

**FROM "GETTING HIGH" TO "GETTING WELL":
MEDICAL CANNABIS USE
AMONG MIDLIFE PATIENTS IN COLORADO**

by

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ABSTRACT OF THE DISSERTATION

From “Getting High to “Getting Well”: Medical Cannabis Use among Midlife Patients in Colorado

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As of 2012, Colorado is on the forefront of cannabis medicalization but medicalization remains incomplete. Between 2010 and 2012, Colorado created the most regulated medical marijuana program in the United States. Over 100,000 patients, 2.5% of Coloradans, are now registered as medical marijuana patients. This dissertation examines the effects of incomplete medicalization among middle-aged medical cannabis patients in the state of Colorado. It is a qualitative study based on interviews with 40 individuals aged 30-68 who each received a physician's recommendation for medical cannabis use in Colorado. Interviews were conducted between June 2011 and November 2012. This period immediately followed the rapid influx of patients into Colorado's system, but preceded the passage of Amendment 64, the constitutional amendment that legalizes all adult use in the state. At the federal level, cannabis use remains illegal and punishable by law.

Medicalization is when a nonmedical issue comes to be defined and treated as medical. When medicalization is incomplete, the issue has not been fully integrated, institutionally or in terms of its cultural framing. Medical cannabis crosses into the formal system of biomedicine, but it straddles institutional boundaries between health care systems and their logics. Culturally, cannabis remains closely associated with recreational use and with stereotypes of its users. So long as medicalization is incomplete, claims that medical cannabis use and the medical patient identity are legitimate remain in contest with nonmedical frames.

Incomplete medicalization affects all aspects of the medical cannabis patient experience. This dissertation looks at how patients navigate the medical cannabis system, including how they manage doctor-patient interactions, establish medicalized routines of use, and integrate cannabis into the management of illness. It also examines how patients make sense of the medical cannabis patient identity. Cultural identity operates in the lifeworld. By looking at patients in midlife, I consider the significance of life course timing and close network ties for medical cannabis patients in Colorado. I also consider how patients disclose illness and/or medical marijuana use to others, and how patients adopt a political position of pride to counteract stigma and stereotypes.

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CONTENTS

Title Page	i
Signature Page	ii
Abstract	iii
Acknowledgments	iv
Table of Contents	v
List of Tables	viii

CHAPTERS

Chapter 1: Understanding Medical Cannabis Use	1
Aims of the Dissertation	11
Background on Cannabis Use in the U.S.	17
Making Sense of Cannabis Policies	29
Criminalization and Medicalization in the Twenty-First Century	35
Normative Stance for this Project	39
Overview of Chapters	40
Chapter 2: Research Methods	43
Entering the Field	45
Focusing on Patients	47
Recruitment and Sample Considerations	51
Collecting Data: The Interview-based Qualitative Approach	56
Analytical Approach	61
The Study Sample: Colorado Patients at Midlife	64

Chapter 3: Literature Review	68
Literature on Medical Marijuana Patients and Patient Programs	68
Using Concepts from the Sociology of Health and Illness	74
Theories about Drug Use	82
The Relevance of Life Course Literature	83
Literature on Stigma Management and Networks	85
Chapter 4: Becoming a Medical Cannabis Patient in Colorado	90
Introduction.	90
Qualifying for Medical Cannabis	92
Deciding to Try Cannabis Medically	96
Giving Medical Cannabis a “Test Run”	105
Experiences with Doctors in the Recommendation Appointment	109
Face-work in the Recommendation Setting	124
Conclusion	127
Chapter 5: Medical Cannabis Use in Everyday Life.	133
Interpreting Cannabis Effects	134
Adaptations of Drug, Set, and Setting in Medical Use.	138
Changing the Set: Medical Routines of Cannabis Use	142
Changes to Setting	164
Life Course as Setting	173

Chapter 6: Cannabis and Trends of Health, Medicine, and Pharmaceutical Intervention	179
Defining Healthism and Pharmaceuticalization	179
Healthism & Harms	184
Healthism as a Pluralistic Space	191
Cannabis, Pain, and Big Pharma	193
Patient's Opinions of Pharmaceuticalizing Cannabis	202
Conclusion	204
Chapter 7: Cannabis & Stigma	206
Introduction	206
Stereotypes & Stigmas	211
Illness as Stigma	212
Identifying with Cannabis: Practical Risks	220
"Coming Out" for Cannabis: Stigma & Disclosing Cannabis Use	226
Cannabis: From Shame to Pride	228
Medical Marijuana as a "Thought Community"	233
Shifting the Game: From Stigma to Prejudice	238
Conclusion	243
Chapter 8: Conclusion	244
Summary of Findings	244
Limitations & Recommendations for Future Research	253
Conclusion	256

References 259

TABLES

Table 1: Drug Schedules.....	31
Table 2: Patient Summary Statistics	67
Table 3: Patients by Year of First Doctor's Recommendation	95

CHAPTER 1: Understanding Medical Cannabis Use

Karen uses medical cannabis¹ for her migraines. Even though she and her husband were social users in their teens and early 20s before they started a family, that was a long time ago. Karen, a Hispanic wife and mom in her early 50s, lives in a small bedroom community outside the Boulder/Denver metro area. Her children are now the age she was when she last used cannabis. It never would have crossed Karen's mind to try cannabis as a treatment for her migraines. It isn't something that shows up in her world, and anyway, she would not have believed it would work, or that it was a very intelligent choice out of the available treatment options. What changed her mind? Her husband of over 30 years, Marcus, and his car accident.

Back in 2000, Marcus was driving home from work. Another driver ran a stop sign and nailed the front end of his car, swinging his vehicle around until it landed on its side in a ditch. As dramatic as it sounds, the damage seemed to be mostly to the vehicles. Marcus, a healthy and athletic man, walked away from the accident, seemingly unscathed. When the ambulance arrived on the scene, he deferred medical treatment, but within days it was evident that he had suffered a serious closed head injury. Ultimately this injury was the source of a great deal of suffering: blinding headaches and unyielding back and neck pain that transformed his life completely. He was forced to quit working. With no breadwinner, his family very nearly lost their home.

Marcus' medical treatment after the accident was extensive and ongoing. He cycled

¹ Cannabis and marijuana are used interchangeably throughout the dissertation as identical terms.

through a long list of pharmaceutical drugs to manage his severe pain. Some led to dependency problems, others rendered him zombie-like, and still others turned him into Jekyll and Hyde, his moods unpredictably angry and incorrigible. It was nearly impossible to interact with him in a normal way. He moved into a basement room of the house, gained weight, and became depressed.

From the beginning, Marcus' ordeal was his family's ordeal. Karen describes it as five years of hell, during which little changed for the better. At first, the accident seemed like a temporary crisis, but as time passed and Marcus did not recover, it slowly sank in: There was no "going back to normal." For most of their marriage, Karen had been a stay-at-home mom who was involved in her church and the PTA, and volunteered with underprivileged children, but after the accident, she had to forego many of these activities and find new ways to pull in income. She took over many of the family's responsibilities while also managing the household and organizing her husband's healthcare—doctor's appointments, prescriptions, keeping records, filing insurance paperwork.

When a nephew who was using medical cannabis for a digestive disorder suggested to Karen and Marcus that Marcus should try medical cannabis, Karen dismissed him as idiotic. Despite this reaction, the nephew persisted, and eventually, more out of desperation than any genuine belief that it would work, Marcus did try medical cannabis. To their shock, he experienced success. Medical cannabis allowed Marcus a new level of control over his neurological pain. He was able to wean off of other pain medications, which also lessened their significant and problematic side effects. He returned, if not to his former athletic self, at least to the best level of functioning, the most "normal" life he had experienced since the accident.

Once Karen accepted that cannabis could work medically, she was much more willing to accept that it might work for other conditions. She began to research it. Karen suffered from migraines, but when she learned that cannabis could be used to treat them, she was still reluctant to try it herself. It made sense for Marcus given how dire his situation had been. Even

though her migraines could be quite severe, the idea of “getting high” from cannabis to treat them just seemed wrong. Probably in part because it was already around for her husband’s care, she did eventually try it by smoking a little bit of one of his joints. She found that the effect of cannabis was quite immediate in halting her migraine’s progression. Better yet, cannabis caused fewer side effects and had no “hangover” that prescription migraine medications often caused.

She did not want other people, especially her children, to see her using cannabis. When she felt a migraine coming on, she would take a few small hits from a pipe after she’d locked herself in her bedroom or the basement. While she was careful about people not seeing her use it, she was quick to spread the news among family and friends that “this works.” Karen’s attitude began in complete skepticism, but her family’s experience radicalized her views. She is open about her family’s success with medicinal cannabis and welcomes the opportunity to share their story. Karen was “the good daughter” growing up. She is the parent of two children and identifies as a good Christian woman who has always been active in her church and her children’s schools. Because Karen sees herself and her family as deviant in no other way, she feels that her willingness to be open about medical cannabis helps to dispel some of the misperceptions that surround its use and users; in fact, she knows she had many of the same misperceptions before this experience. Karen admits that she and her husband now sometimes choose to use cannabis as a part of their social lives. She was never much of a drinker, even when she was younger, and now she and her husband find they prefer cannabis when they have a party at their home, or every so often at the end of a particularly hectic day, to unwind.

She offers assistance to others exploring cannabis as a medical option, and in an attempt to save money and be more self-sufficient, she decided to grow marijuana plants for her husband and become a designated cannabis caregiver for other patients, which is a legally available option under Colorado law. When new patients experience success with cannabis, it only adds to her conviction about the importance of this issue. She has had some interaction with the law. The DEA came to her house after an anonymous tip, probably from an electrician,

prompted their visit. They found her small garden in compliance, but said they would report her to local police. So Karen went to the local police herself and offered any assistance she could toward educating them about medical use. While Karen's views have changed, one of her two children, a freshman in college, still disapproves of her and Marcus' use of medical cannabis. Raised with anti-drug messages at home and at school, he feels that his family's use goes against everything he has been taught, and he refuses to discuss it with them.

Dale used to work in the oil fields of the upper Midwest. When you hear his scruffy, slow drawl, he sounds like so many hardworking roughneck blue collar guys in their 50s. He came up in the working class with two siblings, a mostly absent dad, and a mom who drank too much. Maybe it was his rebellious personality or maybe it was the influence of being a teen in the age of sex, drugs, and rock and roll, but Dale began his career as a juvenile delinquent early. He started smoking and drinking when he was still a kid. By age 12, he'd already been arrested for stealing. In his family's home, alcohol was ever-present, but marijuana was morally opposed as the "devil's weed." After Dale left home, his choice of friends and lifestyle made recreational drugs a normal feature of social life. He's tried a bit of everything.

Despite this, Dale smoked very little marijuana over his adult life. It wasn't that he didn't want to, or that he didn't like it—it was just that the types of jobs he usually had required drug testing, and if you didn't pass, you were out of work. Other drugs pass quickly out of the system within a day or two, but the metabolites from marijuana linger in the system for up to a month and are the most common reason for failure on these tests. He couldn't afford that.

Dale began his story by recounting how he had stood talking to his crew on the oil fields one day many years ago, and announced with complete confidence that there was nothing "medical" about marijuana. As a regular user of alcohol and all sorts of recreational drugs, and even a brief stint in jail for methamphetamines, Dale was quite sure that he had enough expertise in this area to call bull when he heard it. He saw medical marijuana as nothing more

than a clever ploy for recreational drug seekers.

In a series of work-related injuries, Dale damaged the ACL in his right knee, followed by problems with the cartilage in his left knee. After several surgeries in 2005 and 2006, multiple rounds of physical therapy, slews of pharmaceutical painkillers, and a whopping tab in medical bills that were paid out by his employer, Dale was let go from work and given a \$5,000 settlement. He spent six months unable to walk. The painkillers screwed up his stomach and left him feeling zoned out. He barely ate and started losing a lot of weight. His life consisted of waking up, putting on a DVD of something he'd watched ten times before but scarcely remembered, and sitting around by himself all day, legs propped up, watching movies and dozing off.

Dale's friends became concerned about him. At some point, a good friend dropped by with a few bags of groceries and a marijuana joint, insisting that Dale should smoke it and eat something. Dale smoked the joint and for the first time in months, ate with real gusto. Impressed that the marijuana eased his stomach and helped his appetite, he decided to look into a doctor's recommendation. He found that cannabis helped not only with appetite but also with pain management.

Dale did not feel he was going overboard with his cannabis use, but he admits that he used a lot over the first few months. His friends expressed worries that his use was problematic, and told him he needed to be more moderate with his use. After a few months, he scaled back to a modest level. He quit drinking alcohol and cut down smoking tobacco. He had already quit using any other recreational drugs some time ago—he just had the prescription drugs for pain management, and he had to use them sparingly. While he liked the pain relief, he hated the side effects. It had been a constant balancing act, but now he could substitute cannabis and reduce the number of painkillers he took. His stomach improved as a result.

At 52, Dale's daily life for most of the last 6 years had been spent managing his health problems. A few years after being laid off, he qualified for permanent disability. Partying was a

thing of the past. He had long since quit going to bars, and his lifestyle was sedate. After using medical cannabis for six months, Dale's functional health measurements improved significantly, especially his liver function. In 1996 Dale was diagnosed with Type 1A Hepatitis C and told this type could not be treated with the standard treatment for hepatitis, Interferon. Dale reports that when he went to the doctor after six months of using medical cannabis, the physician insisted that his liver enzymes were normal with no sign of Hepatitis C. His physicians are scratching their heads over it, but Dale attributes it directly to his medical cannabis use.

Given his checkered past, Dale is a dubious poster child for medical cannabis, but he devotes a considerable amount of energy to advocating for its use in whatever ways he finds to contribute. He lives in a conservative area of Colorado, where dispensaries have been banned. He claims that he has been harassed by local police over his medical marijuana activism, including being pulled over, and refusing to submit to a urine test for drugs, which caused him to lose his commercial drivers license for life. Dale has become a die-hard libertarian who claims to love his country and hate his government. He advocates for medical cannabis because, as he sees it, it is just one more example that supports this political outlook.

Karen and Dale are two of the 40 patients interviewed in the course of this study on middle-aged medical cannabis patients in Colorado. Their stories provide a glimpse into the range to be found among patients who use medical cannabis at midlife. While these two stories alone cannot capture all dimensions of diversity among this study's participants—for example, the full spectrum of variation in prior cannabis use, current health status, or lifestyle choices—they do illustrate several patterns and differences among midlife medical cannabis patients that are relevant to this dissertation. For instance, these two stories share what many patients express as a change in attitude that occurs among middle-aged patients when they initiate use of medical cannabis. Attitude change is two-fold—when individuals adopt medical cannabis use, they accept that cannabis can be used in a medically effective way. Accepting cannabis as a

legitimate medicine shifts the emphasis from lifestyle choice to the more neutral ground inhabited by medicine. This allows patients to incorporate cannabis use into midlife and admit use without necessarily adopting a cultural identity associated with recreational use. However, because the medicinal use of cannabis remains controversial and competes with recreational definitions, patients often must decide how to navigate marijuana's cultural associations. The degree to which patients relate to the identities associated with cannabis are influenced by their own prior use, personal preferences, and political orientation.

Most patients in this study first tried cannabis in their teen years. Lifetime use rates for Americans 30 and over are between 65% and 80%, which implies that members of the Baby Boomer and Generation X cohorts have encountered social situations where marijuana is being used, and the majority have personally tried it recreationally at least once in their youths (Johnston et al. 2012). Recreational cannabis use is tied to timing in the life course, but this association is often taken for granted. Adolescence and young adulthood are known to be times of experimentation, and the most likely time that individuals will engage in deviant behaviors over the entire life course (Sampson and Laub 1992). Individuals usually encounter cannabis for the first time during adolescence. It is part of a broader set of choices teens face about alcohol, tobacco, and sexual activity as they transition into adulthood. Most have decided whether to try marijuana or not by age 19. The majority who try it will stop using it in mid- to late 20s, but some will go on to use it intermittently or regularly into midlife and later life.

Even though marijuana is treated as a "deviant" behavior, it still has a normative place in the life course. Recreational cannabis use is generally a shared social activity and tied to social settings. Its normative life course timing means that these settings are often affiliated with youth culture and its social scenes. When individuals "age out" of youth settings, they often cease to encounter social marijuana use with much regularity. Even when cannabis is present, many adults cease to use it due to role obligations related to life course milestones, such as entering the workforce, getting married, or having children. Some individuals choose to continue

cannabis use, but this use often migrates from a socially driven phenomenon to a more individually driven one, and social use becomes intermittent. Culturally, the life course timing of cannabis use in young adulthood associates cannabis use with youthfulness but it may also retain associations with immaturity, which are played up in its stereotypical representations in the media. By contrast, other activities begun in youth, such as alcohol use and sexual behavior, are often acknowledged to have an immature youthful mode, but also shift meaning across the life course to have an acceptable place in midlife and later life.

The attitudes of adults at midlife around recreational and medical cannabis use are influenced by their own life choices and the choices of those around them. Karen illustrates a case in which “on-time” use of recreational cannabis during young adulthood was discontinued at an appropriate life course juncture, after she and her husband assumed adult responsibilities, primarily through having children. They made conscious choices about creating a nurturing and stable family environment for their children, and for them, this included maintaining a drug-free household. For Karen, medical marijuana raised concerns, not only because she was doubtful of its medical efficacy, but also because its use signified a deviant behavior that seemed inappropriate for her and her husband in relation to their current age and roles as parents and responsible adults. When Karen’s husband, and then Karen, adopted medical use, her family’s reputation as upstanding members of their community allowed them to counteract the stigma associated with cannabis and Karen’s decision to be more vocal about it was in part based on her own self-awareness about the power of supporting such use from her otherwise normative position. She and her husband could advocate for the legitimacy of medical marijuana in part because they could claim an otherwise nondeviant social standing.

Although Dale’s initiation to use was also “on-time,” it was intertwined with other deviant behaviors in young adulthood. Dale quit using cannabis recreationally because he didn’t want to fail drug tests and lose employment, but that alone did not alter Dale’s lifestyle. He continued to party and use hard drugs and alcohol. He chose friendships or networks that

included similar lifestyle choices. Drugs were a regular and unsurprising feature of adult social life; they became ordinary. So when Dale considered medical marijuana, his concern was not with marijuana's "deviant" reputation. The use of illegal drugs had a normative presence throughout his adult life. Rather, for Dale, the real issue was with the idea that a recreational drug could have legitimate medical uses. Throughout most patient interviews, some combination of concerns with medical effectiveness and reputational risks accompany decisions regarding the adoption of medical cannabis use.

Karen and Dale also illustrate that adverse health events and assessments about medical cannabis use are intimately connected to one's social networks. Decisions about one's illness and treatment are only rarely managed individually. They nearly always involve networks of family and friends. In both Karen and Dale's case, someone in their close networks persistently recommended cannabis for medical purposes. Some patients had experiences similar to Karen, where someone with whom they had a close relationship had a visibly positive medical experience with cannabis, and witnessing another person's success with cannabis emboldened the person's own eventual decision to become a patient. Others, like Dale, were encouraged by others to try an impromptu self-experiment and determine from direct experience if it was medically useful. Patients with more recent social use of cannabis may not have required these prompts, but often still discussed a shift during which they tested marijuana's medical efficacy and began a discussion with family or friends about the legitimacy of its medical use.

After overcoming the barriers to try medical cannabis and experiencing some success, many patients also shared this knowledge with others, essentially taking on the role of the person who had initially prompted them. This distribution of information along networks plays a key role in introducing patients to cannabis, and when they have success, they often pass along this information within their own networks. Some patients go beyond this by participating in more public forums for education or advocacy, but others express various reasons that public identification was either undesirable or represented unacceptable practical risks for them, and

chose to maintain privacy around their medical marijuana patient status.

In the chapters that follow, I propose that the experiences reported by Karen, Dale, and the other patients in this study are shaped by the fact that medical cannabis is undergoing a process of medicalization that is not yet complete. Medicalization means that, “a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or ‘treated’ with a medical intervention” (Conrad 2007:5). This process is partial or incomplete because cannabis is not yet fully accepted as a medical treatment. Medicalization has an institutional and a cultural component—on the one hand, it is a process of incorporation within the system of biomedicine, but on the other, it is about the cultural acceptance of medical categorization. The literature has tended to separate the medicalization process into conceptual, institutional, and interactional components (Conrad and Barker 2010). The first indicates an incorporation of medical language and categories. The institutional component indicates an issue’s incorporation within the domain of the formal biomedical institution. The interaction component typically focuses on negotiations within the doctor-patient interaction. I would also argue that medicalization has a cultural component, in which an issue comes to be framed medically in the broader cultural discourse.

Although medicalization is most commonly applied to diagnoses and illnesses such as fibromyalgia, chronic fatigue syndrome, male menopause, or attention deficit/hyperactivity disorder (ADHD) (Conrad 2005, 2007; Conrad and Barker 2010; Conrad and Leiter 2004; Figert 2011; Turner 2004; Watkins 2007; Williams and Calnan 1996), it has also been applied to treatments, including opiate use (Conrad and Schneider 1998 [1980]), hormone replacement therapy, and complementary and alternative medicine (CAM) (Conrad 2007; Conrad and Leiter 2004). A few recent studies have applied it specifically to medical cannabis (London 2006; Pedersen and Sandberg 2013; Taylor 2008). Medicalization processes are not removed from everyday life; they involve contest and negotiation between medical professionals, patients, and the government (Conrad and Stults 2008). In the case of cannabis, medicalization is also tied to

its relationship with other institutions, most importantly, its criminalization within the legal system. Medicalization is not always driven by the medical profession or its attendant industries; as is the case with cannabis, it can be driven from the ground up (Conrad 2007). In fact, Conrad (2010) suggests that “contested illness” (or contested treatments) and “medicalization” are two sides of the same coin, separated mainly by which actors are engaged in advocating for inclusion in the medical domain, and which actors are resisting such inclusion.

The incomplete medicalization of cannabis affects patient experiences. This dissertation examines how patients navigate the use of medical cannabis in Colorado even as cannabis makes uneven progress in its acceptance as a medicine in culture, in medical interactions, and in the institution of medicine. It describes how patients qualify to use cannabis through doctor recommendations, how patients use marijuana for medical purposes, and how they navigate distinctions between medical and recreational use. It also considers how medical use of marijuana is managed in relation to other health goals and beliefs. Finally, it analyzes the relevance of stigma and networks for medical cannabis patients. Here is a brief overview presenting the aims and themes of the dissertation.

AIMS OF THE DISSERTATION

Aim 1: Cannabis Use as a Medical Behavior

My first overarching aim is to describe patient practices in the context of incomplete medicalization. In the chapters that follow, I aim to describe the process by which patients qualify for medical cannabis access in Colorado and how they use cannabis medically. Incomplete medicalization affects how cannabis is managed institutionally and how it is interpreted by patients and others.

Medicalization changes social interpretations of behaviors, and this dissertation aims to describe how patients reinterpret cannabis use. Becker’s (1953) classic article, “Becoming a Marihuana User,” characterizes marijuana use as an experience that its consumers learn to interpret through an intersubjective process. Zinberg (1984) suggests that any drug’s effects are

caused by more than the drug's pharmacological properties; they are also determined by factors of "set and setting." By "set," Zinberg means the individual's mindset and personality. By "setting," he means the context in which the person ingested the drug. In the use of both set and setting, Zinberg (1984) implies layered meanings about the individual and environment that are at once related to one's immediate and transient state and setting, and also consist of more enduring qualities of the individual and his or her social status. Medical use engenders a reinterpretation that significantly revises the practices, beliefs, and experiences around the use of cannabis. It also changes basic aspects of drug, set, and setting, an observation that is explored in chapter 5.

Institutionally speaking, the incomplete medicalization of marijuana in Colorado's current program means that it is not fully integrated into formal healthcare. Instead it spans what Britten (2008) terms the formal, informal, and popular sectors. While the formal sector is mainstream medicine, the informal sector includes any medical or health services that are rendered outside of biomedicine, by practitioners who were not trained in biomedical medicine (Britten 2008). The popular sector, by contrast, is the domain of self-care, where folk medicine, natural remedies, exercise, and nutrition fit. In the medical cannabis program, patients obtain an evaluation through a regular licensed physician in the formal sector of biomedicine, access supply in the informal sector, and determine routines of use in the popular sector. This structure affects patient behavior and influences processes of legitimacy.

In Chapter 6, I also consider medicalization and its companion concepts: "healthism" and "pharmaceuticalization." These concepts help to point out that even though they have some overlap, there are important distinctions between treatments, health behaviors, and medications. A treatment is a course of action that may include taking medicines, and may or may not be "healthy." Treatments often have a limited course but in the case of chronic conditions, they may be ongoing. Medications are drugs or substances that are ingested. They may be part of a treatment, but they can also be used in off-label, inconsistent, or inappropriate

ways. Medications are typically meant to maintain or restore a state of health, but are not in and of themselves “healthful,” and in fact regularly raise concerns about toxicity and side effects. Finally, health behaviors include things like dietary restrictions, exercise, and other self-care regimens, and do not necessarily involve medicines or treatments. Medicalization encompasses the movement of a social issue or life domain into the realm of formal medical treatment, healthism indicates that an issue is now considered in the domain of health, and pharmaceuticalization suggests that an issue should be treated through a pharmaceutical medicine-based regimen (Abraham 2010; Cheek 2008; Greenhalgh and Wessely 2004; Schuster et al. 2004). To some degree, “healthism” and “pharmaceuticalization” capture additional facets that medicalization may subsume or miss. In examining patient uses of cannabis, I consider how patients see cannabis as a treatment, medicine, and/or a health behavior. These separable but nonexclusive categories help to tease out the relationship between cannabis, pharmaceuticalization, and healthism.

Aim 2: Cannabis Use in the Lifeworld

My second aim seeks to capture how patients think about medical behavior, and how this outlook may differ from expert perspectives, but applies predictable forms of “lifeworld” logic across all medical systems including medical cannabis. Habermas first used the terms “system,” and “lifeworld” to distinguish between the logic and actions of institutions and those of individuals in the context of everyday life. In her work, *Medicines and Society*, Britten (2008) applies these concepts to healthcare and medicine in order to emphasize the different perspectives of the layperson and the expert in medical systems. Within health care, the system and the lifeworld invoke different logics. When patients accept cannabis as a medical treatment, they often apply similar criteria to those they use for other medical behaviors. Lifeworld concerns are with maintaining normative functioning in the course of daily life, and being able to carry out roles and responsibilities. This may run counter to experts within the formal sector of biomedicine.

The layperson engages in most health care outside of formal medicine, but when care is needed that is beyond what can be managed at home, it is necessary to navigate the professional system of medicine to receive care. Patients often balance the imperatives of the system with their own lifeworld concerns, and may not always agree or comply with system approaches that privilege objective measures, scientific rationality, and professionalism. Patients can attempt to persuade or resist expert recommendations, and tend to adapt treatments to conform to the demands or wants of the lifeworld.

This aim draws medical cannabis use into comparisons with how patients think about and use other forms of medicine, in both the formal sector of biomedicine, and in the informal and popular sectors, where lifeworld logics and concerns often play a more predominant role, and first-hand experiential knowledge is treated as valid.

