using cannabis, and while this may be true, men also experience gender-related stigmas surrounding cannabis use. This is surprising because cannabis culture, like most other drug cultures, is coded as masculine (Arnull & Ryder 2019; Mostaghim 2019; Dahl & Sandberg 2015; Haines-Saah et al. 2014; Haines et al. 2009). Yet there is something about cannabis stereotypes that trouble hegemonic notions of masculinity such as competency, power, and the provider role. For example, Focus Group 2 linked hegemonic ideals such as breadwinning to social disapproval over men using cannabis:

Moderator: Do we think that women use medical cannabis differently than men?

Irene: I don't think so.

Wanda: I think it's more of a personal thing.

Sean: I think women use it more discreetly than men do, or in a more discreet way than men do.

Darlene: I think men are stigmatized more than women are.

Sean: I can see that.
Darlene: Because with women, it’s seen as a casual recreational thing. But if men are doing it, then they are just potheads. I have seen women that have gotten that label too, but in my family...

Sean: Women can get by with it more nonchalantly than a guy can, I think. You know what I mean?

Darlene: My whole family was extremely gender oriented... Like, you need to cook, you clean, but you can have a job...

Greg: So for females, it’s more acceptable because they're viewed as less important to the family structure is what you mean?

Darlene: Pretty much, yeah.

Andrew: Yeah. Like, historically, they don't have to go out and be the breadwinner.

Sean: The same is true in my family, and they were a bunch of bible thumpers, but you hit it right on the head...

Darlene: The man was the head of the household, the breadwinner...

Sean: Exactly. There were different expectations.

Greg: Yeah, more is expected from the breadwinner. And if you're smoking pot, then you're not doing your best to provide for your family.

Sean: But you can go out and drink all you want to...

Greg: Yeah, yeah...

Since hegemonic masculinity encompasses attributes like career attainment, providing for the family, and hard work (Schwalbe 2014; Peralta 2007; Connell 1995), cultural stereotypes surrounding cannabis may be incompatible with the hegemonic ideal. If we believe cannabis makes one lazy and unmotivated, then men who use cannabis are seen as failing to strive for the hegemonic form of masculinity. Other research has suggested men can internalize these stereotypes, possibly resulting in less personal confidence (Looby & Earleywine 2010). I believe this is what happened to Alexander from Focus Group 4 who was unhappy with his “dead end” job in construction (see Chapter 7). He connected his use of medical cannabis to lower career attainment despite the existence of other factors like occupational discrimination through drug
testing, stagnating wages among the working classes, and more. Nonetheless, Alexander’s account suggests the stereotype of being a cannabis user is counter to masculine ideals.

A final interesting example of the intersection between masculinity, medical cannabis, and stigma concerns illness itself. Focus Group 2 continued their conversation from above:

Irene: I also think that medically speaking, men will face more stigma because they’re not supposed to have pain. They are supposed to be stronger and not complain about those types of things.

Sean: Yep, and that goes back to what Greg said about men being the breadwinners.

Wanda: Right! Whereas with women, it all hurts and all the time, but men think it’s just because we are super sensitive.

Irene: I think we should hook men up to that labor simulator, and then we can have this conversation again.

Being a cannabis patient, in particular, requires admitting that something about one’s health is bothersome. Patients must be certified by a physician where they discuss their pain or discomfort, and in order to access medicine through a dispensary, a patient must show their registry cards at every visit. These acts alone may be seen as unbecoming for a cultural definition of masculinity based on toughness (Schwalbe 2014; Connell 1995). Fortunately, some evidence exists that cannabis facilitates a reconsideration of hegemonic masculine attributes.

Cannabis Challenges Masculinity

Rather than saying that one gender experiences more stigma concerning cannabis use (though this may indeed be true), my research illuminates how gender mediates cannabis-related stigmas. Both men and women face stigma for using cannabis, whether it be medical or recreational, perhaps indicating that cannabis is incompatible with traditional constructions of gender. Yet this was perceived as somewhat positive to both the men and women in my sample. For women, defying feminine ideals of sobriety can be empowering. For men, cannabis may
facilitate alternative constructions of masculinity where aggression and indifference fade from the picture. The men in Focus Group 3 acknowledge this:

Gavin: As I was growing up, I was on Ritalin as well as for most of my adult life until I just like, *enough is enough*. With cannabis, they always told me it'll make you depressed. Bullshit. It doesn't focus me like Ritalin as far as that part, but I find that I'm more than willing to listen and therefore have a lot better chance of being reasonable, especially in adverse situations. Like, if I was just on Ritalin alone, if I got into a car accident, chances are tempers would flare... There would be some aggression or hostility. Whereas when I'm on cannabis, I'm like, *damn, are you okay?*... You know, I would worry about the other person because I have a whole different mindset.

Wade: I had an uncle and I'm sure he was smoking way before it was legal. He was bright, like a hippie and stuff. You could tell when he wasn't smoking because when he was smoking, he would become the nicest person. But when he wasn't smoking, you would think he had some tequila or something, and he would be this angry, violent person. But then when he was smoking, he was smiley, a lot calmer...

Gavin: In my opinion, when you're smoking, you have a tendency to do more inner reflection. Like, you're laid back, and everything you kind of bottled up... You sit there and you think about it, or last month’s events or, you know, instead of just popping on the TV or reading the newspaper. I mean, there's a focus, and it's more inwards than outwards.

These comments are similar to those made by men who use medical cannabis in interviews done by Joan Bottorff and colleagues (2011). In that study as well as my own, men credited cannabis with tempering the propensity towards anger that is culturally associated with masculinity. Similar findings were uncovered by Eeva Sointu (2011) in her interviews of individuals using CAM therapies. She found CAM challenges aspects of hegemonic masculinity through focusing on emotional awareness, vulnerability, and intimacy. Indeed, alternative medicines often provide a sense of tranquility and serenity achieved through an exploration of one’s weaknesses.

Likewise, while my review of the literature in Chapter 4 cautions against inferring results from drug studies on youth populations, these expressions are highly reminiscent of research on boys who smoke cannabis (Haines et al. 2009; Warner et al. 1999). This tendency towards
relaxation or tranquility was observed in some way within all five of my focus groups. Jimmy from Focus Group 1, who identifies as a queer man, had an insightful perspective on this effect where he likened hegemonic masculinity to a mask:

Jimmy: I do feel that role or that narrative that men put on to be masculine, like to be a man and be aggressive and etc, I feel like those gender roles stem from previous trauma or upbringing around masculine identity in the binary. So marijuana as a medical thing kind of helps relax people so they don't have to stand with that mask in front of them.

The metaphor of a mask was even used by Wade from Focus Group 3:

Wade: I think the biggest misconception about medical marijuana is that it doesn't actually help you. People still actually believe that, and it's bullshit, and they think we just want to get high. If that's the case, then what's so bad that I would want to get high? What you have to do is figure out what in your life is so bad where you think you have to go out and do drugs to get through it. So therefore, you have to peel away... we have mask, upon mask, upon mask in our persona. And you have to peel away all the layers to get down to the core issue and deal with that core issue. And then you won't have a need for all the things to make you forget that. Even though you might not think of it consciously, it's still there nonetheless.

As the certifying physician I interviewed mentioned in the previous chapter, cannabis as medicine facilitates a form of mindful reflection. Whether our attention is dominated by illness or conforming to socially prescribed gender expectations, cannabis may allow us to deeply examine the roots of our frustration, perhaps easing our break with social pressures to be manly or act as if our lives are perfect.

Though cannabis is often described as calming, another explanation for the alternative gendered expression with the cannabis community could be due to the type of people who are attracted to the culture. Perhaps the kind of people who use cannabis are less invested in mainstream cultural norms, including hegemonic gender norms. After all, cannabis has long been position as a countercultural substance (Chasteen 2016; Becker 1973/1963), so maybe it appeals to those who are less interested in adhering to dominant cultural codes. Yet the reality is likely that it is a mix of drug, set, and setting (Lau et al. 2015a; Zinberg & Harding 1979), where the
substance, individual’s motives for use, and cultural environment all impact the resulting effect.

While participants in my study did not have a consensus on the issue, we can see that the tridimensional construct being discussed in Focus Group 2:

Darlene: I think [cannabis] allows men to be different. Not just because they smoked, but in that atmosphere…

Wanda: The social construct changes. Cannabis changes everything. It's a whole different community, and the expectations of the way you should act are entirely different.

Darlene: Yes.

Greg: You were talking about socializing earlier… Cannabis has always determined who is in my social circle. I have no friends that don't smoke. Period. It's a determining factor. You're either in my life or you're not, and if you are in my life, then you smoke pot.

Darlene: I think it allows men to be more gentle and more calm… it lets them drop away some of that social toughness they put on.

Wanda: Without feeling bad too, because everybody is calm and chill.

Greg: As I was saying, smoking together it's like a completely different social construct… more akin to a Japanese tea ceremony than a bar.

Irene: I think it is more of the mindset in general, or the type of people that gravitate towards cannabis more so than the actual cannabis use itself. I think it's more of the people that are geared towards using it.

Sean: Right, it's the attitude of the person that determines how they behave on cannabis.

Andrew: Right, that's a huge factor.

While others have also found that men who use cannabis more readily break with hegemonic masculine ideals (Taggart, Brown & Kershaw 2018; Dahl & Sandberg 2015; Haines et al. 2009), it is unclear if cannabis causes this reformation of masculinity or if non-hegemonic men are more drawn to consume cannabis. My research is unable to settle that debate, though I did uncover structural factors that distance cannabis from hegemonic masculinity.

Firearms are strongly associated with masculinity, but existing laws forbid medical cannabis patients and even cannabis users from owning or using firearms. The subject of gun...
rights was brought up in two focus groups, each time by men. However, there was a good deal of confusion regarding the specifics of the law. Nonetheless, participants knew that guns and marijuana were mutually exclusive in the eyes of the law, which was concerning to men in a hunting state like Michigan. The exchange below from Focus Group 4 arose near the end of the group after I asked if anyone had any final thoughts. Alexander brought up the subject of guns, and he thought the law was about the proximity of a firearm to marijuana itself:

Alexander: There's a couple of things that we didn't discuss that I feel are a problem.

Moderator: Oh, sure. Go ahead...

Alexander: One is guns and medical marijuana... They're not allowed to be within a certain amount of feet or whatever of marijuana. So now people don't have a way to protect their homes or their marijuana.

Moderator: Really? It's by feet?

Alexander: Yep. And why is it okay for somebody who is drunk to have an open carry license and wander around wherever? Whereas somebody who's growing marijuana can't... or if you have your medical marijuana license, you can't carry a weapon.

Moderator: Can you still purchase a weapon, though, if your patient?

Audrey: I think you can purchase it as long as they don't know you have your card.

Alexander: Patient laws I don't know, because I only have looked into caregiver laws because those pertain to me. Caregivers are not allowed to own any guns at all. But yes, technically, yes. You can go purchase a gun, and they will give you the gun, but it is not legal for you to own it. And I mean, they classify a lot of things as guns, you know, air rifles, bows and arrows, and such. So, we're taking away somebody's amendment right because they smoke or because they have medical marijuana. But now if I were to not tell the state and I was just growing marijuana illegally, they could come in and bust me, and if they found guns, I would not be charged for those guns.

The actual law related to firearms and marijuana is very confusing, but you still have to pick one. The confusion stems from the fact that the federal government is responsible for regulating the permissible use of firearms. Since the federal government defines cannabis as a Schedule I prohibited drug, it is a violation of federal law to purchase, own, or operate a firearm
(or ammunition) in conjunction with using cannabis\textsuperscript{31}. This applies to both medical patients and recreational users, the latter of which does not have to worry about having their information available in a state database of registered patients. Technically, an individual must forfeit all of the firearms upon becoming a patient, but states do not seem to consider it their duty to enforce this provision. Nonetheless, when combined with the possibility of employment penalties, the inability to lawfully own a firearm as a cannabis user may erect barriers to conforming to hegemonic masculine ideals.

Conclusion

This chapter provides some of the first empirical evidence on how gender manifests in the medical cannabis community. Overall, gender norms were adhered to in mostly traditional ways, though cannabis patients appeared comfortable in eschewing some ingrained cultural expectations about masculinity and femininity. Like research by Mullen and colleagues (2007), it is likely these cannabis patients were more influenced by a complex combination of social context and personal history over socially prescribed gender roles. Even when it comes to roles within the community (growers especially), these appear to be more influenced by our societal gendered division of labor than anything intrinsic to cannabis.

Nonetheless, something about cannabis appears to be associated with alternative formations of masculinity. It could be an effect of the plant or how the subculture attracts a particular type of man (or both), but cannabis facilitated a breaking with the hegemonic standard of toughness and aggression. When we consider the structural stipulations that firearms are

\textsuperscript{31} The United States Department of Justice, Bureau of Alcohol, Tobacco, Firearms and Explosives (BATFE) made this clear in an open letter to all Federal Firearms Licensees on September 21, 2011: https://www.atf.gov/file/60211/download
incompatible with cannabis use, hegemonic masculinity within the cannabis community becomes further unlikely. Does this mean that men who use medical cannabis feel subordinated among other men? Absolutely not. While they were aware of cannabis stigmas and stereotypes related to lower achievement, these were ultimately minor considerations when contrasted with the benefits that cannabis bestows.

The women in my study appeared to reach similar conclusions about their use of cannabis as medicine. They knew women were judged more than men for engaging in any deviant behavior, but the judgments of others pale in comparison to the relief received through cannabis. Instead of worrying over whether they were failing at feminine ideals of modesty, more consequential sources of disapproval were those by their families or employers. The possible exception to this concerns mothers who fear intrusion by CPS. While Haines and colleagues (2009) found femininity impedes marijuana use among girls, my study suggests that being a parent may impede medical cannabis use among women. This does not mean mothers are less likely to use cannabis medicines, but rather that they recognize they face heightened social disapproval. Remarkably, the mothers in my focus groups resisted the internalization of this social attitude, even going as far as to credit medical cannabis with making them a better parent. After all, untreated chronic illness or pharmaceutical side effects detract more from the parental role than the opinions of others.

Perhaps the most conventional organization of gendered practices occurs among business owners and business practices. The cut-throat culture of masculinized corporations is steadily extending its reach over the newly legitimized industry, and this poses problems for more cooperative models of dispensaries and cultivation facilities. In the “winner take all” world of investment capital, those who already have vast sums of money have a better chance of gaining a
foothold and squeezing out the competition. Unfortunately, men as a social group are the ones who control most of this capital in our society, and the boy's clubs of the board room may soon own a sizeable portion of cannabis businesses throughout the country. While the gray market favored the (legal and financial) risk-taking propensity of masculinity, the legal market also favors men in a society where men own and control most of the wealth and political power. Regulations at the state level could be made more accommodating to women, racial/ethnic minorities, and others who lack privilege in the economic realm, but when we look at the people making such regulations, they tend to come from the more privileged groups in our society.

Ideally, social equity programs should be crafted and administered by the people such programs are designed to help, but in lieu of such structural adjustments, resistance to the white patriarchy of cannabis will have to come from elsewhere. The women I interviewed as key informants were all involved in women-centered organizations like Women Grow, a national association centered on empowering women in the cannabis industry. The resources and community offered through such groups may be instrumental in combating male dominance in the emerging industry. After all, most cannabis companies will fail as an overabundance of big-money interests are lured into investing through news reporting which makes consumer demand appear more pronounced than it actually is. Likewise, all of the growers and business owners I interviewed mentioned how growing top-tier cannabis is an astronomically tricky art. The same individuals also expressed they were aware of many who tried to do so but ultimately failed due to the naive rush to make a profit. When the investment bubble in the cannabis market inevitably breaks, the mutual networking offered through organizations like Women Grow may allow women to fare better than their individualistic male competition.
CONCLUSION

This study sought to illuminate the experiences of cannabis patients at a time where adult-use (aka recreational) marijuana was becoming legalized throughout the nation. Specifically, this study is the first to qualitatively investigate cannabis patients in the state of Michigan, as well as the first to examine cannabis patients following the full-scale legalization of marijuana. The use of focus groups as a primary method of inquiry is also novel among studies on cannabis patients, as is the fact that the researcher is a complete member of the medical cannabis community. While the broad scope of this research has been concerned with an array of topics of interest to cannabis patients and users alike, these are both under-studied groups united through their use of a historically maligned plant. Let’s consider what we learned by revisiting the research questions.

Normalization Revisited

(RQ1) How does the medical cannabis community feel about the normative status of medical cannabis in this moment of emerging recreational legalization? And, what challenges do patients face in their social and professional lives?

Despite cannabis use increasing in American society, focus groups of cannabis patients reveal that the plant still carries a deviant label and associated stigmas. This is not to say that things have not improved following medical and recreational legalization—Indeed, criminal penalties have decreased, media representations have diversified, and more people are using cannabis than ever before. As such, it is no longer a substance exclusively confined to criminogenic subcultures, rebellious youth, or other cultural outsiders. “Normal people” use
cannabis, as do high-achievers like executives, athletes, and scientists. Nonetheless, the acceptance of cannabis in society is uneven, and it appears we have a way to go before we can safely say that cannabis is normalized.

The cannabis patients in this study report exercising discretion and experiencing anxiety over their use of medicine. They are aware that even though their use is legal, social disapproval is still found in family members, employers, school districts, neighbors, health care providers, and the media. In particular, senior members in society have deeply internalized the anti-cannabis propaganda that pervaded public discourse for so long. While even the younger generations can harbor negative sentiments towards cannabis, their views appear malleable when confronted with compelling evidence on the plant’s benefits. The same may not be true with older generations. When patients in my focus groups spoke of judgment from their families, it was almost always on the part of their parents or grandparents. It is not surprising then that when my focus groups and key informants spoke of generational cohort replacement, they often did so with a sense of gleeful optimism. In the meantime, however, these disapproving individuals are with us and cast their judgments through scorn, shunning, and civic engagement aimed at preventing cannabis reforms.

Even though the media has improved in how cannabis is represented, they still perpetuate stoner stereotypes in film and television. Some of my focus group participants found these characterizations to be playfully humorous, while others found them distasteful or offensive. Another source of ire was how news coverage of cannabis was often biased. Law enforcement still appears to be a go-to source for commentary on cannabis-related events, and patients in my focus groups were disheartened when airtime was given to opponents of legalization who cited factually incorrect claims. Likewise, censorship still appears to be the default concerning
cannabis or related material. Subcultural literature is placed alongside pornography magazines, while regulations on businesses and advertising marginalize the presence of the cannabis community.

Perhaps the most significant evidence that cannabis has yet to be normalized is that of employment discrimination. Card-carrying patients fear repercussions should their bosses or coworkers discover they use cannabis since zero-tolerance, drug-free workplaces still appear to be the norm. Even when patients find work that accepts their medicine, they feel trapped in their current job for fear they will not be hired by others. This limits the occupational mobility of cannabis patients and may even tarnish their sense of self. Likewise, the added psychic stress associated with the mere possibility of drug testing may detract from productivity or satisfaction with one’s work.

Finally, cannabis may be more or less acceptable based on group membership. If we make the claim that cannabis is normalized, we may be doing so from a privileged position that neglects the experiences of mothers and people of color. Generational membership also factors in here since cannabis may be more normalization among youth, at least for the time being. Overall, while cannabis may become normalized at some point in the future, this study cautions against making such a sweeping claim at this moment in our society.

Medicalization Revisited

(RQ2) How do medical cannabis patients view the legalization of recreational marijuana? And, do patients think medical cannabis will survive once marijuana is fully legalized?