In the context of the lifeworld, the individual is understood more holistically. Because lifeworld medical decisions and behaviors incorporate concerns with meeting role obligations and maintaining normative behavioral expectations, norms are important. None may be quite as important as life course factors, including age, cohort, and generational considerations. Age has been a significant factor in cannabis use patterns for the last 50 years. When studying the primary recreational user groups of cannabis—adolescents and college-age adults—cannabis is understood as a risk behavior. Very few analyses acknowledge the relevance of life course in this formulation.

Within this aim, I acknowledge that appropriate medical behavior is also tied to appropriate behavior in the context of the life course. Those using cannabis medically at midlife are also spending their leisure time differently, and tend to experience the salience of health differently, since many chronic conditions have a typical onset during midlife but are more rare among teens and college-age groups. The lifeworld includes important life course expectations, and this creates very different situations for teens and those in middle age. I argue that these contextual differences in cannabis use matter nearly as much as the medical designation to

distinguish experiences, including the problematic and beneficial aspects of use.

By placing a focus on midlife use and acknowledging the importance of the life course, I address a gap that has stood with little challenge in the social science literature on cannabis use. While teens and young adults are consistently the groups with the highest proportions of current recreational cannabis use, those who use cannabis medically in the greatest proportions are consistently those in their late 30s to mid-40s. This finding has been robust across states and countries. Colorado's medical marijuana patient population is also consistent with this finding—those in midlife comprise the largest proportion of patients in the state (CDPHE 2013b; Reiman 2007; Reinerman et al. 2011; Ware et al. 2003). This dissertation considers not only the significance of medical marijuana practices, but focuses specifically on how medical marijuana is understood and used by patients in midlife.

Aim 3: Cannabis and Communication: Patient Identities in the Context of Stigma

The third and final aim is to elaborate choices patients make about adopting a “medical marijuana patient” identity, and communicating that identity to others. This is a complex decision for a few reasons. First, to be a legitimate medical cannabis user, one must also be legitimately ill or injured; however, both identities exist in an area of contestation and have the potential to confer stigma upon the individual. One's status as a medical cannabis patient can be understood in part using Goffman's (1986 [1963]) discussion of stigma and visibility in *Stigma*. When the individual has choices about whether to hide or disclose an identity because it is not visible or evident to others, it affects how stigma is managed. Many illnesses for which medical cannabis is used are also concealable stigmas. They are not visibly evident, and allow the patient to choose whether they hide or disclose their illness or disease to others. These factors affect not only the individual, but who chooses to reveal or conceal specific identities may distort public identification and stereotypes of that group.

In addition, some illnesses, such as HIV/AIDS and cancer, have definitive diagnoses, whereas other conditions are more nebulously defined through criteria and subjective reports.

When medical conditions are invisible or uncertain, others may be skeptical about one's legitimacy as a medical cannabis patient. The disclosure of medical cannabis use is linked to disclosing illness, but each may have unique effects on an individual's reputation, and this increases the complexity of disclosure.

In many cases, illness and medical cannabis use do not exhaust the list of stigmas that patients experience. Many patients are also marginalized or stigmatized due to other factors, often in ways that are directly connected to illness. For instance, many people who become ill or disabled face financial struggles and become economically marginalized. Medical cannabis patients with HIV/AIDS may also inhabit other marginalized or stigmatized identities, such as identifying as gay, or as a recovering drug addict. In an era in which health and morality are closely tied, individuals with illnesses are often subject to subtle moral judgments by which others assess the degree to which the individual is responsible for their disease or illness through their own behavioral choices.

In addition to the linkages between medical cannabis and legitimate illness or disease, the criminal status of all cannabis use at the federal level complicates disclosure because it opens individuals to the risk of arrest or the loss of many types of benefits, including employment, school funding, driving and gun ownership privileges, and access to some types of public assistance. Patients make decisions about disclosing medical cannabis use based on an assessment of various practical risks, and not solely on their own personal comfort level with their behavior. The uncertainty and contradiction of cannabis laws makes disclosure more contextual to relationships and networks.

Medical cannabis users, much like the gay rights movement, face the difficult challenge of revising a "tainted" identity that has been legally prohibited. This makes identity paramount. Expressions of shame and pride are important for the reclamation of identities that have been subjected to widespread stereotyping. Through the simple act of claiming the medical marijuana patient identity, patients risk ridicule, arrest, and in some cases loss of job, home, the custody of

their children, or access to public or health benefits. When patients choose to adopt this identity, they participate in revising its meaning. Many patients see medical cannabis as an important collective legitimacy project in which more than individual identity is at stake. I consider how openly patients identify as marijuana users, how they reclaim this identity as a morally and normatively acceptable identity, and to what degree they distinguish the medical patient status from that of other cannabis consumers.

Networks often reinforce or dispel the stereotypical connections surrounding cannabis use. Support from close relationships matters, and networking with other patients can also be a key source of knowledge and support. Friend and family networks and support have proven important to all types of health and treatment choices, both within and outside of the formal arena of biomedicine (Britten 2008). Strong network ties provide information and social support that affects the individual experience of illness and may influence the experience of stigma. It is also useful to connect with others who share the medical cannabis identity, in person or online. In addition to transmitting knowledge, weak network ties with other patients helps to build legitimacy around a collective medical cannabis patient identity.

In the last aim of this dissertation I consider how patients communicate with strong and weak networks about their illness and their medical cannabis use, in the context of concerns with stigma. I look at how these considerations affect who patients disclose information to, who influences them, and whom they have tried to influence regarding the use of medical cannabis.

BACKGROUND ON CANNABIS USE IN THE U.S.

Before I examine the experiences of the patients in my sample, some background on cannabis use in the U.S. is useful. This section provides a brief overview of the social, legal, and medical constructions of cannabis that have defined this substance in general terms. Then I provide a brief history of the development of modern medical marijuana laws and programs, with special attention to Colorado's emergence as a leading state in medical marijuana regulation. Finally, an overview of the chapters ends the chapter.

The Social Construction of Cannabis Uses & Users

Cannabis may comprise one of the most interesting and consequential cases involving social construction in the twentieth century. The cannabis plant's legal and cultural status has been highly contested terrain over the last hundred years, shifting from its largely uncontroversial use as a folk medicine at the advent of the twentieth century to its designation as a heavily criminalized drug by its end. This transition was at least in part accomplished by narrowing the socially accepted definition of cannabis to equate with one use and one use only—that of a deviant, recreational drug. Its other traditional uses—as medicine, food, fuel, and fiber—were subsumed by the focus on its potential dangers as an addictive recreational substance. Policies across all levels of government enforced this definition in ways that affected science, culture, and criminality. Mainstream culture, and in large part the social, medical, and natural sciences, adopted this singular definition. Despite intermittent protest and dissenting professional opinions, debates over cannabis were successfully reduced to the frame of recreational use—or its use was demedicalized—and those who fought for a revised, expanded, or different frame were characterized as “drug users” (Ferraiolo 2007).

Framing cannabis users has mattered greatly for how the public perceives this issue's legitimacy (Almanzar 2003). As America's most popular illicit substance for nearly 50 years, there is a tacit understanding that its recreational use is common and widespread. In reality, there are different levels of use, but in its cultural and legal representations, all cannabis use has spent most of the twentieth century lumped together into one totalizing category of problematic use. No official distinctions are drawn between acceptable levels of use for social occasions and problematic levels of use that constitute abuse or indicate addiction, as we do with alcohol (Benoit 2003; Zinberg 1984).

Over the century, marijuana users have been routinely characterized in negative and stigmatizing ways (Almanzar 2003; Ferraiolo 2007). The first half of the twentieth century included a period of moral panic leading to marijuana's criminalization, a transition that has

been well documented by others (Bonnie and Whitebread 1999; Booth 2003; Cohen 1980; Ferraiolo 2007; Gerber 2004; Goode 2008; Goode and Ben-Yehuda 1994; Himmelstein 1983; London 2006). During the “reefer madness” era prior to midcentury, users were depicted as menacing, criminal, and even potentially murderous or insane (Almanzar 2003; Bonnie and Whitebread 1999; Booth 2003; Bostwick 2012; Gerber 2004). The success of these claims is largely attributed to the fact that most Americans had little first-hand experience with marijuana (Almanzar 2003; Gerber 2004). After social uses of cannabis were popularized in the 1970s, extreme characterizations became difficult to maintain since so many more people had tried it or knew people who had, without any of these dire consequences. Modern drug policy began to be drafted around midcentury, but the formal introduction and enforcement of these policies in the U.S. is usually dated to the introduction of the Controlled Substances Act under President Nixon in 1970. Modern claims of harm have shifted away from the most extreme exaggerations, but still maintain a quality of disproportionality that is characteristic of moral panics (Cohen 1980; Goode 2008).

Over the past four decades, claims have focused on harms from cannabis, but have become couched in the language of science and medicine. Specific claims to harm are based on negative effects on mental and physical health, and negative social judgments. These have included theories that combine social and physiological causes in their explanations, such as the “gateway effect” and “amotivational syndrome.” The gateway theory or gateway effect suggests that marijuana use leads to the use of more seriously addictive and damaging drugs. Amotivational syndrome suggests that chronic marijuana use induces an indolent and unmotivated state, causing individuals to cease pursuit of their goals, or even stop maintaining their own appearance and health (Chapkis and Webb 2008; Iversen 2008; Joy, Watson and Benson 1999; Stolick 2009; Zimmer and Morgan 1997).

Many of the modern arguments of harm due to cannabis use share a common challenge. Each requires that clear distinctions be determined between correlation and causation. Teasing

out such relationships takes time and research. Scientific research on marijuana has been skewed, because work whose aim was to prove harm has been well funded, but research meant to discount harms or show benefits has been successfully delayed or blocked, and has not been eligible for funding from most funding sources (Aggarwal 2010; Cohen 2009a; Gerber ; Werner 2011). This imbalance has allowed questions of harm to frame the entire debate. Very little discourse includes considerations of both health and harm, and those who wish to make such arguments are often bootstrapped by lack of scientifically rigorous evidence.

Many have decried this situation, but it has been difficult to successfully revise or reverse the forces of demedicalization through grassroots efforts without concurrent, significant coordinated institutional pressure from medical experts. Even when such institutions have called for change, they have met with governmental agencies that prove formidable in resisting attempts at policy change (Abrams 1995; Aggarwal 2013; Cohen 2010; Gerber 2004; Joy et al. 1999). These competing interests have produced a prolonged period of contest over marijuana's medical status.

Scientific discourse has trickled down to set the terms of popular culture discourse in many respects. Topics about physical harm, mental harm, gateway theories, and amotivational effects dominate media and common understandings of marijuana among the public (Stolick 2009; Vickovic and Fradella 2011; Zimmer and Morgan 1997).

Social Constructions of Harm by Association

Modern social uses of cannabis have also become closely associated with a few youth subcultures (Hammersly, Jenkins and Reid 2001). The hippie counterculture was the largest youth subculture to adopt marijuana, and its influence on college culture accounts for how most Baby Boomers were introduced to marijuana in the 1970s (Almanzar 2003; Harrison 1988). More recent groups to affiliate with cannabis use include hip-hop culture, and a more loosely defined white male variant on fraternity college subculture often depicted in movies. Marijuana's connection with these groups evokes stereotypes that are mutually discrediting

(Bonnie and Whitebread 1999; Ferraiolo 2007; London 2006; Stolick 2009).

Within these subcultures, cannabis use often becomes a multilayered symbol indicating a subversion of mainstream values, a rebellion against social control and authority, and a marker of “cool,” or devotion to a partying lifestyle. Within youth subcultures, these meanings are intended to be deviant and subversive relative to mainstream norms (Williams 2011).

Mainstream depictions of cannabis use often combine stereotypes of these groups with stereotypes of marijuana intoxication in morality tales or for humorous effect (Goode and Ben-Yehuda 1994). Cannabis use becomes the punch line to a cultural inside joke that reinforces marijuana’s relationship with undesirable personality and social-group traits, such as lack of motivation, lower intelligence, poor judgment, or other characteristics that lead to marginalization and social or financial failings. This is not unique; joking often functions to define group boundaries, moral boundaries, and to function as a form of informal social control (Fine and De Soucey 2005). This follows a pattern of well-worn rhetoric whereby exaggerated and stereotyped representations of stigmatized groups serve as a basis for comedy (Schaefer 1999).

Because cannabis use is associated with undesirable qualities in multiple ways across the cultural landscape, casual or occasional users are discouraged from adopting cannabis use as part of their identity. Doing so implies membership in a marijuana-friendly subcultural group, or suggests they share qualities with users or groups (Hammersly et al. 2001; London 2006; Williams 2011). Because occasional users may only feel weakly connected to cannabis, they may downplay their use, or only disclose their use to specific people, in order to avoid negative social judgments (Hathaway, Comeau and Erickson 2011). Those who use cannabis consistently or who identify with a subcultural group that glorifies its use are more inclined to identify as cannabis consumers. In this sense, the framing of cannabis is tied to its legitimacy, and these factors influence who identifies with it.

The Introduction & Expansion of Medical Marijuana

Medical marijuana policies challenge the narrow framing of cannabis use as an addictive recreational substance. Current medical marijuana laws have passed since 1996, but are built on the lessons learned from attempts to introduce medical cannabis exemptions in the U.S. since the late 1970s. Robert Randall became the first modern medical marijuana patient in the United States. Randall suffered from severe glaucoma, and discovered quite by accident that marijuana relieved intraocular pressure from this condition. In 1975, Randall was arrested for cultivating cannabis. He won his federal case on the grounds of medical necessity, which was backed by careful documentation showing that cannabis controlled his glaucoma, and legal pharmaceuticals could not accomplish similar therapeutic results (Ferraiolo 2007). Randall pursued the fight in court, which led not only to the criminal charges being dropped against him, but to a mandate that the government allow him to use cannabis for medical purposes, and create a pathway for acquiring a legitimate supply (Fichtner 2010; Russo et al. 2002; Stolick 2009; Werner 2011). Randall fought to gain access to a supply of cannabis through the government's research facility at the University of Mississippi. (Russo et al. 2002; Werner 2011). In 1978, Randall was provided access, and became the first patient enrolled in the federal Compassionate Investigational New Drug (IND) program set up for this purpose. On the face of it, the IND program was designed to assess damage to Randall caused by smoking marijuana. This maintained the mandate that NIDA only fund research directed at harms caused by drugs rather than studying their benefits (Werner 2011).

The government encouraged Randall to keep quiet about his arrangement, but instead he became a tireless vocal advocate for the benefits of medical cannabis, publicizing its benefits and working to help others gain access (Rosenfeld 2010; Russo et al. 2002; Werner 2011). Government agencies attempted to curtail or remove his supply, rebuffed or denied additional applications for enrollment in the IND program, and maintained restrictive processes for entry. A few seriously ill patients applied, but passed away before gaining access. It would be 1981

before another patient successfully gained access to the program. By the early 1980s, only eight patients had successfully gained entry to the program (Gerber 2004; Russo et al. 2002).

The late 1970s also saw a push at the state level to decriminalize marijuana use and acknowledge medical uses. By 1978, eleven states had passed decriminalization measures for cannabis possession, reducing charges to a civil matter equivalent with a traffic ticket (Ferraiolo 2004; MPP 2008). An additional 26 states introduced and passed programs that allowed cannabis to be used therapeutically for specific conditions, but these programs were designed to obtain medical cannabis through a central federally approved source. Programs adopted this design in an attempt to follow all treaties and laws, but the federal government refused to supply the programs, making the policies mainly symbolic. Very few of these first-wave medical marijuana programs were able to become operational for any length of time due to the lack of federal cooperation (Ferraiolo 2004; MPP 2008).

Colorado and California were among the states to adopt therapeutic research programs in 1979 (Project 2008). After California passed its therapeutic program into law, the state requested a supply of one million joints from NIDA (Werner 2011). Instead, the federal government supplied California with the newly developed but therapeutically inferior THC capsule known as Marinol (Werner 2011). This became the government's response to other states with such programs who made requests as well, effectively deferring access to whole cannabis plant material for other programs (Werner 2011).

When the HIV/AIDS crisis began in the mid-1980s, Robert Randall was instrumental in helping these patients apply to the Compassionate IND program. By 1991, Randall claimed that 34 had successfully been enrolled, while other sources place the number at 15 (Russo et al. 2002). Facing a flood of new applications to the IND program, largely from HIV/AIDS patients, the Bush administration decided to close the program to new patients in 1992. The newly enrolled HIV/AIDS patients were supplied with Marinol. Others received medical approval, but were never enrolled and received no supply (Russo et al. 2002)

California's 1996 medical marijuana law, Proposition 215, emerged directly out of these developments and was largely driven by the HIV/AIDS crisis. When patients suffering from HIV/AIDS found the federal route to cannabis as medicine blocked, they sought access to cannabis through the state that would minimize risk of arrest or prosecution.

It was the passage of Proposition 215 in California that ushered in successful access at the state level, in contradiction to the federal law. Prior to this law, only a handful of patients had gained medical access to cannabis, and in fact, the patients enrolled in the federal IND program who are still living continue to receive cannabis through the federal government to this day (Rosenfeld 2010). However, Proposition 215 created more widespread access for the patient population, ushering in the contemporary "medical marijuana patient" identity on a broader scale (Chapkis and Webb 2008; Feldman and Mandel 1998; Grinspoon 2001; London 2006). This law exempted patients from state-level criminal penalties (Eddy 2010; Geluardi 2010).

Shortly after California passed Proposition 215, other states followed suit. First the remaining West Coast states passed citizen-initiated bills, and then states in the Northeast and greater West, Alaska, and Hawaii (Eddy 2010). Many, though not all of these states had attempted therapeutic programs or decriminalization in the late 1970s (MPP 2008).

Medical Cannabis in Colorado

Colorado became the eighth state to follow California in passing a state law that allows medical cannabis use when its voters passed a state constitutional amendment, Amendment 20, in 2000 (CDPHE 2011a; Ferraiolo 2007). Between 2000 and 2009, this program was relatively unremarkable. Only 5,000 Colorado residents applied to the state medical cannabis registry during its first eight years of operation (CDPHE 2010b). Then, in 2009, the Obama administration released a memo, now known as the Ogden memo. Through this memo, the Department of Justice recommended that federal attorneys devote less attention to intervention in marijuana-related cases where individuals and businesses were in clear compliance with their state's medical marijuana laws (Ogden 2009).

The memo's contents were informal and nonbinding, but this move toward acknowledgment and tolerance was an unmistakable departure from previous administrations. The memo caused a huge ripple effect, increasing efforts to pass medical cannabis policies in states without such policies, and motivating greater participation in states that had existing medical marijuana policies. The largest effect was probably in Colorado (Kondrad and Reid 2013). Following the release of the Ogden memo, applications to Colorado's medical cannabis registry skyrocketed, and by the end of 2010, there would be more than 100,000 new medical cannabis patients on the state's registry (Kondrad and Reid 2013; Weinstein 2010). This was matched by a surge of medical marijuana centers or "dispensaries" opening storefronts in towns and cities across the state, with their highest concentration in Denver, a city that had already relaxed its marijuana possession policies (Fox, Armentano and Tvert 2009; Ingold 2011b; Reuteman 2010).

Medical marijuana dispensaries suddenly dotted the Colorado landscape, cropping up so quickly that comparisons with Starbucks were irresistible to the media and others (Kamin 2012; Reuteman 2010; Ross 2012; Weissmann 2012). This expansion was nicknamed the "Green Rush," an obvious play on the Gold Rush of 150 years before (Weinstein 2010). This moniker fit not only because of the swiftness of those rushing in to join, but also due to the atmosphere of Wild West lawlessness and the sense that a new industry was being pioneered where very little regulation was in place. State legislation did indeed play catch up between 2009 and 2012, developing and passing three new bills to regulate the now highly visible businesses in towns and cities around the state. House Bill 1284, Senate Bill 109, and House Bill 1043 defined the rules, limits, and boundaries for relationships between grow operations, dispensaries, physicians, and patients. Colorado's regulatory choices have created the most regulated for-profit medical cannabis program in the United States, and perhaps in the world (CDPHE 2010a; Kondrad and Reid 2013).

The Government Responds

Since 2009, the Obama administration's position on medical marijuana has been anything but straightforward, and has often raised more questions than it has answered. The federal Drug Enforcement Administration (DEA) emphatically denies any legitimate medical uses of marijuana, and has continued to raid and prosecute medical marijuana dispensaries and related individuals and businesses. Given the high stakes of noncompliance, many states have sought clarification on what they can and cannot do from Attorney General Eric Holder (Dickinson 2012; Dwoskin 2012; Kondrad and Reid 2013).

In an attempt to stem the chaos created after the Ogden memo, a second memorandum was released in June 2011 (Cole 2011). The Cole memo's goal on its face was to clarify points from the Ogden memo, but some saw it as a significant departure rather than a clarification, and with major consequences for those who had opened medical marijuana dispensaries based on the Ogden memo's guidance (Dwoskin 2012; Weissmann 2012). In essence, this new memorandum distinguished between individual patients and their caregivers and medical marijuana businesses. While the federal government would not pursue individuals, they opened the door to prosecution of medical marijuana dispensary businesses or grow operations, even if they complied with state laws (Dickinson 2012; Weissmann 2012). There have now been more raids on medical marijuana centers under Obama than during any previous administration, but most have taken place in states with less standardized regulation than Colorado (Dickinson 2012). Since 2009, over 200 dispensaries have been raided and 60 individual dispensary operators have been indicted (Weissmann 2012). California has been the prime target for these actions. This has been attributed to the vagueness of their medical marijuana policies, which make it easier to claim noncompliance (Dickinson 2012; Weissmann 2012), but scores of dispensaries operating in Oregon, Washington, Michigan, Nevada, Montana, and Colorado have received letters from federal attorneys warning them about compliance based on various limiting criteria (Dickinson 2012; Weissmann 2012).

As a result, the differences between state medical marijuana programs have been increased by uneven federal enforcement. In addition, federal strategies have included a prohibition on gun ownership for medical marijuana users, threats to federally insured banks that do business with cannabis dispensaries, and enforcement of statutes within the tax code that greatly increase the cost of running a dispensary business (Chun ; Dwoskin ; Ingold 2011a; Matonis 2012; Wyatt 2012). Even as the stated risk to individual patients has lowered, this is mitigated by the pressure on the supply side, because caregivers and dispensaries still face big risks, and growing for one's self also heightens risk of legal intervention at some level, whether local, state, or federal.

As the fight continues to be waged over medical access, polls have moved in a considerably more favorable direction on cannabis over the past decade. Public opinion overwhelmingly supports medical marijuana. According to a 2010 Congressional Research Service report, 23 national polls posed questions about medical marijuana between 1995 and 2010, and all of them showed “substantial margins,” between 60% and 85%, in support of medical marijuana policies (Eddy 2010). Conservative figures currently estimate the nationwide population of legally registered medical marijuana patients at 1 – 1.5 million (Belville 2011). Colorado leads the nation in its regulatory structure for medical cannabis, and in its number of medical marijuana registrants based on their proportion of the state's population (163,856 patients, or 2% of the state's population) (Kondrad and Reid 2013).

The Structure of Medical Cannabis Regulation in Colorado

Amendment 20, Colorado's constitutional amendment for medical marijuana, specifically exempts patients and their designated caregivers from criminal penalty by allowing an affirmative defense in state court cases, and allowing exceptions to Colorado criminal law for patients and caregivers who possess a state registry card (Constitution 2000). The amendment tasked the Colorado Department of Public Health and Environment (CDPHE) with creating and managing the state registry system. In this role, the CDPHE defines rules for patients,

physicians, and caregivers, which are based on the terms outlined by the amendment and by subsequent legislation. These rules have evolved over the period of this study; legislation was introduced to tighten regulation in response to the exponential increase in size and visibility of Colorado's program after the release of the Ogden memo by the Obama administration (Ogden 2009). The CDPHE rules are incorporated into the Colorado Code of Regulation 5 CCR 1006-2, which is established through the Colorado Board of Health (CDPHE 2011b).

While the CDPHE establishes the rights and regulations of patients and defines relationships between patients, providers, and physicians, the industry's regulations are defined and managed through the Medical Marijuana Enforcement Division (MMED) of the Colorado Department of Revenue. MMED rules are not covered in the state's constitutional amendment. Instead, industry rules have evolved through stakeholder negotiations that took place after the passage of Amendment 20. A few different business structures were considered for the state's industry; ultimately Colorado defined the industry by the adoption of two legislative bills: House Bill 1284, which passed in May 2010, and House Bill 1043, which passed in May 2011 (Kamin 2012; Representatives 2010, 2011).

The adopted legislation created an architecture based on a regulated for-profit dispensary model. It is essentially a tightly regulated market that has comparisons with other regulated models such as prescription drugs or alcohol, with exceptions in how production, manufacture, and retail sales sectors are integrated. The industry rules are now written into the Colorado Revised Statutes as Article 43.3 of Title 12, better known as the Colorado Medical Marijuana Code (MMED 2011). These rules detail three types of business licenses: production licenses for marijuana gardens (OPCs), retail licenses for dispensary outlets, also called medical marijuana centers or MMCs, and a third license to manufacture cannabis-infused products such as edibles and tinctures, called a medical marijuana infused products (MMIP) license.

The MMED rules translate the legislation that defines the proper relationships between these business types into an operating system. In addition, the MMED rules codify the

obligations for privacy, confidentiality, surveillance, and recordkeeping in relation to patients as defined in this legislation. Finally, the MMED manages the credentialing process for employees who work at any licensed facility in this industry, and administers the mandatory “badges” to workers who pass the background check and meet the criteria. Taken together, the CDPHE and MMED systems comprise Colorado’s regulatory system, and serve to regulate each type of actor, and each life stage of the plant from seed to sale. Since the rules have evolved over the period of this study, and the patients in this study have entered the system at different times since the medical marijuana program’s inception, patient interactions with the system vary at least in part based on the timing of that experience.

It is also worth noting that a provision in HB 1284 allows municipalities to modify rules to prohibit or restrict the cultivation or sale of medical cannabis within their jurisdictions (Mulvihill 2012; Representatives 2010). As an example, Denver has created Municipal Code Chapter 24 Article 11, which specifies that no one under 18 can be a visitor in a dispensary, and dispensaries cannot be located within 1,000 feet of a school or childcare facility. Article 12 of the same Chapter of the Municipal Code limits or prohibits highly visible forms of public advertising and signage that promote medical marijuana facilities (Code 2011). Other towns have issued moratoria on any new medical marijuana centers, and others have banned them outright. These choices often have the ability to alter the local conditions in ways that influence patient’s interactions with the system.

MAKING SENSE OF CANNABIS POLICIES

To understand the importance of the differences in marijuana’s legal status at the state and federal levels, it is necessary to understand that drug policies, including those for cannabis, are layered across levels of government from the municipal or city level to the level of international treaty agreements (Ferraiolo 2007; Gerber 2004; Sinha 2001; Suissa 2001). These policies scaffold in such a way that each successively smaller jurisdiction is constrained by the limits set for the larger entity. For instance, every nation that signed the three major

international drug treaties has agreed to restrict drug use and enforce drug laws at or above the minimum yet flexible requirements of these treaties' terms. If a nation attempts to deviate to a less restrictive policy that does not meet the minimum criteria of the international treaties, they face review and threat of sanction (Bewley-Taylor and Jelsma 2012; Sinha 2001).