Cannabis patients in my focus groups welcome the post-prohibition world. They mostly believe the plant should have never been criminalized to begin with, and that it should be
accessible to all who seek it. Their primary concern about the legalization of recreational marijuana was around how the state handles the situation. Overall, patients found existing regulations too onerous and nonsensical, and they feared bureaucratic actions will somehow reduce access to their medicine. For example, in December 2019, Michigan allowed the transfer of medical cannabis into the state’s new adult-use system. This would not have been problematic should it not have been for the banishment of caregiver-grown product from the medical system earlier that summer. By requiring licensed provisioning centers to purchase only from licensed growers (as opposed to hobbyists registered in the MMMP), regulators made medicine scare leading up the rollout of recreational stores. It was a move that overwhelmingly favored the interests of big businesses and corporate investors, and even though patients dreaded the arrival of these players in the community, they favored legalization nonetheless.

Popular discourse frames medical cannabis as a hoax or intermediary phase on the path to legalization, but that is not a sentiment shared by medical cannabis patients. The vast majority of patients in this study plan to continue their participation in the MMMP even though adult-use stores are emerging. Patients and key informants even commented that they have seen a growing interest in medical cannabis following legalization in November 2018. This is likely due to the reduction (not elimination) of stigma in the post-prohibition world as curious individuals no longer feel in the wrong for experimenting with cannabis medicines. While the same substances are available without a medical card, there is value in the legitimization a state-sponsored patient registry provides.

Since the larger medical profession appears hostile to cannabis as a medicine, patients benefit from having an alternative system that provides them with relief (and this relief may also be greater than that received through allopathic medicine). Moreover, the relief cannabis
provides also comes without toxicity, side effects, intrusive contracts, judgmental clinicians, and dictatorial supervision. Patients favor the alternative medicalization of cannabis in that it restores their control over their medical regimen, is more accessible than prescription-only medications, allows them to reduce their reliance on pharmaceuticals, and drives patients to learn more about their health, conditions, and medications. All in all, patients in this study desire this alternative medicalization of cannabis to continue in the future. Although institutionalized medicine has yet to incorporate cannabis into biomedicine, patients fear it is only a matter of time until Big Pharma attempts to control the plant. Aside from increased understanding gained through clinical trials, the patient community sees this as wholly negative.

Gender Revisited

(RQ3) How does gender shape the experiences of medical cannabis patients? And, how might hegemonic gender roles be adhered to or challenged by cannabis patients?

Hegemonic gender roles influence how gender is experienced in the cannabis community, but patients also report a willingness to eschew some of the constraints placed on traditional notions of femininity and masculinity. The consensus seemed to be that women face more stigma than men for using cannabis, either medically or recreationally. This is likely because women are judged more for engaging in any deviant behavior as cultural constructions of femininity demand modesty and subservience on the part of women. Using cannabis may signal that one is challenging cultural codes, and perhaps men even feel more empowered to call out the women they find doing so. Women in this study reported using more discreet cannabis products than men, but at the same time, they placed little consideration on the gendered messages their use conveyed. Some women even expressed that using cannabis was empowering to their sense of
self. Additionally, nearly all participants in this study denounced the sexualization of women by cannabis businesses, advertisers, and the media. Nonetheless, a traditional gendered division of labor was evident in how growers and budtenders were primarily male.

Cannabis may also facilitate a break with hegemonic constructions of masculinity. Women in the focus groups commented on how cannabis appears to mellow men, and the men agreed. Instead of the dispassionate toughness favored in our culture’s male archetype, men who used cannabis were said to be more willing to examine their emotions while quelling anger or aggression. This may be an effect of cannabis or related to the type of men who are drawn into cannabis culture, but something about the plant appears to encourage an alternative construction of masculinity. Similarly, structural limitations on gun rights and employment protections may impede male cannabis users who strive for the hegemonic ideal. Finally, while this reconstruction of masculinity is not total, it seems to be a healthier and more positive version of manhood than that which is celebrated throughout our society.

Sociological Contributions

My dissertation expands sustentative knowledge related to medical cannabis and gender. Sustentative theories are those which address problems in a discipline’s subareas, such as theories applied to medicalization and masculinities (Charmaz 2006). Despite sustentative knowledge having a good degree of utility, it is important to remember all theories are rhetorical in that they do not exist independently of the data on which they are based. Formal theory, on the other hand, is concerned with discipline-wide theories, especially those that link together substantive areas. These theories speak about causal relationships between subareas by using general theoretical models that can be applied to any given topic. The formalist approach is more
related to the positivist paradigm which concerns itself with explanations and predictions. Despite the generalizing tendency of this approach, qualitative explorations of substantive areas can help refine formal theory (Charmaz 2006).

Generalizability has also not been a concern of my study, though some degree of transferability can be established wherein results can illuminate similar groups, situations, or contexts (Marshall & Rossman 2011). My research is descriptive with the goal of broadening understanding of how medical cannabis patients perceive their situation in a unique moment of recreational legalization. Nonetheless, my findings may be of use of others interested in researching cannabis, medicalization, normalization, and gender. The important thing to keep in mind here is to generalize or transfer with extreme care (Marshall & Rossman 2011).

My research also has a goal of empowerment. Medical cannabis patients exist in a social environment which discredits their use of medicine and doubts their identity can continue when recreational marijuana is fully legalized. According to Denzin (2013), qualitative research can also be evaluated by its moral, ethical, and political commitments. From this perspective, which borrows heavily from feminism, claims to knowledge are judged relative to their ability to empower. Feminist researchers, for example, have a shared goal of empowering women and dismantling patriarchal oppression (Fonow & Cook 2005). They make no apologies for their political commitments and do not attempt to hide their position by using convoluted language. Essentially, this way of doing sociology uses passion as motivation and produces practical research that can be utilized in the pursuit of social change (Denzin 2013; Denzin & Lincoln 2013; Fonow & Cook 2005). Furthermore, Altheide and Johnson (2013) say the validity of a study can be established by its utility and potential for empowerment, something they term validity-as-relevance/advocacy.
Many scholars now believe sociological research should be useful for those who participate in the study and oriented towards social justice. While some researchers may feel that this would compromise sociology’s supposed value-neutrality, this idea of neutrality is illusionary, as sociology as a discipline is firmly embedded in webs of power, values, and ideology (Denzin & Lincoln 2013). Moreover, there is a good reason for doing sociological research based on its potential for social justice. Aldon Morris (2017) argues that some of the greatest insights made in the discipline have come from scholars who saw sociology as a science of human emancipation. The pedantic and oppressive push towards value-neutrality has neutered the transformative potential of sociology and has led to theories that are unengaging and abstract (Morris 2017). The way to change this is by rewarding research that serves a purpose other than standard contributions to a discipline’s knowledge base.

My research may not be liberating, per se, but I hope it is affirming for patients in my focus groups and all those who use cannabis as a medicine. I also hope my work can be used to sustain the viability of medical cannabis in a time of emerging recreational legalization. This research is highly value-laden for a good reason. Most commentators on medical cannabis have no affinity to the issue, and they write as if medical cannabis will be nothing more than a footnote in the history of marijuana legalization. My results here should not be interpreted as conclusively disproving such theorizing. Rather, findings from this study should be used to maintain a dynamic dialogue between scholars, policymakers, health care providers, and entrepreneurs as laws change and new issues arise.

Medical cannabis patients and non-patient aficionados are a heterogeneous group, but researchers tend to adopt singular frameworks that nullify diverse perspectives and experiences (Newhart & Dolphin 2019; Temple et al. 2010). I hope I have problematized the single story of
cannabis as framed through normalization, much like feminists successfully problematized the single story of gender as framed through sex roles. Feminists have taught us all that much can be learned by embracing and exploring ambiguity and uncertainty (Flax 1987). After all, “feminist objectivity makes room for surprises and ironies at the heart of all knowledge production; we are not in charge of the world” (Haraway 1988:594). I think it would be a wonderful thing if cannabis scholars and commentators adopted a similar stance of infinite possibility rather than absolute certainty. The social history of cannabis in American society is still evolving, and we should resist the urge to impose totalizing frameworks during this transformational time.
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APPENDIX A

CANNABIS IN THE UNITED STATES

Cannabis Enters the Western World (prehistory to 1800)

Like all earth medicines, therapeutic uses of cannabis stretch back thousands of years, and though the plant is believed to have originated in Asia and the Middle East, localized varieties of cannabis are now found on nearly every continent (Preston 2002). Yet applications of the plant extend far beyond medicine. Archeological evidence suggests cannabis is one of humanity’s oldest cultivated crops with uses of hemp fiber appearing around the same time as pottery making, approximately 10,000 years ago (Herer 1985). Likewise, for most of recorded history, cannabis was primarily used as an entheogen (Ferrara 2016; Chasteen 2016).

Cannabis was an important crop throughout Europe for around 2000 years dating back to at least the fifth century BCE. It was used for fiber, food, and medicine, and texts of the time speak to slight effects “on the head.” Early Christians even considered the plant to be magical and they would sow seeds on the days of saints who were known to be tall (Lawrence 2019). Yet cannabis became heretical following a mandate by Pope Innocent VIII in 1484. His papal fiat was part of the Church’s war on pre-Christian traditions which included witches’ unguents and potions containing hemp extracts (Lee 2012). In this papal condemnation of witchcraft, cannabis was explicitly cited as an anti-sacrament since pagan masses of the era commonly featured cannabis in place of wine. As Michael Pollan postulates, “The fact that witches and sorcerers were the first Europeans to exploit the psychoactive properties of cannabis probably
sealed its fate in the West as a drug identified with feared outsiders and cultures conceived in opposition: pagans, Africans, hippies” (2001:174).\footnote{32 “Christianity and capitalism are both probably right to detest a plant like cannabis. Both faiths bid us to set our sights on the future; both reject the pleasures of the moment and the senses in favor of the expectation of a fulfillment yet to come—whether by earning salvation or by getting and spending. More even than most plant drugs, cannabis, by immersing us in the present and offering something like a fulfillment here and now, short-circuits the metaphysics of desire on which Christianity and capitalism depend” (Pollan 2001:175).}

As for the Americas, historian John Charles Chasteen (2016) says there is a dearth of information about cannabis prior to 1900, but it is likely that hemp was introduced on the continent in the 1500s by the Spanish. Perhaps the first cultivation came when one of the Spaniards led by Cortez forced his indigenous laborers to plant hemp around Mexico City in the 1530s. However, Lee (2012) says the first documented instance of cannabis in the Western Hemisphere occurs in the early 1500s in Brazil where slaves working on sugar plantations miraculously managed to bring seeds with them from Africa. Yet these plants were for commercial purposes as there are no accounts of cannabis being used as a recreational intoxicant. The first recorded instance of intoxication came in the 1760s when a Catholic priest learned indigenous people around Mexico City were eating something known as \textit{pipiltzintzintlis}. The cannabis-containing concoction was used to access the spirit world, and as such, the Catholic church condemned it once again as pagan (Chasteen 2016). Indeed, indigenous peoples in the early Americas primarily utilized the plant’s psychoactive properties for spiritual pursuits: “Psychoactive plants are bridges between the worlds of matter and spirit or, to update the vocabulary, chemistry and consciousness” (Pollan 2001:144).

As a historical commodity, cannabis was primarily used as hemp where it had a vast range of applications including ropes, textiles, and sails. Hemp was so versatile and valuable that Jamestown Colony ordered all farmers to grow hemp starting in 1619 (though it was introduced
in North America in 1606). Other colonial settlements adopted similar laws, and it is even true that hemp was accepted as tax payment for over 200 years (Herer 1985). The importance of hemp in Colonial America is evidenced by the numerous variations of town names like Hempstead, Hemp Hill, and Hemp Field. An English-language guidebook for raising hemp was first published in 1765, popularizing and refining hemp production throughout the young country (Lee 2012).

**Medicine, Marijuana, and Hashish (1800 to 1910)**

While cannabis was used for thousands of years in different ways, it is Dr. William O’Shaughnessy who is credited with popularizing its medicinal uses in the Americas in the nineteenth century. In 1839, O’Shaughnessy reported Ayurvedic medical practitioners in India were using hemp extracts to treat all sorts of illnesses his Western colleagues thought untreatable. His work directly influenced the listing of cannabis in the U.S. Pharmacopoeia from 1854 to 1937 where it was used for over 100 separate conditions. Many patent medicines like the famous Tilden’s Hemp Extract would go on to use cannabis as their primary ingredient (Herer 1985). However, while O’Shaughnessy’s reports predominantly frame cannabis as a harmless and useful medical tool, he also acknowledged rare instances of delirium. These exceptions helped fan the flames of preexisting rumors that cannabis induced violence and sexual aggression, and the later was particularly terrifying in the prudish Victorian era (Lawrence 2019). This re-discovery of cannabis as medicine was also happening around the same time that industrial hemp fiber production was beginning to decline, thanks to the inventions of the cotton gin and steamship (Herer 1985).
Yet cannabis is not only an industrial commodity or a medicine. It can also become an intoxicating euphoriant when the female buds are heated. Martin Lee claims plantation owners in Brazil permitted slaves to cultivate and smoke cannabis since it appeared to make them better handle their work in the brutal tropical heat. He also says linguistic evidence suggests that the word *marijuana* came from the Portuguese word for “intoxicant,” *mariguango* (Lee 2012). When the Mexican Academy of Pharmacy published the nation’s first pharmacopeia in 1846, it noted *Cannabis sativa* was used for medicinal hempseed oil while a separate entry for “Rosa María” was used for “narcotic leaves.” The pharmacopeia also listed another name for Rosa María as *marijuana*, and in the 1850s, a pharmacist noted for the first time that it was smoked in cigarettes (Chasteen 2016:54).

As for north of the Equator, unconfirmed accounts suggest Native Americans used cannabis for many purposes, though likely primarily as an entheogen, following its introduction to the continent in the sixteenth century (Ferrara 2016). Since it is unclear if they smoked it for insight or pleasure, the first reliable reports of recreational marijuana smoking come from Jamaica in the 1870s. “Ganja” was introduced to Jamaica by Indian indentured servants following the abolition of slavery on the island in 1834 (Lawrence 2019; Chasteen 2016). Smoking ganja was later adopted by sailors, many of whom were Black or Latino, who spread the practice to Mexico and the southern United States. Cannabis was thought of as the “opium of the poor” and “those of a more affluent standing tended to blame the problems of the less fortunate on the consumption of cannabis. Its initial association with the dregs of society… made marijuana a convenient scapegoat for deep-rooted social inequalities” (Lee 2012:39). The first recorded instance of cannabis being smoked in the United States was by Mexicans in
Brownsville, Texas in 1903. That same year the region passed the nation’s first marijuana prohibition law though it applied only to Mexicans, not white people (Herer 1985).

Interestingly, white people were already accustomed to the idea that cannabis contained intoxicating properties, but they were more familiar with cannabis as hashish as opposed to marijuana. Hashish appeared in the Middle East around the year 1100, but it did not become well-known in Europe until Napoleon’s army returned from their failed conquest of Egypt in 1798. At first confined to a few bohemians who chronicled exotic experiences in art and literature, hashish eating became vogue by the 1840s when it was consumed by luminaries like Honoré de Balzac, Victor Hugo, Charles Baudelaire, and Alexandre Dumas who featured hashish in his adventure tale, *The Count of Monte Cristo* (Chasteen 2016). Around the same time, an American travel writer named Bayard Taylor published a book recounting his trip to Egypt where he consumed a large dose of “hasheesh.” Taylor’s vivid description of the high inspired fellow American writer Fitz Hugh Ludlow to down an entire bottle of Tilden’s Cannabis Indica, a common hash-based elixir of the era. Ludlow published his experience in his 1857 best-selling book, *The Hashish Eater: Being Passages from the Life of a Pythagorean*. This is perhaps the first time cannabis and hashish enter into popular discourse within the middle and upper stratas of American society (Lawrence 2019; Chasteen 2016).

Just like the current popularization of candies and other edibles containing cannabis extracts, Americans in the nineteenth century were perhaps most familiar with a hashish confection. In the 1860s, the Gunjah Wallah Company began selling a maple sugar candy with hashish throughout the United States. It was immensely popular and easy or order through catalogs like Sears & Roebuck. Both general Ulysses S. Grant and general Robert E. Lee would endorse the candy as a medicine and stimulant for tired, wounded soldiers. Physicians, however,
were quick to condemn the candy as quack medicine, though it would remain available until the turn of the twentieth century (Lawrence 2019).

The fad of hashish eater’s clubs eventually reaches the United States where there was a Turkish Hashish Pavilion at the Philadelphia Centennial Expedition in 1876. Afterwards, several hashish parlors popped up in New York City, Chicago, and San Francisco. These establishments were typically patronized by middle- and upper-class citizens while patent medicines containing cannabis were available to all, though few knew hashish and medicinal cannabis extracts contained the same psychoactive substance (Lawrence 2019; Chasteen 2016). There were also sensationalized press accounts of the era decrying the phenomenon in publications like *Harper’s* and *The New York Times*.

Perhaps since hashish was eaten and cannabis extracts were primarily a medicinal ingredient, few Americans understood these came from the same plant as the marijuana smoked by cultural outsiders. Throughout the 1910s and 1920s, recreational uses of marijuana were on the rise throughout the country, and many states responded by passing laws banning the plant. California and Utah were the first to enact state-wide marijuana prohibition in 1915 (Torgoff 2016) though El Paso, Texas, did so a year earlier (Lee 2012). While smoking marijuana was a relatively recent introduction in the United States, scholars have also identified at least three overlapping social currents that help explain these early efforts to prohibit marijuana.

The first and most often cited is that of xenophobia spurred further by economic uncertainty. Mexican immigrants (and to some extent those immigrants from India) brought with them the cultural practice of smoking marijuana, and it was soon adopted by other cultural outsiders including black jazz musicians (Chasteen 2016; Torgoff 2016; Chapkis & Webb 2008;
Gahlinger 2004; Marez 2004). Secondly, Conrad and Schrieder (1980) identify the growing social awareness of addiction to (relatively new) intoxicating medicines like heroin and cocaine. Widely used by doctors without thought given to their addictive qualities, these were ultimately tightly regulated by the Harrison Narcotics Act of 1914 which asserted the first legal distinction between recreational and medical drug use on the federal level (Fyre 2018; Lee 2012). Finally, this was an era marked by a prohibitionist reform movement towards all intoxicants but most notably that of alcohol. Federal prohibition of alcohol would be established after the ratification of the Eighteenth Amendment in 1920 and would continue until 1933. With these three factors in mind, it is hardly surprising that by the time the federal government passed the Marihuana Tax Act of 1937, 38 of the 48 states had already enacted laws prohibiting marijuana (Torgoff 2016).

Jazz and Marijuana (1910s to 1930s)

An under-cited segment of marijuana’s history in the United States is that of jazz culture. Scholars tend to begin their narratives in the counterculture of the 1960s though developments in the roaring 1920s were equally impactful. Marijuana first appeared on the streets of New Orleans sometime around 1910 when jazz culture was sprouting in vice-heavy neighborhoods like Storyville. Realizing there was too much fun to be had for innocent young servicemen, in 1917 the U.S. Navy closed Storyville by banishing prostitution and drug use from the neighborhood (Torgoff 2016). This occurred during the same time the Great Migration where African

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33 Sociologist Curtis Marez (2004) notes that arrests of Mexicans for smoking marijuana were most common in places and in times of labor organization efforts, particularly those led by Mexican anarchists and revolutionaries. Arresting workers for smoking marijuana was a particularly convenient way for the nativist Texas Rangers to quell collectivizing before it began.

34 Xenophobia was also a key factor in Canada’s decision to ban cannabis in 1923. The targeted group in this instance were Chinese immigrants who occasionally consumed hashish. Among other sensationalized claims, Canadian propaganda warned that hashish would lead white women to have mixed-race babies (Lawrence 2019).
Americans were leaving the South for more industrious urban centers in the North. Many New Orleans jazz musicians would join this migration, including Louis Armstrong, who would only become enamored with marijuana after moving to Chicago in 1921.

Cultural historian Martin Torgoff says, “[Armstrong] became the first in a line of powerful musical innovators and improvisers who are renowned for the use a particular substance, and who also changed the face of music after them” (2016:44). He was even the first celebrity in American history to be busted for pot when he was arrested in Los Angeles in 1930. Though Armstrong was forced to apologize and publicly denounce marijuana, he continued to smoke it regularly (probably daily) throughout his life (Torgoff 2016). Yet this was not purely a recreationally-oriented style of use, for jazz musicians like Louis Armstrong also saw cannabis as a way to self-medicate in the face of an exclusionary white society: “Armstrong said he used reefer to unwind, to relieve stress, to ease the chronic pain of racism. Smoking marijuana helped him deal with the daily humiliation meted out by Jim Crow- white society’s relentless, sickening assault on his self-respect” (Lee 2012:12). It is likely cannabis found its way into numerous African and Southern folk medicines of the era, and these remedies were more familiar to impoverished musicians than anything the medical establishment had to offer.

The “New Orleans golden leaf” also moved from Chicago to New York and beyond:

Marijuana was hitting Harlem at a crucial moment in its history. Along with jazz, it became a part of the experience of the first generation of African Americans to come of age in New York after the Great Dispersal had transformed Harlem from a small middle-class neighborhood with housing designed for sixty thousand into a black city-within-a city of three hundred thousand. It arrived right at the time when the promise and cultural fermentation of what had become known as the Harlem Renaissance of the 1920s was fading, dissolving away to the despair of the Great Depression, which would hit African Americans so hard (Torgoff 2016:32).
Above all other places, Harlem cemented marijuana’s association with jazz music and an underground culture. While Chasteen (2016) says only Mexico, Jamaica, and Brazil had local traditions of intoxicating cannabis use prior to the 1960s, by the early 1930s, marijuana had become a central part of the night club experience in most major American cities. At first it was smoked openly on the dance floor, but mounting disapproval eventually forced smokers into more discreet areas such as the bathrooms, cloakrooms, or telephone booths. There were even entire establishments called tea pads dedicated to the after-hours crowd who wanted to relax, smoke marijuana, and listen to music on a Victrola. These jazz-centered establishments lacked the sophistication of fancy night clubs frequented by white people, and this helped solidify marijuana’s status as something outside of the mainstream culture. It was also a cheap, easy, and fun way to let loose as evidenced in the scores of jazz songs where marijuana is presented as a mild and safe euphoriant rather than the demonic drug narrative pushed by the Federal Bureau of Narcotics (Torgoff 2016).

The Marihuana Tax Act (1930s to 1960s)

The way the federal government would go about banning marijuana was through a prohibitive tax. Yet in 1937 there were 28 pharmaceutical products containing cannabis on the market (Torgoff 2016). For the most part, politicians, police, and the media had virtually no idea that the marijuana used by Jazz musicians was just a weaker version of the potent cannabis medicines they’d been taking since childhood (Herer 1985). So, when hearings for the Marihuana Tax Act (MTA) began, the little-understood plant was easily distorted by fear-mongering bureaucrats like Harry Anslinger.
Harry Anslinger had worked in various enforcement agencies focused on thwarting narcotics trafficking throughout his early career. Yet he was relatively silent on marijuana issues until he was appointed to the new Federal Bureau of Narcotics (FBN) in 1930. What made Anslinger despise cannabis so fervently? One could argue it was a paternalistic sense of morality (McWilliams 1990), but sociologist Howard Becker believes Anslinger’s war on weed was primarily undertaken to justify the existence of the new FBN. Manufacturing a marijuana epidemic provided the bureau with a clear and urgent task for the floundering bureau, thus making Anslinger a moral entrepreneur in exploiting deviance to advance his own interests (Becker 1963). He also tactfully exploited pre-existing societal fears based in racism and xenophobia, but perhaps most notably, he cited an Islamic legend as proof of marijuana’s ability to provoke violence.

In the 1100s, an Islamic sect based in Syria was rumored to recruit innocent young men to become assassins with the aid of a vision-producing potion thought to contain cannabis. Specifically, these were religious dissenters known as the Nizari Ismailis but called “hashish eaters” as a slur by other Muslims. Their leader was Hassan-ibn-Sabbah, also known as the Old Man of the Mountain, who is widely seen as an Islamic heretic. This sect resorted to radical acts including assassination, and while the legend diverges much from true events of the era, it has been extensively cited as proof of cannabis’ evil properties. In fact, the Islamic word for hashish (hashishin) is derived from their word for assassins (ashishin) (Lawrence 2019; Chasteen 2016). Anslinger’s narrative portrayed marijuana as the assassin of youth, something that could trigger aggression in non-white people, and a gateway to interracial romance. Author Martin Lee also adds:

In addition to hexing blacks and Mexicans, Anslinger’s antimarijuana diatribes served as a not-so-subtle reminder to white women, who had only recently won
the right to vote, that they still needed strong men to protect them from the “degenerate races”. He never tired of telling new versions of the same morality tale, which featured a vulnerable young white woman whose tragic downfall is triggered by smoking marijuana with dark-skinned rogues (Lee 2012:52).

As a moral crusader, Anslinger fabricated sensational stories, ignored facts which did not match his worldview, and deliberately excluded non-sympathetic authorities from public hearings regarding cannabis. In fact, during congressional deliberation on the MTA, only one expert witness was ever called from the American Medical Association. This witness was quickly dismissed for challenging Anslinger’s views by testifying cannabis had been a safe, respected medicine and that addicts needed treatment and education, not punishment. More time was spent hearing from representatives from companies that utilized parts of cannabis plants for industrial purposes, most notably that of the birdseed industry and the Sherwin Williams Paint Company (Torgoff 2016; McWilliams 1990; Becker 1973/1963).35 This was an issue where “[y]ellow journalism, racial bias, and political opportunism had triumphed over medical science and common sense” (Lee 2012:54).

Like the Harrison Narcotics Act of 1914, the MTA of 1937 permitted use of the drug for medicinal purposes but required prescribing doctors to register with the federal government and pay an exorbitant tax of $100 per ounce (Lawrence 2019). After these new bureaucratic requirements, many doctors stopped prescribing marijuana, and the plant gradually fell out of medical texts and the standard pharmacopeia (Pacula et al. 2001). Even before the MTA, cannabis medicines were on the decline thanks to the popularization of pharmaceutical tablets during the early twentieth century. Patent medicines with cannabis were commonly in the form of alcohol or oil-based tinctures, and since production methods and the type of cannabis used

35 Howard Becker (1973/1963) also notes that during the hearings associated with the Marihuana Tax Act of 1937, marijuana smokers did not have their view entered into the public record. They were unorganized and thus powerless to protect the plant during the brief debate on prohibition.
varied, the effects of these tinctures were unpredictable. Pills provided physicians and patients with a means to dose medication in a consistent manner (Fyre 2018). As such, the MTA was likely the final nail in the coffin for cannabis medicines in the United States.

Perhaps the most authoritative challenge to the MTA came from a 1944 report commissioned by New York City Mayor Fiorello La Guardia. The report was both sociological and clinical, and found marijuana did none of the things purported by the Federal Bureau of Narcotics: it did not make users commit crime, it was not addictive, it did not lead to other types of substance use, and it was not associated with juvenile delinquency. The FBN quickly condemned the La Guardia report and quietly worked to have it removed from American libraries (Torgoff 2016; McWilliams 1990; Herer 1985).

Censorship, denial, and refutation became the line of march for the government concerning anything to do with cannabis. The only exception was made during World War II when the USDA encouraged farmers to plant hemp by subsidizing mass cultivation, even making a 15-minute promotional film called *Hemp for Victory* (1942). Following such victory, law enforcement spent countless hours trying to eradicate the non-psychoactive hemp plants which had escaped farmer’s fields while the government set out to destroy all copies of the film and strived to eliminate all knowledge of the wartime hemp program from public record (Lee 2012; Herer 1985). They were successful at first, and the government denied the film ever existed until 1989 when hemp activists donated two exhaustingly-recovered copies to the National Archives. This is just one of the many examples of how the government would attempt to monopolize information on marijuana, thus creating a legacy that would long outlive the law itself36:

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36 Another telling example of government censorship concerns something said on television by poet Alan Ginsberg. Appearing on the John Crosby show in 1961 along with Ashley Montagu and Norman Mailer, Ginsberg said in their discussion on modern sensibility that marijuana should be legalized or decriminalized. Montagu agreed and Mailer
The moral panic and press sensationalism of [Anslinger’s] antimarijuana campaign, along with his penchant for playing fast and loose with the facts about drugs in America, established the template for all of the drug hysterias that followed. It was Anslinger who first institutionalized the entire ideology of drug prohibitionism that launched our drug war (Torgoff 2016:345).

Marijuana would be a relatively unknown drug throughout the 1950s where it was largely consigned to underground cultural circles such as the Beat poets and novelists. Celebrated literary works like Jack Kerouac’s *On The Road* (1957) helped construct marijuana as a hip substance and are partly responsible for the resurgence of interest in marijuana as a countercultural drug and therapeutic substance in the 1960s. The Beats get their name from their bucking of a culture where “the good life” was characterized by holding a steady nine-to-five job to fuel one’s addiction to consumerism. Straight society, as they called it, left them feeling beaten down and exhausted to the point where they disconnected from the national mood. The Cold War had also begun, and defeating communism meant working as hard as one possibly could with unflinching patriotism. Perhaps this is why Harry Anslinger shifted his rhetoric to depict marijuana as the drop-out drug, something that would pacify Americans and facilitate the Red’s takeover of our hardworking country (Torgoff 2016; Lee 2012). This, of course, was the total opposite of the crazed, aggressive marijuana fiend sensationalized in previous decades. But then again, facts were never a priority to Anslinger.

Facts do matter, though. “As the use of marijuana soared among middle-class youth, officialdom started to get anxious, especially when the sons and daughters of prominent politicians were caught smoking it” (Lee 2012:80). In the early 1960s, marijuana-related arrests along with Crosby even admitted to trying it before without negative effect. After the broadcast, the Federal Communications Commission forced CBS to run a 7-minute PSA made by the Narcotics Bureau that denounced Ginsberg, Montagu, and Mailer. Enraged by this official, mandated rebuke of a citizen’s freedom of speech, Ginsberg began to compile an archive of government lies regarding marijuana. The information Ginsberg collected would become valuable in the ensuing fight for marijuana reform (see Torgoff 2016 and Lee 2012).
for whites were on the rise, and President Kennedy, dissatisfied with the FBN’s assault on his people, sacked Anslinger in 1962. Though still fervently anti-marijuana, the National Institutes of Health (NIH) was able to convince the FBN to permit the funding of research exploring the plant. Partly funded by the NIH, a breakthrough came in 1964 when Dr. Raphael Mechoulam at the University of Tel Aviv discovered THC, and for the first time, scientists understood exactly what produced the sensation of being high (Lee 2012; Herer 1985)\(^3\). The United States government even began sponsoring some research into the therapeutic uses of natural cannabis in 1966. Most important of all, The MTA would be overturned by the Supreme Court in their 1969 decision on *Leary v. United States*. Psychedelic activist Dr. Timothy Leary (the ex-Harvard professor who told the world to “turn on, tune in, drop out”) had been arrested in 1965 for possession of marijuana at the U.S./Mexico border. He successfully appealed his case on the basis the MTA violated the Fifth Amendment since you had to incriminate yourself in order to pay your marijuana taxes. However, this would prove to be little more than a personal victory for Leary since Congress was already working on a new drug law (Torgoff 2001).

**Sociology and the Marijuana Tax Act.**

The MTA’s legacy is one of lasting disgrace and embarrassment on the part of the government. Official statements on cannabis made by Harry Anslinger and the FBN have about the same degree of integrity as Donald Trump’s Twitter account. As I hope this dissertation has made clear, prohibition not only limits a drug’s availability, it also limits social and scientific understanding of the drug. Federally mandated prohibition effectively creates a monopoly on

\(^3\) Mechoulam would later discover a non-psychoactive THC metabolite in urine, the compound leftover after the body breaks down psychoactive THC. He regrettably did not patent his discovery which would serve as the foundation for drug testing urine (Lee 2012).
information about a substance because it is unavailable to others, including researchers. In the early twentieth century, almost all commentary on prohibited drugs came from the very government officials and organizations that established the laws. In situations like this, lies readily replace facts to further support a political agenda. Yet throughout the twentieth century, the discipline of sociology provided valuable critiques of these policies based on myths, fears, and exaggerations.

Sociologist Bingham Dai was one of the first to actually ask drug users about their lives rather than rely on information from authorities. His book, *Opium Addiction in Chicago* (1937), is cited as the first drug ethnography in American history (Torgoff 2004). Alfred E. Lindesmith, a sociologist and student of Dai’s, furthered this line of work with a series of books refuting claims made by the Federal Bureau of Narcotics. In fact, Lindesmith would become an avowed enemy of Harry Anslinger as the nation’s first drug czar repeatedly attempted to have Lindesmith fired from his tenured position at the University of Indiana (Torgoff 2004; McWilliams 1990). The poet Alan Ginsberg spent an entire summer in Lindesmith’s basement pouring over the sociologist’s curated archive of marijuana-related documents (Torgoff 2016). He would use this information to fight marijuana prohibition in addition to writing a piece in *The Atlantic Monthly* called “The Great Marijuana Hoax: First Manifesto to End the Bringdown”:

> Not only do I propose the end of prohibition of marijuana but I propose a total dismantling of the whole cancerous bureaucracy that has perpetrated this historic screw-up on the United States. And not only is it necessary that the Bureau of Narcotics be dismantled & consigned to the wax museum of history, where it belongs, but it is also about time that a full-scale congressional investigation with all the resources of the embattled medical, legal & sociological authorities, who for years have been complaining in vain, should be undertaken to fix the precise responsibility for this vast swindle on the administrative & mass-media shoulders where it belongs (Ginsberg 1966).  

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38 Ginsberg’s sociologically-inspired essay on the intellectual uses of marijuana may have influenced Carl Sagan to experiment with the plant. Sagan eventually wrote an anonymous essay on marijuana in 1971 under the pseudonym
Other sociological research helped to dispel the myths that drug addiction was permanent and required forced abstinence in order to save the addict. Work by sociologists like Everett Hughes and Charles Winick brought about our understanding of often-temporary deviant careers and drug lifestyles, and these revelations directly influenced Howard Becker. One of the most prominent sociologists in the United States, Howard Becker is well known for his works “Becoming a Marijuana User” (1953) and “Marijuana and Social Control” (1955). These each directly challenged the anti-cannabis narratives concocted by Harry Anslinger and the FBN, the precursor to the DEA. Above all else, Becker found marijuana use did not lead to violence and insanity, but rather users learned to perceive marijuana as pleasurable and calming.

These classic studies have since informed much social scientific research about drugs, but they were written in a context where medical cannabis had faded from academic discourse. As such, while Becker’s studies are immensely valuable in combating anti-drug hegemony, his work has little direct influence on my study. My point in raising it here to show that sociologists have long been on the front lines of the war drugs, though often in opposition to the lies spewed by the government. It fills my heart with joy to know that in retirement, Anslinger complained about “permissive parents, college administrators, pusillanimous judiciary officials, do-gooder bleeding hearts and new-breed sociologists with their fluid notions of morality” (Harry Anslinger as quoted in McWilliams 1990:186).

Mr. X. where he praises being high as a means of attaining profound insight while lamenting the difficulty of believing such insights (which he swears are real) when sober. Like the mystics who consume entheogens to experience something beyond the confines of normative human perception, “[w]e simply don’t have the words to convey the force of these perceptions to our straight selves” (Pollan 2001:167).
A Schedule I Controlled, Dangerous Substance (1970s to 1980s)

Despite the MTA being overturned, the federal government had already been working on a replacement that would make cannabis a flat-out prohibited substance in all forms. The 1970 Comprehensive Drug Abuse Prevention and Control Act (now called the Federal Controlled Substance Act of 1970) created five categories or “schedules” of drug regulation based on a drug’s potential for abuse and the drug’s accepted medical value. Schedule 1 is reserved for drugs that have a high potential for abuse and no currently accepted medical value, and here cannabis was placed along with heroin, LSD, and peyote. Moreover, all Schedule 1 drugs are totally prohibited in the United States; doctors may not prescribe them and research on the substance is effectively killed. Yet there were many government-funded studies into the therapeutic uses of natural cannabis from 1966-1976. Jack Herer (1985) claims that by 1983, there were nearly 10,000 studies published on cannabis with 4,000 being from the United States. Of the dozen which found some negative results, none has ever been replicated.

Marijuana’s designation as a Schedule 1 dangerous drug was supposed to be temporary pending the findings of a presidential commission chaired by the former Republican Governor of Pennsylvania, Raymond P. Shafer. The 480-page Shafer Report was released in March of 1972 and came to a remarkably similar conclusion as the La Guardia Report nearly 30 years earlier: marijuana was not harmful, and problems associated with the drug were more the product of its criminalization. Comparing marijuana to alcohol, the commission recommended it should be regulated by means other than the Controlled Substance Act. Instead of rescheduling or descheduling marijuana, the Nixon Administration ignored the Schafer Report and organized a congressional subcommittee to oppose the original committee’s findings.
Known as the Eastland Hearings, the subcommittee brought in a parade of witnesses who made factually incorrect claims such as marijuana makes men grow breasts, causes people to become homosexuals, leads to all sorts of birth defects and genetic anomalies, and results in “amotivational syndrome.” Many of these conclusions would eventually become textbook examples of scientific fraud, but the steady stream of misinformation was designed to leave the impression that something about cannabis must be dangerous. This spurred the government to continue investigating harms associated with the plant and marijuana remains a Schedule 1 substance at the federal level today (Lee 2012; Torgoff 2004).

In contrast to the artistic and playful protests staged by countercultural activists like the Yippies, NORML (National Organization for the Reform of Marijuana Laws) was created in 1970 by attorney Keith Stroup. Based in Washington D.C., the group retained a panoply of academics, doctors, lawyers, and politicians to lobby against the government’s unyielding prohibitionist agenda. Unlike other pro-legalization activists, NORML embraced professionalism and adopted a politics of respectability. Representatives dawned business suits, worked within the bureaucracy, and attempted to impart the impression that pot smokers were as normal as beer drinkers. Throughout the 1970s, 12 states either decriminalized marijuana possession or reduced it to a misdemeanor thanks to NORML’s efforts. Victory on the federal level appeared to be in reach when President Jimmy Carter, citing the Shafer Report, expressed support for marijuana decriminalization. This support would be short-lived because NORML founder Keith Stroup leaked information regarding alleged cocaine use by Carter’s pot-friendly drug czar. Stroup was infuriated at the administration’s persistent spraying of the toxic herbicide paraquat on Mexican

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39 One study frequently cited in the Eastland hearings involved brain damage in monkeys who put in air-tight gas chambers which were then clouded with marijuana smoke for 5 minutes. The researcher claimed it was marijuana causing brain damage rather than suffocation from a lack of oxygen.
marijuana fields (Lee 2012). Nonetheless, NORML still campaigns for marijuana reform though they heavily focus on recreational legalization rather than expanding access to medical use.

The 1970s was also the time when people suffering from illness began challenging the government’s total prohibition of cannabis. One of the first was Robert Randall who successfully argued before a court that his cultivation of marijuana was a medical necessity since he suffered from glaucoma. With the urging of several organizations, the federal government began an Individual Patient Investigational New Drug (IND) program in 1975 to explore the use of marijuana as a medicine through carefully controlled clinical trials (Pacula et al. 2001). Not much research resulted from the IND because the government never collected data, but patients enrolled in the program received their marijuana directly from the federal government in the form of pre-rolled marijuana cigarettes (joints). However, “[t]he onerous qualification process was designed to deter applicants and their physicians, who had to wade through mountains of paperwork and endure various indignities, including a background check and a visit from DEA agents” (Lee 2012:167).