Likewise, current U.S. federal law takes precedence, which create limits for states and cities who wish to pass more lenient policies than those set at the federal level. The federal government cannot force state and local police to adopt laws identical to federal laws, and cannot force the state and local law enforcement to enforce at a more stringent federal level if more lenient local and state levels have passed (Project 2008). As with drinking age and education laws, the federal government can still try to compel states to maintain a standard through a combination of civil actions, withdrawal of funding or federal resources, and threats of criminal action against the state's residents or officials.

The federal government has successfully delayed or resisted grassroots efforts to revise policies at the federal level (Aggarwal 2010; Barnes 2000; Booth 2003), and blocked medical research (Aggarwal et al. 2009; Cohen 2009a, 2009b; Gerber 2004). Because policy at the federal level has maintained a hard-line "drug war" mentality based on criminalizing drugs as its official policy over the last 50 years, any successful challenges to marijuana's legal status at the state and local levels have faced considerable challenges, and immense pressures to conform (Benoit 2003; Gerber 2004). As the policies from the 1970s showed, the federal government can obstruct policies that rely on federal compliance, leaving states with the choice to comply and concede such changes or to depart from federal law. Attempting to comply with federal law and introduce medical cannabis led to rollbacks, delays, or failure to achieve practical application (Cohen 2009b; Ferraiolo 2004; Gerber 2004).

The Significance of Acknowledging Valid Medical Uses: Drug Schedules

Modern drug laws are constructed so that they are, at least in theory, based on declared medical knowledge. The architecture of modern drug policy was conceived between 1948 and

1961 under the expert guidance and recommendations of the World Health Organization (WHO). It was designed primarily to regulate opium- and coca-based narcotics. In 1961, regulation was formalized at the international level through the Single Convention on Narcotic Drugs, which was amended in 1972, but has since stood. A separate Convention on Psychotropic Substances was introduced in 1971 to introduce regulations for hallucinogenic substances such as LSD and psilocybin mushrooms, but cannabis remained under the Single Convention (Sinha 2001). The last major international treaty is the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Introduced in 1988, this treaty sought to clarify and improve coordinated approaches to reduce international drug trafficking (Sinha 2001).

Table 1: Summary of Drug Scheduling Criteria from the U.S. Controlled Substances Act

Schedule Criteria	Schedule I	Schedule II	Schedule III	Schedule IV	Schedule V
Abuse Potential	High	High	Low to moderate	Lower than Schedule III	Lowest
Medical Applications	None	Prescription with monitoring	Prescription with limits: 6 mos / 5 refills	Prescription, few refill limits	Prescription, no refill limits
Safety & Dependence	Lack of safety	Known safety risks	Low-moderate risk of physical dependence	Low risk to safety	Lowest risk factors for safety and dependence
	Risk of dependence	Risk of dependence	high risk of psychological dependence	Low risk of dependence	
Examples	marijuana, heroin, LSD, mushrooms	cocaine, opium, most opiates, methadone, oxycodone, Percocet, Ritalin	codeine, hydrocodone, anabolic steroids, dronabinol (Marinol)	benzodiazepines (Xanax, Valium, Klonopin), Ambien, Lomotil	cough suppressants with codeine, anti-convulsants, anti-diarrheals

The international treaties, and specifically the Single Convention of 1961, is significant here because it first unveiled the concept of drug scheduling that governs modern drug policy at all levels. Schedules are a categorization scheme by which all drugs are defined using three domains: accepted medical use, potential for public health harms through risk to safety or risk of dependence, and abuse potential. These criteria are used to determine whether any drug requires regulatory control. Cannabis was added to the strictest scheduling criteria in the original terms of the Single Convention in 1961. This was largely due to pressure from the U.S.

(Sinha 2001). When the World Health Organization found that cannabis could have medical applications, these expert opinions were ignored (Gerber 2004; Sinha 2001).

The U.S. adopted drug scheduling as part of the U.S. Comprehensive Drug Abuse Prevention and Control Act of 1970. Title II of this legislation is the Controlled Substances Act (CSA), which includes the U.S. scheduling definitions for controlled substances (Courtwright 2004). This legislation, enacted by congress under Nixon in 1970, set regulatory measures for the manufacture, importation, possession, use, and distribution of drugs as part of our obligation under the international treaty (Bewley-Taylor and Jelsma 2012; Sinha 2001). Alcohol and tobacco were exempted from the CSA based on their widespread social acceptance (USC 2006a).

In the U.S. version of scheduling, Schedule I is reserved for substances that have no accepted medical applications. This criteria separates Schedule I from Schedule II drugs, which are roughly similar in evaluation of risk. This helps to explain why drugs that appear to represent more serious dangers in terms of dependence and toxicity may reside in lower scheduling categories than cannabis—the scheduling difference hinges on accepted medical use. Federal criminal penalties for drugs are derived from their placement in the schedule, as defined in the Controlled Substances Act and managed through the Drug Enforcement Administration (DEA).

The U.S. Controlled Substances Act also placed cannabis in the most restrictive, Schedule I category on a provisional basis pending study (Aggarwal 2010; Gerber 2004). Federal admission of accepted medical uses for cannabis could potentially have a domino effect on the laws, because a drug's schedule status affects every other rule governing the drug. These include the criminal penalties that apply to individuals who possess, use, or sell the substance; the right of a doctor to prescribe the drug (all but Schedule I drugs can be prescribed); access for research and development (Schedule I is strictly limited); and the applicable business tax rules and provisions for those who wish to develop products or sell products containing the substance

(Chun 2012; DEA 2011c; Matonis 2012; NCJRS 1999; USC 2006b; Wyatt 2012). In 1972, the government assigned further study to the U.S. Presidential Commission on Marihuana (sic) and Drug Abuse. This commission recommended cannabis be legalized, but their recommendation was ignored.

Most U.S. states have adopted controlled substances laws that are identical or similar to the federal laws, utilizing a five-schedule format for determining penalties, with lessening charges for lower schedules (NCJRS 1999). Some states have altered, adapted, or added provisions that may set lower penalties for cannabis as an exception to the penalties for Schedule I drugs under state laws. They may also add more restrictive provisions regarding minors and drug-free zones that affect medical cannabis dispensary locations (NCJRS 1999). Any change to marijuana's scheduling at the federal level would not only affect many dimensions of federal policy, but would reverberate up and down the layers of drug policy from the local and state levels to the conditions that govern international treaties.

In the years since the passage of these policies, government commissions from our own country and others have aligned with professional medical organizations to make recommendations calling for decriminalization, legalization, or research, to little effect (Chapkis and Webb 2008; Eddy 2009; Gerber 2004; Joy et al. 1999; Werner 2011).

Attempts to Reschedule Cannabis

Since the passage of the federal Controlled Substances Act, there have been three attempts to reschedule cannabis. The first appeal was filed by a citizens' petition in 1972, led by Robert Randall in cooperation with the National Organization to Reform Marijuana Laws (NORML), requesting that marijuana be rescheduled and made available by prescription (Gerber 2004; Russo et al. 2002). The ruling on this petition was delayed over a 16-year period. In 1988, DEA chief administrative law judge Francis L. Young ruled in favor of rescheduling cannabis to Schedule II, but his ruling was not binding and the DEA rejected his opinion (Eddy 2009; Gerber 2004). A second citizen's petition was submitted in 1995. In response to this

petition, the DEA asked the Department of Health and Human Services (HHS) to provide an evaluation based on scientific and medical data. The HHS backed the Schedule I status, and in 2001, this petition was denied (Eddy 2009). A third citizen's petition was filed in 2002, which the DEA denied in 2011 (DEA 2011b). Citizen groups, led by Americans for Safe Access (ASA), appealed the ruling on the basis that the DEA ruled without review of recent scientific findings, rendering their verdict outdated and capricious (ASA 2012). This appeal was ruled on in 2011, denying the rescheduling petition appeal. The denial was based primarily on a continued assessment by the HHS that marijuana is addictive, does not have an FDA-approved level of safety, and most critically, that the clinical evidence supporting claims of medical use did not meet the stringent, "gold standard" level of controlled, randomized studies needed for medical claims, while the drug's chemistry remains unknown and is not reproducible (DEA 2011a, 2011b).

Ironically, cannabis' Schedule I status places control of the drug's supply for research under the aegis of the DEA and the National Institute on Drug Abuse (NIDA). NIDA's stated mission is to fund studies related to abuse and addiction issues. This organization does not approve studies intended to show positive effects or medical benefit. They have successfully obstructed access to cannabis, with very few studies, after many years, being provided access. Several battles are still underway in the Kafka-esque world of trying to obtain cannabis for gold-standard clinical research (Abrams 1995; Aggarwal et al. 2009; Chapkis and Webb 2008; Grant et al. 2012; Werner 2011). To add to the convolutions of cannabis policies, the HHS, the same federal agency that evaluated and rejected the evidence for the DEA rescheduling petition on the basis of incomplete evidence of medical use, also holds the patent for medical uses of the plant's constituents, known as "cannabinoids." Patent 09/674028 "Cannabinoids as antioxidants and neuroprotectants," was filed by the HHS in 2001 (Hampson, Axelrod and Grimaldi 2001).

In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine (IOM) to conduct a new review of the scientific evidence for

medical uses of marijuana and assess its potential health benefits and risks. That review began in August 1997 and culminated in a report that recommended a full program of research and clinical trials to determine proper medical uses, a necessary step to meet rescheduling criteria. This suggestion was also ignored. In fact, nothing changed on this front. The closure of the Compassionate Investigational New Drug program in 1992 has stood, and applications for exactly the type of research called for in the IOM report have been routinely denied (Fichtner 2010; Russo et al. 2002; Werner 2011).

On another front, Representative Barney Frank has introduced versions of The States' Rights to Medical Marijuana Act in every Congress since 1997, but it has never proceeded beyond committee referral. This act would reschedule cannabis to Schedule II and allow states to set rules for physician recommendations or prescriptions of cannabis that are exempt from provisions of the Controlled Substances Act or Federal Food, Drug and Cosmetic Act that could prohibit or restrict such actions (Eddy). In February 2013, Colorado representative Jared Polis sponsored the bill, HR 499, "Ending Federal Marijuana Prohibition Act of 2013." This pending bill would remove cannabis from the federal Controlled Substances Act with the exception of some transport and shipment, and assign authority for cannabis regulation to the states (2013).

CRIMINALIZATION AND MEDICALIZATION IN THE TWENTY-FIRST CENTURY

Twentieth century cannabis policy was characterized by contests followed by setbacks. Changes at the federal level have been routinely denied because the outlook is focused on the criminalization of drugs, and this position does not acknowledge the medical definitions that form the foundations of drug enforcement laws. The War on Drugs has been a criminal justice war that relies heavily on marijuana prohibition for its budget (Fishbein 1991). When government bodies repeatedly ignore the research and the recommendations of their own commissions and judicial reviews in order to maintain current policies, it seems reasonable to conclude that the system has subverted its own checks and balances, resulting in questions about the government's motivations and concerns with the legitimacy of its decisions (Fichtner

2010; Gerber 2004; Werner 2011).

In every year since 2000, marijuana possession arrests surpass all arrests for violent crime in the United States (Facts 2012). As we entered the 21st century, the trend of heightened criminalization has continued unabated, with over a half-million arrests for cannabis annually—more than for any other drug during the late 20th and early 21st centuries (Eddy 2009; Room et al. 2010). Half of all drug arrests in the U.S. are for marijuana, and nearly 80% of these are for low-level charges—possession, use, and paraphernalia. Recent analyses also show that arrests are distributed in wildly unequal ways, with disproportionate arrests among minority groups and lower income groups (King and Mauer 2006) .

State medical marijuana laws have emerged and re-emerged almost entirely driven by grassroots efforts. At this moment in history, it appears a significant transition on cannabis policy is on the horizon. Polls in the U.S. now show that Americans overwhelmingly support cannabis use for medicinal purposes (Eddy 2010; Gillespie 2001; Langer 2010). Between 2/3 and 4/5 majorities believe that Drug War strategies have been a failure (Gwynne 2011; Riggs 2012). For the first time since marijuana's popularization in the 1970s, polls indicate a majority of Americans agree that all adult use of cannabis should be legalized, representing a peak in support (Gwynne 2011; Newport 2011; Riggs 2012; Saad 2009). In 2012, the passage of two bills—one in Colorado, and one in Washington state—have legalized adult cannabis use, despite federal laws, and are in the process of introducing regulation. The federal government has yet to release a formal statement with regard to these laws. Adult use laws signal an important cultural and political shift around cannabis use, but such policies do not supplant the medicalization of cannabis that is currently underway. How these policies will coexist remains unclear.

Countering Claims to Harm

Despite the significant obstacles to clinical research on cannabis as a medicine in the United States, there have been important developments in basic scientific research, mostly from outside the United States, since the beginning of the 1990s (Aggarwal et al. 2009; Grant 2010;

Hazekamp and Grotenhermen 2010; Vettor et al. 2008; Werner 2011). The most important development has been the identification of a previously unknown receptor system in the body with which cannabis interacts (Russo 2002; Vettor et al. 2008; Werner 2011). This system, now referred to as the endocannabinoid system, has receptors throughout the body and brain, with a lower concentration in the brain stem where involuntary functions are controlled, a fact that has been linked to marijuana's lack of interference with these functions even at high dosages.

Two ligands that naturally occur in the body, named anandamide and 2-AG, have been identified as interacting with this system's receptors (Danovitch 2012). They are lipid (or fat) signaling molecules, and have unique signaling functions, but while this system has unique qualities, it can be grouped with other receptor systems in the body, such as the gland-based endocrine system in which our body releases hormones (Iversen 2008). In this sense, we often find exogenous compounds that mimic those found naturally in the body, because these substances will interact with our body's architecture, to produce physiological effects. So far, the endocannabinoid system has been related to regulating homeostasis in the body, modulating immune function, influencing learning and memory, and affecting pain perception (Danovitch 2012; Werner 2011). Certainly, the knowledge of the endocannabinoid receptor system opens the door to better understanding this plant's intoxicating and medical effects. Cannabis mimics these natural chemicals, so the discovery of this system and its ligands and receptors has helped to elaborate not only this plant's interaction with the body, but it also offers new knowledge about the body's functioning.

Many have proclaimed these breakthroughs as critical neuroscientific findings that will lead to the next generation of new medications (Aggarwal 2010; Bostwick 2012; Eddy 2009; Mechoulam 2012; Vettor et al. 2008). According to clinical researchers, cannabis has the potential to serve as the basis for an entire class of medications, just as the opium plant has, and this possibility becomes a mandate for further exploration of cannabis through research.

While researchers and professional medical associations are warming to the medical

potential of cannabis, members of the practicing medical community are much more divided over using the plant in its current form as a therapy (Kondrad and Reid 2013; Vettor et al. 2008). The most prestigious of America's professional medical associations have only recently adjusted their positions to more favorable, but still tempered, opinions (Aggarwal 2010; Danovitch 2012; Eddy 2010; Joy et al. 1999). Opinion among individual medical professionals range from rejection of marijuana's medical uses and skepticism about even its palliative benefits, to full-fledged support for cannabis use across multiple scenarios that include palliative, ameliorative, and even preventive or maintenance use in conditions such as multiple sclerosis and epilepsy (Barthwell et al. 2010; Kondrad and Reid 2013; MacDonald 2009).

Medical cannabis critics have expressed concerns that cannabis patients are gaining entry to the system based on nebulous and subjective symptoms associated with pain (Caplan 2012; O'Brien 2013). However, it is also one of the areas where biomedicine is seen as lacking solutions, and is one of the most cited reasons for which patients seek out forms of complementary and alternative care or CAM (Barnes et al. 2004). In the same time period during which medical cannabis has expanded, there has been a fourfold increase in opiate use and an exponential increase in CAM use as a longer trend, but increasing since the mid-1990s (Ayers and Kronenfeld 2010; Kessler et al. 2001). According to a report from the Centers for Disease Control (2012), "enough prescription analgesics were prescribed in 2010 to medicate every American adult around the clock for a month" (44). While these facts are not meant to suggest that no individuals make false claims based on pain for medical marijuana—clearly, some do—this also happens when patients try to obtain other pain-related medications for improper uses and is why doctors are assigned as gatekeepers to assess patient need. However, these numbers also show that high proportions of pain reports are not out of step with the use of other types of medical therapies and treatments.

Ironically, the federal government's choices to block or delay medical research and medical access, and to maintain pressure up and down the legal chain from international law to

state and local policies, has led to a situation that pits ideology against the will of the public in the area of policy, and limits the influence of expert medical opinion (Bostwick 2012). This constrains the ability to base policy decisions on sound scientific expertise and medical evaluation and marginalizes the role of medical experts and professional associations. These choices have shaped the pathways for patients, doctors, advocates, and policymakers when it comes to setting medical cannabis policy, and played a critical role in marijuana's incomplete medicalization.

NORMATIVE STANCE FOR THIS PROJECT

This dissertation does not address whether or not cannabis is medically efficacious, either generally or for specific conditions. It does not evaluate any medical claims or personal outcomes reported in interviews, or attempt to make a case that establishes any specific uses for which cannabis use is warranted. These are questions better left to medical experts. I have explained that physiologically, cannabis interacts with receptors in the body in ways that are still being explicated, but that appear to be both unique in specifics, and similar to other substances that people ingest for medicine or intoxication. As a social scientist, I acknowledge that regardless of marijuana's clinical efficacy, individuals are engaging in its use as a medical treatment. Outcomes from treatment are important, but it is also useful to learn specific, practical information about how patients take medical marijuana, on what factors they base decisions to take cannabis, and how they make choices to participate in the official state medical marijuana program. Patient perspectives can offer useful information for many audiences, including those undertaking study on other aspects of medical marijuana including clinical studies, or for physicians treating medical marijuana patients.

My recruitment materials and interview questions were designed to encourage all medical marijuana patients to participate, regardless of their qualifying condition or reason for seeking a recommendation (although they did have to receive a doctor's recommendation in Colorado to participate). Making distinctions between legitimate and illegitimate patients has

been an important part of the discourse surrounding medical marijuana programs. These distinctions have their basis not only in linguistic choices, but in practical efforts to define adequate boundaries around legitimate medical uses so that patients who benefit from medical use can gain access, while diversion to the recreational or unqualified consumer is minimized. I will address many of these themes, but in the design of my study, I did not place particular focus on capturing illegitimate registrants, nor did I attempt to exclude such individuals from my study. Rather, in my recruitment materials and interview questioning, I made conscious wording decisions to be inclusive of any patients who had received a physician's recommendation, regardless of their state registry status, condition, or the perceived legitimacy of such a recommendation by themselves or others. I did not presume that patient motivations were always medical in orientation. In these matters, I assumed that physician recommendations were sufficient for participation, and I allowed patients to characterize the legitimacy of their claim to the medical marijuana patient status, rather than imposing external criteria to arrive at such determinations.

OVERVIEW OF CHAPTERS

Chapter 2: Research Methods. This chapter summarizes the methods by which the dissertation data was collected, and explains the approach to analysis. It also describes the participants in this study, including an overview of sociodemographic information about the 40 patients who comprise the primary interviews.

Chapter 3: Literature Review. This chapter reviews the existing studies on medical cannabis use and introduces other significant literature that applies to the individual chapters.

Chapter 4: Becoming a Medical Cannabis Patient in Colorado. This chapter describes the process by which patients manage the process of becoming a medical cannabis patient in Colorado. When patients seek to qualify as medical cannabis patients, they interact with the formal system of health care through the physician recommendation. I consider the role that incomplete medicalization plays in their choices and assessments of risk.

Chapter 5: Medical Cannabis Use in Everyday Life. After describing Colorado's system, I turn to the basic trends and variations in patients' day-to-day use of cannabis. I examine the pathways by which patients adopt cannabis use as a health practice. Drawing on Zinberg's (1984) concept of "drug, set, and setting," I examine how changes to all three factors play a role in patients' interpretive shift from recreational to medical use. I also discuss the distinctions that patients make between recreational and medical use through their language and behavioral choices. I examine how patients establish a sense of boundaries around medical use and the patient status, and how strongly they feel about those boundaries.

Chapter 6: Cannabis, Medical Use, and Systems of Medicine. This chapter differentiates the trends of medicalization, healthism, and pharmaceuticalization, three trends that have been discussed in the sociological literature. I argue that these three concepts have emerged in an attempt to capture the overlapping yet distinct trends between treatment-seeking through biomedicine (medicalization), attempts to manage life and self in health terms (healthism), and the expansion of use of drug medications as the best remedy (pharmaceuticalization). Patients may see the role of medical cannabis as operating differently in relation to health and medical practices depending on which of these domains is under consideration. This chapter also describes patient concerns with pharmaceutical drugs, alternative medicine, and any medicalized uses of other recreational substances.

Chapter 7: Cannabis & Stigma. This chapter considers how illness and medical cannabis patient stigmas are linked and are both intimately connected to the body. As a concealable stigma, medical cannabis use can be fully hidden or disclosed. Illnesses may or may not be concealable, and diagnoses carry differing levels of legitimacy. Cannabis is also linked to criminality and managed through the criminal justice system. Identification with cannabis use can result in arrest or the loss of other vital resources and benefits. This chapter considers how the patients manage stigma and stereotypes, and fight for the legitimacy of the medical cannabis patient identity as a fundamental right to their own bodies and their own health practices.

Finally, it considers how stigma and stereotype management of cannabis is intimately connected to the management of strong and weak networks.

Chapter 8: Conclusion. This chapter summarizes the significance of the findings from this study. It also explains limitations of the study, offers suggestions for further study, and comments on the future of medical cannabis in the context of pending legalization for all adult use in Colorado.

CHAPTER 2: Research Methods

I made the decision to write my dissertation on medical cannabis during the summer of 2010. At the time, I had been engaged in research on how individuals made decisions to use over-the-counter nutritional and herbal supplements as a form of self-treatment, but I had yet to settle on a specific direction. Then over the summer of 2010, medical cannabis became a sudden, visible presence in Colorado. Every day, I drove past the iconic green crosses that indicated a medical marijuana dispensary had opened. It was taking place literally right before my eyes. Medical cannabis was compelling as a dissertation topic for me on many levels. As a contested form of treatment that was largely initiated, maintained, and evaluated by the patient or layperson, it seemed to share many of the themes that interested me about complementary and alternative medicine, but it was more than that. No other form of nontraditional medicine was as controversial as medical cannabis. No other possible treatment had a similar legacy of contest. It was uncharted territory.

I knew a lot about medical cannabis already. I am not a medical marijuana patient, but prior to graduate school, I had worked as a book editor, and in the course of this career, I had significant involvement with several book projects on marijuana. I moved to California shortly after the passage of Proposition 215, the bill that ushered in the first state medical marijuana program. I had an undergraduate sociology degree and a few years of editing experience, mostly on academic books. I needed work, and when I was offered a position collecting information and editing books for one of the foremost advocates of cannabis in the U.S., I was intrigued. The job turned out to be an education in many aspects of modern cannabis policy. It also led me to meet

many people who were involved with marijuana issues in the Bay Area and beyond: advocates, physicians, patients, owners of some of the first Bay Area cannabis clubs, Dutch cannabis breeders, and long-time underground cannabis growers. I had the opportunity to interview many of them for book projects. I have to admit—before this job, I really had no particular knowledge or interest in cannabis or drug policy. However, it turned out to be a fascinating and fun use of my education and skills, and it appealed to my sociological curiosity by giving me access to a world that few people could access and experience—at least at that time.

While my familiarity with the issue was an asset, I was concerned about pursuing a dissertation on the topic for two reasons. First, I was not sure that I could look at the issue with a fresh perspective. I knew there were aspects of cannabis culture that were once new and novel to me, but I had long since lost that sense of surprise. The second concern required more soul searching. I had left that work to pursue an advanced degree—did I really want to return to that topic? I was already familiar with the pang of anticipatory chagrin that comes from working on a stigmatized topic. My prior work had taught me that the cannabis stigma has a long reach. Even as a book editor or academic researcher, the stigma might pull me into an orbit that would be difficult to escape. Perhaps if I were to do one of these jobs, employers would overlook it, but doing two projects related to cannabis back-to-back? I knew it had the potential to instill doubt in my own habits and limit my prospects.

While many topics of research may serve as cues about a person's political leanings, few other areas of research led others to so casually assume you were deeply engaged in the behavior you studied. Prostitution, heroin use, and perhaps most recently, gay rights issues did not allow people to assume you were also a prostitute, heroin user, or a gay or lesbian-identified person. With cannabis-related research, people rarely make this distinction. Perhaps this is currently undergoing revision, but for now, it remains a polarized topic, and proximity often serve as a proxy for personal involvement, unless of course, the research position seeks to prove cannabis

is harmful. As it turns out, the mechanics of this stigma are significant to cannabis' legal and cultural status, a topic discussed later in Chapter 7. After weighing these concerns and discussing it with those close to me, I decided that I was more fascinated than fearful, and I began to research the huge transitions underway in Colorado's medical cannabis program.

ENTERING THE FIELD

After deciding on my topic, my first goal was to gain entry to the field. I wanted to be sure I could access the people and events I needed to reach to understand medical marijuana in Colorado. Through my prior employment, I had maintained contact with marijuana advocates in California, but I was not sure how interconnected medical cannabis networks were across states, or whether California connections would help me reach key people in Colorado. I began preliminary fieldwork in September 2010 by attending a conference on medical cannabis in Denver. I was seeking two things from this initial contact: first, I wanted to find out if I could develop rapport with people and groups involved in Colorado's medical marijuana community, and second, I was seeking a sense of the moving parts in Colorado's dynamic medical marijuana environment in order to help me determine a specific direction to pursue for my dissertation.

I had attended such events in the early years after medical marijuana was allowed in California, and it was clear that medical cannabis had changed since then. I had never been at a cannabis event in which people wore name tags with first and last names on them. Now not only were attendees wearing badges with their full legal names (rather than pseudonyms) freely visible, but many also had names of cannabis businesses on them, and people were handing around business cards. The mundaneness of name tags and business cards in a conference setting may seem unremarkable, but to me, it signaled a real shift in attitudes and norms.

The time seemed ripe for research, and I found that this intuition was corroborated by the response I received. Nearly everyone I talked with welcomed research eagerly. Rather than being met with suspicion, I was welcomed by people who thanked me for pursuing such work,

even before I had completed a single thing. I was invited to events and included in informal networks quite readily. I had entered the field anticipating that my “cannabis credentials” from California would be critical for entry, but it turned out that my university affiliation was at least as important if not much more important than any “friend of a friend” network on which I had expected to rely—it signaled serious, professional work, and in an industry seeking professionalization and legitimacy, the prospect of being treated seriously is welcome.

After a few months of attending events and speaking with people, I began to recognize many key actors who were active on the issue, and I got a feel for the various constituents. I really had expected to find a patient-driven social movement underway, but I soon realized that this was not the case. Much of the public activity around medical marijuana in Colorado was not coordinated or attended primarily by patients. Rather, most events constituted the networking activities of an emergent industry in the midst of negotiating its transition out of the black or gray market. Many (though not all) individuals at these events were registered medical marijuana patients, but they were there because they were small business entrepreneurs invested financially in the newly forming medical marijuana industry: dispensary owners, infused product developers, or providers of one of the many secondary services that cannabis businesses require to function.

Some were not patients. The non-patient group included more than a small handful of refugees from the financial and real estate industries who had left these sectors after the economic downturn. In medical cannabis they saw a sector that required their skills and offered an enticing potential to work for something meaningful, and—every entrepreneur’s dream—to get in “on the ground floor.” Many mentioned their passionate feelings about the issue, but it was also clear they found it thrilling to be part of an industry that was emerging where literally nothing had existed before. Many felt a sense of accomplishment in helping to shape that industry in its early days. Of course, many hoped to hit the right niche, build successful

companies, and make handsome amounts of money. The prospect of making money and doing something meaningful held a strong allure and gave the room a feeling of civil rights meets alternative healthcare meets dot-com boom.

In addition to the businesspeople, there were many seriously ill, chronically ill, or disabled patients who had been radicalized by the relief cannabis had brought them, now looking for where they fit. There were old-school “outlaw” growers looking to turn legit in a market where their expertise had unexpected value. There were a handful of stereotypical old hippie types who had adopted this issue long ago and stayed the course, and there were members of the younger counterculture, many of whom were the front-line employees in the service and manufacturing sectors of this new industry. People told stories about their own experiences or about the recovery of people close to them. But events typically revolved around industry talk: interpreting the latest industry rules that had come down the pike, learning about security or tracking systems available for dispensaries, or figuring out how to conduct banking when regular, federally insured banks refused them service out of fear of federal reprisals. Despite looking for more patient-centered events, it turned out that most of the visible, public activities related to medical cannabis revolved around businesses development, and the population they were meant to serve—the patients—remained largely invisible. I found myself wondering—where *are* the patients?

FOCUSING ON PATIENTS

I decided to focus my dissertation specifically on patients for several reasons. First, patients are at the core of the issue. All activities related to industry development and the corresponding regulation are ultimately directed at patients—serving their needs while also constraining and regulating who can claim the patient identity. Yet this group is also defined by the rules for who can claim this formal identity, and who cannot. Understanding who participates in this system becomes useful for understanding its successes and failures. Right

now, at the center of this system is a patient population that is poorly understood.

Privacy rules and industry restrictions serve to protect individual patients in very important ways, but they also make this population hidden from the eye of the public, the media, and policymakers, and more vulnerable to stereotypical characterizations. Not only are patient identities protected in ways that are similar to other types of medical patients, but the medical marijuana laws have placed limits on creating public spaces, on how patient-serving businesses operate and on collective gardens, and these constrain any social or collective activities that might have emerged without such restrictions. For these reasons, studies that help to describe the patients for whom this system is meant to function, can offer valuable contributions.

There are currently many different policy experiments taking place for coordinating medical marijuana programs. It is useful to have states craft different systems, since such experiments help to determine best practices in an area of policy where there are only rough analogues, but few direct precedents to draw upon for practical guidance. Policy experimentation becomes more useful when information about each system is available to be evaluated and compared. Policies create a more publicly accessible record, but capturing the experiences within the systems created by the policies is a more slippery and fleeting thing to capture.

While quantitative studies help to describe how many people are using medical marijuana and the sociodemographics of that group, they say little about the meaning people associate with the behavior under study. Qualitative interviews are considered appropriate for studies where the goal is discovery rather than confirmation (Blee and Taylor 2002). They are considered particularly well suited to examine sensitive topics, hard-to-sample populations, and to examine behaviors undergoing change or where little is known about the behavior being studied (Blee and Taylor 2002; Hathaway and Rossiter 2007). By capturing rich contextual

information, findings from such research can also help to inform quantitative or large-scale studies.

For the duration of this study, Colorado's medical marijuana program has stood alone in many respects. Because of the timing of Colorado's medical marijuana boom in late 2009, the state was able to learn some important lessons from its predecessors, most notably California and the West Coast states. The regulatory structures in these states, and their successes and failures, have provided insights for how to create this type of regulation. As I discussed in the introduction, Colorado has since 2010 come to be considered a leading state on the issue. At the end of 2012, it is the state with the strictest statewide regulations currently in use, and is one of the only states with a functioning medical marijuana dispensary system, in part because some states have decided not to implement a dispensary-based system, and in part because some states that plan to have a dispensary-style system are not yet fully operational. Many states are still deciding whether to allow medical marijuana. In states that have passed such laws, many are still in early stages of determining the type of infrastructure and regulations they will adopt for their medical marijuana program. Colorado has emerged as a flagship state with a model that has experienced some success, and as such, it influences the shape of medical marijuana programs around the country.

To my knowledge, this is the first academic study that focuses on medical marijuana patients based in Colorado. It is one of only about ten existing qualitative social science studies in the U.S., Canada, and the UK. Medical marijuana has captured the imagination and interest of many journalists, who have interviewed patients and published books. Academic work includes another 20-25 quantitative survey studies, most of which were conducted in California, but a few were in other states, or in other English-speaking countries—Australia, Canada, and England. By contrast, policy reviews and economic analyses articles range in the hundreds, but even while these works are very helpful for understanding changes to the policy environment,

they rarely include primary or secondary data collected directly from patients and other people engaged in the medical marijuana industry.

This work makes a unique contribution to the existing literature, and helps create knowledge about medical marijuana patients and their place within the health landscape. The following dissertation focuses on patient utilization of medical marijuana, and draws from the literature about other health practices, especially in the areas of complementary and alternative medicine, stigma, and identity. This study's design choices were made with the goal of allowing patients to narrate their use of this contested treatment and describe how they integrate it into their healthcare, their relationships, and their lives. In so doing, this study offers a unique and unexplored case study on stigma and health, by acknowledging medical marijuana as a form of contested medicine, and examining how patients negotiate multiple, conjoined identities that confer stigma (illness or disability and marijuana use). It also seeks to understand the mechanisms by which patients reclaim and rehabilitate "spoiled identities," which may be relevant to other identity-based movements within and outside of the realm of health. Very few works have tackled these themes, but a few have offered insights into cannabis, stigma, medicalization, and health utilization. Chapkis and Webb's 2008 ethnographic study on terminally ill members of the Santa Cruz, California cooperative, Women's Alliance for Medical Marijuana, addressed many similar themes under different conditions, and Hathaway's (1997, 2004; 2011; 2007) work included insights on stigma and normalization for medical and recreational use in Canada.

This dissertation study was completed before the November 2012 vote on Amendment 64. This constitutional amendment allows adults to possess, consume, and grow cannabis in limited amounts and in non-public spaces. Although it does not formally alter the rules for medical marijuana under Colorado's Amendment 20, it will undoubtedly have effects on the state's medical marijuana program. It is still unclear how the federal government will respond to

Amendment 64, given that cannabis remains illegal at the federal level for all uses. As one among only two states to venture into this new territory, Colorado has only been further jettisoned onto the national stage when it comes to cannabis policies in the U.S.

While I could not have known it at the outset of this research, I have managed to capture a unique period in the history of medical cannabis laws. I believe understanding patients within the medical system prior to legal recreational access will provide useful insights for understanding behavior by medical and recreational users after the new law is implemented and all adults have access, but the market becomes bifurcated between recreational and medical uses.

RECRUITMENT AND SAMPLE CONSIDERATIONS

Between September 2010 and May 2011, my preliminary work allowed me to explore the field, establish rapport, get a sense of the activities related to medical cannabis, and determine my own research focus on patients. During the winter and spring of 2011, I formulated my research plan for recruiting and conducting interviews with medical marijuana patients in Colorado. I received approval for my research plan through the Institutional Review Board (IRB) at the University of Colorado at Boulder in May 2011 under protocol number 11-0245.

Medical marijuana patients are a challenging population to reach (Hathaway and Rossiter 2007; O'Connell and Bou-Matar 2007). They share many of the challenges associated with recruitment for hidden populations. Due to concerns with stigma, privacy, and legality, individuals in hidden populations often have reasons to be reluctant about participation in a study. However, underrepresented populations may also have motivations for participation, because they would like their group to have a voice in an issue of key importance to them (Chapkis and Webb 2008). Contradictions between state law which allows medical use, and federal law which maintains criminal penalties for all uses, adds significance to the protected status of patients. This perception of risk is complicated by a sense that current laws are a

moving target. As the state and the federal agencies determine what constitutes legal and acceptable behavior, the rules change in ways that can alter who is safe from prosecution and who is not. These distinctions are more than an academic exercise—as I mentioned in chapter 1, dispensaries continue to be raided in record numbers, and patients continue to be arrested, even in states with medical marijuana protections (Chun 2012; Dwoskin 2012).

My recruitment strategies were sensitive to these considerations. In addition to patient protections to privacy by law, medical marijuana dispensaries are protected environments that require identification to enter and are designed to uphold patient privacy. Within dispensaries, transactions are monitored as a part of the tight regulations on patients and the industry. Based on these factors, my approach to recruitment was indirect.

It is easier to reach patients who engage in activities such as political advocacy or business ventures in medical marijuana, but this subsection of the patient population is undoubtedly skewed. My goal became to recruit patients using methods that respected confidentiality while attempting to reach the most diverse sample of patients possible, based on characteristics such as level of activism, public identification with marijuana issues, type, and severity of illness or injury, age, and region.

Most patients interact with the system somewhere. They may get their supply from dispensaries, they may follow or participate in advocacy organizations or online communities voluntarily, and they may pick up the free cannabis-specific publications that are disseminated around the state. My main recruitment strategy entailed networking extensively with these different outlets that served patients. I contacted dispensaries, websites, and advocacy organizations who directly served patient populations. After obtaining permissions from these organizations, I provided them with a description of my study that could be displayed, published, posted, or emailed to their patient base. Patients were instructed to contact me directly by phone or email if they wished to volunteer for participation in the study, and my

contact information was provided.

These methods may have reached some patients more readily than others. The study's description as related to health experiences may also have increased the likelihood of attracting patients who perceive themselves as unquestionably "legitimate." To compensate for some of the limits imposed by these recruitment techniques, I sought out groups and organizations that serve patients in different ways, that were located in different regions throughout Colorado, and that varied in the styles they used for marketing to clientele, from dispensaries and organizations that branded themselves in a more clinical, medical, and professionalized style, to dispensaries and organizations that exhibited a greater overlap with recreational subculture. By covering a spectrum of organizations based on function, style, and geographic location, I attempted to maximize the variation in the patients who would hear about the study.

I strived to make it plain that all patients who had received a doctor's recommendation were invited to participate, regardless of the seriousness of their illness or condition, or their motivations for seeking out a recommendation, and I reiterated this message with the organizations that advertised my study to try to mitigate any potential cherry picking or other filtering effects through the advertising organizations.

I continued to renew my recruitment through dispensaries, medical marijuana publications, and online medical marijuana groups by reposting my advertisements, and by calling, emailing or visiting employees, owners, or leaders at my recruitment locations to thank them, answer any questions, and ensure that they were informed on any details about the study and the process of recruitment, and felt comfortable advertising the study to their clientele based on meeting me as the principal researcher, and having questions about the study answered.

Several industry organizations, websites, and free specialty cannabis magazines advertised my study by posting information to their websites, publishing an announcement

about the study in their publication, or sending my recruitment text to their patient base through their own organizations' private email lists. In locations where fliers were posted, patients could opt to take a discreet business card or tear sheet with my information. These items did not contain the words "marijuana" or "cannabis" on them in order to extend discretion for those who opted to take away my contact information. Word-of-mouth assisted in recruiting patients, but at the level of organizations that advertised my study. I did not employ a "snowball" approach in which participants referred other patients to me, either by providing me or providing other patients with my information. All patients were recruited as a result of reading my recruitment materials from one of the many places where it appeared. This approach to patient recruitment most closely resembles a clinical study approach, where a large number of potential interviewees are informed about the study, but the rate of participation is relatively low.

My goals in recruitment drew on practical and theoretical considerations to recruit the strongest sample possible. In determining my sampling needs and sample size, I strived to realize two goals: completeness and the principle of similarity/dissimilarity (Blee and Taylor 2002). Completeness is described as the construction of a thorough knowledge about the topic. The goal has been to continue interviewing new participants until I no longer received new narratives and interpretations on the main topics of inquiry. At this point, the topic was considered "saturated." The principle of similarity/dissimilarity directed interviewee selection to include some similar cases in order to compare interpretations or accounts with other similarly situated participants, and to also select differently situated participants to see if accounts differ based on differences in social location or other categories (Blee and Taylor 2002). I sought diversity on prior experience with marijuana, region, health condition, gender, and ages within my range of recruitment.

Focusing on Middle Age

After conducting an initial set of interviews, I decided to focus specifically on patients in middle age. Respondents range in age from 30 to 68 years old. This age range encompasses the Gen X generation and the Baby Boomer generation. I made this sampling choice for a few reasons. First, life course is an important element in experiences with marijuana, and I wanted to focus my study on use by those beyond college age, up to and including ages that included the entire Baby Boomer generation. This generation was the first to experience the popularized use of cannabis in their teen and college age years, their most likely point of initiation in their own life course.

Since life course places importance not only on individual age, but on cohort and period—when one came of age, and what one's peers were doing—I allowed the established markers for these two generational groups to define my age range. As I have already noted, research has focused on the teen and college age groups, but it is also worth pointing out that this work rarely foregrounds the life course implications that result from this focus. The best available survey reports corroborate that recreational use has been the highest among the 18-22 year old age group. Use peaks in this age group, with nearly one-quarter reporting use in the last 30 days, and then gradually declines over the life course, flattening out for those aged 40 and older, among which 6-7% report use in the last 30 days (Johnston et al. 2012). It is also the case that medical cannabis patients who have tried cannabis previously had usually first tried cannabis during their teens or early adult years. This was followed by highly variable careers of use over their adult lives (Coomber, Oliver and Morris 2003; Hathaway et al. 2011; O'Connell and Bou-Matar 2007). The choice to focus on patients at midlife fits the same criteria as many recreational use studies – study the group with highest use; the majority of medical cannabis users across states and countries are in their late 30s and early 40s (CDPHE 2011a; Janichek and Reiman 2012; Reiman 2007; Reinerman et al. 2011; Ware et al. 2003).

COLLECTING DATA: THE INTERVIEW-BASED QUALITATIVE APPROACH

Over the course of my data collection, I conducted a total of 42 interviews. Two early interviews were conducted with patients who were under 30 years of age. After making the decision to narrow my focus on midlife patients, I eliminated the two that did not meet the criteria, which left me with a total of 40 qualifying interviews with Colorado medical marijuana patients who are 30 years or older.

In interviews, I sought to discover what the subjects themselves experience and believe about using marijuana medicinally (Creswell 2006). In-depth, semi-structured interviews are well suited to discover emergent topics of importance for those engaged in the activity. Patient interviews resemble “life history” interviewing, which are geared toward the personal history of the individual, specifically focusing on the individuals’ health history, including their medical history, their experiences with traditional and nontraditional forms of medicine, and their health beliefs. In order to gain context and additional topic breadth, patient interviews are supplemented with additional forms of data collection: supplemental interviews with key organizational actors, and observations in non-dispensary settings where medical patients or advocates meet for social, political, or educational purposes related to medical marijuana.

While the aim of this study has no basis in statistical representativeness, validity and bias issues are still worthy of consideration. To create a strong study, I sought to meet a few generally recognized criteria. The first was to collect enough data so that both heterogeneity and redundancy are sufficient to argue that the study has “internal generalizability,” that is, that the findings adequately elaborate the concepts under study for the setting or group of interest (Maxwell 2005). Sources on qualitative research methodology recommend that the milestone of “theoretical saturation” be used to determine the number of interviews (Charmaz 2006; Guest 2006). Theoretical saturation, a term common to the grounded theory approach of qualitative analysis, is now widely adopted in research programs across several social scientific disciplines

(Charmaz 2004). It is meant to indicate a point at which information collected from interview subjects is no longer expanding the theoretical categories of interest, and new interviews, rather than adding variation within these categories, prove redundant with responses from prior interviews. While one cannot be fully certain that all responses have been represented, it is important to seek a sample that encompasses diverse experiences and views, and is exhaustive enough to represent the common range of responses (Charmaz 2006).

Patient Interviews: Conversations with Medical Cannabis Users at Midlife

I began patient interviews during the summer of 2011. These semi-structured interviews ask patients about how they use medical marijuana in their day-to-day lives, how they attribute medical significance of cannabis use, and in what ways they choose to identify themselves as medical cannabis patients. I remained interested in some of the same issues that applied to the use of other self-initiated care using non-prescription herbal remedies. How do individuals choose particular treatments, how do they implement these treatments, and how do they assess the outcomes? How do their choices connect with their health experiences and beliefs? However, I found that direct comparisons with complementary and alternative medicine (CAM) often resonated less with patients than I had originally anticipated, a development that caused me to adapt my questions. Despite this, I retained questions that allowed comparisons with the literature on CAM patient populations.

With medical marijuana, I was also interested to find out if they shifted their understanding of marijuana from a recreational substance to a medicine, how they explained this shift and saw it as significant, and how they managed the identity of being a medical marijuana patient. This was a narrative with which most patients were already familiar.

Interview Details

Interviews were conducted in-person and ranged in length from one to three hours. All interviews were digitally recorded and then transcribed and coded using NVivo version 10, a

qualitative coding software program (NVivo 10 2012) . Interview locations varied. Some interviews were conducted at the individual's home; others took place at a neutral but private location, typically a private study room at a public or university library that was local to the participant.

When patients responded to my recruitment materials, they often wanted to know my status as a patient. Most also wanted to be sure that my research contributed to a better understanding of patients, and was not intended to discredit medical marijuana or disparage its users. I clearly identified that I was not a registered medical marijuana patient, and presented myself as friendly to medical marijuana and interested in patients. I did not inform patients about my prior involvement with cannabis research in California before the interview because I felt this would cause them to make certain assumptions about my knowledge and insider status, and such assumptions might cause them to elide information that I wanted them to include. If patients asked me more about my background and project after the interview, I would offer greater detail about my background if this information seemed appropriate to the conversation.

Patients were generally very forthcoming in their interviews. In many cases, patients began the interview by offering a health biography, which often took the organic form of a life history that weaved in and out of the interview schedule and was often more patient driven. Others were more passive and let the questions drive their responses.

Key Informant Interviews & Observation

I supplemented in-depth patient interviews with ongoing observations at public events related to medical cannabis and informal interviews with key actors. Key interviews and observations at public locations have involved a mixture of digital recording and field notes. While only a few key interviews were recorded transcribed, I maintained extensive notes for all of these events, which were entered into NVivo for coding.

These additional forms of data allowed me to reach a broader range of patients through

those with more direct access, to gain insights on patients as an aggregate population from those who regularly interacted with many patients, and to learn of developments in policy, politics, and community that were had to access through any formal sources. These sources also offered me another form of feedback on my assessment of the themes emerging in my interviews, and to gauge their importance, or gaps. Collecting multiple forms of data and looking at patient experiences from different angles is a common recommendation for strengthening qualitative research findings (Boeije 2010; Denzin and Lincoln 2000; Hathaway and Rossiter 2007; Maxwell 2005).

Blee and Taylor (2002) describe approaches to key informant interviewing: “the researcher questions a few well-placed informants, sometimes over an extensive period of time, to obtain descriptive information that might be too difficult or time-consuming to uncover through more structured data-gathering techniques” (105). Within the medical marijuana community, there are many moving pieces. One reason to draw on the knowledge of key organizational actors is that they often know unpublished information, or may have in-depth knowledge about how one aspect of the medical marijuana community is currently operating. A second reason to talk with key organizational actors is that many in these positions serve as the public mouthpiece for the medical marijuana community, and as such, they play a pivotal role in the cultural discourse surrounding medical marijuana, including the ability to provide grounds and factual information or rumor-level information that circulates behind assertions.

Key informants and observations offered useful information regarding the business and legislative environment that surrounds patient provision, and in particular the change of rules for caregivers and dispensary operation, which affects the ways that patients can obtain a supply of medical marijuana. Observation also served a dual purpose. First, attending and observing events helped me to identify key organizational actors. I could identify people to recruit for informal interviews when I was seeking information about specific developments or sectors of

the medical marijuana community. Second, it created opportunities to network with key organizational actors for assistance in patient recruitment. Beyond these uses, observations at events allowed me to listen in on how the medical marijuana community communicates amongst itself, discusses strategy, networks, and disseminates appropriate messages for a broader public.

In total, I conducted eight key informant interviews. Three were conducted near the outset of my data collection, interspersed with my first 10 patient interviews. I elected to intersperse key interviews in the beginning of my data collection, along with observations, to help me formulate a better starting schedule of interview questions. Specifically, because key actor interviews often had direct interaction with many patients, they had insights that I did not yet have, and that individual patients often had little cause to notice. Five of the key informant interviews were collected toward the end of my data collection, interspersed with my last 15 patient interviews. These were used to help me determine that my patient interviews had captured important themes sufficiently. Specifically, I used these final interviews to find out details about specific topics raised by patients about their interaction with the industry. Through questions to key informants, I could visit the themes that had emerged from my patient data in more detail and probe to see if I had reached a reasonable level of saturation based on the experiences that key actors had. While key actors were drawing from informal experience, they often have insights that are based on lengthier involvements and interactions with a larger cross-section of patients than me.

In addition to these more in-depth discussions with key actors, I attended more than 25 medical marijuana–related functions, conferences, and events between September 2010 and November 2012, listening to speakers and having informal discussions with many organizers and individuals who are actively involved with patients. Observation helped me to better contextualize patient interviews through collection of public talk surrounding medical

marijuana and patient issues. Observations have included attendance at meetings among key Colorado patient or dispensary organizations, or at public hearings regarding medical marijuana policies. Observation allowed me to reach beyond this study's basis in interviews and strengthen my understanding of the relationship between patient narratives and the collective, public language about the medical marijuana identities. In the words of Zussman (2004), these supplemental forms of data collection have helped me to understand "people in places," to acknowledge the importance of public discussion, policy debate, and the implementation of rules on individual patient's decision-making around medical marijuana.

ANALYTIC APPROACH

In my analysis, I have used an inductive approach, engaging in data analysis simultaneously with data collection, and conducting interviews in stages with intermittent periods where I focused primarily on review and initial coding using NVivo for qualitative coding analysis (NVivo 10 2012). I completed approximately 20 interviews, then assessed the data for themes and considered areas where more patient reports would be helpful (Charmaz 2004). I elected to narrow my age range to those in midlife. While this required me to eliminate two interviews from my initial collection, it was in part a choice based on who was volunteering for my study, and in part to help focus the study on relevant dimensions. Given that patients are diverse, this small adaptation seemed to allow my dissertation to hone in on life course themes that threaded through the interviews of midlife patients.

I collected a short post-interview survey with the patients interviewed in this study, which allowed me to create summary data that ensured the same demographic and summary health information was received from all interview participants. Codes began as "organizational codes," also referred to as "topics," which simply refer to the spheres of activity I expected to find among patients. These included things like "doctor referral experiences," or "patient diagnosis," or "family and friend reactions." They were simply categories without assumption of

what patients would say about each topic (Maxwell 2005). After interviews began, initial coding of transcripts developed analytic themes. This was followed by a period of constant coding to adjust and refine the initial themes, and was used reflexively to adjust interview questions as needed. Coding adjusted as new themes emerged or prior ones changed in response to the interview and observation data, followed by a second stage of ongoing refined coding based on the primary themes of the dissertation, which continued to be improved after data collection ended (Charmaz 2006).

Throughout data collection, I kept theoretical memos to record insights related to relationships between interviews, observations, and relevant theories, especially as they relate to complementary and alternative medicine, identity and stigma, recreational drug use, life course, and collective identity. Theoretical memos assist with the development of themes and their relationships to the data and to one another (Charmaz 2006; Walker and Myrick 2006). Memos are often seen as a “pivotal, intermediate step between data collection and writing drafts of papers” because memos serve as the starting point for building data-driven analysis (Charmaz 2006:72) It is considered a useful companion strategy for creating stronger validity in qualitative research (Whittemore, Chase and Mandle 2001). Memos assisted me in recognizing important themes, noting questions or topics for further consideration to be explored in ongoing interviews, and developing theories based on interview respondents. Themes are ways of classifying discrete concepts and begin to provide a level of abstraction from which theory can be built (Ryan and Bernard 2003). Memos often helped me capture ideas after interviews or after coding—times when I had spent time immersed in data and my focus on details provided interesting ideas to examine. I revisited and added to memos periodically as interviews accumulated, and this helped to determine whether themes had applicability or could be further developed. Themes also helped point me to appropriate literature for review. I also wrote memos when some aspect seemed to stick out as troublesome or problematic to me, to earmark

it as something to think about further. Just as much as conceptual breakthroughs are useful for theory development, many times the parts that seemed to depart from what I expected often became eventually useful, because I could probe more in the remaining interviews, and in at least some instances, this led me to a new insights on patient narratives.

Confidentiality in Analysis

In my analysis, all participants have been assigned pseudonyms. I have also assigned pseudonyms to any friends or relatives named in interviews, and to any specific businesses. Because the site of my study, Colorado, is identified, I have not invented fictitious town names for my study.

In many ways, medical marijuana remains a small community, with under 150,000 members around the state. Those who play key roles in organizations, advocacy, or businesses can be fairly easy to identify without providing names. While patients are more plentiful and less public, making them harder to identify, some have rare conditions that they may share with only dozens or hundreds of people in the state, and others who share their condition may not be using medical marijuana. Simply naming a condition with any other piece of identifying information—the town, the gender, and the age of the person, or details about their families—may be enough to breach confidentiality.

For these reasons, I have taken great care when recounting individual patients stories. I have elected to not create composites, but to let each patient's story retain its unique integrity. While I provide specific geographic, demographic, and health information in aggregate, I have elected to be more vague on some of these details when recounting specific stories, in order to better maintain the confidentiality of those who participated.

THE STUDY SAMPLE: COLORADO PATIENTS AT MIDLIFE

Conditions that Qualify for Medical Marijuana

Each of the 18 medical marijuana states and the District of Columbia¹ list specific conditions for which patients can qualify to be medical marijuana patients in the language of their legislation. Right now, states vary by their list of qualifying conditions, and by the rules for who can extend qualification for conditions not on the list. The qualifying conditions in Colorado, specified in Amendment 20, consist exclusively of the standard conditions that are currently approved in all state medical marijuana policies (MPP 2012). There are eight: severe pain, severe nausea, seizures, muscle spasms, glaucoma, cachexia (better known as wasting syndrome), HIV/AIDS, and cancer (Constitution 2000). Conditions are not considered mutually exclusive categories; patients may report more than one.

Colorado's amendment also aligns with policies in 13 other states in specifying that the managing government agency—usually but not always the state health department—can approve additional medical conditions if evidence warrants such a change. There is a protocol by which citizens can file paperwork to request such a review. In its twelve years of existence, thirteen additional conditions have been submitted for inclusion². All have been rejected, and no additional conditions are currently under review (CDPHE 2013).