Since the gatekeeping to enroll was so strict, only 15 patients were ever accepted before the IND program was closed to new applicants in 1992.40 Three of these individuals continue to receive a giant tin of joints each month from the federal government as of 2019, but the quality of the medicine is very poor. Described as resembling “green talcum powder”, the marijuana is grown outdoors by the University of Mississippi, the only federally approved cultivation established by NIDA in 1968. They also supply all of the cannabis used in clinical trials. This is

40 The IND program was unilaterally terminated in 1991 by James O’Mason, chief of the US Public Health Service and notorious homophobe (Werner 2001). A compromise was reached in 1992 to allow the program to continue but only for existing patients and applicants. Lee (2012) says the program was flooded with applications after Robert Randall distributed information packets walking patients through the application process. If the federal government began a mass distribution of medical cannabis, then they would be forced to acknowledge the medical value of cannabis. Chapkis and Webb (2008) believe the Bush administration supported the termination of the program because many of the new applicants were suffering from AIDS rather than glaucoma or cancer.
concerning because their product does not have a consistent level of THC, being off by 5% according to one independent test. More appalling is the marijuana these patients receive can sometimes be 14 years old, is occasionally infected with mold or yeast, and is always very dry with loads of seeds and stems (Patients Out of Time 2019; Hellerman 2017).

Shortly after the creation of the IND program, publicly accessible research into cannabis ended in 1976 when pharmaceutical companies lobbied the government for exclusive control over cannabis research to find patentable synthetic preparations. The Ford administration agreed to their requests and allowed private pharmaceutical corporations to do "no high" research on THC only, not any of the hundreds of other compounds in the plant. This action took cannabis research away from the public sector—out of the universities and government-sponsored studies—and placed it into the sole hands of the for-profit sector (Herer 1985). They would eventually develop one drug known as Marinol which is 100% pure THC, and as such, does not produce benefits anywhere near those achieved by the “entourage effect” where the multitudes of cannabinoids work in synergy.

Because the federal government refused to reschedule cannabis to recognize its medicinal value, activists pressured states to permit medical marijuana consumption or research in some form. Robert Randall, the first IND patient and former college professor, teamed up with Alice O’Leary to form the Alliance for Cannabis Therapeutics in 1981, a nonprofit with an agenda to advance medical cannabis access. By 1983, 34 states (including Michigan) had passed some sort of legislation that theoretically allowed for medical marijuana under clinical trials, but nothing practical resulted since the federal government supervises licenses for prescription medicines and controlled the supply of cannabis for medical research (Pacula et al. 2001; Werner 2001). It was also the reign of Ronald Reagan and his administration showed zero sympathy for loosening
marijuana laws. Under his administration, the rhetoric around legal and medical cannabis began to shift with advocates for prohibition stressing the “message” such policies would send to youth as well as a religious desire to protect the country from the demons of communist sympathizers (Lee 2012; Chapkis & Webb 2008). Since many of the early medical marijuana state laws were passed in hopes that cannabis would be rescheduled on the federal level, most of these laws were eventually allowed to expire or would be repealed amidst the anti-drug zeitgeist of the 1980s.

Like the La Guardia Report and the Schafer Report, in 1982 the National Academy of Sciences published findings from a six-year investigation that concluded marijuana was not physically or socially harmful and that a better approach of regulating the drug would be decriminalization at the federal level. And just like Presidents Roosevelt and Nixon, President Reagan totally ignored the report. In fact, he did just the opposite of the report’s recommendations by ramping up a drug war to where a person could be arrested for selling pot paraphernalia (Lee 2012). The Reagan Administration even floated the idea in 1983 of forcing American universities to destroy all copies of the cannabis research sponsored by the federal government between 1966 to 1976 (Herer 1985). The plans were dropped after fierce backlash, but information still disappeared and many important historical documents vanished from public archives. NIDA, for example, blacklisted 64 of its previous publications which included favorable comments regarding marijuana use. They purportedly did this by eliminating all documents that included the word “social” in conjunction with variations of the word “marijuana” (Lee 2012).

One hallmark of Reagan’s War on Drugs was the escalation of the civil asset forfeiture provisions for marijuana and other drugs. In 1984, law enforcement was permitted to sell all confiscated property involved or purchased with drug possession, cultivation, and sales. This was
designed to prevent drug dealers from continuing their vice while awaiting trial, but the policy has since morphed into a lucrative way to strip citizens of their earthly possessions upon being suspected of selling an illicit substance. In 2014, Michigan couple Annette and Dale Shattuck had their home raided and property confiscated after they tried to open a medical cannabis dispensary. Law enforcement trashed their house and took their children’s’ Christmas presents, important documents like health insurance cards and driver licenses, and nude photos the couple shared between themselves. In a similar case, Michigan resident Ginnifer Hency had property like her vibrator confiscated after a task force raided her home following information that she was a caregiver in the state’s medical marijuana program (Komorn 2015). The vast majority of sized assets belong to individuals who are never charged with a crime or have their charges dismissed, like each of the examples raised here. Nonetheless, these innocent individuals must fight the government in court for the return of their property which totaled more than $80,000 for the Shattucks (Andavolu 2016).

Some progress was still made in terms of medicalizing cannabis though it had its drawbacks. The mono-cannabinoid drug Marinol was approved by the FDA in 1985 and classified as a Schedule II controlled substance (alongside cocaine and morphine) and was later placed within Schedule III. Made by infusing THC into sesame oil, Marinol pills were large, expensive, and mostly inaccessible (Werner 2001). With something similar to marijuana now prescriptible, some advocates no longer felt the need to push for marijuana reform. Unfortunately, those whose bodies were deteriorating from cancer or AIDS (and had the money

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41 Michigan’s government took steps to amend the state’s civil asset forfeiture laws following the bad publicity generated by these two cases. The laws were also amended in 2019 to require a criminal conviction before property can be confiscated.
to afford a pharmaceutical drug) found little relief from Marinol. They wanted accessible whole plant medicine.

Gay People Make Marijuana a Medicine Again (1990s)

The next part of the story occurs in California with Dennis Peron, a gay Vietnam veteran who became an advocate for marijuana legalization in 1970s. Even though he would be busted for selling cannabis more than a dozen times, Peron was politically active in San Francisco where he was good friends with Harvey Milk. As Milk was making his fourth run for city council, Peron was trying to decriminalize marijuana in San Francisco with Proposition W. His dream was to make San Francisco the Amsterdam of America, and he boldly operated an open-air marijuana marketplace called the Big Top until it was raided by city police in 1977 (Gardner 2007). During the bust, Peron was shot in the leg by a homophobic officer, and this would actually prove beneficial to Peron’s defense:

We knew the cops hated gay people so we teased them a lot… One day outside in the hallway, I said to [the officer] ‘We love your shoes today. Where’d you get those Guccis?’ And he said, ‘You motherfucking faggot, I should have killed you so there’d be one less faggot in San Francisco!’ He didn’t know that there was a whole string of lawyers behind him who heard him say it. They got him back on the stand and then they just wore him down (Dennis Peron quoted in Torgoff 2004:299).

Even though the raid on Peron’s marketplace yielded 200lbs of cannabis along with loads of other drugs, Peron received a mere six months in jail due to police misconduct. By this time, Proposition W had received enough signatures and it was placed on San Francisco’s city ballot. It passed with 56% of the vote in November 1978 along with the reelection of Harvey Milk and the city’s pot-friendly mayor. Regrettably, several weeks later, Milk and the mayor were murdered by an ex-council member with a record of homophobic and anti-marijuana remarks.
Peron was in jail at the time and the city’s new mayor, Diane Feinstein, refused to implement any of Proposition W’s decriminalization measures (Torgoff 2004).

Dennis Peron’s emphasis on medical cannabis would come in 1990 as his partner, Jonathan West, was dying of AIDS. The couple’s home was raided by police who made AIDS-related and homophobic jokes after seeing a photograph of Peron with Harvey Milk. Only Peron was charged when the cops found four ounces of cannabis, and while spending the night in jail, Denis Peron had a vivid dream:

He saw sick people, people in wheelchairs, men and women, young and old, black and white, all sitting in a large room, laughing, hugging, and sharing cannabis. That’s how Peron got the idea for a public medical marijuana dispensary, a place where people like Jonathan could gather and smoke pot with friends, unashamed of their skin abrasions and their obvious infirmities (Lee 2012:231).

Frail from wasting syndrome, Jonathan West would eventually testify at the trial that the confiscated marijuana was his own, and this got Peron off the hook. The judge even scolded the officers for their harassment of a dying man and his caretaker. Jonathan West would die in September of 1990 as the AIDS virus reached epidemic proportions in queer communities throughout the nation.

There was widespread apathy towards individuals with AIDS at this time in our history. First documented in 1981, the disease was commonly called Gay-Related Immune Deficiency (GRID) or even “gay cancer.” Moreover, since its victims were largely gay men or drug addicts, popular sentiment for these so-called “guilty victims” anything but empathetic. Chapkis & Webb (2008) even say that AIDS victims replaced immigrants as the despised group connected to marijuana, becoming the new “dangerous class” (Reinarman 1994) upon which the government justified continued marijuana prohibition. This created a sense that if anything were to be done about AIDS, it would have to come from within the affected community. Pharmaceutical
companies felt developing a treatment would be unprofitable while the Reagan administration allocated a mere $8,991 per AIDS death to the National Institute of Health42 (Werner 2001).

Those who used marijuana as medicine quickly found an effective message to garner popular support. They emphasized that the federal prohibition of marijuana resulted in unnecessary suffering most often for those nearing the end of the lives. Chapkis and Webb (2008) say the momentum for medical cannabis was akin to a “social movement spillover” since the community was already steeped in activism from the gay liberation movement. Many early AIDS victims were pioneers in the gay rights movement and had already established an infrastructure of activism (Werner 2001). Yet sexuality was not the only identity pertinent to their struggle. These individuals were also marginalized due to their social class and race, both of which affect the quality of professional care individuals receive at medical institutions. Furthermore, the only legal option at the time was Marinol, and this was not only less effective than whole-plant cannabis, but it also was not accessible to those without health insurance or the means to navigate the health care bureaucracy.

Part of the appeal of cannabis as a medicine was its cost, availability, and familiarity. Networks of cultivators, dealers, and users were already well established when the AIDS crisis hit, and the relatively inexpensive street drug was quickly found to be more effective in dulling pain and stimulating appetite than anything available through a physician. Cannabis also eliminated the need to visit judgmental health care providers and it was undeniably pleasurable. While the low cost of cannabis certainly made it more accessible for many, the major challenge was in distribution. Patients needed a reliable and trustworthy source, and many were too ill to scour an underworld of vice for a reputable supply.

42 Compare to $36,100 per death from Toxic Shock Syndrome and $34,841 for Legionaire’s disease in 1982.
Buyer’s clubs for non-FDA-approved AIDS medicines were already in existence when Dennis Peron decided to apply the business model to cannabis. These facilities would enroll club members who would then have access to the club’s supply of medicine, usually with nominal cost. Beginning in San Francisco and New York City in 1987, buyers’ clubs placed all the risk onto the owner(s) since members could pick up from a secure location rather than pushing their luck on the streets (Chapkis & Webb 2008; Werner 2001). At the time, there were limited conventional treatment options for those with AIDS since the disease was not well understood by medical institutions. The preferred way of managing the disease was with AZT, an antiretroviral medication, but this suppressed appetite to an extreme degree and resulted in many deaths due to wasting syndrome. Early buyers’ clubs for AIDS patients focused on vitamin infusions and drugs with anecdotal reports of relieving AIDS symptoms, among them an AL-721 (an Israeli egg-yolk extract) that was commercially unavailable in the U.S. (Gardner 2007).

In 1991, Peron teamed up with psychiatrist Tod Mikuriya to open the nation’s first cannabis buyers club in San Francisco. Dr. Mikuriya was an early proponent of harm reduction strategies and headed the National Institute of Mental Health’s marijuana research program in the late 1960s. After becoming frustrated with the government’s mandate to exclusively study harms associated with marijuana, he quit the organization after several months and later released a compendium called Marijuana: Medical Papers 1839-1972. The anthology contained 25 previously published studies and served as a call for medicine for rediscovering marijuana’s therapeutic properties. Released in 1973, the book is cited by some as the beginning of the modern medical cannabis movement (Lee 2012). Mikuriya’s medical expertise combined with Dennis Peron’s political capital resulted in two significant initiatives, the first of which was a

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43 Peron’s buyers’ club opened at the site of a short-lived medicinal marijuana retail location. It had been organized by Thomas O’Malley to help patients with AIDS before O’Malley succumbed to the disease himself.
city ordinance known as Proposition P. Permitting the use and sale of cannabis medicines to anyone who could benefit, Proposition P passed with 80% of the votes in 1991, effectively making San Francisco the nation’s first medical marijuana oasis. The city of Santa Cruz passed a similar ordinance in 1992 (Chapkis & Webb 2008) and others would follow in the future as well.

Dr. Mikuriya refers to Peron’s buyer’s club as a “medical speakeasy” (1995:10) where individuals carrying a doctor’s note enter through a nondescript door with a peephole lens. Senior citizens were granted automatic admission and free cannabis was regularly given to poor patients (Lee 2012). Yet unlike many medical cannabis facilities of today, patients could consume cannabis on-site through smoking or vaping. Like other buyers’ clubs, this one offered support services, opportunities to connect with other patients, and encouraged its members to become politically active. Denis Peron is quoted as saying, “[M]arijuana is part of it, but the biggest part of healing is not being alone. They always find that people who are alone die faster” (Gardner 1997).

Dennis Peron and his associates would ultimately mobilize their political capital to endorse two bills introduced in California’s state legislature. Each was focused on permitting medical uses of cannabis, each passed both houses of the legislature, and each was vetoed by the state’s Republican governor. The activists eventually turned their sights to a ballot initiative (Proposition 215), which rather than legalizing cannabis, would create a doctor-recommended exception at the state level as to not conflict with federal law (Lee 2012). The most controversial component of the ballot measure was the inclusion of a catch-all category allowing medical cannabis to anyone who could benefit. Being very attentive to how the language would be perceived, many feared the open-ended nature of qualifying conditions would cost the initiative
support. However, Dennis Peron and Dr. Mikuriya insisted medical cannabis should not be limited to a handful of major diseases:

The final draft [language] filed with the Secretary of State reflects Dennis’s view of himself as a “caregiver” and of his club as an extension of his living room and personality. Its open-ended nature is asserted in the first sentence, which allows doctors to approve “the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief” (Gardner 2007:18).

Initially, Peron and the buyers’ club wanted to keep the signature drive a grassroots affair. However, they were slow to collect enough signatures until a now-renowned drug policy expert named Ethan Nadelmann offered help. Nadelmann was able to bring in big money backers, including billionaire George Soros\(^44\) and George Zimmer, the owner of Men’s Wearhouse suit stores. They would form a group called Californians for Medical Rights (CMR) and would eventually submit over 800,000 signatures, nearly double the number required. The initiative was opposed by the governor, most of California’s politicians (both Republican and Democrat), the state police, and even President Bill Clinton. In fact, after the initiative was officially placed on the ballot, the first moves by the opposition were to shut down Peron’s buyers’ club and conduct raids on the homes of his staff and patients. Undeterred, Peron was such an advocate for medical cannabis that the CMA struggled to convince him to stop providing cannabis until after the election was over (Gardner 2007)

Dennis Peron is also famous for saying “all use is medical” to reporters during their coverage of the AIDS epidemic\(^45\). He received intense criticisms for this statement, with many medical advocates saying it trivializes individuals with severe health issues and provides

\(^{44}\) “Soros became interested in drug policy after he met Allen Ginsberg. The intellectually engaging poet told Soros about how he had spent an entire summer researching the files of Indiana University sociologist Alfred Lindesmith, the first prominent U.S. academic to challenge America’s heavy-handed war on drugs” (Lee 2012:241).

\(^{45}\) Dennis Peron told author Martin Lee that he actually said: “In a society where kids are prescribed Prozac for shyness, all marijuana use is medical” (2012:247).
ammunition to those opposed to medical cannabis laws (Preston 2002). True to his word, Peron would spend the latter part of his life growing cannabis in rural California, an act he interpreted as making a public statement about a patient’s right to grow their medicine. He would also sell his crop to patients at $200 a pound compared to the going price of $4,000 a pound. It’s no wonder, then, that Peron barely hung onto a dime during his lifetime despite dealing mountains of cannabis (Preston 2002). He saw the plant as curative or therapeutic regardless of how it was used, and he fervently dedicated his life to making it more available to those who could benefit. He was not alone.

Mary Rathburn is known as San Francisco’s Mother Teresa and was twice awarded “Volunteer of the Year” at San Francisco General Hospital prior to becoming a media sensation. A pro-union, pro-choice activist turned IHOP waitress, Rathburn first met Dennis Peron in 1972 when she asked for a hit of his joint while waitressing. She supplemented her income by selling brownies made with cannabis butter, and following her second arrest, her mandated community service included driving AIDS patients to the hospital. Realizing her brownies could be of help to these patients, “Brownie Mary” would eventually give away 1,600 cannabis-infused brownies per month to what she called “her kids” (Lawrence 2019; Ewbank 2018). In 1992, she would be arrested for the third time after a raid on her home uncovered 20lbs of cannabis along with massive piles of ingredients for brownies. In the police car she is reported to have said: “If the narcs think I’m gonna stop baking brownies for my kids with AIDS, they can go fuck themselves in Macy's window” (Margolin 2019). The image of a 69-year old lady being arrested for giving

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46 The “pot brownie” made its debut in the original 1954 edition of The Alice B. Toklas Cook Book, though it was not included in the U.S. edition until 1961. A life-long partner of poet Gertrude Stein, Toklas was an epicurean who collected recipes during the couple’s years hosting luminaries and bohemians at their home in Paris. She would publish these at the age of 74 along with exotic contributions from fellow bohemians like Brion Gysin, a Canadian poet who submitted a recipe for “Hashish Fudge”. In 1968 the fudge was transformed into a brownie for the film I Love You, Alice B. Toklas!, the first major motion picture which featured cannabis-laced foods (Lawrence 2019). It is unknown if Toklas ever actually ate an infused brownie.
away medicinal brownies made international headlines, and the charges against Rathburn were soon dropped. She would work side-by-side with Dennis Peron on legalizing cannabis and they both served as grand marshals for San Francisco’s gay pride parade in 1997 (Ewbank 2018).

News stories of Rathburn’s 1992 arrest reached two significant individuals. Rick Doblin was the founder of the Multidisciplinary Association for Psychedelic Studies (MAPS) which facilitated clinical research on Schedule I drugs. Seeing Rathburn volunteered at a renowned AIDS facility, Doblin wrote to the hospital about the possibility of establishing a clinical trial on cannabis’ efficacy. The letter eventually reached Dr. Donald Abrams, the Assistant Director of San Francisco General’s AIDS Program where he specialized in community-based clinical trials. Luckily, Dr. Abrams had also seen Brownie Mary’s arrest on the news and was motivated to begin working with Doblin in designing a community-based clinical trial on smoked cannabis (Werner 2001). They would need the approval of eight different agencies to proceed (Lee 2012).