Other states have approved additional qualifying conditions in their initial legislation or through amendment procedures. The most common of these is Crohn's disease, which is approved in eight states, nine if you include New Jersey, which does not specify Crohn's disease but does allow Irritable Bowel Syndrome, a diagnosis with which Crohn's is often grouped as a subtype. Here is a list of additional approved conditions, with the number of states approving in parentheses: Hepatitis C (7), Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease") (7),

¹ To simplify descriptions, the District of Columbia is grouped as a "state" with the other 18 states that have medical marijuana programs for the rest of this chapter.

² Conditions petitioned and rejected in Colorado: asthma, atherosclerosis, bipolar disease, Crohn's disease, diabetes mellitus types 1 & 2, diabetic retinopathy, Hepatitis C, hypertension, Methicillin-Resistant Staphylococcus Aureus (MRSA), opioid dependence, Post-traumatic Stress Disorder (PTSD), severe anxiety, clinical depression, and Tourette's Syndrome.

Multiple Sclerosis (MS) (7), Alzheimer's disease (6), Post-traumatic Stress Disorder (PTSD) (3), Parkinson's disease (2), and nail patella syndrome (2). Three states explicitly specify that spinal injury/peripheral neuropathy is a qualifying condition, although most states allow these conditions to qualify under severe pain. Anorexia, decompensated cirrhosis, migraine, and muscular dystrophy are each included in one state. Two states define entry to hospice or diagnosis with terminal illness as basis for qualification (MPP 2012).

The Colorado registry has ranged between 85,124 (January 2012) and 127,816 (July 2011) registered patients, with a present (January 2013) count of currently registered patients at 108,656 (CDPHE 2013). The cumulative total of all new applications for patient status is 207,223. The composition of patients has remained relatively steady over time. Based on the CDPHE statistics, the average age of patients in Colorado is currently 41 years of age. Sixty-eight percent of patients are men. An overwhelming 94% of currently registered patients qualify due to chronic severe pain. The next largest categories are muscle spasms (16%) and severe nausea (11%), while the remaining categories account for 1-3% of patient reports on qualifying conditions (CDPHE 2013). No statistical information regarding race was available for Colorado's patient population.

Patients in this Study: Demographics and Health Characteristics

The 40 patients in this study range in age from 30 to late 60s, with an average age of 46.6. The sample consists of 28 men (70% of sample) and 12 women (30% of sample) with a diverse set of conditions ranging from moderate neuropathic pain and migraines to stage-4 cancer to HIV to spinal injuries. Nearly all patients in my sample reported chronic severe pain; eight patients (20%) reported another qualifying condition—HIV/AIDS, cancer, or muscle spasm—as the primary qualifying condition. Nearly all patients reported secondary non-qualifying conditions from which they also suffered and that also benefited from the medicinal use of marijuana. These included conditions as diverse as Hepatitis C, bipolar disorder, PTSD,

insomnia, anxiety disorder, diabetes, and depression. Racial diversity was minimal, with only 5 patients reporting any other race or ethnicity than white, and often in combination as a multiracial identification that included white and another race. While theoretical sampling does not attempt to achieve a representative demographic sample, my interview sample has the same approximate distribution of age, gender, and medical conditions reported for the entire patient population in state of Colorado.

Because my study focuses on midlife patients, my sample is on average slightly older than the entire population of medical cannabis patients in Colorado. In my patient interviews, more serious conditions may also be overrepresented, which may indicate a bias in terms of which patients were more willing to volunteer for interviews. For similar reasons, my interviews may also include a higher proportion of individuals who engage in activism on medical marijuana issues, but there is a subsample of patients in these interviews who keep their medical marijuana status private and do not participate in advocacy.

There are more men than women in this sample: Gender proportions are in line with other studies and with the overall Colorado patient population. While no information on educational level was available from the Colorado Department of Public Health and Environment (CDPHE) on the overall medical marijuana patient population, and few other studies reported this information, education in my sample was slightly higher proportionally for those who have some college education when compared to samples from Aggarwal (2012) and Janichek and colleagues (2012). It approximates educational levels reported by the total population census numbers on Colorado (U.S. Census Bureau 2012). Marital status also reflected proportions found among Colorado's general population (U.S. Census Bureau 2012).

The remaining chapters of this dissertation will now address the medical use of marijuana by midlife patients in Colorado.

Table 2: Patient Summary Statistics
Sample n = 40, Statewide Registry (January 2013) N = 108,656

Geographic Location ¹	Sample (#)	Sample (%)	Statewide Registry (%) ²
Denver Metro Area (including suburbs)	17	42.5%	47.5%
Colorado Springs Metro Area	11	27.5%	14%
Boulder/Front Range Area	8	20%	13.5%
Fort Collins and surrounding area	2	5%	5%
Other (Western Slope & Pueblo)	2	5%	6%
Primary Qualifying Condition ³			
Cachexia (Wasting Syndrome)	0	0%	1%
Cancer	3	7.5%	3%
Glaucoma	0	0%	1%
HIV/AIDS	4	10%	1%
Muscle Spasm	12	30%	17%
Seizures	1	2.5%	2%
Severe Pain	36	90%	94%
Severe Nausea	9	22.5%	11%
Gender			
Women	12	30%	32%
Men	28	70%	68%
Race			
White	36	90%	
Nonwhite	4	10%	
Age			Average: 41 years
30-39 years old	10	25%	
40-49 years old	14	35%	
50-59 years old	10	25%	
60-69 years old	6	15%	
Education (highest level)			
High School Graduate	9	22.5%	
Some College	12	30%	
Associate degree/Trade School	5	12.5%	
Bachelor's Degree	9	22.5%	
Professional Degree	5	12.5%	
Marital Status			
Single	11	27.5%	
Married	20	50%	
Divorced/Separated	9	22.5%	
Sexual Orientation			
Heterosexual	36	90%	
Gay/Lesbian	4	10%	
Parent Status			
Total with kids	27	67.5%	
Kids under 18 living with Patient	8	20%	

¹ Statewide percentages by region are based on combined county numbers for the area described. Percent is out of all counties. Unrepresented counties each have 2% or fewer of the state's registered patients.

² Registry numbers from the September 2012 report provided on the CDPHE website.

³ Patients may report more than one qualifying condition so state registry numbers do not total to 100%.

CHAPTER 3: Literature Review

LITERATURE ON MEDICAL CANNABIS PATIENTS & PATIENT PROGRAMS

Although it has been fifteen years since the first medical marijuana law passed, and the patient population is currently estimated at over 1 million American adults, research on medical marijuana patients is limited (Belville 2011; Caplan 2012). In a search of *Sociological Abstracts* for articles in English-language, peer-reviewed scholarly journals whose titles contained the word “marijuana” or “cannabis” under the subject “sociology” during the time period January 1, 1996 to December 31, 2012, I found 205 articles. Nearly all articles address recreational marijuana use, with a particular emphasis on initiation of use among adolescents, or negative outcomes later in life due to use of marijuana in early adulthood. Another group of articles analyzes marijuana policy. These articles encompass varying ranges of time within the last century, and focus on various levels of government from local to international. Policy articles often consider effects on social behaviors, but they typically do not involve data collected directly from people. After 2000, topics relating cannabis use with social identity, stigma, perceptions of cannabis users and cannabis normalization can be found in the literature. There remains a gap in studies of medical marijuana patient experiences. Only a dozen articles, less than 6% of the 205 articles from 1996 – 2012 with “marijuana” or “cannabis” in the title included a focus on medical marijuana.

Other contemporary researchers on medical marijuana have noted the lack of even basic demographic information and health profiles on patients and programs, even as they work to correct this deficit (Aggarwal et al. 2012; Kamin 2012; Nunberg et al. 2011; Reiman 2006). One challenge with data derives from the fact that most states do not collect data on even the most

basic level, such as patient numbers, aggregates on conditions and diseases treated, or patient age distributions (Caplan 2012). Colorado is better than many state programs; it publishes basic demographics monthly and maintains an archive dating back to January 2009 so enrollment can be tracked over time. Still, this data is very thin. It includes the number of patients who have applied, the number currently registered, and the summary statistics on qualifying conditions, gender, county of residence, and average age. No information is provided on age distribution, race, education, or other common demographic categories (CDPHE 2013).

Social science research about medical marijuana patients and medical marijuana programs in the U.S. has been conducted almost entirely in California (Chapkis 2007; Harris et al. 2000; Janichek and Reiman 2012; Mikuriya 2004; Nunberg et al. 2011; O'Connell and Bou-Matar 2007; Reiman 2006, 2007; Reinerman et al. 2011). The exception is Sunil Aggarwal's recent work in medical geography, which is focused on patients and services in Washington state (Aggarwal 2008; Aggarwal et al. 2012).

Two quantitative projects have been carried out in California to offer a snapshot of that state's medical cannabis patients. The first, a survey by Nunberg and colleagues (2011), which is also analyzed by Reinerman and colleagues (Reinerman et al. 2011), collected questionnaires from 1,655 Californians who were visiting a medical clinic to receive a medical marijuana evaluation from a physician at one of nine California medical clinics during the summer months of 2006. When analyzing patients applying for medical cannabis use, Nunberg and colleagues found that most patients were seeking treatment for chronic pain, and few applications were for cancer, HIV, glaucoma, and multiple sclerosis. Second, they found that patients often used cannabis as a substitute for prescription drugs. Reinerman and colleagues (2011) analysis of the same data provided a description of the demographic and health characteristics of the patient sample. They found that back, spine, and neck pain accounted for the most frequent reason physicians approved medical cannabis recommendations in California, followed by sleep

disorders, anxiety or depression, and muscle spasm. In addition, they found that medical cannabis users reported higher levels of tobacco use and lower levels of alcohol use than was found among those surveyed in the National Survey on Drug Use and Health (NSDUH), although they cautioned that comparisons were preliminary and needed better rigor to indicate significance (Reinarman et al. 2011). Reinarman also reported on other therapies tried by medical marijuana patients, and their routines of use. His team also addressed the issue of diversion to recreational uses, noting the complications in teasing apart medical and recreational uses.

O'Connell and Bou-Matar (2007) also provided a general overview of patients, drawing on the records of 4117 California marijuana users who applied for medical recommendations between 2001 and 2007, with special attention to their reports on initiation of cannabis, alcohol, and tobacco use. They provided information on patient demographics, and routines and modes of use. From their analysis, O'Connell and Bou-Matar (2007) concluded that nearly all medical cannabis patients in the sample had initiated cannabis during adolescence, following experimentation with alcohol and tobacco. Baby Boomers generally tried cannabis later in life than subsequent generations due to cultural timing of marijuana's rise to mainstream popularity. The authors did not find a link between marijuana use and subsequent use of harder drugs. While medical marijuana patients had varied careers of lifetime cannabis use, long-term use was generally non-problematic among the sample, with modest use levels. They also reported that use contributed to rather than detracted from performance and achievement in other domains of life. They also found that beyond alcohol and tobacco use, cannabis "is the only drug used past the age of twenty-five by most. Indeed their total drug use histories suggest that by competing successfully with other, potentially more harmful agents, cannabis may have actually been protective" (O'Connell and Bou-Matar 2007).

A handful of smaller survey projects have also been conducted in California. Harris and

colleagues (2000) surveyed 100 patients in a major dispensary in the San Francisco Bay Area, and reported on demographics, most reported conditions, routines of cannabis use, use of alcohol and tobacco, and outcomes from medical uses of cannabis. An early study after the passage of California's medical marijuana law, this sample had an uncharacteristically high proportion of HIV/AIDS patients compared to other studies who recruited from a general patient population.

Reiman's (2006) dissertation study surveyed 130 patients from seven Bay Area medical marijuana centers. Her work focused on patients' utilization of health services and on specific questions around the use of cannabis as a substitute for other substances. Her methods included surveying dispensary staff as well as patients in order to explain patient healthcare utilization. Reiman (2006) grounded her analysis in Andersen's behavioral model of health services use. This model assumes that people use health services based on two factors: their predisposition to use services, and their need for care. Patients in this study also assess their satisfaction with the care they received through dispensaries.

With the exception of a rare, early, and less scientifically rigorous study by Feldman and Mandel (1998), Reiman offers one of the few studies that examine medical cannabis facilities as well as patients. Because Feldman and Mandel's (1998) study predates Reiman's by about a decade, it offers an interesting comparison point. Feldman and Mandel captured patient experiences in California during a time when dispensaries were modeled more in the form of a "social club" than a "pharmacy." Under the social model, friend connections played a key role in patients' selection of dispensaries as providers, whereas Reiman (2006) found this factor to have reduced in importance. Colorado's dispensaries are even more closely modeled to an individualistic, pharmacy model, and this structure is more standardized across the state, so it may affect relationships and networks in important ways.

Reiman (2006) contributes several important findings to the literature. First, this study

found that medical marijuana use often creates substitution effects. Patients who find cannabis helpful for management of pain or other symptoms often voluntarily decrease their use of other drugs, including prescribed pharmaceuticals and recreational substances. The “substitution effect” found by Reiman has been supported by additional work, starting with research of California physician Todd Mikuriya (2004) and also discussed by Swartz (2010) and Lucas (2012).

Reiman (2006) also found that patients use many substances as medications, including prescribed pharmaceuticals, over-the-counter remedies, herbal and homeopathic remedies, and nonmedical recreational substances such as alcohol, heroin, and cocaine. Finally, Reiman’s (2006) study shows that interpersonal relationships with dispensary staff and with other patients provide important social support, but privacy protections are also highly valued by California medical marijuana patients.

Finding little work to draw from in the U.S., researchers have relied on comparative research from other countries where medical marijuana patient programs have emerged, such as Canada, Australia, and England. The studies on medical cannabis patients in these countries offer some useful comparisons and underline some interesting commonalities across programs and cultures (Bottorff et al. 2011; Coomber et al. 2003; Fogarty et al. 2007; Hathaway and Rossiter 2007; Ogborne, Smart and Adlaf 2000b; Swift, Gates and Dillon 2005; Ware et al. 2003). For instance, these studies show similar demographic profiles in terms of age and gender ratios, and include similar reports of conditions treated, and routines of use. They also offer insights into some questions that have not been commonly addressed in U.S. studies, such as feelings about legal status and choices about disclosing use to family, friends, and physicians.

A few additional studies are available that report on prevalence and uses of cannabis among specific patient populations, such as HIV/AIDS patients, MS patients, or terminally ill patients (Fogarty et al. 2007; Gallagher et al. 2003; Page et al. 2003; Ware et al. 2003).

When studies are looked at across settings, a robust portrait of the medical marijuana patient emerges. Most studies have found that medical marijuana populations range across the entire adult range, but the most prevalent group, and the typical average age, is in the late 30s or early 40s (Aggarwal 2008; Aggarwal et al. 2012; Coomber et al. 2003; Harris et al. 2000; Hathaway et al. 2011; Hathaway and Rossiter 2007; Janichek and Reiman 2012; Nunberg et al. 2011; Ogborne et al. 2000a; Reiman 2006; Swift et al. 2005). Every study finds that there are more men than women, typically at a predictable ratio of roughly 2:1. Medical cannabis users tend to have a higher rate of multiple conditions than the general population, and a significant rate of drug use, both prescription drugs, and licit and illicit recreational substances. Finally, across different settings, individuals tend to seek out medical marijuana to treat similar conditions and symptoms. These include HIV/AIDS, cancer, and ocular pressure from glaucoma, but also tend to include multiple sclerosis, nausea, depression, muscle spasms, digestive disorders, seizure disorders, and chronic pain especially as it is associated with migraines, menstrual cramps, musculoskeletal disorders such as arthritis and fibromyalgia, and neuropathic pain related to spinal injuries. These were the treated conditions across studies and across cultures in nearly every study reviewed.

In addition, studies show that medical cannabis patients share similar health attitudes and therapeutic aims as those who seek out other forms of complementary and alternative care, which include dissatisfaction with traditional biomedicine or a lack of effective options from traditional biomedicine, a desire for “more natural” treatment options, and a desire to have more control (Astin 1998; Barrett et al. 2003; Bishop and Lewith 2010; Bottorff et al. 2011; Coomber et al. 2003; Feldman and Mandel 1998; Hathaway and Rossiter 2007; Reiman 2006; Swift et al. 2005; Ware et al. 2003). In fact, studies have found that medical cannabis patients are more likely to have used complementary and alternative care than the general population (Fogarty et al. 2007; Reiman 2006; Reinerman et al. 2011). Many note the widespread use of

cannabis for pain, both historically, and throughout other areas of the world (Caplan 2012; Gallagher et al. 2003; Grinspoon 2001; Lucas 2012; Ogborne et al. 2000a; Swift et al. 2005; Ware et al. 2003).

These themes are found in qualitative and ethnographic studies as well. Chapkis and Webb's (2008) ethnographic study on patient members of the Women's Alliance for Medical Marijuana (WAMM) in Santa Cruz, California examines the experiences of patients within a single, pioneering non-profit organization with a membership of seriously ill patients in California. It is the only extensive ethnographic study on medical marijuana patients in the U.S. This study examines the constructions surrounding cannabis and its location in the medical landscape in the early 2000s in California. Along these lines, Chapkis and Webb (2008) address the meanings associated with cannabis as medicine, the ways it is used by patients, the significance of context for the phenomenological experience with cannabis, and the stigmas it brings. Its focus on a specific organization during an earlier medical marijuana era make it a valuable comparison for examining similar themes among middle-aged cannabis patients in Colorado who are not affiliated with one another through a specific organization, and who are governed under a different set of regulations.

Qualitative studies outside the U.S. include the work of Coomber and colleagues (2003) in the UK, and research by Ogborne (2000a), Hathaway and Rossiter (2007), and Bottorff and colleagues (2011) in Canada. These qualitative reports offer insights into patient interpretations of medical cannabis through language and behavior, as well as context for patient decisions regarding use. They also address issues around stigma, gender differences, and the influence of various factors such as stereotypes and relationships, on decisions to try marijuana medically.

USING CONCEPTS FROM SOCIOLOGY OF HEALTH & ILLNESS

Medical uses of cannabis engender a reinterpretation of cannabis use that significantly revises the practices, beliefs, and experiences of its consumers. To address this interpretive shift,

I have framed my dissertation to address cannabis use, first and foremost, through the lens of medicine. I treat medical cannabis use as a partially medicalized, contested health practice, and consider how patient practices align with theories on health and medical behaviors from the literature on the sociology of health and illness. The focus on cannabis use as a medical behavior carries throughout the chapters, and draws upon several segments of the sociology of health literature, but none is more central than the literature on medicalization.

Medicalization

As I described briefly in the introduction, medical marijuana is undergoing a process of medicalization, but this process has been uneven across states, and is far from complete. Medicalization has been around as a concept since the 1960s, when it was first used to explain the incorporation of deviance into medicine, such as in the cases of homosexuality and alcoholism (Conrad 2007). Over the latter part of the twentieth century, medicalization has rapidly expanded, and many types of human problems have been redefined as medical issues. Medicalization means that, “a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or ‘treated’ with a medical intervention” (Conrad 2007:5). This includes an understanding that the problem falls under medical jurisdiction, and specifies medical professionals as the locus of power and authority (Conrad 2007:9). Medicalization processes have often been analyzed as having conceptual, institutional, and interactional components (Conrad and Barker 2010). Chapter 4 focuses on the role of the doctor-patient interaction in medical cannabis recommendations, and relates this to the cannabis’s partial inclusion in biomedicine. Chapter 5 considers the ways that patients enact medicalization, but the focus is less on language and more on routines that fit within cultural expectations and definitions of “medical behavior.” Chapter 6 considers where medical cannabis fits in the broader cultural discourse on medicine and health.

For 100 years, cannabis was listed in the *U.S. Pharmacopoeia* as a medicine. It was

quietly removed in 1936, a year ahead of the Marijuana Tax Act, by the order of the first Federal Narcotics Bureau (FNB) chief Harry Anslinger. The only objections at the time of marijuana's removal from the medical domain came from the head of the American Medical Association (Gerber 2004; Werner 2011). The demedicalization of cannabis 75 years ago was swift, backed by authority, and garnered little response, but attempts to reintroduce its medical use have been slow, uneven, resisted by authority, and driven mostly by those with little power. As I discussed in the introduction, the medicalization project has involved many, varied attempts, but has only gained real traction since the mid-1990s.

Partial medicalization often happens when competing definitions or the “remnants of previous definition[s]” muddy the waters and weaken claims (6). Certainly these competing definitions, steeped in decades of moral panic exaggeration, are unlikely to be completely displaced, in part because cannabis does continue to have a well established social use, and creates a unique, temporary state of intoxication that many find enjoyable.

In *Deviance and Medicalization: From Badness to Sickness*, Conrad and Schneider (1998 [1980]) feature a case study on opiate use that outlines the continuous, century-long debate over the appropriate management of opiates given that these drugs have medical utility and a high potential for misuse. Cannabis presents similar difficulties in defining acceptable boundaries, but requires a different balancing act because the qualities of intoxication, abuse potential, toxicity, and medicinal benefit are unlike those of opiates. The reincorporation of cannabis into medicine has been slower, in part because of its intractability to other processes used to create medically standardized products—but the legitimate development of such processes has also been paved with obstacles. As a result, the risks associated with opiates are presented more accurately than those presented on cannabis. Because cannabis presents much lower risks across the spectrum physiologically, its recreational and medical uses may turn out to be much more determined by policy and culture than by threats to public health.

In the same book, Conrad and Schneider (1998 [1980]) proposed a five-step model by which deviant behaviors come to be medicalized. These included: 1) definition of the behavior as morally deviant; 2) “prospection,” or the first instances in which the behavior is defined as being really medical, even if it may not yet appear to be so; 3) moral entrepreneurship, in which various organized interests, lay or professional, organize and attempt to fully claim medical territory for the issue by emphasizing its seriousness, scope, and its connection to “rights”; 4) legitimacy and consolidation, in which the state recognizes the medicalized status and begins to construct its management in these terms through legislation, court actions, and task forces; and 5) institutionalization, in which the medical definition becomes the dominant paradigm. This opens access, to diagnosis and treatment, to research through major institutions, insurance reimbursement, and the public and media adopt and promulgate the view as normative (266-70).

While many cases studies on medicalization describe problems that have reached the institutionalization phase, cannabis is currently engaged in steps 3 and 4. Moral entrepreneurs argue on both sides of the issue to claim or disclaim marijuana’s value, but much of the public dialog has not shifted to one of “benefit,” and remains anchored by debating relative levels of harm. Similarly, while Colorado as a state has recognized the medicalized status of cannabis and undertaken processes of legitimation and consolidation, many other states have not yet done so, and the federal and international bodies have actively rejected such opportunities.

It has been commonplace to suggest that medicalized cannabis is simply a “front” or a “stepping stone” to legalize recreational use. Distinctions between medical and recreational cannabis use are vague, but the two are neither synonymous nor can it be assumed that they always share the same goals. However, while medicalization implies a contest between a deviant identity and a legitimate medical one, this oppositional relationship also fails to accurately capture the relationship between medical and recreational use.

Medicalization can be helpful in thinking through the relationship between the two, but as a case, cannabis may bring out new complexities. Health care is a complex social and institutional space. Medical cannabis use has arisen in an environment where medical pluralism abounds. Since the beginning of the 1990s, biomedicine has shifted from outright opposition of complementary and alternative medicines (CAM) as “quackery,” to skeptical cooperation and incorporation when CAM modalities meet biomedicine’s scientific criteria (Baer 2004; Pray 2006; Ruggie 2004, 2005). Use of CAM has also grown exponentially over this period (Barnes et al. 2004; Barnes, Bloom and Nahin 2008; Eisenberg et al. 1998; Nichter and Thompson 2006). In addition, people are living longer and the disease burden has shifted to chronic illnesses (Cockerham 2008; Porter 1997). The availability of prescriptions has expanded, and they are now directly marketed to patients through direct-to-consumer (DTC) advertising (Britten 2008; Conrad 2007; Conrad and Leiter 2004; Taylor and Bury 2007). Biomedicine has been very successful for treating acute conditions and its success has been largely responsible for shifting the disease burden toward chronic illness, but the logic of biomedicine is in many ways ill equipped to address chronic problems. These problems depart from the one-to-one correspondence between illness and treatment and often present the need for greater knowledge of the individual (Bivins 2008; Gabe, Bury and Elston). As Cockerham (2008) states, “Contemporary physicians now treat many health maladies that are aptly described as ‘problems of living,’ dysfunctions that may involve multiple sources of causation, including those that are social in origin and part of everyday life” (8). At the same time, “wellness” has taken on increasing prominence since mid-century, stressing the importance of individual efforts to reduce risk factors and make healthy lifestyle choices (Cockerham 2008; Goldstein 2004). The growth in CAM use, the increase in chronic illness, the emphasis on individual responsibility for maintaining a healthy lifestyle, and a corresponding increase in lay expertise are trends that have defined the medical environment in which cannabis has been reintroduced as a medicine.

Pharmaceuticalization

Between 1960 and the early 1980s, prescription drug sales were nearly flat in western countries as a proportion of gross domestic product. Then, in the period from 1980 to 2002, prescription drugs tripled worldwide to almost \$400 billion. Nowhere was this increase more pronounced than in the U.S. where sales reached nearly \$200 billion. By 2007, global prescription drug sales surpassed \$600 billion (Abraham 2010). Direct-to-consumer (DTC) advertising of prescriptions in the U.S. has driven sales and increased patient demand. America comprises 4.6% of the world's population but consumes 80% of the world's opioid supply and 99% of the global Hydrocodone supply (Manchikanti et al. 2010).

The number of prescriptions has increased exponentially, and prescribed dosages per patient increased over 400% on average between 1997 and 2007 (Manchikanti et al. 2010). In the same period of time, overdose deaths from prescription analgesics has skyrocketed, and is now considered at epidemic levels (CDC 2012). Prescription painkillers led to the death of 4,000 people in the U.S. in 1999, but by 2008, the figure was 15,000 (Alexander, Kruszewski and Webster 2012; CDC 2012). In 2008, 36,000 people died of drug overdoses in the U.S. and more than 20,000 of those were attributed to legally prescribed drugs (CDC 2012). In the U.S. middle aged adults have the highest prescription painkiller overdose rates (CDC 2011). In addition, nearly half a million visits to the emergency room in 2009 were a result of the abuse or misuse of prescription painkillers, and the nonmedical use of these drugs is estimated to cost health insurers \$72.5 billion annually in direct health care costs (CDC 2012).

These trends have occurred even as awareness of the undertreatment of chronic pain has become a priority for clinicians and policymakers (Alexander et al. 2012). Over 145 million people, almost half of all Americans, suffer from a chronic condition such as asthma, diabetes, heart disease, and depression, among others (Institute 2011a). Almost half of all people with chronic illness have multiple conditions. This requires care coordination and illness

management techniques, but both are currently inadequate (Institute 2011b; Jerant, von Friderichs-Fitzwater and Moore 2005). The Institute of Medicine reports that chronic pain affects about 100 million American adults, and costs about \$635 billion each year in medical treatment and lost productivity, representing a huge national challenge that requires “cultural transformation” (IOM 2011). A survey by Johannes and colleagues (2010) found chronic lower back pain and osteoarthritis pain were prevalent among those reporting long-lasting pain—conditions for which some have found relief using cannabis (1230).