The main challenge for such a study was in acquiring cannabis, which even today is only available to researchers through the National Institute of Drug Abuse (NIDA). Dr. Abrams submitted their rigorous and vetted design to the NIDA in 1994, the organization purposefully stalled on issuing a decision. Nine months later, NIDA rejected the study without explanation, and Dr. Abrams went on a media blitz. Controversy ensued and NIDA was forced to restructure their application process so any study passing the organization’s peer review would be granted cannabis. The resubmitted application would also be rejected with Dr. Abrams explaining:

Two of the three reviewers mentioned in their comments that they were unclear as to why the Consortium investigators would choose to conduct a trial with a “toxic” substance. The final reviewer was concerned that if patients with AIDS wasting developed increased appetite following marijuana ingestion… that they may subsequently develop hypertension (high cholesterol and triglycerides) and atherosclerosis (Werner 2001:30).
While this second rejection was disappointing, it also came three months before the citizens of California voted on Proposition 215. Medical activists would use the rejection as proof of the government’s dishonesty on the issue, and another national debate ensued where former general and drug czar Barry McCaffrey repeatedly came off as ignorant on the issue (Werner 2001). Pro-cannabis activists emphasized that the federal prohibition of marijuana and blockade on cannabis research resulted in unnecessary suffering (Chapkis & Webb 2008). In November of 1996, Proposition 215 would pass with the support of 55.6% of California’s voters. In fact, more people voted for Proposition 215 than they did for Bill Clinton (Herer 1985).

With victory in hand, Dennis Peron would go on to open another buyers club and continue to advocate for marijuana reform. He would be joined by countless others, some of whom pioneered different models of delivering medicine and support to those who need it. Among them were Valerie and Michael Corral who founded the Wo/Men’s Alliance for Medical Marijuana (WAMM), an experimental communal support group where members were asked (not required) to volunteer in exchange for free medicine. Their mission was informed by the recent women’s health care movements which saw “health care as a right rather than a commercial commodity and patients as active participants in (not passive recipients of) medical care” (Chapkis & Webb 2008:51). The WAMM would ask members to help cultivate and prepare cannabis-infused muffins and soymilk beverages which would be dispensed at no cost to members at weekly meetings. In turn, the organization provides a sense of family and a type of long-term care policy. For example, members routinely provide informal hospice care to others, and for those suffering from a stigmatized disease like AIDS, this provided the invaluable possibility of “dying in the embrace of friends” (Chapkis & Webb 2008:104).
Yet the federal government did not acquiesce on their anti-cannabis position. In response to California and Arizona\(^{47}\), the DEA and Attorney General Janet Reno (with support from NIDA) threatened to crack down on any physician who recommended a prohibited substance. Fortunately, other models of care outside of mainstream medicine like buyers’ clubs and the WAMM had already been established. Unfortunately, in the years to come these clubs would be frequently raided by DEA agents, and many of their owners would be imprisoned for long periods of time. The federal government would also eventually adopt a new strategy following the rise of medical cannabis programs. As juries could be persuaded someone’s use was medically justified, the federal government began suing distributors in civil court where a judge can be the sole decider of the case (Preston 2002).

Likewise, state medical cannabis programs did little to ease bureaucratic barriers in studying cannabis. At a time when nearly anyone with a few dollars could acquire cannabis being sold on the streets, Dr. Abrams still struggled to get cannabis for his clinical trial. Yet after more public outrage following the government’s announced crackdown, the NIDA director informed Dr. Abrams:

> [T]hat the Institute was “the National Institute on Drug Abuse, not for Drug Abuse”. Consequently, Dr. Abrams and the marijuana team devised a study to assess the potential harm that marijuana or [Marinol] might cause by interfering with the new AIDS drugs, protease inhibitors. The study also included an examination of weight gain and other measures that could indicate if there was a therapeutic benefit of cannabis for the subjects (Werner 2001:31).

With the target of the proposed study now seeking to measure harm associated with cannabis use, the NIDA agreed to supply the medicine, and the research team began enrolling

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\(^{47}\) Also in November of 1996, Arizona voters also passed a sweeping measure allowing for the medical use of all Schedule I substances. Afterwards, and for the first time in 90 years, the state’s governor and legislature exercised their ability to veto a ballot initiative. The angry citizens of Arizona began working once again to collect signatures for a 1998 ballot initiative for medical cannabis use which would go on to become law (Herer 1985).
patients in May of 1998. Results of the trial would be among the first to support the anecdotal claims of tens of thousands of AIDS patients that marijuana eased their suffering, particularly for a condition called peripheral neuropathy which also affects cancer patients and diabetics (Lee 2012; Werner 2001). Yet it took nearly four years for NIDA to approve the study, and this tactic of bureaucratic delay would be adopted by other agencies.

In June of 2001, Dr. Lyle Cracker submitted an application to the DEA for the development of an additional medical cannabis production facility at the University of Massachusetts Amherst. After waiting six months for a reply, he was informed the application had been lost and that a photocopy would not be accepted. Over a year later, in July 2002, while still working to reassemble the original application documents, Dr. Cracker received the original application back in the mail. It was stamped as received by the DEA over a year earlier (Chapkis & Webb 2008). Undeterred, he sent the application back, and in March of 2003, 20 months after the original submission, his request was denied. The DEA wanted credible evidence that NIDA cannabis was not adequately made available to researchers. Once again, Dr. Cracker sent the revised application back and received no word from the DEA for an entire year. In July 2004, three years after the original submission, the DEA was sued by Dr. Cracker, Rick Doblin, and Valerie Corral for unreasonable delay. It would take the courts until 2013 to ultimately rule in favor of the DEA. Yet in August of 2016, the DEA announced it intended to end NIDA’s 48-year monopoly on cannabis cultivation for science by licensing other production facilities.

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48 The tactic of losing applications for cannabis research stretches back many decades. McWilliams (1990) describes attempts by the National Institute of Mental Health (NIMH) to conduct research on marijuana back in the 1960s. It took months for the NIMH to obtain permission from the Federal Bureau of Narcotics because the bureau claimed they had lost the application multiple times. The bureau also repeatedly questioned why NIMH would want to study marijuana since the organization’s director, Dr. Tod Mikuriya, was known to have views opposed to cannabis prohibition.
(MAPS 2019). As of early 2020, no other cultivation facilities have been granted licenses, perhaps indicating the tactic of bureaucratic delay is still in the gamebook.

The way the government approaches cannabis still defies all logic. They say it has no medical value by classifying it as a Schedule I substance, but they also ship canisters of joints to patients in the IND program. They declare more evidence is needed to change this scheduling though no evidence was consulted in placing cannabis there, and they deny almost all attempts to study cannabis further. Even when citizens practice their democratic rights by voting for changes in cannabis law, elected officials attempt to neutralize such changes in complex bureaucratic maneuvering. In this environment of entrenched political resistance, it is remarkable that patients—many of whom are severely ill or dying – were able to make some progress in expanding access to the plant. Much work still needs to be done, though, as access varies widely by state and municipality.

This appendix was designed to educate readers on how we got to where we are now regarding cannabis’ status in the United States. It is not exhaustive and omits more detail than it contains, but an over-arching trend appears to be twilight for prohibition as we know it. Several significant developments occurred at the federal level under the Obama administration. In 2009, the United States Department of Justice sent a letter to U.S. Attorneys saying it will “not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana” (Ogden 2009). In 2013, the Department of Justice also extended this hands-off approach to state recreational marijuana laws, saying it will not intervene in “jurisdictions that have enacted laws legalizing marijuana in some form and that have also implemented strong and effective regulatory and enforcement systems to control the cultivation, distribution, sale and possession of marijuana"
(Cole 2013). While each of these memorandums did not change federal law, they each gave state lawmakers reassurance that the federal government would not crack down on state marijuana reform. Fortunately, Congress passed the Rohrabacher-Blumenauer Amendment in 2014 which also forbids the Justice Department from using federal funds to interfere with a state cannabis program so long as it follows state law, though the amendment needs to be renewed each fiscal year as part of the omnibus spending bill. Following these memos, many states revised their medical and/or recreational cannabis laws to permit licensed growers and dispensaries, and we shall see this with Michigan in the next appendix.

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49 Attorney General Jeff Sessions rescinded the Cole memo on January 4, 2018. This caused anxiety in states with recreational marijuana laws, but the Department of Justice had no actual plans for a crackdown or change in federal enforcement. Following the termination of Jeff Sessions by President Trump in November 2018, the administration verbally reassured states that it would continue to tolerate state-level marijuana reform.
APPENDIX B

THE HISTORY OF CANNABIS IN MICHIGAN

Earlier Activism (1960s-2000s)

John Sinclair is a jazz poet as well as an early figurehead in Michigan’s marijuana legalization movement. After his first marijuana bust in 1964, Sinclair started the Michigan chapter of LEMAR, an organization short for “legalize marijuana” championed by fellow poets Ed Sanders and Allen Ginsberg. While LEMAR would fizzle out in the years to come, John Sinclair became a legend after he was convicted for the possession of two joints in 1969. Michigan had some of the most stringent marijuana laws at the time, and since it was Sinclair’s third marijuana-related arrest, the judge handed down a sentence of 10 years. His wife, Leni Sinclair, worked relentlessly on his freedom with her efforts cumulating on December 10, 1971, at the John Sinclair Freedom Rally in Ann Arbor. The rally drew an estimated crowd of 10,000 people thanks to a lineup of artistic talent that included Stevie Wonder, Bob Seger, and John Lennon. Three days later, Sinclair was released on appeal bond and would begin to adjudicate his original sentence (Gabriel 2019b).

On March 9, 1972, Michigan’s Supreme Court decided Sinclair’s original sentence was cruel and unusual, and even more surprisingly, deemed the state’s marijuana law as unconstitutional. This left Michigan without an enforceable marijuana law for 22 days until the legislature passed a new law on April 1, 1972. To protest this new law and to “re-legalize” marijuana, Sinclair and his supporters organized the first Hash Bash at the University of

50 LEMAR was the first organization dedicated to challenging cannabis prohibition. It was started by libertarian attorney James R. White III as part of a defense strategy for his client, Lowell Eggemeier. As an act of civil disobedience, Eggemeier smoked marijuana in front of the San Francisco police station on August 16, 1964. He was ultimately convicted of possession and served a short sentence.
Michigan campus in Ann Arbor. This pro-legalization rally has been held each April for the past 48 years (Gabriel 2019b; Glenn 2009). The original Hash Bash of 1972 also saw the beginning of the Michigan Marijuana Initiative, the first serious attempt at putting marijuana legalization on Michigan’s ballot. This effort failed to collect anywhere near the required number of signatures to make the ballot, and even if it did, Huey (2018) cites that over 80% of Americans disapproved of legalization at this time.

Michigan’s marijuana movement continued through the 1970s with a predominantly local focus. John Sinclair became a part of the Human Rights Party which won seats on town councils in cities like Ann Arbor, Ypsilanti, and East Lansing. These political activists used their newly found authority to amend local marijuana laws, often making simple possession a civil offense punishable by a mere $5 fine. There was an unsuccessful push to enact something similar in the state’s legislature in 1977, and while attempts at legalization dwindled afterward, a symbolic push for medical cannabis research was successful in 1979.

Known as “Grandma Marijuana”, Mae Nutt became an advocate for therapeutic use after her son Keith developed cancer. Marijuana was the only thing that reduced the nausea associated with her son’s chemotherapy, and she began her crusade in Michigan in the late 1970s. Keith would die on October 10, 1979, the same day The Michigan Controlled Substances Therapeutic Research Program was signed into law. Unfortunately, the state-level research programs of this era were largely symbolic in that no research or therapies were implemented. Nonetheless, Mae began operating the “Green Cross” from her home in Beaverton, Michigan, where she gave marijuana, edibles, and suppositories to those who could benefit (Clarke Historical Library). She would eventually join Robert Randall as a co-founder for the Alliance for Cannabis
Therapeutics, and later served as the director for Patients Out of Time, an educational charity dedicated to teaching the efficacy of therapeutic cannabis.

The 1980s were an era marked by conservative anti-drug crusades like Reagan’s war on drugs, and Michigan’s marijuana community was largely driven underground. Their political activism may have stalled, but they secretly adopted indoor and underground grow operations which were the precursors to today’s legal production infrastructure (Gabriel 2019b). As the war on drugs ramped into full gear, another legendary figure in the struggle for cannabis reform would arise in the mid-1990s. “Highway Howie” Wooldridge was a detective from Bath Township, Michigan, who was known for his tough stance on drunk drivers. In his retirement, officer Wooldridge became critical of the war on drugs and founded LEAP (Law Enforcement Against Prohibition) in 2002, and within a decade the organization had over 40,000 members. He would go on to ride his horse Misty across the country while on a publicity campaign, calling marijuana prohibition “the most dysfunctional, immoral domestic policy since slavery and Jim Crow” (Lee 2012:2). Yet right before Highway Howie’s activism came another pivotal moment in Michigan’s cannabis movement.

Rainbow Farm was Michigan’s center for cannabis activism from 1996 through 2001. Located about an hour south of Kalamazoo, the property was the site of biannual marijuana-centered festivals aptly named Hemp Aid and Roach Roast. These festivals were organized and funded by the farm’s owner, Tom Crosslin, along with his boyfriend Rollie Rohm and a team of blue-collar activists. Tom Crosslin was surely a larger-than-life character. He was a Vietnam veteran and is further epitomized by author Dean Kuipers (2006) as a gay libertarian pot-smoker who cultivated a troubling relationship with authorities over his beliefs in absolute freedom of property rights. Crosslin’s staunch ideology is credited as the source of the pot festivals, several
early attempts to legalize marijuana in Michigan, and the tragic reason why Rainbow Farm is legendary in Michigan’s cannabis community.

Following a 2001 tax raid on the farm which also revealed a basement garden with some 200 immature plants (Gabriel 2019b), Crosslin decided to set fire to the structures on the farm rather than surrender the property peacefully in an upcoming civil asset forfeiture case. The Michigan State Police came to the farm as did the FBI, and both Crosslin and Rohm were killed after an ensuing three-day standoff. The disaster garnered national media attention for several days until the morning of September 11, 2001. Much controversy remains regarding the arson, deaths, and validity of the prosecutor’s civil asset forfeiture case. Rainbow Farm was always careful to stay out of activities that could lead to civil asset forfeiture, and many believe the authorities were more motivated by Crosslin’s politics, particularly his role in the proposed Personal Responsibility Amendment (PRA).

Ballot initiatives work well when popular issues are too hot for politicians to handle themselves. By 1999, five states and the District of Columbia had passed ballot measures legalizing medical cannabis, and activists in Michigan thought they could accomplish something similar but more profound. A lawyer named Greg Schmid hoped Michigan’s libertarian-leaning conservatives would enthusiastically support a constitutional amendment legalizing hemp production, establishing cannabis as a medicine, and decriminalizing small-scale possession and growth of marijuana\(^5\). The PRA was much more radical than the medical cannabis initiatives in other states, and for this reason, mainstream pro-legalization organizations like NORML

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\(^5\) Information on the Personal Responsibility Amendment (as well as other initiatives that never made it to the ballot) is surprisingly difficult to find. The exact wording of the PRA can only be found in this guest blog post from the year 2000: https://www.420magazine.com/community/threads/the-personal-responsibility-amendment-michigan.4133/
withheld their support. Rainbow Farm, however, enthusiastically sponsored the amendment and began collecting the near 400,000 signatures needed to get it on the ballot (Kuipers 2006).

The PRA campaign had no official office, lacked fulltime staff, and only spent around $24,000. While they were short roughly 150,000 signatures by the July 10, 2000 deadline, the momentum was strong enough for authorities to view the PRA as a legitimate threat. This was one of the first times the state’s marijuana movement organized around a single initiative and they would try again in 2001, only to fall short by another 112,000 signatures. That same year, a George Soros-backed organization called American for Medical Rights (AMR) launch a similar campaign in Michigan with ballot language modeled after states who successfully passed medical cannabis initiatives. This campaign would spend over $1 million, and while they achieved the required number of signatures, Michigan’s Supreme Court invalidated the measure on the technicality that the MRA had misnumbered some paperwork (Kuipers 2006).

Rainbow Farm became a clarion call for Michigan’s marijuana movement and is cited as evidence of law enforcement overreach a la the war on drugs. Cops had harassed festival attendees and organizers for years leading up to the tragedy, but their investigations rendered nothing aside from small-scale illicit drug dealing by attendees (not the festival organizers). Dean Kuipers thoroughly documented the story in his book Burning Rainbow Farm: How a Stoner Utopia Went Up in Smoke (2006), and his detailed account advocates that Crosslin wanted little more than the right to enjoy cannabis on his private property. Many believe Crosslin may have never become a marijuana activist if authorities had simply left him and his property alone. While his farm and festivals were far from a utopia, often being plagued by fighting, mismanaged finances, and numerous other problems, the farm was far from the public threat authorities claim. In the wake of September 11, authorities tried to paint Crosslin and his crew as
domestic terrorists in a politicized attempt to justify police actions. Their distortions of the facts were met with backlash from supporters and festival attendees, arguably adding more fuel on the political fire. In the end, law enforcement has since been cleared of any wrongdoing, but the civil asset forfeiture lawsuit was also dropped (Kuipers 2006). Debates surrounding the incident continue through this day and Rainbow Farm will forever remain a landmark in Michigan’s history of cannabis reform.

On the heels of the Rainbow Farm incident and the series of unsuccessful state ballot initiatives, cannabis activism began to focus more on the local level. In August of 2004, Detroitera passed a ballot initiative permitting medical marijuana use within the city. Following this example, similar measures received a majority vote in the cities of Ann Arbor, Ferndale, Traverse City, and Flint. Additionally, decriminalization and deprioritization measures would pass in 14 Michigan municipalities, including Kalamazoo, Berkley, and Grand Rapids (Gabriel 2019b). These local successes would give activists in the state valuable political experience necessary to launch another state-wide effort which came in 2008.

Michigan’s Medical Marihuana Act

The Michigan Coalition for Compassionate Care (MCCC) headed by former state representative Dianne Byrum launched a successful signature drive for the November 2008 state ballot. Their proposal was called the Michigan Compassionate Care Initiative which would create a state registry of patients and establish the right to cultivate cannabis for medical use by registered patients or their caregivers. It also gave patients an affirmative defense to use in court.

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52 Despite it still being illegal on the national and state levels, municipalities can direct their police departments to lower the priority of marijuana-related issues. Since most small-scale drug enforcement is done at the local level, deprioritizing marijuana enforcement effectively permits responsible individual use within the municipality. Marijuana possession is still illegal in these places but the cops won’t bust you for it.
should they be arrested and charged. The coalition partnered with the Marijuana Policy Project (MPP), a national policy reform organization, and together they raised $1.5 million for their campaign. Their opposition was a conservative collation called Citizens Protecting Michigan's Kids chaired by future gubernatorial candidate Bill Schuette (it’s worth noting that medical and recreational marijuana laws have no effect on youth use rates). The opposition raised a mere $125,500 and funded a fear-mongering television commercial warning of California-style “pot shops” in Michigan communities. Meanwhile, the MCCC and MPP had commercials featuring patients suffering from cancer and multiple sclerosis (Associated Press 2008). Numerous polling agencies found strong voter support for the measure (Ballotpedia 2019).

Michigan’s Compassionate Care Initiative was approved on November 6, 2008 with 63% of voters supporting the ballot measure. The measure implemented the Michigan Medical Marihuana Act (MMMA) which later established the state’s patient registry called the Michigan Medical Marihuana Program (MMMP). Since going into effect, the law has continually been challenged, revised, updated, and clarified by lawmakers, and issues pertaining to the law have been heard by Michigan’s Supreme Court nine times (Ballotpedia 2019). Yet the basic law pertaining to patients has not changed much since its 2008 inception. Patients may possess up to 2.5 ounces of herbal cannabis, grow up to 12 plants, and are immune from prosecution for growing and using cannabis within legal limits. Patients may also designate a caregiver who is responsible for growing or obtaining their medicine. The caregiver does not need to be a patient themselves but must still register with the state. This caregiver provision was designed so gravely-ill patients have access to medicine should they be unable to acquire it on their own. It has also been used as a cooperative-like cultivation model where a patient transfers their right to grow 12 plants onto their caregiver, who in turn, provides them with medicine (often for a small
fee). Caregivers must be at least 21 years of age and cannot have any prior felonies. Each caregiver can provide for up to five patients for a total of 60 plants. Furthermore, the state has allowed the selling of excess medicine grown by caregivers to dispensaries and other registered patients. This process enabled buyers’ clubs and provisioning centers in the state in the first eight years of the MMMP before the 2016 licensing process. Unfortunately, these organizations were frequently raided or forced to close through hostile town councils.

Unlike California, Michigan has a state registry of patients, caregivers, and businesses participating in the MMMP. Most recent statistics find there are 297,515 card-carrying patients in the state, with 93% approved for severe and chronic pain. Michigan also has the most patients when considering the state's population, nearly 30 for every 1000 residents (Biolchini 2019a). The registration process involves having a bona fide relationship with the recommending physician which often means checking in at least once per year. Patients in Michigan must also file for renewal through the state every two years, a process that costs somewhere in the region of $200 when considering the physician certification. A list of qualifying conditions in Michigan can found as FIGURE 1 in Appendix L.

Regulations, Licenses, and Headaches

The most significant changes to medical cannabis in Michigan came in 2016 when the state implemented a licensing process for dispensaries (also called provisioning centers) and other medical cannabis businesses. Known as the Medical Marihuana Facilities Licensing Act (MMFLA), the legislation created a clear pathway for businesses to serve patients while complying with state law. Prior to this, businesses operated in a grey area and were frequently targeted by state and local authorities. This produced a landscape where many patients had
inconsistent access to their medicine, particularly in southwest Michigan where medical dispensaries are few and far between when compared with the east side of the state. A map of currently licensed provisioning centers has been included as Figure 2 in Appendix M. The scarcity of facilities in southwest Michigan is often attributed to the region’s conservative political climate and anti-cannabis attitudes held by municipal leaders.

While registered but unlicensed caregivers provided most of the state’s medicine in the first eight years of the MMMP, the MMFLA restricts cannabis production and sales to licensed businesses only. This policy is designed to be “business-friendly” for the primary purposes of shrinking the black market and collecting more tax revenue. As such, the MMFLA has been criticized as being more interested in permitting corporate profit than serving the needs of patients. However, the owners and investors in one type of business are limited in their abilities to invest in other sectors. These sectors include (see LARA 2019):

(1) **Growers**: permitted to cultivate, dry, trim, cure, and package cannabis for sale to a processor or provisioning center. There are three levels of growing licenses with Class A permitting up to 500 plants, Class B up to 1,000 plants, and Class C up to 1,500 plants.

(2) **Secure Transporters**: permitted to store and transport cannabis between licensed facilities. Only these entities can transport cannabis in the regulated system but they do not transport cannabis to patients or caregivers.

(3) **Processors**: permitted to purchase cannabis from a grower for processing. This can involve extracting resin or creating cannabis-infused products for sale and transfer in packaged form to a licensed provisioning center.
(4) **Testing Facilities** (referred to as *Safety Compliance Centers*): permitted to test cannabis and products from licensed facilities for contaminants as well as to ascertain THC and other cannabinoid levels.

(5) **Dispensaries** (referred to as *Provisioning Centers*): permitted to sell cannabis and cannabis-infused products to patients and caregivers. These facilities must purchase cannabis from a licensed grower or processor. They can only sell or provide cannabis or cannabis products to registered patients or to the patient’s caregiver.

Most patients in Michigan will only ever interact with dispensaries or caregivers, as the other four businesses are restricted to serving licensed facilities. Nonetheless, patient purchases of medicine support the entire system, and some fear this will result in higher prices. For example, one Ann Arbor edible company reports paying $500 for a one-mile delivery by a secure transport van (Stanton 2019). Businesses are also wary of the stringent safety-compliance standards for cannabis flowers and cannabis products, with the same Ann Arbor company saying the cost to test products at a licensed testing facility has increased from $60 to $400. Yet the most significant financial hurdle is getting through the licensing system. One family-operated medical dispensary in Detroit reports spending more than $120,000 on their state license and another $6,000 for their local license, and these figures do not include overhead or other routine operations while the business awaits state and local approval (Gabriel 2019a). Other medical cannabis businesses face similar regulatory and financial hurdles, including growers, processors, secure transportation operators, and testing facilities. Many business experts believe these costs are the primary factor hindering the development of minority-owned cannabis businesses, especially since asset requirements range from $150,000 to $500,000 depending on the type of license (Gray 2019).
Even though the licensing system provided hope for some businesses, 2018 was a difficult year for Michigan’s medical cannabis industry. As new operational licenses were now required for businesses working in the industry, a regulatory backlog forced many businesses to close and created an atmosphere of uncertainty for others. In the start of 2019, only a quarter of the 900 prospective medical cannabis businesses were reviewed by Michigan’s Department of Licensing and Regulatory Affairs (LARA), and only 99 of these were approved (Biolchini 2019a). Many of these businesses, from growers to dispensaries, were in operation prior to the licensing mandate, but LARA created a deadline wherein unlicensed businesses would be forced to close. Operating without a license jeopardizes the chances of being approved for a license, even if the application was already submitted and pending review. As such, the beginning of 2019 saw the closure of at least 72 dispensaries and many other unlicensed businesses, though most of these had submitted licensing applications nearly one year prior (Biolchini 2019a). This shut-down deadline was extended by courts multiple times in 2019, with May 31 being the final date to terminate unlicensed commerce. Thankfully, it appears enough facilities had been licensed to where a scarcity of medicine was avoided. Though in the State of Michigan, getting state approval is just one part of a prolonged process. Local approval can be just as difficult, especially since municipalities can ban or impose a moratorium on medical and/or recreational cannabis businesses.

A survey of municipal officials by the University of Michigan found only 17% favored medical cannabis businesses operating in their communities, and just 21% expressed their support for legalizing recreational marijuana use (Fitzpatrick et al. 2018). These figures show a significant disjunction between the attitudes of voters and the attitudes of their elected officials, as 63% of Michiganders voted for medical cannabis in 2008, and 56% percent voted in favor of
recreational marijuana in 2018. Michigan’s law makes it possible for municipalities to pass their own regulations as well as opt-out of cannabis commerce altogether. Nearly 75% of Michigan’s local jurisdictions have barred any cannabis businesses from operating, leaving little more than 100 municipalities where state-approved medical facilities can operate (Fitzpatrick, Horner & Ivacko 2018). Communities opting-in to medical cannabis can expect increases in their tax revenue, more employment opportunities, and the goodwill of providing accessible medication for patients living in the area.

The present situation is one where Michigan’s medical cannabis businesses are feeling a squeeze from tough regulatory mandates, hostile municipal leaders, and fierce competition. Yet their incentive to keep operating is obvious from an economic perspective. As more states legalize medical and recreational cannabis, a “green rush” has ensued as entrepreneurs race to claim turf in the budding industry. Over $10 billion was invested in North America’s cannabis market in 2018, and sales are projected to exceed $16 billion in 2019 (Associated Press 2018a). Figures like these may get hopeful entrepreneurs excited, but as I have already shown, establishing a medical cannabis business is enormously expensive in Michigan. However, there is talk of an added benefit for licensed medical cannabis facilities: preferred approval for recreational marijuana licenses.

Recreational Marijuana and The Uncertain Future

Before marijuana legalization was successfully placed on Michigan’s ballot in 2018, there were two other attempts that both failed to collect enough valid signatures. In 2012 The Committee for a Safer Michigan launched its drive for the Michigan Marijuana Legalization Amendment but only collected around 50,000 of the 322,609 signatures needed (Sands 2012).
They pledged to try again in 2014 but turned their efforts towards local initiatives instead. In the meanwhile, MI NORML began urging supporters to participate in the annual Labor Day Mackinac Bridge Walk, a tradition led by the state’s governor stretching back to 1958 in commemoration of the bridge’s completion. Starting in 2013, hundreds of activists wearing conspicuous green shirts joined the crowds to express their solidarity and make a visible public statement.

In the wake of the failed 2012 initiative, a coalition known as MI Legalize launched a well-funded effort at a ballot measure for the state’s 2016 November election. They collected more signatures than needed for their statute, but election officials declared many were collected outside of the mandated 180-day period for signature gathering. MI Legalize was a grassroots effort and prone to misinterpreting Michigan’s complex election code, and while they may have had a chance to excuse their oversight in court, the Republican-controlled state legislature removed that provision shortly after signatures were filed. It was a bitter blow to the movement which took the issue to the state’s Supreme Court only to be defeated (Laitner 2016).

Yet since popular support for legalization was evident in the state, it would only be a matter of time until something was put to the voters. Shortly after the 2016 defeat, MI Legalize partnered with the Marijuana Policy Project, the same national policy reform organization which helped get medical cannabis on the ballot in 2008, and the two organizations created the Coalition to Regulate Marijuana Like Alcohol (Gabriel 2019b). They surpassed the number of signatures needed within the 180-day window and had their initiative placed on the November 2018 ballot. The law would legalize possession of up to 2.5 ounces of dried marijuana, permit consumption in private residences, authorize individuals to grow up to 12 plants, and establish a regulated production and sales system for adults over age 21 (often called a “seed to sale”
system). The initiative would pass with 56% of voters approving. It did not, however, institute a process of expungement for an activity that is now legal. Of the 11 states where marijuana has been legalized, Michigan and Alaska are the only states where there has been no action to clear marijuana-related criminal records. More than 10,000 Michiganders have been convicted of minor pot-related offenses in the past decades, and an additional 3,500 residents are still behind bars or on probation for felony marijuana offense (Neavling, Jayyousi & Emrich 2019). Governor Gretchen Whitmer ran on a pro-legalization platform and promised swift action to clear marijuana-related crimes, but as of January 2020, nothing has been discussed by her or the state’s legislature.

Although Michigan voters legalized recreational marijuana in November 2018, commercial sales only began in a limited fashion in December 2019. While the state legislature was negotiating regulatory guidelines, a gray market has arose where marijuana was “gifted” to customers who purchased select items. Some of these business schemes sell over-priced books, chocolate, or t-shirts which all conveniently come with “free” marijuana (Biolchini 2019b). Other schemes include cannabis membership clubs which often meet at bars once a month with the promise of being able to consume (but not purchase) cannabis on-site. Regulators have so far tolerated such operations and expect them to disappear once licensed recreational dispensaries begin to flourish. In the meanwhile, hopeful businesses are preparing themselves for the forthcoming recreational market which promises to quickly eclipse the scale of the current medical market. Even if medical cannabis in Michigan is dwarfed by recreational marijuana, having two separate systems and regulatory processes is probably a better solution than what Washington state decided to do.

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53 On the morning on December 1, 2019, John Sinclair was the first person to legally purchase non-medical marijuana at a dispensary in Ann Arbor.
Lessons from Other States

Like most marijuana reform, the citizens of Washington voted in favor of initiatives for medical cannabis in 1998 and recreational marijuana in 2012. Under the medical cannabis initiative, patients could grow their own medicine or purchase it through unregulated and untaxed dispensaries throughout the state. Yet the 2012 initiative established a strict regulatory and taxation system for recreational marijuana, and shortly afterward, regulators decided upon a maximum of 334 retail licenses. Washington medical cannabis dispensaries did not pursue these because they were operating under a different legal provision, but in 2015 the state legislature decided it would be best to merge or “align” the two systems under the state Liquor and Cannabis Board (Young 2016). As the original 334 retail licenses had already been granted to recreational facilities, they created another 222 retail licenses to replace the state’s estimated 1,500 unlicensed medical cannabis storefronts. The new licenses were also supposed to be competitive, but unscrupulous applicants found a loophole, and most newly issued retail licenses went to business owners with little to no intention of opening a medically focused facility. When the new licensing requirements went into effect on July 1, 2016, the vast majority of existing medical cannabis retailers were forced to closed while more recreational stores opened (Coughlin-Bogue 2016a).

Washington “folded” their medical cannabis into their recreational system, but mishaps in the licensing system marginalized medical facilities. The state did institute a certification process

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54 Washington’s licensing processes favored applicants with prior experience operating or working in medical cannabis dispensaries. To prove this experience, applicants were apparently asked to submit pay stubs. Unscrupulous applicants turned to online forums where they sought to purchase old pay stubs, sometimes offering upwards of $100,000. The other approach was to an individual with experience sign on the license application, though this individual had no real role or stake in the business (see Coughlin-Bogue 2016a for more information).
for “medical marijuana consultants” to work at recreational dispensaries, but this does not necessarily mean the dispensary carries specialized medicines favored by many patients. Patients can also buy more cannabis than non-patients as well as products with higher levels of THC. In terms of taxes, medical patients still must pay the state’s 37% marijuana excise tax but are exempt from local sales taxes (Young 2016). Interestingly, though, Washington also established a voluntary patient registry in 2016, and it has grown each month despite accessible recreational marijuana. However, it is unknown how many patients were in the state prior to this registry or how many current patients have decided not to register.

In Michigan, medical cannabis businesses know they will be given preference in the impending recreational licensing process. The first year of adult-use licensing will only consider applications that already hold medical business licenses. This has caused some concern among patients in the state. One woman in Grand Rapids told news reporters: “What happened in Colorado, 90 percent of their medicinal switched to recreational. It's like going into a liquor store” (WoodTV8 2018). This sentiment was also expressed by another woman in the same broadcast: “I hope that it doesn't just bring more pot shops, where its strings away from medicine and into just more of how we have breweries everywhere and things like that… I'd like it to stay where medicine is an option” (WoodTV8 2018). It will be interesting to see what becomes of the cannabis landscape in Michigan over the next year or so. Unlike states on the west coast, Michigan will be the only midwestern state with a legal recreational marijuana industry and there are currently no plans to restrict sales to Michigan residents only. The potential for profit is enormous, but there are also cautionary tales from other states who have experienced similar

55 Patients certified by a physician who do not want to be entered into Washington’s state database are allowed six ounces of dried cannabis and may grow up to four plants in their homes. Patients who enter themselves into the database can have eight ounces and six plants. Patients not in the state database may only purchase the same amount as nonpatients in stores.
transformations in their cannabis economies. With California leading the way on this issue, it is worthwhile to examine what happened in the wake of their shift to a legal recreational market.

*Murder Mountain* is a six-part documentary series released on Netflix in late 2018. Despite the sensationalized title, the plot centers on cannabis cultivation in Northern California’s fabled “Emerald Triangle”, the legendary epicenter of marijuana production in the United States for the past 50 years. Both licensed and law-breaking farmers there are estimated to produce most of the nation’s domestic supply of cannabis. Since the region is remote and culturally inhospitable to law enforcement, crimes related to cannabis cultivation tend to be severely underreported. The series traces the unsolved murders of several individuals who all arrived in the region with hopes of working in the famous marijuana industry. Many of them sought to start their own grow operations and compete in the market. Though violent crime in the marijuana industry is exceedingly rare, the series illuminates anomie (normlessness) among the long-time growers of California.

Oddly enough, legalization has made things harder for California’s marijuana businesses. Crop prices have plummeted as legal product has flooded the market. Newly licensed businesses may have invested hundreds of thousands of dollars to established legal grow sites, and now they are losing money due to oversupply problems. Since cannabis cannot be legally shipped over state lines, all legally-grown cannabis must remain in its state of origin. Indeed, prices have declined exponentially. The price per pound of marijuana in California peaked at around $5000 in 1994 and fell to around $1200 in 2011 (Rendon 2012). In 2018, that price fell further to less than $500 per pound (Andersen 2018). A similar situation has occurred in Oregon where approximately 1 million pounds of extra marijuana now sits in the state’s tracking system, enough to meet residents’ current demand for approximately 6.5 years. When Oregon began to
permit recreational dispensaries in October 2015, the median price per gram of marijuana was around $14. As of early 2019, the median price per gram of marijuana at retail dispensaries had dropped to below $5 (Danko 2019). In both California and Oregon, businesses typically blame the state’s liberal licensing system for granting too many operational and production permits.

While this is good news for individual consumers and patients in these states, it is devastating news for entrepreneurs looking to make a return on their investment. It is also bad news for small-scale “mom and pop” businesses as the trend has been towards consolidation (Danko 2019). Larger businesses can bleed money longer, attract additional investors when needed, and they often buy up struggling independent businesses as a convenient means to damper competition. There are also environmental concerns over legalized marijuana production as growers fail to comply with costly regulations and engage in more intensive farming practices. The problem here, however, is not inherent in cannabis as a crop but rather the capitalistic propensity to turn a profit while ignoring sustainability (Polson 2019). It is also likely that as cannabis cultivation continues to scale, we will see the same exploitative labor practices endemic in the American agriculture system. Instead of paying competitive wages to individuals from the local community, large growers may find it economically advantageous to bring in underpaid immigrant workers.

With commercialized cultivation becoming the norm, many believe more money can be made selling cannabis on the black market which has reportedly grown since California legalized

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56 Declining prices of marijuana are also a result of the burgeoning demand of oils, concentrates, edibles, and other processed products. It takes a significant amount of raw cannabis to refine down to a concentrate, but this raw cannabis does not need to be immaculate like the cannabis buds sold in dispensaries. When you buy smokable cannabis buds from a dispensary, you are essentially purchasing the highest-quality crop available. Most of the cannabis grown (especially outdoor crops) may have imperfections, discoloration, and other defects which make it less desirable to sell in raw form. It commands a lower price and is most often processed into oils or tinctures with concentrated amounts of THC. This is analogous to most other agricultural products. The best-looking apples can be sold as produce in stores while blemished apples are mainly transformed into processed products such as apple sauce.
recreational cannabis in 2016. Even customers have begun to illegally profit from cheap legal marijuana. In a practice known as “looping”, a customer makes numerous trips to one or more dispensaries where they buy the maximum amount of bud allowed under state law (hence the loop). They then take their purchases to a neighboring state without recreational marijuana facilities and make a profit from selling a legally purchased product where it is unavailable or prohibited (Schaneman 2016). The incentive of higher returns also has the potential to entangle licensed cultivators with an illicit supply chain, effectively mirroring how cannabis was sold in a pre-legalized era. Anecdotally, I know many patients fear a similar situation could happen in Michigan, and just as Rendon (2012) interviewed California growers against legalization, something leads me to believe similar sentiments can be uncovered here. Rumor has it that Michigan regulators are turning to Colorado as a model for the forthcoming recreational system, and while far from perfect, Colorado’s marijuana system has fared better than others discussed in this chapter.

Voters in Colorado passed a ballot measure legalizing medical cannabis in 2000 but a 2010 bill in the state’s legislature finally paved the way for a formalized dispensary system. Following this bill, the number of registered patients in Colorado grew exponentially, reaching a peak of 128,698 in June 2011. In the years to follow, the number of registered patients would hold steady around the 110,000 mark before declining in 2015 (CDPHE 2019; Warner 2010). What happened in this time period was that voters passed a ballot measure legalizing recreational marijuana in 2012, and the state legislature formalized a public sales system in 2014. Many believed it would be the end of the medical cannabis in Colorado, and while sales dropped and the number of registered patients bottomed out to near 86,000 in 2018, it is far from the collapse of a system as many anticipated. In fact, the latest available data indicates the number of
registered patients has been growing slightly, reaching 89,492 in April 2019 (CDPHE 2019). This growth could be partly due to some parts of the state banning recreational marijuana stores while permitting medical ones (Markus 2018).