Theories of Biomedicine, CAM, & Self-Care

Britten’s (2008) book, *Medicines and Society*, borrows from Habermas and describes the everyday management of health and illness as a lifeworld activity, while healthcare is a system with which individuals interact. This invokes the different logics and influences in these contexts. While the lifeworld is “the everyday world” that “provides culturally transmitted ways of interpreting experiences as well as the language to describe them,” the system operates based on “scientific rationality and objective measurements” (Britten 2008:18). Borrowing from anthropologist Kleinman, Britten (2008) defines three sectors: the formal sector or system of mainstream biomedicine; the informal sector, which encompasses forms of health care that are delivered by practitioners outside of the biomedical health system; and the popular sector, in which individuals engage in self-care behaviors such as diet, exercise, or home remedies.

In its current form in Colorado, medical cannabis spans all three, and this span defines the chapters that follow. Medical cannabis is spread across these sectors as a consequence of its incomplete medicalization, and creates a point of critique for its claim to medical status. The process of becoming a formal medical marijuana patient requires an interaction with the formal sector by acquiring a physician recommendation to submit to the state registry. After patients have qualified, physicians only rarely direct medical cannabis care. Patients may access the informal sector, and purchase cannabis and its derivative products through the dispensary

system. Patients may also forego the informal sector and cultivate their own plants for medicine, or assign their plants to an individual caregiver. Finally, everyday use is largely within the popular sector as a self-managed behavior or regimen.

Patient motivations to use medical cannabis are similar to those who access other forms of informal and popular treatments. Britten(2008) suggests that these sectors provide services that “biomedicine cannot or does not wish to offer” (33). Patients with chronic illnesses often assess medicines based on a calculus of functionality, and work to maximize their own normative functionality between the effects of an illness and the effects of medications. Britten (2008) draws on the work of Pound and colleagues to show that personal considerations and personality both play a role in one’s willingness to depart from a physician’s advice. In making these determinations, patients often consider their phenomenological experiences with prescribed medications, the dangers or “natural” qualities of medications, and often conduct their own “tests” of medicines and adapt prescription regimens, even when instructions are precise in ways that show different logics of system and lifeworld, patients often try to optimize the benefits of taking a medicine while minimizing side effects or other risks (Britten 2008).

These raise some differences between medicines, treatments, and health behaviors. Patients often recognize that while medicines mitigate symptoms or may cure some problems, their ability to resolve or cure chronic problems is limited. Drugs or treatments are not synonymous with “health” behaviors, and may present their own risks. Patients often adapt advice based on their own assessments of how useful they find a medicine or treatment, what types of side effects they cause, and whether they are “healthy” or present long-term risks.

A review on changing patterns of pharmaceutical use in self-care (Vuckovic and Nichter 1997) suggests that individuals seek information from a number of sources including pharmacists, store clerks, and family, friends, and neighbors. Sirois and Purc-Stephenson 2008) also find that friends and family are particularly well-trusted sources for health information, and

71% of their sample reported trying a CAM practice on the recommendation of friends or family (12). Individuals may also tap into social networks online to seek out information on specific health topics. Even though friends, families, or available “experts” are influential, the Pew Internet and American Life Project found that nearly half of those seeking health information reported that supplemental information influenced their decisions regarding treatment (Cline and Haynes 2001:673).

THEORIES ABOUT DRUG USE

The drug use literature tends to frame cannabis use in terms of deviance and criminalization, and to have different concerns than are presented here. By focusing on medical uses, I have bracketed concerns about recreational use to consider how medical use of marijuana conforms to other types of medical or health behavior. However, as I mentioned above, I have used a few classic pieces of literature that discuss the construction of recreational cannabis use because they offer useful insights that can help to understand the interpretive shifts that occur when individuals adopt a medical view of cannabis use. First, Howard Becker’s (1953) classic article, “Becoming a Marihuana [sic] User,” offers the first analysis in which the experience of marijuana is described as an interpretive process that consumers learn intersubjectively from more experienced users. Becker proposes that individuals must make the connection between cannabis use, bodily sensation, and an interpretation of pleasure to understand cannabis as a meaningful drug experience.

A second foundational work is Zinberg’s (1984) book, *Drug, Set, and Setting*. Like Becker, Zinberg conducted interviews with drug users, and further elaborated the process of interpretation that are significant to the experience of drug use. He called these three components, “drug, set, and setting.” According to Zinberg (1984), a drug’s effect is not simply created by the drug itself. Rather, it is a combination of the drug’s pharmacological influence, the “set” of the individual, defined as their personal characteristics and state of mind, and the

setting, or the context within which the effects are being interpreted. In chapter 5, I follow in the footsteps of Chapkis and Webb (2008) and borrow Zinberg's (1984) structure of drug, set, and setting to consider how each of these components undergoes important changes when cannabis is revised from a recreational interpretation to a medical one.

THE RELEVANCE OF LIFE COURSE LITERATURE

My choice to focus on patients who are 30 years of age and older was intentionally designed to acknowledge the significance of life course in the use of medical marijuana. It is clear that age has been a significant criteria for all cannabis use over the last 50 years. Most sociological work on cannabis since increase in drug criminalization during the 1980s has focused on adolescent use and its negative short-and long-term effects. Just as much as cannabis has been narrowly framed as a recreational substance, this focus has included a focus on marijuana's influence on teens.

Since the 1960s, cultural and structural changes gradually extended the adolescent and young adult phase of the life course into the college years, especially for "mainstream," white, middle-class Americans (Arnett ; Furstenberg et al.). This longer period of young adulthood was accompanied by new worries about forms of experimentation and risky or deviant behavior that are typically initiated during adolescence and young adulthood, such as sexual activity and drug use. It was also found that many "age out" of cannabis use and other deviant behaviors when life course hallmarks such as graduation, job, marriage, or children prompt a different lifestyle, others fall prey to the consequences of these youthful indiscretions, being arrested, getting pregnant outside of marriage, contracting STDs, becoming addicted to substances, or essentially derailing a successful progression to the next stage in the life course (Johnston et al. ; Sampson and Laub). Some individuals will maintain a deviance career, but there is a drop in deviant behaviors with age, as individuals desist from these activities (Giordano, Cernkovich and Holland 2003; Kazemian 2007; Warr 1998). This is not simply a reflection of aging, but shows

strong connections to life course transitions including marriage, work life, parenting, and changes in friendship networks and their activities (Adams and Markus 2001; Giordano et al. 2003).

This literature offers some useful insights on marijuana use over the life course. While research literature on deviance careers and desistance often involves more serious crime than cannabis use, and may involve multiple forms of deviance whereas cannabis is often the only “criminal behavior” that many individuals engage in, there are still some interesting insights to be gained (Hathaway 1997; Stolick 2009). Hammersly (2001) calls recreational cannabis use “conventionally unconventional,” a form of deviance-lite that requires minimal commitment, but can still signify important qualities about an individual. This type of signaling for cultural meanings may be more relevant to youth settings than to older ones; certainly it has different meanings that often remain tied to meanings from youth and change generationally as youth subcultures change. Settersten’s work on the life course (2004) describes how age structuring includes institutional and social network relationships. Age-related ideals and timing of behaviors based on age, matter for how those behaviors are interpreted.

A recent report by *Monitoring the Future* showed that use reports remain highest among the 18-22 age groups, with 20-23% reporting cannabis use in the last month (Johnston et al. 2012). After 22, use rates decline gradually with age, inching down a few percentage points for each successive age group, from 23/24 year olds (18%) to the 31-35 group (10%) until it flattens out around age 40 (7%). Between 40 and 60 years old, use reports on the last 30 days remain consistent, around 6-7%. Use rates drop off precipitously among the oldest categories, basically among those on the other side of the Baby Boom generation, who were already out of their teen years at the time when cannabis was popularized (Johnston et al. 2012).

I believe that *both* the medical frame and timing in the life course are significant for how cannabis is used, and how cannabis consumers integrate their use into their lives and self-

concepts. By framing this study in terms of sociological literature on health and illness, and taking a life course approach with a focus on midlife, this work strives to draw attention to and address a gap that has stood with little challenge in the social science literature addressing cannabis use—the concentration on research that conforms to “War on Drugs” frames that limit the discussion to deviant recreational uses among adolescents and college age teens.

Uses at midlife for medical purposes radically change the “set and setting” of cannabis use, which in turn radically alters the experience of use. Timing matters. Age may affect the experience of cannabis in physiological as well as social ways. Cohorts create different referents related to cannabis use. While I think other work has implied the importance of life course for marijuana use, I found no work that explicitly addressed it, so this work will be the first to do so.

LITERATURE ON STIGMA MANAGEMENT AND NETWORKS

The last set of concepts in this dissertation draws on theories regarding stigma management and its relationship to networks. Howard Becker’s (1963) *Outsiders* and Erving Goffman’s (1986 [1963]) *Stigma* are among the classic works that created nuanced theories of norms, deviance, and stigma, and established an understanding of these processes as fundamentally relational and variable. Goffman’s (1986 [1963]) original typology identified three primary sources of stigma: tribal-based stigma derived from a person’s identification with a specific race, gender, religion, or nationality; character-based stigma came from factors such as mental illness, prior incarceration, or addiction; and body-based stigma were due to physical abnormalities or disabilities. These categories vary in the degree of choice or control that an individual can employ in stigma management. Jones and colleagues (1984) are also widely referenced in the stigma literature for their elaboration of six important dimensions of stigma. By focusing on dimensions, Jones and colleagues present analytic tools that help compare and contrast cases of stigma (LeBel 2008; Quinn 2005; Yang et al. 2007). According to their model, stigma varies based on origin, visibility or concealability, aesthetics, disruptiveness, risk of

danger to others, and mutability over time (in other words, will it change as time passes and in what way?) (Jones et al. 1984).

For the purposes of this dissertation, norms indicate “the rules,” deviance indicates breaking the rules through some action or inherent characteristic, and stigma is the group reaction to the individual who exhibits deviance. In this respect, deviance may be constituted of specific one-time or repeated behaviors or acts, while stigma is something addressed to the identity or character of the person. Whether engaged in deviant or regular activities, individuals generally work on impression management to present themselves in a good light (Goffman 1959). When deviance is involved, individuals often engage in stigma management in order to minimize any discrediting characteristics assigned by others to their self or identity. While some stigmas result from characteristics that are out of a person’s control—culturally defined racial identities or visible disabilities, for instance—others are based on deviant behaviors. Deviant behavior is often episodic in nature and is unlikely to be visible or immediately apparent, making it a concealable stigma that others may not link to one’s identity (Goffman 1986 [1963]; Jones et al. 1984). Stereotypes are generalizations, that operate as mental schema, to offer us categories by which to make sense of the world (Zerubavel 1997). Stereotypes are accessible at a societal or group level, and have less weight as they are formed at smaller groupings. In contrast to stereotypes, the processes of stigma are interactional, and involve the application of norms, definitions of deviance, and stereotypes in specific situations to evaluate whether a person’s identity is discredited based on this information. As such, they are interpretive because they incorporate interpretations of norms, deviance, and stereotypes. These acts of interpretation are usually at the level of the group, or “thought community,” which employs a specific “group style” (Arksey 1994; Eliasoph and Lichterman 2003; Rose 2007; Zerubavel 1997). Each person tends to belong to different thought communities and to understand how to adapt to different group styles of tone and interpretive frame.

Over the last forty years, the growing literature on stigma has moved in a relational direction. Many modern scholars have shifted from earlier, individualistic terms such as “attributes” to more interactional terms such as “social identity.” This shift has also emphasized social context (LeBel 2008). Social stigma is now understood to be a variable process that resists universal explanation, instead encompassing various types of stigma, which invoke different cultural rules and relationships (Quinn 2005). Even though social context matters, much of the existing literature treats stigmatized identities without any significant reference to group norms (LeBel 2008). Stigmatized identities are often presumed to invoke societal norms rather than a more refined interpretational level. Certainly stereotypes exist at a societal level such that, through media or other forms of culture, most members of a society come to recognize enduring stereotypes associated with specific groups. However, stigma is a communicative process, and as such, it requires the application of these categories in relationships.

Most stigma research focuses on the experiences of people with visible rather than concealable stigmas (Quinn). In her chapter on concealable versus visible stigma, Quinn (2005) helps to identify some of the key differences between these types; namely, that while concealable stigmas allow the individual a greater measure of choice in hiding or disclosing, they create dilemmas around the norms of appropriate disclosure.

Disclosure may be related to how morally or culturally associated an individual is to a behavior. Quinn (2005) argues that this is dictated in part on how much the behavior is repeated and also possibly by the level of its potential disruption. In other words, when a person sees a behavior as an expression of their desired social identity, they are more likely to maintain the connection and manage the stigma. If the connection is more distant from one’s self-concept, biography, or status, some choose to “disidentify” with the behavior, by distancing themselves from associations with the behavior, or compartmentalizing it as rare or situational. They may also limit associations by avoiding other associative qualities that are often linked

with the behavior through stereotypes (Goffman 1986 [1963]; Hathaway et al. 2011).

Behaviors may have differing interpretations across groups. Marginalized groups can be more vulnerable to labels of deviance, even when other groups engage in the same behaviors. Those who are labeled deviant may use strategies of concealment or self-segregation (Blinde and Taub ; Williams 2011). When behaviors are linked to threats to identity, strategies for stigma management range from passive, reactive responses, such as concealment, to intermediate strategies of selective or gradual disclosure, to more proactive strategies that include pre-emptive disclosure, public education, and social activism (LeBel 2008). Collective action often serves to provide an alternate history associated with the behavior that scrutinizes the legitimacy of normative views and recreates positive associations with the behavior (Britt and Heise 2000). These strategies attempt to deconstruct or change the meaning of the identity and negate the stigma attached to it, which may also involve downplaying its most stigmatizing aspects.

Political action can also be a form of stigma management, by working toward legitimacy and recognition. Work on health social movements by Brown and Zavetoski (2010) presents cases of environmental illness where “disease sufferers-turned-activists and their lay and professional allies challenged public and scientific understanding of diseases and conditions. These social movement groups offer a strong critique of contemporary science, medicine, and policy by emphasizing how ideological and political-economic factors shape medical research and treatment to systematically overlook the contribution of environmental (largely chemical) factors in disease etiology” (Brown et al. 2010:103). Similar health-social movements for breast cancer and HIV/AIDS have taken place.

Stigma is associated with cannabis use and with illness. Both are related to bodily states and embodiment. Concerns with the body and treatment of the body often invoke concerns with privacy, and raises questions about who has the right to make determinations about one’s body. Patients may also possess additional stigmatizing qualities that increase or lessen their claims to

legitimate cannabis use. In chapter 7, I discuss the relationship between multiple stigmatizing identities and the body. I consider the experiences of the cannabis patients in this sample in the context of the literature on other health- and body-related stigmas. Often, medicalization is one strategy for reducing stigma. Cannabis shares characteristics with other health-related stigmas, but it differs in that most are related to illnesses rather than treatments.

CHAPTER 4: Becoming a Medical Cannabis Patient in Colorado: Interactions with the Biomedical Sector

INTRODUCTION

How do individuals decide to enter the medical cannabis system in Colorado? This chapter examines the ways that patients find out about cannabis as an option that is of interest to them, how they make determinations to pursue it, and the steps they undergo to officially qualify to participate in the system. It describes patients' experimentation with medical use before they decide to pursue a recommendation. Then it turns to experiences with the physician recommendation interaction. Physicians serve as gatekeepers to the medical cannabis system, controlling entry to "legitimate" patients. Once a patient has been approved, the remaining management of obtaining supply, selecting products, determining a routine for use, and evaluating effectiveness are managed by the patient, usually independent of biomedical guidance. The doctor-patient interaction provides insights into medical cannabis's incomplete medicalization. In examining the interactions reported by patients in this study, I use Broom and Woodward's (1996) typology, developed when studying patients negotiating the diagnosis of Chronic Fatigue Syndrome with their physicians. In the last part of this chapter, I turn my attention to patient responses to the recommendation experience. I describe the emergence of medical cannabis evaluations as a physician specialty, and its role in bridging the requirement for formal sector approval by employing the logic of the informal CAM sector.

Just as medicalization processes play out at the interactional level of the doctor-patient interaction, the incomplete medicalization of cannabis creates issues for the recommendation experience that patients and physicians must negotiate. Doctors and patients view the issue of

medical cannabis use from the vantage point of different logics and the different goals of the system and the lifeworld. This chapter expands the understanding of the medical logics and lifeworld considerations that patients employ when seeking approval for medical marijuana from doctors. In doing so, it goes beyond a simple dichotomy in which patients are either “legitimate” or “cheating” to show the more complex nature of the cannabis recommendation.

In their study on Chronic Fatigue Syndrome, Broom and Woodward (1996) created a model for doctor-patient interactions under conditions of incomplete medicalization. They found that three types of interactions with physicians are most common in cases of incomplete medicalization (Broom and Woodward 1996). In the first, doctors take a paternalistic attitude that the “doctor knows best,” and privilege expertise significantly over patient lay research or experiential knowledge. In the second type of interaction, doctors do not dismiss patient reports, but express discomfort with labeling the patient with a certain diagnosis, because it lends authority to the diagnosis when in fact the doctor is uncertain that the label is constructive. Even though doctors in this second category do not dismiss patient’s experiential accounts, they still refuse to officially label the patient. Patients’ concerns are outweighed by considerations of risk from the perspective of medical expertise. In the third instance, the doctor “works with” patients in what Broom and Woodward termed “constructive medicalization.” These physicians acknowledge the limitations of medical knowledge, and are more willing to allow the patient’s definition of the situation to contribute to their recommendations. Among this group, some physicians exhibit a greater willingness to experiment or try patient-initiated forms of treatment, while others are less willing to experiment but serve more as case managers, passing along useful information and encouraging patients to be active in independently managing their conditions. This chapter seeks to expand the application of Broom and Woodward’s model beyond contested illnesses to also include contested treatments.

Although Broom and Woodward’s (1996) model does not take into account physician’s

prior views on the legitimacy of the CFS diagnosis in their willingness to diagnose, a recent survey of 520 Colorado family physicians by Kondrad (2013) suggests that doctors' pre-existing views on medical cannabis definitely play a role in their willingness to recommend it, independent of their approach to patients. According to this survey, 46% of family physicians in Colorado believed that marijuana should not be recommended as a medical therapy at all, while only 19% agreed that doctors should recommend medical cannabis (Kondrad and Reid 2013:55). Most doctors in Kondrad's study believed that cannabis use posed significant physical (61%) and mental health (64%) risks and many were unaware of or unconvinced by data that suggested these risks were low when compared with common pharmaceuticals. This is a factor I explore more below.

QUALIFYING FOR MEDICAL CANNABIS

Colorado's regulations structure the experiences of patients. They establish the legitimate pathways by which patients can qualify for cannabis, access it, possess it, and use it. Regulations affect who tries to access the system, and who in fact gains access to the system. More subtly, regulations influence how patients perceive the boundaries around the system, and how permeable and rational those boundaries seem to be. The first boundary that defines medical cannabis use is the physician evaluation. This section describes patients' decisions to seek a recommendation for medical cannabis, and their experiences with doctor evaluations and recommendations in the formal sector of biomedicine.

Medical cannabis evaluations share qualities with other doctor-patient interactions that involve contested medicine, but most studies have addressed cases where the contest is over diagnosis rather than approval of treatment. This may be because most contested treatments reside outside of the formal sector and do not need a physician's approval for access. Medical cannabis offers a different case, expanding the knowledge about doctor-patient interactions around a treatment that has only been partially medicalized.

Medical cannabis determinations are almost always separate from diagnosis. Most patients in this study had received their qualifying medical diagnosis years or decades before deciding to try cannabis as a treatment. Clearly, the legitimacy of any treatment has little connection to the legitimacy of diagnosis. No patients described their qualifying medical diagnoses as illegitimate, even in the few cases where the motivation to become a “legal medical cannabis patient” was driven primarily by nonmedical concerns.

Prior to seeking a recommendation through a doctor, patients usually know they “qualify” based on the terms set by the state. Because the state defines and restricts medical cannabis to qualifying conditions, physician autonomy is constrained in the evaluation. These constraints are treated as uniquely problematic, but in truth, there are other comparable situations. In an era of the “lay expert,” where medical information abounds and prescription drugs are advertised directly to patients, doctors must balance patient requests for prescriptions or treatments with medical judgment under constraints imposed by the directives of HMOs, insurance reimbursement rules, and the standards of evidence-based medicine enforced by employers (Britten 2008; Dumit 2006). Perhaps the closest comparison is with determinations for disability eligibility, in which physicians may also be subject to nonmedical motivations from the state, their decision is typically not concurrent with diagnosis, and it confers benefits that are located outside of the medical domain (Joffe-Walt 2013; Rainville et al. 2005).

The difference between accepted medicines and contested ones often lies in the physician’s knowledge about the treatment, its appropriateness to the case, and its likelihood of being effective. Patients and physicians rely on different types of evidence to assess whether cannabis can work medically. The formal biomedical model demands evidence produced through clinical trial and scientific methods, while patients are willing to accept less formal and more diverse forms of evidence. In addition, patients often consider that research on cannabis has been blocked by political forces, but the studies that have been completed support medical

applications. This creates a gap between patients' and physicians' assessments about cannabis as a medicine (Aggarwal et al. 2009). In conditions where a diagnosis or treatment is uncertain and controversial, patients often feel anxious or distressed in anticipation of the appointment with their doctor. Occasionally, this is validated by experience, in cases where doctors exert their authority to respond in rude or dismissive ways (Broom and Woodward 1996). In cases of controversial diagnoses or in this case, treatments, patients often come to feel they know more about the issue than their doctors, while doctors may feel that patients accept unscientific evidence to reach these conclusions, and possess unrealistic expectations. When physicians serve as the gatekeepers that determine patient access, these epistemological differences create tensions in the doctor-patient interaction (Broom and Woodward 1996).

Evaluations determine access to benefits, creating an incentive to gain entry to the system. This creates concerns with setting boundaries so that those who are meant to gain access can do so, but those who seek illegitimate access are kept out. Few such rules existed in Colorado's medical cannabis program prior to 2010, because few people tried to register with the state. When patient applications flooded the system in 2009, the rules had to evolve.

New legislation in 2010 defined the relationship between physicians and medical marijuana centers, and pushed medical marijuana doctor-patient interactions toward greater conformity with other types of medical interactions. It also separated physicians from any direct financial involvement in the industry and prohibited doctors from writing recommendations at or near dispensary locations. Many patients in this study received their first recommendation prior to the 2010 legislation, and experienced the industry before these divisions were in place.

The new rules create organizational barriers that separate the physician recommendation from the rest of the system. Under the current system, medical cannabis is still more outside the boundaries of biomedicine than within them. Until suitable clinical evidence or standardized prescription versions of cannabis bring it more fully into conformity with the logic

of the formal sector, cannabis is likely to be grouped with treatments outside of biomedicine. Because of this, many physicians are likely to see cannabis as outside of the formal sector, yet in spite of its similarities, few physicians, patients, or CAM practitioners connect it to other complementary and alternative (CAM) therapies.

Table 3: Patients by Year of First Doctor's Recommendation

Year of First Doctor's Recommendation	Number of Patients
2002	3
2005	4
2006	4
2007	2
2008	5
2009	13
2010	7
2011	1
2012	1

As of now, U.S. state models only connect cannabis and biomedicine at the point of entry into the system, through the physician evaluation. Cannabis is “recommended” rather than prescribed because the federal government prohibits the prescription of drugs with a Schedule I status. As with opiate medications, doctors evaluations include concerns that patients will use cannabis for recreational rather than medical purposes (Barthwell et al. 2010; Merrill et al. 2002). These concerns reflect the framing of harm commonly associated with cannabis. Doctors vary in their awareness that marijuana’s potential for physical dependence is low, and studies have been accumulating that show cannabis helps patients “exit” other addictive and more potentially harmful substances such as opiates (Lucas 2012; Reiman 2006). Medicine in the formal system also relies on standardized products that are used in precise doses, and cannabis does not conform to this structure. Because cannabis exits the formal system of medicine after the recommendation, is not prescribed, and comes in a variety of whole-plant derived herbal forms rather than precise dosages, most doctors offer few instructions for its medical use, and

may offer little management on its medical use subsequent to the evaluation appointment. Some physicians have expressed this lack of control as a source of concern (Kondrad and Reid 2013).

DECIDING TO TRY CANNABIS MEDICALLY

When I asked the 40 patients in my sample where they first got the idea to seek a recommendation, all patients had a prompting incident that led them to realize they would qualify for a doctor's recommendation. All participants could identify a prior diagnosis of at least one, and often more than one, clearly qualifying condition. All but three had required significant ongoing medical treatment related to their condition(s). A small minority of patients (5) already defined their cannabis use as medical prior to seeking an official recommendation. The majority of patients had used cannabis recreationally in the past, most typically during their late teens or early 20s, but a small subgroup had never used cannabis recreationally. About one-third of patients had used cannabis in the recent past, while over half claimed they had not used cannabis since their teen or college years. Given these different profiles, patients came to the decision to seek a medical cannabis recommendation with different levels of cannabis experience, and different ideas about who used it and what dangers or benefits it could offer.

Patients decided to seek an official recommendation from a doctor and apply to the registry by four routes: their regular physician recommended it; friends or family suggested it; the patient heard about medical cannabis indirectly and initiated more research; or the patient had nonmedical motivations to seek legal protections through the official patient status. In my sample, the most common routes leading to recommendation were the patient's own initiative and research, or the suggestions of friends and family. Evidence shows that people often discuss issues of health, illness, and treatment with their families and friends (Britten 2008). This pattern seems to match the status of medical cannabis as partially medicalized through lay efforts. It is less common for doctors to recommend cannabis than for patients to seek a

recommendation. The strong networks of the lifeworld help individuals to determine the best course of action for managing health conditions using treatments in the formal sector as well as those outside of it (Bouldin et al. 2000; Britten 2008; Cameron and Leventhal 2003; Fagerlin, Wang and Ubel 2005).

Physician Suggestion

Not all medical marijuana recommendations were driven by patients. In eight interviews, patients reported that they arrived at the idea to try medical cannabis after their physician suggested it might work for their condition. In many of these cases, patients either had been diagnosed with a serious progressive disease for which cannabis use is well established or the doctor specialized in pain management. However, there was no clear pattern based on condition, location or any other remarkable characteristic that clearly separated cases where doctors recommended and similar cases where no recommendation was made. For instance, two of the patients in my sample with HIV/AIDS had doctors who suggested medical cannabis use, but the other two approached doctors who initially discouraged the idea. Cannabis was suggested to one cancer patient, while another was recommended the THC-based drug Marinol and had to negotiate for a cannabis recommendation, and a third cancer patient, who was uninsured, had no regular physician to make such a suggestion. In two cases, general practitioners suggested use for pain and treatment of seizures. One woman claims to have received multiple informal suggestions from different psychiatrists, who thought she would benefit from medical cannabis, but she could not recall the exact circumstances of the official recommendation. From patients' reports, it seems clear that physicians do not act uniformly when it comes to medical cannabis recommendations. This finding aligns with Kondrad's (2013) research on physician attitudes on medical cannabis in Colorado, which showed significant differences in family physician's attitudes toward medical cannabis use. Several patients reported that their doctors mentioned personal rather than scientific views on medical cannabis

as an effective therapy, often recounting prior personal or professional experiences with a patient, friend, or family member who had successfully used medical cannabis.