Regardless, patients in Colorado did not vacate the medical system in favor of the recreational system, but lawmakers have been attempting to funnel patients towards the recreational system. As with many states, medical cannabis has some tax exemptions while recreational marijuana does not. This means the state and municipalities receive greater revenue from recreational sales than they do medical. While patients must pay for a physician certification and a registration fee, this source of revenue largely funds the regulatory system. Recreational marijuana taxes, however, can be a significant source of revenue for the state and municipalities. This has led some cities like Aurora to ban medical cannabis facilities while welcoming recreational facilities (Roberts 2018). Colorado also imposed a strict 12 plant limit in 2017 for both recreational and medical cannabis, and many patients feel this was an effort to push them towards taxable retail outlets (Simmons 2017).

Colorado was also able to strike a balance between supply and demand, avoiding market collapses like those in California, Oregon, and Washington. While the price of cannabis in Colorado has declined since recreational production began, the state had at least two wise policies to avoid a rampant black market. The first was giving existing medical marijuana growers priority for new recreational grower applications. The second was requiring recreational growers to sell at least 85% of their crop before permitting them to expand their growing operations. These measures have helped protect against overproduction through deterring accumulation and giving scarce licenses to individuals with a stake in the community (Associated Press 2018b).
Many medical growers and dispensaries did switch to the recreational market, but the major reason appears to be in the hurdles of becoming a patient and operating a medical store. Like Michigan, Colorado patients must pay for a physician's recommendation, file paperwork with the state, and pay an additional application fee on top of the physician’s fee. Unlike Michigan, however, patients in Colorado must also find a store to designate as their official caregiver. This allows the store to grow more medicine but some dispensary owners have expressed concern about not having enough patients on their rolls. Growing fewer plants not only means less product for sale, but also less diversity. Different strains of cannabis produce different bodily effects, and patients like to have a wide variety of choices as some work better for different ailments and different medication regimens. One Colorado dispensary owner says of the medical system's regulations: “It becomes a ridiculous business model that the State of Colorado put together that makes absolutely no sense from a business standpoint or from a patient standpoint. And that’s why medical marijuana is not working” (Markus 2018). She and other dispensary owners also remark that many of their customers at recreational stores are there for explicitly medical purposes, and while they pay a higher tax rate, they are free from the arduous registration process and restrictive supply policies.

Colorado’s model may have deterred the expansion of a black market and transforming such illegal sales into taxable, legal sales have been the primary focus of many regulators. Yet among patients and their caregivers, a related controversy may have serious implications for the future of safe access to medicine. It may be stretch to say the cannabis community was united under blanket prohibition, but a divisive war of perception may well be occurring as we shift to a regulated market. Both medical and recreational businesses with the privilege of a license enjoy throwing around words like “black market,” “illegal,” “unregulated,” and “untested” to disparage
their unlicensed competition. These labels are technically correct, but the reality is far less shady or dangerous than such terms imply. Take the case of Maria, a medical dispensary owner in Washington state, as reported by Tobias Coughlin-Bogue of Seattle Weekly:

After her attempts to get a license failed, Maria gave up on pot, at least publicly. However, I recently attended an “Ice Cream Social” at her former storefront, now converted to something of a hangout for her patients… As a bunch of friendly suburbanites—some of whom brought their kids—passed around infused brownies a la mode, Maria stepped frequently into her office for what she called “the other party”: providing the rest of her inventory to patients desperately seeking cheap medicine. Though the scene was aggressively tame, this was technically a black-market deal. One patient picked up what in a retail store would have been $380 worth of flowers, kief, and edibles. Maria hooked him up for $180. Trent [a patient] said he bought all his weed on the black market since the new law passed. “What are we to do?” he asked. “It’s inhumane for anyone to deny us anything that medically benefits us.” He’d tried the [recreational] store, he said, but they didn’t have the right strains and the prices were way too high. Maria, however, still had some of the particular high-THC indica that worked to calm his PTSD without putting him to sleep. And that, more than money, was what drove Maria to host her polite little party (Coughlin-Bogue 2016).

It seems unfair to lump Maria into the same category as a stereotypical smuggler or street dealer with suspicious product. All are technically illegal, but Maria’s crime is qualitatively different. If anything, she and her clients are more the victims of an inadequate regulatory system, legally proving medicine for years but being forced to close through an unfair licensing process. While money certainly plays a role in this illicit commerce, it is undoubtedly not the only factor of importance to Maria or her customers. The recreational marijuana industry does not prioritize the needs of patients and licensed medical cannabis facilities may be few and far between. Something akin to the case above is currently occurring in Michigan.
Caregivers and Controversy

As discussed previously in this chapter, state regulators have allowed medical cannabis grown by unlicensed caregivers to be sold to provisioning centers and patients. This medicine has supported Michigan’s medical cannabis community for over a decade and is still necessary because newly licensed growers have thus far been unable to produce enough to meet patient demand. In the six months preceding April 2019, caregiver grown medicine accounted for 92.8% of the cannabis in the state’s tracking system (Biolchini 2019e). However, caregiver-grown medicine is not required to be tested for contamination like the medicine grown by licensed cultivators. This has so far resulted in a series of seven recalls in 2019 after independent analysis found contaminants like mold, E. coli, Salmonella, and heavy metals (Biolchini 2019c). While no illnesses have been reported, and while this contaminated medicine represents a mere fraction of the total medicine produced by caregivers in the state, the recalls have provided fuel for intense politicking on the part of corporatized cultivators.

Green Peak Innovations (aka SkyMint) reportedly spent $13 million to open its licensed cultivation facility near Lansing in early 2019. As of early 2020, the corporation holds over half of all cannabis licenses granted in Michigan. With 27 different grow rooms, they are permitted to grow up to 15,000 plants for Michigan’s medical market and have the capacity to produce roughly 30,000 pounds of marijuana per year. While this facility and others like it may eventually push small growers out of the market, they are currently competing with unregulated and less-expensive caregiver-grown medicine. To end this competition, Green Peak Innovations launched a massive public relations blitz in April 2019 with the goal of getting Governor Gretchen Whitmer to stop the sale of all caregiver-grown cannabis to dispensaries. They

57 To paraphrase a common expression about lab testing controversies: “I’ve been smoking untested marijuana for decades and never had a problem”.

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purchased full-page ads in several Michigan newspapers, bought eight billboards around Lansing, and started a website called micleancannabis.org:

When the voters of Michigan made marijuana legal, they did it believing that it would move from being a dirty, illegal business into one that was clean. It would be an industry that was a force for health and healing, as well as force in driving the Michigan economy. Right now, that’s not happening. Currently, the laws as they are written, are not being followed, and that’s putting people’s lives in danger. For years, anyone who used marijuana for medical purposes had to accept what they could get their hands. Once they found a trusted caregiver, they’d be highly loyal to the person and products that helped keep them well. It was an imperfect system, but one that had to be maintained for the health and well-being of the patients. Today, it is possible to cultivate and harvest marijuana that’s free from harmful pesticides, toxins and poisons. Grown with the best seeds and soil, as well as the utmost dedication, it’s free of harmful organisms that can make you worse, and not better. Why is the State of Michigan allowing untested, unsafe and illegal medical marijuana to continue to be sold? (MI Clean Cannabis 2019).

It is clear Green Peak Innovations stands to profit from a system that prohibits the sale of caregiver-grown medicine in retail dispensaries. It’s also clear their ambitions have less to do with the medical market and more to do with the recreational market. In late-April 2019, a small protest occurred outside of the Lansing capitol building involving around 100 employees from Green Peak and other corporate growers with hopes of moving the governor towards action. They were met by around 20 counter-protestors who were angry at the corporate take over of medical cannabis in Michigan (Biolchini 2019d). Patient discontent at Green Peak is best captured in a news article from earlier in April where they loathed how corporate growers were not producing specialty medicinal products commonly used by patients (Biolchini 2019c). Instead of THC/CBD tinctures and Rick Simpson Oil, large-scale cultivators are primarily producing edibles and other recreationally-focused products. Without an ample supply of affordable caregiver-grown medicine, patients fear they will run out of the specialty products they have relied upon for so long. Neither side received the exact outcome they had hoped for, as
the courts ruled caregiver sales to dispensaries must stop after April 30, 2019. However, regulators will allow caregivers to sell their medicine to licensed growers and processors, who are then obligated to have it tested before it can be sold to dispensaries. Unfortunately, the black market offers a higher price for caregiver-grown cannabis than licensed growers or processors are willing to pay (Biolchini 2019f).

While not total, this decision was more of a victory for corporate interests than patients. Competition from unlicensed growers may have slightly decreased but so too did the availability of specialty medical products. This is what led Sherry Hoover, a 57-year-old cancer patient, to file suit against Michigan’s Department of Licensing and Regulatory Affairs in early June 2019. Hoover’s lawsuit says the new state restrictions against caregiver-grown cannabis violate her due process rights as her specialty medicine is no longer available at her local dispensary. She was seeking a temporary reintroduction of direct-to-dispensary caregiver cannabis back into the regulated market, but her case was eventually dismissed (Biolchini 2019f). Corporate mega growers have said they will eventually focus on replicating these medicines but are more concerned now with producing products with mass appeal. Jeff Radway, the CEO of Green Peak Innovations, is even quoted as saying:

We have started with flower, we have started with distillate; we’re launching edibles next month, we’re launching vape carts -- we’re starting with the medicines the patients need most… We’re one of many dozens licensed suppliers. GPI has never claimed we’re going to make every product. GM doesn’t make every car: there’s room in the market for Alfa, and Chrysler, and Ford. We are one of many suppliers, but we make 98 percent of the products that patients want (Biolchini 2019d).

While Radway’s comparison to the auto industry contains a kernel of truth, it is unlikely that GM is trying to shut down their competition by claiming their competitors’ vehicles are unsafe and should thus be barred from sale. The statement also reveals that Radway’s top
priorities are in producing products that sell at the highest volumes. In other words, patient needs are an after-thought *even though his business is a licensed medical cannabis facility*. His priorities make more sense for a recreational market which he will surely pursue once regulators start a licensing system for recreational facilities. In the meantime, Radway and Green Peak obtained over half of the scarce medical licenses issued by the state, licenses which could have gone to one of the many medically-focused growers who are patiently waiting.

**Looking Up**

This chapter has so far explored cannabis activism in Michigan and the inevitable problems arising from new regulatory systems across the United States. It is also worthwhile to look beyond our borders, especially since our neighbor to the north has also recently reformed its cannabis laws. On October 17, 2018, Canada became the first North American country to legalize marijuana for adult use. They also established a regulated sales system that exists alongside of the country’s medical cannabis program. While legalization in areas of the United States has seen prices plummet and declines in the number of enrolled medical patients, the exact opposite has occurred in Canada. The number of patients has increased and so has the average price of both medical and recreational cannabis. However, Canada’s situation may not be exactly comparable to the United States as their national system is structured very differently. Perhaps the most important difference is the regulated legal market in Canada was established through bureaucratic action rather than grassroots mobilization like the ballot initiatives in the United States.

In contrast to many state models, Canada’s system operates on a clear public health mandate, which gives the government monopolistic control over cannabis commerce. They not
only banned all branding, advertising, and marketing, but they also gave health professionals oversight on where and how cannabis could be manufactured and sold (Rolles 2018). This resulted in a system much more restrictive than any in the United States. Unsurprisingly, when recreational marijuana was legalized in Canada, licensed stores quickly ran out of available products. Several months later, stores are still facing product shortfalls with one survey finding over half of the listed products were out of stock (Alpert 2019).

Statistics Canada also found prices of dried cannabis flower increased 17.6% following legalization, though these figures are based on a small sample size (NCS 2019). This is partly due to increased consumer demand, a lack of licensed growers, and grower anticipation of lucrative edibles market opening in October 2019. Infused foods are not currently permitted in Canada’s recreational marijuana industry\textsuperscript{58}, but that is about to change later this year. In the meanwhile, producers have been stockpiling cannabis and cannabis oils in preparation for what they perceive as the “second wave” of legalization (Armstrong 2019). Edibles are essentially cannabis oil baked into food or added to a beverage, and while anyone can easily do this themselves, the convenience of pre-packed “magic” food is arguably more appealing.

With shortages of recreational marijuana and inflated retail prices, it is no surprise that a recent study found 60% of Canadians are still buying from illicit sources, top reasons being price, quality, and convenience (Charlebois et al. 2019). The same study also found popular support for marijuana legalization decreased from 68.6% in 2017 to 50.1% when survey data was collected in April 2019. Not many changed their opinion to against legalization, but frustrations with how legalization unfolded caused many respondents to become “uncertain” of legalization. Canada’s media has also aired many stories about children being hospitalized and pets becoming

\textsuperscript{58} Canada did not initially legalize edibles because of “the gummy bear problem”, the fear that children will accidentally ingest cannabis by consuming candies and cookies infused with THC (Lawrence 2019).
ill after ingesting cannabis. Despite these concerns, 18% of Canadian adults report using cannabis within the last three months. This is up from 14% pre-legalization, the largest increases occurring among males and people ages 45 to 64 (NCS 2019). With shortages and frustrations with Canada’s legal marijuana system, it is no surprise that their medical cannabis system has remained strong, perhaps even flourishing.

Canada’s medical cannabis program was created in 2001 and expanded in 2013 to include large-scale production and distribution. This increased accessibility caused the number of registered patients to quickly grow from less than 30,000 in 2015 to 345,520 in October 2018, the same month as recreational legalization (Health Canada 2019). The Canadian system is structured where patients must choose one of three suppliers after getting a physician’s recommendation. The patient can either grow their own medicine or designate a personal grower, they can purchase dried cannabis directly through Health Canada, or they can submit their patient certificate to a dispensary where they will be allowed to purchase products for sale. Patients can only purchase in dispensaries where they have submitted a certificate, but additional certificates are available through Health Canada (Health Canada 2016).

Despite the availability of recreational marijuana, Canada’s medical cannabis program continues to expand under legalization. As already stated, there were 345,520 registered patients in October 2018, but as of March 2019, that figure increased to 354,538 (Health Canada 2019). Moreover, monthly calls answered by Health Canada about questions about becoming a patient have tripled since legalization, growing to nearly 1900 in June 2019 alone. Dr. Sana-Ara Ahmed, a Calgary physician who prescribes medical cannabis to her patients, says the increase is due to lessened drug stigma from legalization. She also estimates the total number of patients to be around 400,000 as of June 2019 (data from Health Canada not yet available) and believes it will
reach one million by 2025. Many health care professionals say legalization has facilitated discussions between medical providers and their patients, and patients are more willing to try medicines made from the once-prohibited plant (Kaufmann 2019). This paints an encouraging picture for the future of medical cannabis, but it will be interesting to see how the medical cannabis program fares once recreational suppliers manage to stock a steady stream of products. Nonetheless, medical cannabis systems appear to fare well even after the plant is fully legalized.
APPENDIX C
ANNOTATED DICTIONARY

- **Cannabinoids** = Chemical compounds produced by the cannabis plant that bond the cellular receptors in the human body (called the endocannabinoid system). There are at least 85 unique cannabinoids, each with differing effects, though more may be discovered as scientific interest in this area expands. Some prominent cannabinoids include tetrahydrocannabinol (THC), cannabidiol (CBD), cannabinol (CBN), and cannabigerol (CBG). Each of these is also activated at different temperatures. If the cannabinoid is not activated before being ingested, it will not be efficiently absorbed in the body. This also means it is impossible to get high just by touching raw cannabis.

- **Cannabis** = a term used in this study to refer to marijuana used for medical purposes. Cannabis is the scientific term for the plant’s genus and is commonly described as having three unique subspecies: *Cannabis sativa* has uplifting mental effects and is widely used as day medicine among patients. *Cannabis indica* has sedating bodily effects and is widely used as night medicine among patients. In reality, the vast majority of cannabis has been hybridized between these two subspecies with nearly all commercially available strains being various degrees of cross-breeds between sativa and indica. There is also *Cannabis ruderalis* but this rarely used for commercial purposes since it is small and has scant amounts of THC. Nonetheless, ruderalis has been incredibly valuable to cannabis cultivation since it is flowers as it ages rather than being dependent on changing light levels like the other two varieties. Most cannabis plants require diminishing levels of light in order to bloom while “auto-flowering” plants bloom after a certain number of days regardless of light exposure.

- **CBD** = Cannabidiol, a non-psychoactive component found in cannabis plants with many medical benefits. CBD is commonly described as relieving physical pain and muscle spasms without the effects of feeling high. It is also an anti-inflammatory and can be used as a mild sedative. Many believe CBD helps “balance” the high resulting from psychoactive THC. The compound can be extracted from marijuana or hemp plants, as well as synthesized in a lab. The State of Michigan does not consider CBD to be marijuana if the plant or extract contains less than 0.3% THC. This makes it quasi-legal to buy and sell CBD without being registered in Michigan’s Medical Marihuana Program, but the state is waiting for the 2020 federal farm bill to solidify their CBD regulations (CBD is currently regulated like hemp and hemp is classified as an agricultural commodity). Since CBD does not get one high, it has historically been bred out of cannabis plants as growers opted for varieties with increasingly concentrated amounts of THC. This has made CBD-rich strains rarer though they are becoming more popular. The genes that moderate THC and CBD are located on the same chromosome, making it currently impossible to have a single plant produce high levels of each cannabinoid.

- **Edibles** = Foods infused with cannabis and/or cannabinoids. Since cannabinoids are soluble in fat as opposed to water, many edibles are made with infused butter or oils.
Alcohol can also be used to extract cannabinoids making non-fatty foods like gummy bears possible. The range of edibles on store shelves today is truly impressive. I have seen brownies, cookies, cakes, sugary candies, chocolates, ice cream, soda, juice, pretzels, granola, peanut butter, honey sticks, and more. None of these are healthy but they do not need to be since you typically only consume a small amount per dose. Edibles range in their concentrations of THC and other cannabinoids, and the effects can take one to two hours to be felt. This has resulted in many people over-medicating since they eat more than they should.

- **The Entourage Effect** = How multiple compounds in cannabis plants work in synergy to produce an effect greater than the sum of isolated compounds. THC, CBD, other cannabinoids, and terpenes work together to make “whole plant medicine” the most potent form of cannabis medicine. This is why patients prefer natural cannabis compared to existing pharmaceuticals that contain only one or two cannabinoids. This is also why different cannabis products produce different effects. Edibles, oil extracts, and other processed products often contain THC-only as the other cannabinoids and terpenes are destroyed in the extraction process or the extracts are made from near-exclusive THC plants. Mono-cannabinoid products have a much different “psychological texture” than smoking cannabis flowers.

- **Hemp** = Cannabis plants or parts of cannabis plants little to no psychoactive THC and often used for industrial purposes. The federal government defines hemp as cannabis plant matter with less than 0.3% THC by dry weight. Hemp fibers can be made into cloth, rope, paper, and more. Hemp seeds are widely available as a health food boasting high levels of fatty acids and protein. One of the more recent and interesting developments is “Hempcrete”, an eco-friendly concrete fortified with hemp for use in construction and insulation. In 2018 hemp was removed from the controlled substances act, effectively legalizing CBD on a national level.

- **Kief** = Sometimes spelled keef, this is the potent crystalline resin produced by female cannabis plants. The flowers of female cannabis plants are covered in sticky trichomes which contain THC and other cannabinoids. When some of these trichomes fall off the bud during processing (e.g, grinding), they become a brownish powder known as kief. There are many different uses for kief and it is very high in THC since it lacks green plant matter. Kief is often slightly heated and pressed into hash or hashish, a form of cannabis more popular in Europe. In the United States, “moonrocks” are fresh cannabis buds rolled in kief to boost THC levels. Kief can also be dissolved in oil or alcohol extracts.

- **Marijuana** = a term used in this study to refer to cannabis used for recreational purposes. Many laws and official programs spell marihuana with an “H” including Michigan’s Medical Marihuana Act of 2008. The state defines marijuana as cannabis plant matter containing more than 0.3% THC. Only registered patients and licensed businesses can buy and sell marijuana in Michigan. The penal code changed when voters legalized recreational marijuana in November 2018, but state regulators are still working out
details on how it will be commercially regulated. The initial projection for marijuana retail shops for those over age 21 is in early 2020.