Travis offers an example where a medical cannabis recommendation was doctor-initiated. Now in his early 40s, Travis suffered a serious head injury as a boy, when he was accosted during an encounter with a psychologically unstable stranger who wandered onto his parent's property. Head injuries sustained in the attack caused Travis to have migraines from that point forward. The seizures started in early adulthood. After 20 years on serious prescription seizure medication, Travis developed negative side effects. He tried several new combinations to control seizures. These drugs had to be coordinated with his full treatment plan, which includes multiple prescriptions for anxiety and PTSD that developed as a result of the attack. He has been on serious anti-convulsants such as Phenytoin (Dilantin) and Phenobarbital. These drugs have significant counter-indications, require monitoring, and come with side effects, including dizziness and stomach pain. Travis works each day to manage stomach pain and to keep his anxiety levels low. He says of his doctor's recommendation:

He was my primary care doctor for 20 years.... He was actually working with two other patients before me, who were having seizures and he saw that it [medical cannabis] was working for them. He just told me, "Get the paperwork and we'll get you on and we'll see what it does." And he told me at that time there were some doctors that weren't signing because of the laws and stuff, but he told me he would go ahead and stand up for me in court if need be because my seizures were so bad at that time.

Travis has multiple chronic and serious conditions for which he has received care over a long period of time, including pharmaceutical drugs that present some serious side effects and long-term risks. The suggestion to use medical cannabis by Travis' regular physician of 20 years creates a clear sense of legitimacy for his cannabis use, because it is well integrated with his regular biomedical care. Additionally, due to Travis' lengthy experience with pharmaceutical regimens, he is accustomed to an experimental approach: "These doctors don't know what's wrong. They just figure, try this, try this, if it doesn't work, we'll put you on something else." While he accepts this "system" approach to his medical issues, Travis feels that his doctors

“don’t realize [the medications] are tearing up my body and my mind.... With all the pills they have me on, there’s times when I’ve been on so many pills that I almost have a stroke, so they kept me in the hospital for a couple of days.” In this light, medical cannabis offers an option with less frightening side effects and controls the seizures.

Friend and Family Suggestion

About one-quarter of patients report having specific conversations with close friends or family members in which a person close to them explicitly suggested medical cannabis use, or actually brought them marijuana and offered it to them when they were symptomatic. In most cases, the friend or family member identified as a regular cannabis consumer; some were medical cannabis patients. Those who were neither could often reference a person that both people knew in common who was experiencing relief from medical marijuana use. It is interesting that this route was so common, because it tends to apply to situations in which one’s network has relevant first-hand or second-hand experiences on which to base such recommendations.

Eileen provides an example. A social user in her teens, Eileen reports a lifelong preference for cannabis over alcohol, but except on rare special occasions, she stopped using cannabis after marrying and having children during her 20s. In the time since her days of social use, Eileen was diagnosed with rheumatoid arthritis. She was still living in a southern state with no medical marijuana program when her daughter left to attend college in Colorado. After becoming an “empty nester,” Eileen attended a friend’s party in her southern town, and people at the party were smoking a joint. When they offered it to her, she figured why not indulge, now that her kids had left home. Quite immediately, Eileen discovered that cannabis provided considerable relief for her arthritis symptoms. Later, when she moved to Colorado, she would discover that it also worked for migraines. Eileen says of her decision to pursue a recommendation:

Well, when I moved here in 2009 a girlfriend of mine said, ‘you know, you could probably [qualify for medical cannabis]—because that’s when everything was going more public, with centers and doctors and places where you could actually go. Which is great from a patient’s point of view because before [there was a program], it had to be like you knew somebody [who sold marijuana on the black market].

Eileen already recognized that cannabis might have medical benefits, but the decision to become a patient was in part based on the encouragement of friend or family recommendation, which helped to validate medical marijuana as a reasonable and effective option. It was appealing because it allowed easy and consistent access without having to negotiate the black market, friend-of-a-friend purchases.

The Grapevine: Research Discovery

The most common route by which patients arrived at the idea that cannabis might work for them, involved a combination of hearing about its use indirectly, followed by research via the internet, books, seeking people out, or in some cases, acquiring some marijuana to try for their symptoms. This is the most patient-driven route, since no outside person made a direct suggestion; instead, it evolved out of the patient’s investigation and pursuit.

One patient who reported this route was Jason, a 40-year old professional in finance living in an urban area of Colorado, who had been diagnosed with gastroesophageal reflux disease or GERD, over 10 years ago. This condition causes severe heartburn and acid reflux. Jason says of his diagnosis, “I never knew what it was. I just thought I had heartburn. But it started to get to the point where I couldn’t swallow food. It would get stuck in my esophagus.... I would choke, basically. And then at night, I would wake up with stomach acid coming into my esophagus and lungs. So it’s nasty.” In addition to being uncomfortable, the stomach acid can cause considerable damage to the esophagus. He treated it with prescription drugs, but they are not recommended for long-term use. Jason is a clean-cut, married, fiscally conservative but socially liberal republican and father of two. He has used cannabis socially since he was 16, but he never considered applying for a card, because:

I thought it was [only] for critically ill people. Like cancer or AIDS. So there wasn’t even a thought to

attempt to get a card. And then one day I was reading the local alternative weekly, and in the back—this was five years ago, I’ve had my license for five years—on the back of it there was this little thing, get your medical marijuana license. And then it listed all the conditions, and GERD was on there.

I asked Jason if he ever thought about going to get his card before he realized that his condition qualified, and he said he never even considered it until he realized that his condition qualified, despite the fact that he had been a long-time recreational user. For Jason to decide to apply as a patient, the key piece of information was that his specific condition qualified. He did not mention doing any further medical or legal research. Because of his recreational use, Jason was already comfortable with cannabis, and believed it was safe. He didn’t identify with any lifestyle associations commonly attributed to cannabis use. His lack of interest in getting a card as a nonmedical, recreational user was echoed by others. Ethically, it just wasn’t acceptable behavior. However, possessing a card also does not mean that individuals who were recreational users prior to medical use completely stop using cannabis recreationally, a topic I will touch on in Chapter 5.

Gary’s starting point was different. Gary had not used cannabis since his teens. He reports a more intensive research process, and stronger skepticism, in part because he had not used cannabis for many years. Now in his 50s, Gary relocated to Colorado from the Midwest after the death of his wife’s father, who he and his wife had cared for in the father-in-law’s final years. Gary had worked as a delivery truck driver until he sustained a serious back injury at work when he slipped on ice while carrying heavy cargo. After a long battle with worker’s compensation and multiple applications to the Social Security Administration, he failed to receive a significant settlement but he did qualify for permanent disability. Since his injury, Gary has been through several prescription drug regimens, decompressive surgeries, and most recently, he was considered for a more intrusive, electrical “pain interruption” device that, should it prove to work during a temporary “test period,” would operate via permanently implanted leads surgically inserted next to his spine. After moving to Colorado, Gary and his

wife were out to dinner with old friends, who mentioned in passing that Colorado had legalized medical cannabis. Although they did not specifically recommend it to him, Gary says,

I started looking into it. I read the works of Dr. Mitch Earlywine [an author on cannabis], and I went to different sites on the internet and started doing research on it because I wanted to find out whether or not there was, if this wasn't just a Trojan Horse for pure legalization or whether or not there were actual, like there was something to this cannabis helping people for different ailments. And I found that it helped people with neurological issues. And since my problem is neurologically based, I thought I would go ahead and apply.

Like many other patients, Jason and Gary both suffer from chronic conditions that can be disruptive to everyday life. In both cases, no one directly suggested cannabis use. Jason simply saw his condition listed in a newspaper ad; Gary heard it mentioned in a casual, passing conversation on the topic. The “grapevine” effect functioned to raise the salience of medical cannabis use, and triggered enough curiosity to prompt further investigation.

Jason and Gary had each tried various other medicines and treatments for their conditions, but had failed to find a safe and effective long-term treatment option. In terms of recent use, these two men represented opposite ends of the spectrum. While Jason had long been known among his close friends as a recreational user, Gary had not used cannabis since his teens, and had no ongoing relationship with or connections to recreational use. Jason may have been more inclined to try cannabis medically since he was already accustomed to using it. For Gary, the entry barrier was more significant, but the severity of his condition and the intrusiveness of his current treatment options may have tipped the scales in favor to consider any treatment that had potential to work, including cannabis.

Both men share with other patients a lack of interest in medical cannabis prior to connecting it with their own disorder. Once this connection was made, Jason was almost completely uncritical of its medical potential, an attitude that was probably driven by marijuana's normal presence in his life, and may have also been due to more exposure to positive information about cannabis overall. Gary, on the other hand, had not really revised his impression of cannabis. In his youth it had been fun, but as with most “fun” things, it was

probably bad for you—a message reiterated by mainstream media. Gary’s lack of recent experience led him to question whether cannabis was a “Trojan horse,” or if it could in fact be useful to treat pain. Individual research included looking into cannabis as a medicine as well as researching its efficacy for his specific condition.

Nonmedical Motivations

Three patients cited their primary motivation to seek a recommendation as something other than medical use. Brett, a man in his 50s, and Avery, a woman in her early 30s, both sought out recommendations because they decided to pursue employment opportunities in the medical cannabis industry. A third patient, Neil, pursued a card based on advice from his attorney after an unfortunate event in which he was arrested while driving through another state after returning from a major cultural event, and the passenger in his car, an acquaintance, was carrying a significant amount of psychedelic drugs.

These individuals had qualifying conditions, but their use of biomedical care was less intensive, constant, or recent than many others in the study. Brett had experienced a significant trauma to his back, Avery had experienced a serious head injury that left her with migraines, and Neil had been diagnosed with sciatica—all potentially qualifying conditions, but these diagnoses had happened years before. After the initial care, these patients had managed ongoing symptoms primarily through self-care and care from the informal sector. Brett and Avery both expressed viewpoints in which they had resisted medical interventions. Brett, for instance, described his reaction after his back injury as follows:

I was lifting a heavy wooden lid, and literally, my back snapped. It made a loud popping noise. And from the beginning I—when I went to my doctor, they wanted to perform surgery. Bone spurs were growing off the side of my vertebrae, and they—yeah, they have been telling me all along that I need surgery. I’ve never had it. I refuse to do it. I do a lot of yoga, stretching out my spine. Between that and pain management with cannabis, I’ve got it under control. but yeah, I’ve been dealing with it my entire adult life.

Brett’s preference was for natural treatments, and he avoided interventions and prescription drugs unless they were absolutely required, such as after his appendix burst. Even

then, he used them judiciously and quit using them as soon as he felt he could. Avery's view of biomedicine was more positive, which she attributed in part to success in treating health issues she had experienced as a child. However, she had also chosen a career path that incorporated natural health. She learned in detail about Eastern health philosophies and favored natural forms of care. She trained as a nutrition counselor and teaches yoga. Both Brett and Avery see medical cannabis use as aligning with other forms of natural care for which they each expressed a strong preference. Although many patients in this study had tried complementary and alternative (CAM) treatments to care for their conditions, Brett and Avery stood out in the degree to which they incorporated holistic health practices into their work and lifestyle.

In sum, the patients in this study came to contemplate the adoption of medical cannabis use based on a few different types of prompting experiences. Some patients were directly recommended, and others came to the idea on their own based on little other than realizing it was available and being used for a condition that were experiencing. Once the idea was introduced, individuals often decide how to proceed based on an assessment of the risks involved in joining the registry, and their knowledge about cannabis use. Many patients determine that the best course of action to determine whether to register as a medical cannabis patient is to first try it for medical purposes and see if it works for them.

GIVING MEDICAL CANNABIS A "TEST RUN"

Cannabis presents an interesting set of circumstances because it is widely available on the black market. Some people contemplating medical cannabis use are able to access it prior to receiving a recommendation by seeking it out through friends or family networks, or by directly accessing the black market. Because cannabis remains a controversial request within the medical domain, and can be obtained through illicit channels, patients often elect to experiment with medical use in order to test its effectiveness *prior* to receiving a recommendation.

Britten (2008) reports that patients regularly engage in "lay testing" with prescriptions

as well, adjusting dosages or other routines of use to assess the efficacy of the treatment as well as its side effects. However with cannabis, this testing often precedes rather than follows the doctor-patient consultation. This allows patients to determine whether it is useful before exposing themselves to reputational risks in the doctor-patient interaction, and to make a more informed decision when deciding whether to sign on to a list with the state that indicates they use cannabis.

Patients often want some assurance that the legal risk, and the potential for stigma will be worth the effort. Experimentation was more common among patients who had limited or no prior use, or who had only used cannabis many years or decades before, during their teens. Approximately one-third of patients in this study reported engaging in some form of pre-card medical trial use. Half of experimenters acted as a direct result of a suggestion of a friend, who often provided assistance with obtaining a supply. The other half made an independent decision to experiment prior to a card application.

Anita helps to illustrate the patients who engaged in pre-medical experimentation. A more complete explanation of her situation helps to illustrate how she tested cannabis for medical use. Anita is a compact and fit 40-year old woman who looks professional but with an artsy-punk edge. She has been diagnosed with a rare form of MS, caused by a lesion on the left side of her brain. This lesion grew quite suddenly, causing a shocking, immediate onset of symptoms that led to her diagnosis. One night at the end of a dinner party with friends, Anita teetered and took a dive into the host's couch as they were saying goodnight. Everyone had a justification for the gaffe. She was in heels, it was late and she was probably just tired, maybe she'd had more wine than she realized. Little did they know it was the first symptom of the complete right-side paralysis that would follow.

By morning, Anita looked like she had had a stroke. In some ways, the manifestations were similar. With the right side of her face paralyzed, her words were mumbled. She was

bedridden, and confined to a wheelchair for six months. Prior to this development, Anita had been a teacher, but she had to quit her job due to the seriousness of her symptoms that impaired her ability to function. She was treated with high doses of prednisone, anti-inflammatory drugs, and an antidepressant to help her cope with the sudden change in life's circumstances. Unable to work or maintain her parenting role in the home, she stubbornly struggled over the next six months to retrain herself to walk with a cane. Between the brain lesion, the traumatic circumstances, and the intense medication, she was no longer "herself." She moved to the basement of her home and withdrew completely from family life, because as she puts it, "I couldn't stand to be around anybody."

Recovery required years of work. For three self-described "miserable" years she followed the protocol her doctors recommended, but the side effects of the medications were terrible. A friend who was a medical marijuana patient became determined to convince Anita to try it. Anita was reluctant, but her friend persisted. When I ask Anita why she was resistant she says: "My job. My kids. The stigma. It's not easy to hide the smell of marijuana when it's being smoked. And I was skeptical that it would help because at that point in time, I had pretty much decided that nothing was going to help."

Before trying it, she researched its use and found articles that specifically discussed using marijuana for MS that had resulted in "huge success rates in people who could get their THC levels up in their blood. They just maintained a certain level ... So I thought it was worth the risk for sure." Anita had used cannabis very casually and occasionally in college, but it wasn't something she really pursued, and when it faded out of her social circles, she barely noticed its absence. After her friend's insistence and her own research, she decided to experiment before seeking out a recommendation. On this she says,

Number one, I didn't want to expose myself to a state agency if I was unsure, because of my job. I didn't know the level of anonymity between the agencies. So I wanted to make sure this was a path that I wanted to commit to before actually making the paper commitment. I knew as soon as I put my name on a paper, I was going to be put on the list and that list was going to be shared with other people.

Like other patients, Anita only requested a doctor's recommendation after determining that it helped her condition through direct experience. Her "trial" prior to seeking a recommendation was a method that many other patients with limited or no prior use also tried. Another group of patients experimented with medical use prior to receiving a recommendation because they had been living in a non-medical state. Five patients in my sample tried using cannabis medically in another state; many based their choice to move to Colorado in part to apply for legal medical cannabis status.

About a fourth of the patients in my study were not consuming cannabis regularly or recently, but did not "test" cannabis first; instead they opted to wait to try cannabis until they had official sanction to use it medically. This group included several patients who simply relied on experiences from many years ago as an indicator that using cannabis was a safe and non-addictive substance worth exploring. Generally, prior experience, even when it had been many years before, led to reduced fear around initiating use for medical reasons. Instead these users focused on the risk of arrest or scandal. Using marijuana without a legitimate card seemed foolhardy in their estimations. A few in this category expressed moral outlooks from their religious beliefs or military backgrounds that led them to only try cannabis when it was considered legal for them, even if they had little to no prior experience.

The incomplete medicalization of cannabis means that its access is not completely controlled through medical institutions. Patients have the option of accessing cannabis legally or illegally, although access through "black market" relies on networks that some patients simply do not have, and others prefer to avoid or see as inferior for seeking consistent, medical-grade options. Nevertheless, patients often consider factors that have little to do with medical efficacy. For instance, patients often weigh the legal protections they gain by becoming a patient with the potential legal risks that this status may bring if the law is overturned. They may also see increased accessibility to safe cannabis as a benefit but worry about reputational risks or the loss

of practical benefits or employment if their status is considered grounds for denial or dismissal. In other words, patients express broad lifeworld concerns, and often treat the decision to use cannabis medically as a separate but interrelated decision to registering with the state. Whether they engage in experimentation or not, patients who decide to pursue entry to the state registry need a doctor's recommendation.

EXPERIENCES WITH DOCTORS IN THE RECOMMENDATION APPOINTMENT

Recommendation experiences among patients suggest that medical cannabis recommendations have similar patterns to those found among doctor-patient interactions for contested illnesses. These roughly correspond to Broom and Woodward's (1996) three models for such interactions. Doctor evaluations are based on several factors, including the suitability of the treatment, but also their beliefs about the validity of the treatment, and its risks or potential for dependence.

Following Broom and Woodward's (1996) model, some doctors adopt a paternalistic attitude and discount patient accounts in favor of medical expertise. Kondrad (2013) found that physicians who relied primarily on results of clinical trials and professional journals for medical information found little basis for support in the mainstream literature. This often led physicians to reject medical cannabis as a legitimate medical treatment. In a second type of interaction, doctors did not reject cannabis as potentially useful, but its uncertain legal status and perceived potential for abuse or harmful effects often discouraged physicians from incurring professional risk by officially recommending use. These doctors might neither encourage or discourage patients from trying medical cannabis, but they are unwilling to sign official paperwork or accept responsibility for sanctioning the use of medical cannabis for the patient.

Medical cannabis interactions raise different types of uncertainties than diagnostic interactions, including those based on bureaucratic or institutional limitations. Doctors may fear actions by their employers or the loss of their license to prescribe, which is granted through the

federal government, since cannabis is still federally illegal. In the third and final type of doctor-patient interaction, doctors engage in “constructive medicalization” by exhibiting a willingness to experiment with patient-initiated forms of treatment. These doctors are often more willing to officially sign a recommendation form and talk openly with patients about their medical use of cannabis. However, some doctors in this category may only offer informal support but express a lack of knowledge or expertise with medical cannabis, and refuse to sign the recommendation.

Although Broom and Woodward’s (1996) model offered little regarding the significance of doctors pre-existing beliefs about the medical issue under contest, the factor does seem to play an important role in medical cannabis recommendations. With medical cannabis, some patients report that their doctors had favorable pre-existing views, while others held strong views against the possibility of cannabis use as a medical treatment. Such differences are not surprising given Kondrad’s (2013) report that a minority of doctors were in favor of medical cannabis use, while the majority still held negative or skeptical opinions on the issue. This consideration adds complexity because doctors may be more or less open to cannabis as a medical option, regardless of their inclusion or dismissal of patient viewpoints, and patients often face a situation where they do not know the doctor’s viewpoint until they broach the topic.

Medical cannabis recommendations were most commonly initiated by patients. About half of the patients interviewed in this study began the process of qualifying as a medical cannabis patient by approaching their regular physician.. Among those who approached their regular physicians, most were rebuffed based on doctor’s rejection of cannabis as medicine or on their claims to institutional limitations. The other half bypassed regular physicians and went straight to the “doctor mill,” a nickname associated with the collective of doctors who advertise that they evaluate patients for medical cannabis.

“Doctor Knows Best”

Among the individuals who approached their regular physician, several encountered

resistance in which the doctor's expert opinion was not swayed by the patient's claim to experiential knowledge that cannabis was effective. Andy provides a good example. Andy has degenerative disc disease. The symptoms for this disorder were gradual, and it took several years for Andy to get a diagnosis. This was a frustrating process during which he was in and out of the doctor's office looking for answers. When Andy decided to try medical cannabis to treat his back pain, he first asked his primary doctor for a recommendation.

Andy had only smoked cannabis once as a teen, found he disliked it, and never revisited recreational use. His condition had led him to try many different treatments and medications, but he developed a sensitivity to opiates as an adult, so these drugs were off the table.

Andy: I must have read some news story that reminded me that [marijuana] was an alternative. I asked my doctor would he be inclined to write a note, and he seemed very afraid of the concept. This was a D.O. (doctor of osteopathy)—very naturopathic, a very discussing kind of person, and it was almost like he clammed up immediately....

Me: So [this] was your regular doctor?

Andy: It was, and I wouldn't even call it a discussion...It was—I asked him if he could send me to a pain specialist. And the pain specialist he recommended wouldn't talk about it. I sensed fear. Bluntly speaking, because—this was in 2005. I get the feeling that things blossomed between 2005 and 2008 in the industry. Then, I think most doctors just didn't want to deal with it. So I got on the internet and looked up the topic, and I found [a medical marijuana organization] that had doctors... who kind of do the rounds... They were the ones that believed in it and were willing to do a physical and decide whether you're a good candidate or not. Even though they weren't the ones that normally saw you for pain or anything else.

After trying to access cannabis through his regular health care providers, Andy resorted to the specialty market for an evaluation. This was quite common among patients. Even though half of the patients in this study began by approaching their regular physicians, over 80% ended up getting recommendations through a doctor who specialized in evaluations.

Like Andy, Wes has never been a recreational user, and had zero interest in it. He had only tried cannabis recreationally a few times in his youth, but he just never noticed any “high” effects from cannabis use. Now in his 50s, Wes suffers from advanced diabetes. Wes tells me that his wife was a regular recreational cannabis user, a behavior that he had purely disliked. He says, “I forbade her doing it [smoking pot], and she was doing it behind my back... So I told her, well, you can smoke it only on the weekends. So she was smoking during the week behind my

back and then on weekends she would smoke it in front of me.” Around the time that Amendment 20 passed, Wes’s wife was diagnosed with a musculoskeletal disorder. He noticed that on the nights and weekends when he did not complain if she used cannabis openly, she seemed less symptomatic and slept better.

“That’s when I started researching medical marijuana and [her condition] and I realized that it helps.” At that point, he changed his mind about his wife’s use, and suggested that she become a registered patient. Once she was a patient, he saw how much it helped her manage her disorder. Wes says, “that’s when it was good enough for me.”

Wes’s story is similar to Karen’s description from the introduction. While researching his wife’s condition, Wes discovered that cannabis might also help him, because it was reputed to be effective for neuropathic pain and other symptoms associated with diabetes. So he gathered his paperwork and prepared to apply. After downloading the paperwork from the state, he talked to a woman who worked with the state program about approaching his doctor, Dr. D, for a recommendation.

She said, here are a couple of pieces, a couple of letters or whatever. And she sent them to me and it was basically saying that no doctor has been reprimanded by the federal government and so on and so forth and everything. And she said hand these to your physician also. And I said, okay. So I went in to my primary care doctor and I was talking to him and he would say, is there anything else I can do for you? And I said, I would like to talk to you about medical marijuana. And he goes, what about it? And I go, well, the state has a program and if I can get a doctor to sign a piece of paper that says that I may benefit from it, I can get a card and then I’m legal to use it.

Wes tried to pave a path for his physician by providing the legal rules, but this also may have limited the doctor’s options to object within the interaction on institutional grounds. According to Wes, Dr. D. directly expressed his own skepticism about marijuana’s medical benefits.

[The doctor] looks at me and didn’t say anything. I said I brought the paperwork, would you be willing to sign it for me? And he said, no. And I go, why not? And he said, I don’t think it works. And he says I don’t believe in it. And I said, I’m telling you it does work because I’m already using it. I said, the reason you had to reduce my blood pressure medication is because of it and so on and so forth. And he said, well no, I won’t sign it. And I said, okay, then I need a recommendation to [see Dr. M] here in town, a neurologist. And he said, what do you need to see him for? And I said, so I can talk to him about cannabis because he will sign it if you won’t. So he said, fine. And he gave me a recommendation to go see a neurologist. I went

to see the neurologist and talk to him and he said, yeah, I think it's the greatest thing in the world for you. And with all your conditions and all that. He gave me the once over and what have you. And he said, here you go, give it a try. Let me hear back from you good or bad, let me know how it works for you and all that. And I've had a relationship with him now since 2001.

Wes's primary care doctor privileged clinical evidence over Wes's experiential claims.

Through referral, Wes formed a relationship with another doctor who supported his medical use of cannabis, and accepted that it could be beneficial for his conditions. Even though Wes's primary care physician seemed unaffected by his ongoing success, he reports that it did seem to persuade Dr. D., but the changes were incremental. Despite Wes's openness about his medical cannabis use, his only additional conversations with Dr. D. on the topic were indirect:

Wes: About three years after [this interaction], my primary care doctor, his office girl, called me and she said, Wes, this is Meg at Dr. D's office.... Dr. D is wondering who signs your cannabis recommendation for you? And I go, why? And she goes, well, he has a patient in the office here that he thinks may benefit from it but he is not willing to put his name on the paperwork. And I said, well, it's Dr. M. And she said, okay, thank you. And I said, if there's anything else he wants to know, have him give me a call.

Me: So you think he's shifted his views?

Wes: I think he has shifted his view. I don't know if he's signed any recommendations yet, but I do believe, I haven't talked to him personally about it. I have of course, seen him a couple of times a year every year. He is still my primary care doctor. And he just tells me, keep doing what you're doing because it's working. ... when I first went to him in 2000, he called me "walking death." In fact, he had my wife and I up in arms that I wasn't going to make it six months, and here I am 11 years later, still going strong. We haven't specifically mentioned the word "marijuana" or "cannabis" in our office visits other than I give them a list of my prescriptions and medications and it's on there, how much I use and everything. And he looks at it and he says, "good for you," and that's about it.

In both Andy's and Wes's cases, doctors expressed discomfort or complete dismissal that cannabis could be an appropriate treatment. In both cases, physician considerations were unrelated to the patients' recreational use history, which was negligible, nor was it related to whether their conditions "qualified" with the state. Rather, the refusal appear to be directly related to physicians' existing opinions about marijuana's legitimacy as a medicine. However, when Wes's health benefited from medical cannabis use, his doctor offered a vague, "keep doing what you're doing," and even inquired about resources, all while still avoiding any direct mention of the subject. As we will see below, this was a common response from physicians who did not recommend medical cannabis use, but maintained a relationship with the patient.

Anita was one of very few patients who persisted with her primary care doctor despite his

initial refusal to recommend. Anita, the MS patient mentioned above, knew that she required a plan for ongoing care, and she was stubborn about getting her primary physician on board with her treatment plan, rather than going through a referral or a specialty evaluation doctor. Anita recounts the process of obtaining a recommendation from her resistant neurologist:

Anita: Neurologists, usually...don't have any bedside manner at all. They are fairly stoic, they really don't have a sense of humor. My neurologist...when I brought it up... [he] essentially told me that I might as well drill a hole in my head and let the pressure relieve like they used to in the dark ages. I'm guessing that was his attempt at humor? But it really felt kind of like he was making me feel stupid that I would try something so outrageous.