- **Terpenes** = organic chemical compounds produced by plants with distinct odors and tastes. Interest in terpenes by cannabis researchers and consumers is relatively new, and much is still to be discovered. Simply put, each strain of cannabis has a different odor and sometimes the same strain of cannabis can smell different based on how it is cultivated. Terpenes are not unique to cannabis plants, but they interact with cannabinoids to moderate bodily effects. For example, *Alpha-Pinene* smells like pine trees and is said to boost alertness, *Linalool* smells like lavender and is said to promote relaxation, and *Limonene* smells like citrus and is said to elevate mood. These different terpenes are why visitors to dispensaries are encouraged to use their nose when selecting cannabis to buy. Many labs now offer tests for common terpene levels and over 350 different terpenes have been discovered in cannabis plants. While research is still developing in this area, some experts have even claimed terpenes are better indicators of a strain’s effects than the traditional sativa/indica divide. Terpenes have certainly added another level of connoisseurship to cannabis as smell increasingly becomes an important quality to consumers.

- **THC** = Tetrahydrocannabinol, the main psychoactive component in cannabis plants. THC is produced by female cannabis plants through their flowers, commonly called buds. The compound is most concentrated in the crystalline resin found on flowering parts of the plant. While consuming THC produces the high associated with marijuana, it has also been shown to help with pain, nausea, and glaucoma. Since THC has well-known psychoactive effects, cannabis breeders have focused on increasing THC levels in their plants over the past several decades. Overtime, this has resulted in marijuana becoming significantly more potent. There are also different types of THC each of which is activated at a different temperature. THC and other cannabinoids must be heated in order to be felt.

- **Vaping** = Heating cannabis or cannabis resins without combustion. There are two basic types of vaporizers available today. First are flower vaporizers that heat ground cannabis flowers, essentially baking rather than smoking the “bud”. This method allows one to inhale cannabis vapors without the risks associated with smoking. Since cannabinoids are activated at different temperatures, adjustable-temperature vaporizers allow one to precisely control which cannabinoids are consumed. These flower vaporizers are often large or bulky since they require large batteries or electrical cords. The second type of vaporizer involves heating oil placed inside a cartridge. The oil contains varying levels of cannabinoids like THC, CBD, and others, but there are health concerns over some of the chemical solvents used in extracting these cannabinoids. The advantage, though, is that oil vaporizers are efficient and very small. Some are the size of pens or smaller (hence the term “vape pen”). However, something unique to whole-plant cannabis is lost in the oil extraction process. Some cannabinoids may be destroyed upon extraction and others may be left behind, limiting the “entourage effect” received from consuming the 85+ known cannabinoids. This difference was perhaps best expressed on the Howard Stern
Show by comedian Jonah Hill in 2015, who said: “[Vaping] gives me a high I don’t understand”.
APPENDIX D

TABLE 1: KEY INFORMANT INTERVIEWS

<table>
<thead>
<tr>
<th>KEY INFORMANT INTERVIEWS</th>
<th>Description</th>
<th>Date</th>
<th>Duration</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy</td>
<td>Board member for MI NORML and cannabis activist.</td>
<td>June 25</td>
<td>43 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Justin</td>
<td>Cannabis activist, dispensary co-owner, and radio host.</td>
<td>June 25</td>
<td>65 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Ramona</td>
<td>Owner of a cannabis marketing firm and public relations professional.</td>
<td>June 27</td>
<td>30 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Madison</td>
<td>Executive in the Michigan Cannabis Industry Association and cannabis lobbyist.</td>
<td>June 28</td>
<td>70 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Kayla</td>
<td>Dispensary owner in southwest Michigan</td>
<td>June 28</td>
<td>50 Minutes</td>
<td>In Person</td>
</tr>
<tr>
<td>Jackie</td>
<td>Founder of a cannabis networking association and a leader in Michigan’s chapter of Women Grow.</td>
<td>July 2</td>
<td>44 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Dr. Steven</td>
<td>A certifying physician in the MMMP and the owner of a holistic health center.</td>
<td>July 5</td>
<td>78 Minutes</td>
<td>In Person</td>
</tr>
<tr>
<td>May</td>
<td>A long-time caregiver in the MMMP.</td>
<td>August 15</td>
<td>39 Minutes</td>
<td>Phone</td>
</tr>
<tr>
<td>Michael</td>
<td>A long-time caregiver in the MMMP and former commercial grower.</td>
<td>August 23</td>
<td>120 Minutes</td>
<td>In Person</td>
</tr>
</tbody>
</table>
APPENDIX E
INTERVIEW GUIDE

- What is cannabis?
- Describe your typical customer (age, race, gender, social class, etc.)
- What questions are you asked the most?
- Why did you enter this business?
- Aside from your customers, how does the public view your business?
- What is the most frustrating part of being a ---------?
- What does the media get right or wrong about your role?
- What will medical cannabis look like 20 years from now?
- If you could change one thing about medical cannabis in MI, what would it be and why?
- How do you think your business will change over the next few years with the emerging recreational market?
- Is recreational cannabis a friend or foe to medical cannabis?
- What is different about medical cannabis in SW Michigan compared to other places?
- If the cannabis community had a gender, what would it be and why?
- Is there a difference in how society looks at a man or woman who uses cannabis?

Certifying Physician:
- If you had the power to change the state’s list of qualifying conditions, what would you add and what would you remove?
- What role does the pharmaceutical industry play in medicalizing cannabis?
- Would you like to see cannabis absorbed more into mainstream medicine, or something else?

Marketing Professionals:
- What are the legal parameters of how cannabis can be marketed here in Michigan?
- Is there a difference in marketing medical cannabis?
- Have you seen people take cannabis advertising too far?

NORML Board Member:
- Could you briefly describe how cannabis came to be medicalized in Michigan?
## TABLE 2: OBSERVATIONS

<table>
<thead>
<tr>
<th>OBSERVATIONS</th>
<th>Description</th>
<th>Observation 1</th>
<th>Observation 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature’s Healing</td>
<td>A provisioning center only accessible to those in the MMMP. Access limited to the waiting room as patients are taken into private rooms for sales.</td>
<td>July 5 6:00pm to 7:05pm</td>
<td>July 13 2:00pm to 3:00pm</td>
</tr>
<tr>
<td>Alternative Midwestern Medicine</td>
<td>Office of a physician who certifies patients for the MMMP in addition to offering a range of classes and hemp products. Not able to observe doctor-patient consultations.</td>
<td>July 10 10:20am to 11:30am</td>
<td>July 15 10:00am to 11:00am</td>
</tr>
<tr>
<td>MMMP Conference</td>
<td>An event for patients and caregivers in a large hotel’s conference area. There were two main rooms with one devoted to presentations and another for vendor booths.</td>
<td>July 28 1:00pm to 4:00pm</td>
<td>na</td>
</tr>
<tr>
<td>Boutique Herb (pop in)</td>
<td>An upscale dispensary chain new to the West Michigan area. I visited as a first-time patient.</td>
<td>July 6 4:00pm to 4:15pm</td>
<td>na</td>
</tr>
<tr>
<td>Kosmic Buds (pop in)</td>
<td>A new dispensary in the West Michigan area with plans of vertical integration. I visited as a first-time patient.</td>
<td>July 24 5:20pm to 5:35pm</td>
<td>na</td>
</tr>
<tr>
<td>MI Harvest Fest</td>
<td>The first public cannabis event in the area following legalization. Akin to a smaller “cannabis cup” competition.</td>
<td>October 27 3:00pm to 5:30pm</td>
<td>na</td>
</tr>
</tbody>
</table>
APPENDIX G

OBSERVATION GUIDE

Notes on Physical Setting:
- Journeying to the place (general location, nearby points of interest, etc.)
- Outside of the place (parking, pavement, physical building, neighboring sites, vibe, etc.)
- Décor (non-functional items)
  - Particularly, how much is cannabis-related? How much is related to medicine and/or health?
- Signage
  - Bulletin boards, announcements, notifications, instructions, business information, etc.
- Lighting and texture
  - Is the place well-lit? Natural or artificial light? Is the place organized? How does it feel?
- Smells and atmosphere (Does it smell like cannabis? Something else? Is the air clear or cloudy?)
- Security (Cameras, locks, ID checks, signs, windows, etc… Are security devices conspicuous or no?)
- Sounds:
  - Non-verbal noises
  - Music / entertainment

Notes on People:
- Number of visitors (distinguishing between those who come to purchase medicine and those who do not)
- Characteristics of people (general age, perceived race and gender, overall physical health, clothing and style, energy/enthusiasm, etc.)

Notes on Talk:
- Who is speaking? What are they saying? Who is actively listening? Is it routine language for the business? Or is it personalized communication? Is it hushed or loud? Is it said with emotion? How long does it last? How do others respond?

Notes on Action:
- What are people doing? Are they avoidant or open? Are they engaged in something or are they idle?
- What is purchased? How long does someone spend at the counter or in the office?

Notes on Products or Services:
- What is for sale? How many brands/types/flavors/styles? Are shelves stocked full or empty?
- What services are offered here? What services or products are suggested (through ads such as fliers, pamphlets, etc.)?
**APPENDIX H**

**TABLE 3: FOCUS GROUPS**

<table>
<thead>
<tr>
<th>FOCUS GROUPS</th>
<th>Participants (n=21)</th>
<th>Gender</th>
<th>Race</th>
<th>Age Range</th>
<th>Duration</th>
<th>Average Years in MMMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>n=4 (6 confirmed)</td>
<td>1 Man</td>
<td>3 White</td>
<td>18 to 43</td>
<td>1 Hour, 45 Minutes</td>
<td>2.75 (1 to 6)</td>
</tr>
<tr>
<td>July 16</td>
<td></td>
<td>1 Woman</td>
<td>1 Biracial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Non-binary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>n=6 (7 confirmed)</td>
<td>3 Men</td>
<td>6 White</td>
<td>34 to 66</td>
<td>2 Hours</td>
<td>3.33 (1 to 6)</td>
</tr>
<tr>
<td>July 23</td>
<td></td>
<td>2 Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Non-binary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 3</td>
<td>n=2 (6 confirmed)</td>
<td>2 Men</td>
<td>1 White</td>
<td>39 to 53</td>
<td>1 Hour, 15 Minutes</td>
<td>7 (4 to 10)</td>
</tr>
<tr>
<td>July 25</td>
<td></td>
<td></td>
<td>1 Biracial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 4</td>
<td>n=2 (6 confirmed)</td>
<td>1 Man</td>
<td>2 White</td>
<td>32 to 41</td>
<td>1 Hour, 30 Minutes</td>
<td>5.5 (2 to 9)</td>
</tr>
<tr>
<td>August 4</td>
<td></td>
<td>1 Woman</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 5</td>
<td>n=7 (8 confirmed)</td>
<td>4 Men</td>
<td>6 White</td>
<td>28 to 64</td>
<td>2 Hours</td>
<td>3.42 (1 to 8)</td>
</tr>
<tr>
<td>August 11</td>
<td></td>
<td>3 Women</td>
<td>1 Native American</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX I

FOCUS GROUP QUESTIONS

Opening Questions:

- [Write down answer and share] To me, cannabis is…
- Tell us who you are, how long you’ve been a patient, and your favorite way to medicate.
- Imagination Question (Krueger & Casey 2009):
  - Suppose you’ve been frozen, asleep, or in a coma for 20 years. You wake up. What do you think “medical cannabis” will look like?

Medical v. Recreational:

- By a show of hands, who plans to renew their medical card after it expires? (Does this change a year from now when recreational stores will be open)?
- In your opinion, what separates “medical marijuana” from “recreational marijuana”?
- Do you think medical marijuana will exist if or when marijuana is fully legalized?
- If you could change the law surrounding medical marijuana in Michigan, what would you change and why?
- Do you think some people exploit the system by claiming to need medical marijuana when they want to recreate with it?
- Thinking of how marijuana is commonly portrayed in media… Is it presented as amore of a medical or recreational thing?

Stigma:

- By a show of hands, whose family members know about your medical marijuana use?
- By a show of hands, whose co-workers know about your medical marijuana use?
- By a show of hands, who is open to their family about their cannabis use? To most of their friends?
  - Why do we remain secretive about our medicine around these individuals?
  - What factors made you feel comfortable about disclosing your use of medicine to others at your job, around your friends, or with your family?
  - Do you think your professional image would suffer if others found out? (Or has it suffered when others found out?)
- Have there been cases where someone raised concern about your cannabis consumption?
- How do people generally react when you tell them that you are a cannabis patient?
- Do you ever feel as though you have been alienated in some way as a result of your cannabis use?
- Have you ever experienced direct discrimination due to your identification as a cannabis patient? (or cannabis use)?
- Some people say marijuana is no longer a deviant thing. Do you agree with this sort of claim?
Gender:

- If cannabis culture had a gender, what would it be and why?
- Have you ever purchased medicine geared towards one gender or another?
- Do you think medical marijuana does a better job appealing to men or women?
- What image is projected by someone who uses a lot of cannabis? Is this image different in the person is male or female?
- Is there a difference in how society looks at a man or woman who uses cannabis?
- Do you think more men or more women are cannabis users, or do you think its about the same? Why?
- FOR OPPOSITE GENDERS: Do ---- use medical marijuana differently than ----?

Closing Questions:

- What is the best thing about medical cannabis? (write and share these with the group).
- What is the biggest misconception about medical cannabis? (write down and then share these with the group).
- What advice would you have for someone who has just received their medical marijuana card? (Hathaway 2004)

PROBES (from Krueger & Casey 2009):

- Would you explain further?
- Can you give us an example?
- Would you say more?
- What experiences have you had that make you feel that way?
- Tell us more.
- Say more.
- Is there anything else?
- Please describe what you mean.
- I don’t understand.
- Does anyone see it differently?
- Has anyone had a different experience?
- Are there other points of view?
- Thank you -----, are there others who wish to comment on the question/topic?
- [NAME], I don’t want to leave you out of the conversation. What do you think?
- [NAME], you haven’t had a chance. How do you feel about this?
This brief survey is designed to evaluate your eligibility in the study as well as to gather some personal information of interest to the researcher. The survey is 17 questions and should take approximately 15 minutes of your time. Some of these questions will determine whether you are eligible to participate in the focus group, so leaving items blank may result in you being removed from the study.

1. INFORMED CONSENT [see Appendix 9] (selection required to proceed)
   a. I agree to participate in this study.
   b. I do not agree to participate in this study.
      i. Ends survey if selected and submitted.
2. Do you possess an active, valid card for Michigan’s Medical Marihuana Program (MMMP)?
   a. Yes
   b. No
3. Approximately how many years have you been a registered MMMP patient in the State of Michigan?
   a. [OPEN ENDED]
4. For what condition(s) do you use cannabis?
   a. [OPEN ENDED]
5. Do any of the following apply to you? Please select all that apply.
   a. I use medical cannabis for a terminal illness.
   b. I have an appointed legal guardian.
   c. I cannot read questionnaires in English.
   d. I cannot speak or understand spoken English.
   e. None of these apply to me.
6. What is your current employment status?
   a. I work full time
   b. I work part time
   c. I am currently unemployed
7. What is your current job title or occupation? Please be as specific as you are comfortable with. If you are unemployed, please say so.
   a. [OPEN ENDED]
8. Which best describes your gender identity?
   a. Man
   b. Woman
   c. Trans / Non-binary
9. What is your age?
   a. [OPEN ENDED]
10. How would you describe your race? (check all that apply)
    a. White
b. Black or African American
c. Latino or Hispanic
d. Asian
e. Middle Eastern
f. Native American
g. Other (please describe)
h. None of these

11. What is the highest level of education you have completed?
   a. High School
   b. Vocational / Trade School
   c. Associates Degree
   d. Bachelors Degree
   e. Masters or Professional Degree
   f. Doctoral Degree
   g. Other (specify)

12. What is your individual annual income?
   a. Less than $20,000
   b. $21,000 - $40,000
   c. $41,000 - $60,000
   d. $61,000 - $80,000
   e. $81,000 - $100,000
   f. Over $100,000 per year
   g. Prefer not to answer

13. Thinking back to November 2018, did you vote in favor of Proposal 1 which legalized recreational marijuana in Michigan?
   a. Yes, I voted in favor of this proposal.
   b. No, I voted against this proposal.
   c. I did not vote in the election OR I did not vote on the proposal.
   d. No answer / Do not recall.

14. Do you agree to participate in a focus group discussion regarding your experiences as a medical cannabis patient? Focus groups will consist of 4 to 7 individuals and last no less than 60 minutes and no more than 120 minutes.
   a. Yes
   b. No

15. In which county do you currently live? Focus groups will be held in Kalamazoo county.
   a. [OPEN ENDED]

16. In order to help the researcher schedule focus groups, please indicate your typical availability for each day of the week. Select all where you are typically available.
   a. [Matrix of days of the week by Mornings/Afternoons/Evenings]

17. What is the best email address to send you an invitation to the focus group?
   a. [OPEN ENDED]
APPENDIX K

HSIRB APPROVAL

Date: June 14, 2019

To: Zean Snyder, Principal Investigator
    Matt Reid, Student Investigator for Dissertation
    Olivia McLaughlin, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 19-05-03

This letter will confirm that your research project titled “Medical Cannabis & Recreational Marijuana: Patient Perceptions, Stigma, and Gender During a Time of Emerging Legalization” has been approved under the full category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study”). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 14, 2020
Figure 1: Qualifying Conditions for the MMMP

List of qualifying medical conditions for Michigan’s Medical Marihuana Program as of March 2019. Persons over the age of 18 need a physician to certify their eligibility for the program while those under age 18 need two certifying physicians. This list of conditions was taken directly from Michigan’s Department of Licensing and Regulatory Affairs (LARA) but has been listed in alphabetical order.

1. A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: Cachexia or Wasting Syndrome, Severe and Chronic Pain, Severe Nausea, Seizures (including but not limited to those characteristic of epilepsy), and/or Severe and Persistent Muscle Spasms (including but not limited to those characteristic of multiple sclerosis).
2. Agitation of Alzheimer’s Disease
3. AIDS
4. Amyotrophic Lateral Sclerosis (ALS)
5. Arthritis
6. Autism
7. Cancer
8. Cerebral Palsy
9. Chronic Pain
10. Colitis
11. Crohn’s Disease
12. Glaucoma
13. Hepatitis C
14. HIV Positive
15. Inflammatory Bowel Disease
16. Nail Patella
17. Obsessive Compulsive Disorder (OCD)
18. Parkinson’s Disease
19. Post-Traumatic Stress Disorder (PTSD)
20. Rheumatoid Arthritis
21. Spinal Cord Injury
22. Tourette’s Disease
23. Ulcerative Colitis

Most prevalent conditions among patients in Michigan (LARA 2019):
- Severe and Chronic Pain (36.75%)
- Chronic Pain (24.84%)
- Arthritis (10.38%)
- Muscle Spasms (10.33%)
- Severe Nausea (4.82%)
- Cancer (3.27%)
- PTSD (2.98%)
- Seizures (1.14%)
  - [All other conditions occur at less than 1.00% each]
FIGURE 2: MAP OF LICENSED PROVISIONING CENTERS

Provisioning Centers (Green Dots) and Home Delivery Services (Red Dots)

Map Current as of May 31, 2019

SOURCE: Michigan Department of Licensing and Regulatory Affairs
NOTES: (1) There is one licensed provisioning center in the Upper Penninsula (not shown). (2) Some of these facilities are not open to customers yet. They have received a state license but have not yet opened up shop, which will presumably happen in the near future. (3) My primary purpose for including this map is to show the disparity between facilities on the west side and the east side of the state. Some cities on the east side have facilities so close to one another that it is hard to see exactly how many there are on this map.