Me: So clearly he didn't believe that it was going to work at all?

Anita: Yeah, he really didn't. And I bugged him. I brought it up in conversation at one appointment to kind of feel him out, how he was going to approach the subject. And I left it at that, and just kind of—and the next time I went, I brought it up again, and got a little more information out of him. And the third time I went, I said, 'I have tried this and it really does seem to help with the extended issues that we are unable to control at this moment with the medication regimen you have me on.'

Me: So you wore him down?

Anita: Yeah, I pretty much wore him down.

Because Anita persisted in the interaction, her experience may best illustrate a case where “doctor knows best.” The prolonged negotiation with her neurologist required Anita to press the issue with her doctor, even after he ridiculed her suggestion. After introducing marijuana medically, Anita has been able to reduce and then phase out all other medications, including medications for pain, spasms, and depression. During this time, her brain lesion shrank by 50% and she is now considered in remission. Anita does not appear ill, but she continues to use cannabis to maintain remission. When I asked if her experience affected her neurologist's opinion of medical cannabis, she said, “He actually has said that he is quite impressed,” but she also says, “Most of my doctors now, even the ones who were in state-run agencies, aren't allowed to really do anything about medicinal marijuana because they are federally funded. Even they are like, ‘well, just continue it. Just do what you are doing. I can't sign any papers for you, but just continue what you are doing.’”

Patient interactions with primary care doctors illustrate that doctors do not necessarily accept cannabis as a medicine, even when diagnoses match those that qualify according to the state. These recommendations show that when patient want to involve their physicians, it often

requires a level of determination that some patients are willing to engage, but many are not. Based on patient reports, doctors often seemed to view medical cannabis as they do complementary and alternative medicines—with skepticism based on its lack of scientific evidence, and generally as outside the purview of biomedical expertise (Ruggie 2004). Patients often characterized their regular physicians as uncomfortable, dismissive, and lacking in expertise on medical cannabis. In many respects this aligns with physician’s attitudes about treatments in the informal sector.

Uncertainty in the Doctor-Patient Interaction

Travis’ story at the beginning of this chapter illustrates one case in which the physician suggested medical cannabis to a patient, and also signed the official recommendation paperwork. However, many other cases were less straightforward. Ultimately primary care doctors signed very few official recommendations. In half of the eight cases where doctors initiated the suggestion that the patient try medical marijuana, doctors did not sign the paperwork, mostly based on bureaucratic reasons.

For example, in Mike’s case, a university hospital physician informally recommended use of cannabis as a part of Mike’s treatment for HIV. Mike was diagnosed with HIV in 1986, when he was in his early 20s. He has been in treatment for HIV since 1991, and in the last 20 years, he has volunteered for any and all clinical trials on experimental HIV therapies that would allow him to participate. His regimens have involved many pills. He claims that he has been on as many as 30 pills a day. His current medication requires him to take about 20 pills a day. In 1995, his t-cells dropped to a dangerous level, but for most of this time, Mike has maintained a desirable level of health. From his shaggy head of blond hair framing his two-day old beard, his flannel shirt, and his well-worn steel-toe boots, Mike looks like a typical “mountain man.” His husky voice is punctuated with a breathy snicker that sounds straight out of the cartoons. Mike readily admits that he has an experimental streak, which has extended to his drug use and

sexual choices. He has smoked pot daily since his teen years, with only a few sabbaticals over the years. While he did not see his cannabis use as “medical” for most of this time, he never saw it as unhealthy, addictive, or terribly wrong. He knows, and his doctors know, that cannabis is often recommended to HIV patients to control symptoms. Mike’s recommendation experiences were uneven, and clearly illustrate interactions where doctors approve of cannabis use, but do not officially recommend. When he moved to primary treatment through the university hospital, he was happy with the care, but they could not sign his recommendation:

Mike: The [[university hospital]] won’t let physicians there write recommendations.

Me: Even for qualifying conditions like HIV or cancer?

Mike: It’s because they have a DEA license to write prescriptions. So they’ve got to, I saw this letter—anyway, they told me that my doctor can’t write those recommendations.... [To my doctor,] I’m like, ‘If your license is under the state, and these threats are from the state...’ She said, ‘that’s not where we’re getting the pressure. [It’s] the DEA license.’ That’s what I’m getting from my doctor. When I went to the doctor [for a cannabis evaluation], I was like, I’ve been getting these for years now. This is the first time that I’ve had to see a doctor *about* my doctor. It irritates me that somebody’s come between me and my doctor, you know?.... It’s the federal government, is what she’s saying. But then I don’t know if that’s actually coming from the DEA or if it’s coming from their medical association that, ‘hey, I don’t know, we’ve got all these issues with the DEA, it’s up in the air, we can’t risk it.’ Either way, [the cannabis-recommending doctor] irritated me right off the bat by saying, ‘well, it’s because your doctor’s in the pocket of big pharmaceuticals and doesn’t want to write it for you.’ I was like, ‘How dare you say that about my doctor!’ But he was the cheapest one [among the medical marijuana evaluating doctors]...if I could get it for less, I would go and see a different doctor.

Mike clearly does not feel his doctor is at fault, nor does he reject western medicine. It is not entirely clear if the government or the medical institution causes the added level of bureaucracy for Mike to gain access. Whether a recommendation was doctor- or patient-initiated, Mike’s story summarizes well the pattern of interactions when a doctor claims to support medical use, but for organizational reasons, is constrained from signing an official recommendation.

Patients recounted interactions in which doctors cited various reasons related to marijuana’s legal status for not approving official paperwork. Three patients reported that their doctors cited policies related to federal funding based on their employment at the Veteran’s Administration (VA) or at a university hospital. In a fourth case, the doctor signed the initial recommendation paperwork, but declined to sign the renewal for reasons that were not

explained to the patient, but were unrelated to his ongoing approval of cannabis use in the patient's therapy. These dynamics are found among interactions where the patient initiated the recommendation as well as among those where the doctor informally suggested medical cannabis use but then could not formally recommend. These doctor-patient interactions suggest that patients had experiences in which doctor expert knowledge about medical cannabis varied considerably, but even among those who supported its use, institutional factors often inhibited them from signing paperwork.

The “Doctor Mill” as Constructive Medicalization

By large margins, patients from this study ended up in the specialty evaluation market, or what has come to be called the “doctor mill.” This term is widely used to indicate doctors who advertise that they provide evaluations for medical marijuana, and who may specialize in these evaluations either part-time or full-time. Regardless of whether patients or doctors initiated the idea that the patient should try medical cannabis, 33 of the 40 patients in this study, over 80 percent, ended up going to a specialty evaluation doctor to receive a recommendation at least once⁴.

Twenty-three patients, over half of my sample, went straight to the doctor mill when they realized that they could qualify for a recommendation based on their diagnosed condition and the terms of the state's laws. Most of these patients verified that their condition qualified prior to making an appointment, either by researching qualifying conditions on the internet or by contacting a medical marijuana center or other medical marijuana organization to ask questions. Many sought information, referrals to doctors, or resources for locating specialty evaluation doctors, from these organizations.

The “doctor mill” is often treated as a source of concern because it raises suspicions of

⁴ Patients must obtain a signature recommending cannabis use annually, and file it with their renewal paperwork with the state.

illegitimate recommendations and appropriate boundary maintenance (Nussbaum, Boyer and Kondrad 2011). Physicians may also worry that specialty evaluation doctors fail to follow professional expectations. In some cases, as I discuss below, patients report questionable practices that exemplify this concern. However, another way to see the doctor mill is as an adjunct to the informal sector of complementary and alternative medicine. These doctors may bridge the gap between biomedicine and the more patient-driven models of care found in the informal and popular sectors of medicine.

According to Conrad and Schneider (1998 [1980]), medical professionals who become involved in claims for newly medicalized designations often comprise a specialized group. They may be researchers on a specific problem, or administrators who operate specialized clinics that have a focus on the area being medicalized. Such physicians are rarely typical of the medical profession, and are often in an institutional location that is removed from the medical “rank and file.” Physicians often start out in newly medicalized areas with only loose professional coordination, but they may come to work with other, similarly minded medical professionals to press for greater acceptance of their medical “turf” by the mainstream medical profession (268). Such activity is more directed toward professional development than what we typically think of as political activism. Once these physicians have invested the success of their practice and their professional reputations on an emerging medical area, they may be quite motivated to work for greater professional acceptance in order to maintain their own prestige and financial success.

In recent times, there has been a greater trend toward integrating care from the informal sector with biomedical practice (Ruggie 2005). Patients often turn to CAM treatments when they are not experiencing success with biomedicine (Nichter and Thompson 2006; Ruggie 2004; Testerman et al. 2004). Most CAM users treat CAM as an adjunct that complements the formal sector rather than an alternative that rejects it (Eisenberg et al. 1998; Ruggie 2004). Most patients do not communicate to their doctors about treatments they use in the informal or

popular sectors, such as CAM, precisely because they expect doctors to disapprove or simply lack interest. Patients are also aware that physician expertise does not extend to all health treatments outside of the realm of biomedicine, and they may have very little to offer aside from disapproval. When CAM treatments or holistic concerns are raised, physicians often possess little expertise, and they may be unwilling to consider patient claims or requests when they perceive these suggestions as unscientific or failing to conform to the logic of biomedicine.

In the case of medical cannabis, a doctor's evaluation and approval is required from the state, yet many regular, practicing physicians are uninformed, disapproving, or claim that institutional barriers prohibit them from making recommendations. The doctor mill allows patients to identify physicians where these particular obstacles will not define the interaction. I suggest that patients use the doctor mill in a way that resembles their use of the informal sector.

Like many forms of CAM, medical cannabis has self-care at its core. All other aspects of the medical cannabis system are managed outside of the formal sector of medicine. Although no patients objected to the doctor qualification requirement, many talked about overregulation. They understood why the state set strict rules. Because cannabis is still considered controversial, and such programs represent a full scale change in the laws, it is necessary to create a system that appears to the public as beyond reproach in its criteria, thus enhancing the legitimacy of the system on the whole.

Patients still care about the legitimacy of interactions with physicians, and as we will see, they avoid specialty physicians who do not uphold their interactional expectations. However, some see the requirement to get a doctor's permission as a reflection of the overinflated idea of danger about cannabis that has been reinforced by its scheduling. Since most patients saw it as not only more safe than prescriptions, but safer than other herbs, and even everyday items—patients mentioned aspirin, coffee, and water—in this instance, the doctor's recommendation becomes less about medical advice and more about meeting system obligations in the most

expedient manner available.

Legitimacy concerns differ for actors employing system logic—doctors and regulators—and patients who are employing lifeworld logic. Systems such as biomedicine operate on strategic action, which is largely oriented to succeeding at the goals of the organization. By contrast, the lifeworld is concerned with communicative action, which is not restricted to the success of any specific institutional goals, but is instead oriented toward understanding (Britten 2008). Patients often access resources from across all health sectors to manage practical lifeworld health concerns (Britten 2008). As Baarts and Pedersen (2009) describe, “the use of CAM represents a health strategy through which individuals struggle to gain control over their situation” (720). Options in the formal sector may not address patients’ lifeworld concerns with role functioning or quality of life as well as the informal sector. By offering a form of “constructive medicalization,” and operating from a more patient-driven model, the doctor mill may solve a problem of the lifeworld, even as it seemingly causes a problem from a system point of view.

Another similarity between marijuana evaluations and the informal sector is that patients are more likely to include their regular physician in their use of the informal sector or their marijuana evaluation when all forms of care are used to address the same health problem. Alternatively, patients are less likely to inform or include their regular physician in these choices when the different forms of care are used to address different health concerns (Ruggie 2004). While patients may access different types of care, many still “prefer to keep their two worlds of health care separate” (Ruggie 2004:78). When surveyed, CAM-using patients usually did not inform their physicians of their CAM use unless directly asked about it, because they believed that doctors would be uninterested or disapproving (Kennedy, Wang and Wu 2008; Ruggie 2004).

Sometimes, patients opted to go directly to specialty evaluation doctors because they had

no regular physician managing their care, or because they did not want to disclose their interest in medical marijuana to their regular physician. Lance is a case in point. A highly decorated veteran in his early 30s, Lance was medically retired from the military after incurring a traumatic brain injury (TBI) in the course of his military duty in Iraq. He reports that he had never used cannabis before. His brain injury and serious PTSD symptoms resulted in treatment with antipsychotics at levels he considered near-lethal, and he became concerned that if his injuries had not killed him, the treatments would. About the decision to try marijuana to treat his conditions, he says:

Well, they had me on lethal doses of antipsychotics and it really just made me really crazy... After talking to some people that I had known—my dad is a [medical cannabis] patient in California—I just thought, what could go wrong, you know? It was like—the state condones it, the feds aren't really going to come after me. So I gave it a shot. I tried everything else [first]—like, everything else!

When I ask how he found a recommending doctor, he says he searched the internet to “try to find the most legitimate place.” When I asked if he tried his regular physician first, he says, “Because of my current status [as a veteran], I continued to receive government health care, so no.” Although he did not go through his regular doctors because he surmised that they would not recommend cannabis based on the state-federal conflict in the laws, he mentions,

My [regular] physicians know [about my medical cannabis use]. They condone what I am doing. Unofficially, I mean... They wouldn't say, ‘here's a script’ [prescription], because it is not something they can do, but they're happy to see an active interest and they're seeing results. And the results aren't coming from the pharmaceuticals anymore; they are coming from what I am doing [with the medical cannabis].

On the whole, the patients who went directly to the doctor mill did not have the objective diagnoses that are listed as qualifying conditions: HIV/AIDS, cancer, or glaucoma. Most qualified under severe pain, sometimes combined with severe nausea or muscle spasms. However, it would be incorrect to say that “pain” did not correspond to a clear diagnosis. Some patients had diagnosed conditions, but qualified on the basis of symptoms related to these conditions rather than through the condition itself.

Mark is a great example of this type of case. He was diagnosed with a condition called “Haglund's deformity,” which results in severe neuropathic pain in one's feet. His actual

diagnosis is not on the list, but neuropathic pain is widely considered a legitimately qualifying condition. Many other patients suffered injuries due to specific work or car accidents, leading to well-documented medical histories that they supplied to evaluating doctors.

Only a few patients with objective diagnoses listed explicitly as qualifying—HIV/AIDS, cancer, and glaucoma—went directly to the specialty evaluation market. One of these was Ron. Ron has cancer, but without insurance, he has no regular medical care or primary physician. Ron received his recommendation shortly after his cancer diagnosis in 2008. Ron resides in a conservative area in Colorado, and he expressed a great deal of indignation toward local authorities, who harass local doctors and patients, making it nearly impossible to get a recommendation in his county. He had to travel to Denver to get his first recommendation, and he has experienced significant police harassment despite his best attempts to be transparent and abide to the letter of the law.

Doctors are so intimidated by the district attorney [here] and by the federal government because of [cannabis'] Schedule I status....everybody gets hassled. Any time a doctor tries to help a marijuana patient, he runs the risk of being hassled....The pillars of our communities are doctors now, and they don't have a voice in medicine. The district attorney [in this area] has a larger voice in treating my disease than a doctor.

In the less embattled towns and cities of Colorado, patients with serious objective diagnoses such as HIV/AIDS and cancer, report few concerns with their qualifications as medical marijuana patients, even when in practice, their cannabis use may mix medical and recreational uses. For instance, Tucker, a 33-year old HIV patient who admits that he sometimes uses marijuana recreationally and has only recently needed it medically for the severe nausea brought on by his HIV medication regimen, says of his recommendation, “I walked in with a slew of things to qualify me, and barely uttered one thing, and it was the magic word, because I had the golden condition, so they were like, there were no questions asked, they were like, pfsshh (dismissive sound).” Quite the opposite of Ron’s experience, Tucker’s first recommendation was at the height of the “green rush” phase, when new patient applications were peaking, but before legislation defining more strict doctor-patient rules had not yet passed.

He mentioned it to his regular physician, who immediately declined, but overall he experienced few roadblocks in his recommendation experience.

In cases where recommendations are based on contested or subjectively defined conditions, patients often attend more to providing evidence of qualification. For instance, many pain patients come to the recommending physician with proof that consists of x-rays and extensive prior medical records. Many also rely on the proof of their own physical or bodily condition that bears clear signs of significant traumas. Again, Lance provides a good example: “I went to see the doctor and all I had was a digital copy of my medical records because my medical records are too big. There are over 700 pages now. It really isn’t a gross exaggeration, it really is 700 pages.”

Some patients report that, as the regulations tightened, medical records were not sufficient, but most patients still brought medical records to show their current prescriptions, history of injuries, surgeries, and diagnosis, and these were combined with answering questions and a physical examination that offered evidence of injury or disease.

Patients who have avoided biomedicine may have more challenges to provide sufficient evidence of chronic pain. For instance, Beth, a Jehovah’s Witness, rejects western medicine and prescription drugs based on her religious beliefs, and uses natural remedies. After experiencing two traumatic injuries that left her in chronic pain, she sought out a medical recommendation for cannabis. “I took all the medical records I could find, which since I can’t do medication, I don’t have anything from a doctor. So I went and got from the massage therapist and from the chiropractor all of those records.”

Brett relied on recent x-rays to make his case in the evaluation appointment.

You know, good. I’ve got x-rays and, you know they’re pretty darn good I guess—they show pretty plainly that I definitely have back issues going on. So for me, you know, I wasn’t really concerned whether or not they could I guess quote-unquote qualify?

Perhaps due to Brett’s more extensive involvement on the industry side of medical

cannabis, he was quick to offer a defense of patient qualifications based on “pain.” In doing so, Brett summarized the process by which patients translate lifeworld concerns to the language of the bureaucratic system of recommendation and qualification:

There’s been a common criticism in our industry that our patients are young males, young guys, and they’re all coming in for pain. And that’s accurate, but what’s not being told by the story is that the initial amendment that legalized this only stated eight conditions.... what are you going to do? Well, okay, I don’t have AIDS. I can’t sleep, and I’ve got these migraines, and I’ve got nausea, and I’ve got IBS—or I’ve got posttraumatic stress syndrome. Geez, none of those qualify, I guess I’ll go with pain. There’s a whole slew of other conditions. Everything from sleeping and migraines, and all kinds of other issues that we’re not putting in there. So everything falls back on pain. So everybody will put pain, because if we had migraines on there, or sleeping disorders, then we would pick those.

In pain conditions, patients relied on medical histories and documentation such as x-rays, prescription histories, or clear diagnoses. Darrell had records as well, but also relied primarily on his disability status and the damage to his back that was obvious upon physical examination.

I had to bring documents that showed that I had surgery. He wanted to see my scars. He sat and had an interview like we are having. He really drove me pretty hard. But it doesn’t matter to me. You’ve got to do it.

Darrell has had multiple surgeries due to a serious injury. He has pins and screws that create a cage around his lower back and extend through his spine. He is on permanent disability through social security. Darrell is 40 years old and married to an older woman, with multiple step-children and has a very domestic lifestyle. He has never been a “partier,” and has never used alcohol. Even though he has been a cannabis user for many years, he sees his medical qualification as beyond dispute. He feels a doctor looking at his physical condition would know that he was managing pain, but if there was any question, his disability status, physical state, and prescription history corroborate his claim.

FACE-WORK IN THE RECOMMENDATION SETTING

Patients had different reactions to the doctor mill. Some expressed a strong preference that the interaction comport with the conventions of the doctor’s visit, because this conferred legitimacy. In many respects, these interactions illustrate expectations that align with Goffman’s

(1955) classic theories on how people manage “face-work”; that is, how individuals fulfill the proper role in a social interaction. As a formal interaction, patients have expectations that legitimate medical marijuana evaluations will maintain many of the conventions of a typical doctor-patient interaction, including the appearance of the doctor and the setting. When details did not correspond to the ideals of such an interaction, they attempted to ignore it, but in their interviews, they reported on it as bothersome, and it often led to a decision not to return to a particular doctor.

For example, Avery, a woman in her early 30s with migraines and chronic pain from injuries sustained in a traumatic incident when she was attacked, notes that in her first medical marijuana evaluation, the interaction approximated a typical doctor’s appointment.

Avery: It was in a medical office that was shared with other doctors.... The doctor was very caring and asked me questions. So I liked that part of it, but then the person taking the money at the end, I wasn’t exactly comfortable with.

Me: Like the way he looked or dressed?

Avery: I know I shouldn’t, it’s a stereotypical kind of thing, but he didn’t seem very professional. He didn’t match with the rest of the setting, the doctor, and the building they were in, and things like that. I decided to go to a different doctor next time [based on this]. It was just—t-shirt, jeans, the jewelry he had on. [The office] wasn’t exactly organized, like I could have gotten out of there without paying, but I’m not that type of person so I was looking for the person I was supposed to pay. Up until the very last moment there, it did feel [like a normal appointment]. The doctor gave me a piece of paper, had suggestions for me, he genuinely cared.

Yvonne provided another example. A 60-year old grandmother and self-described earth mama, Yvonne has back issues and a diagnosis of fibromyalgia. She lives in a more remote southern area of Colorado where few medical marijuana centers have opened. She sought a recommendation from her primary physician. This doctor claimed she didn’t handle pain management and referred Yvonne to a specialist. The specialist claimed to be “all for it,” but would not sign the recommendation, instead sending her to a doctor specializing in medical marijuana evaluations:

It was in this really seedy rental space they have out here....I asked [my] kids first, what do you think if I get legal and smoke marijuana, medical marijuana, so they all know about it because they’re going to smell it in the air. They said sure, but they didn’t want me to go [to the recommendation place], they said it was like a back alley abortion place. It’s a seedy motel, like, it was something, and I had to laugh. [The doctor] came down [to our town] one day a week, and in the waiting room, there were only folding chairs. You

went in and he was in one room and was sitting at the end of a long banquet table and he had his receptionist in another little area behind a table, and everybody just sat in his little waiting room..... He did not ask for one bit of proof—I had no medical papers with me whatsoever. I had gotten everything together that I could, and they didn't need anything.

As with other patients, Avery and Yvonne avoided these places in the future. Many patients clearly state their preferences for greater legitimacy in the recommendation interaction, represented by overall professionalism in the interaction and atmosphere of the evaluation. They were disturbed by interactions where doctors did not maintain the appropriate appearance of professionalism because it implied nonmedical motivations for their services. In some cases, patients may have felt that a doctor's lack of legitimacy threatened to make the qualification less legitimate.

Another reaction was to interpret the recommendation experience not as a legitimate medical interaction, but as a bureaucratic obligation. These patients were less concerned with getting an expert evaluation from the recommending doctor. Many felt they already had such validation from their own doctors, and as I have mentioned, some did indeed have explicit but informal approval from their primary healthcare providers. In these cases, the doctor mill was often seen more as a service akin to getting a notary to sign documents than an actual medical evaluation. Participants summed up the appointment rather briefly and with less detail. Patients in this category often shrugged off the interaction with some version of the saying, "it's all political." In other words, patients saw it as a hurdle designed more for political validation than medical ones. However, I think it is significant to note that this had very little to do with their estimation of their medical qualification or legitimacy as patients.

Neil was one of the few patients who was prompted to register with the state due to a nonmedical, legal concern. However, he possessed a qualifying condition, sciatica, and his accounts of use included clear medical patterns. Based on his explanation of his motives as primarily nonmedical, I asked him whether he felt he was a legitimate patient. He says,

Honestly, I felt like I was getting a driver's license. You know, like it's my right to do that. So I didn't feel that I was getting away with anything? But I was getting my right. My right to grow and use marijuana as a medicine. So I didn't feel like it was like, "all right!" [He says 'all right' in the sense of 'cool' or 'awesome,' as in—I got away with something.] It was great. Now I was able to choose things.

Neil's ability to access medical grade cannabis and "choose" products that worked best for him was a benefit, but even though he indicated that his use intertwined pain management with recreational use, he refuted any suggestion that this access was somehow a misuse of the system for recreational purposes. Instead, he insisted on medical framing, and used much of the same health language about cannabis use that was common to other interviews. Neil also shared with many others a broad frame of medical use that extended beyond his "qualifying condition" to legitimately include generalized pain, such as pain caused by the removal of his wisdom teeth.

CONCLUSION

Patients entered the system based on different prompting experiences, which included doctor suggestions, suggestions from friends and family, independent research to determine their eligibility or nonmedical motivations such as legal problems or a desire to enter the medical marijuana industry where official patient status is an advantage. In determining whether to enter the system, many patients engaged in pre-application experimentation with cannabis use as a way to determine whether it would be medically helpful before risking entry to the system. A significant minority of patients interpreted risk differently, as coming from getting caught using cannabis without a qualifying status, and they decided to wait until they had a card to try out cannabis for their medical conditions.

While many patients approached their regular physicians, an overwhelming majority ended up getting their official recommendation from the specialty evaluation sector. Some went directly to the "doctor mill" without consulting another doctor first. I have proposed that the specialty evaluation market may mimic care more commonly found in the informal sector of CAM therapies. Many patients assessed marijuana as very safe, and in many ways felt that it was more like CAM therapies, but they understood that marijuana's overregulation was due to its

remaining controversy. Changes to marijuana's status are still seen as new and tentative, and in some ways, overly strict regulations are seen as protecting Colorado's program from accusations of illegitimacy.

Patients had very different estimations of how easy or difficult it was to get a recommendation regardless of one's medical legitimacy. Some who entered the system very early after it was introduced felt that it was stringent at the time they entered. Not only that, but prior to the emergence of the dispensary sector as a part of the "green rush" in 2009, individuals often struggled more with figuring out how to access the system or find supply. Those who entered between the "rush" period of 2009 but before the 2010 regulations were in effect commented that it seemed easy for anyone to get a recommendation during that time. Many felt that the regulations had helped to shore up some of the "leaks" in the system at the recommendation, and system pressures and sanctions had moved appointments toward greater professionalism. Other felt there were still pockets where the barriers to entry were too low and anyone motivated to get a card could do so whether they qualified or not.

Even though there were concerns that the doctor-patient interaction, as gatekeepers to the system, might be a main source of "leaks" in the system, it is important to acknowledge the role of interpretation. Doctors in the formal sector, the state, specialty doctors, and patients had some predictable differences in their interpretation of the value of medical cannabis use, and who should have access to it.

Patients expressed sympathy and gratitude for doctors who adopted this risky specialty in order to help patients. Indignation was reserved for those who appeared to be profiting unfairly from the system without truly caring for patients. This included doctors who were running unprofessional recommendation practices where the doctor's appointment reflected neither the appropriate level of professionalism or a desired level of patient care. Such determinations were largely based the "face-work" in doctor-patient interactions rather than on

any overview of the industry. However, it also extended to distant players, such as the government and its representatives, and pharmaceutical companies, who many patients believed gaining indirectly but knowingly from the lack of marijuana's availability as a natural substitute, and also did not care that their motives resulted in patient suffering. Quality was important, and a demeanor of authentic caring and ethical motivations for being in the industry mattered to patients.

The patients in this study approached the recommendation interaction believing that their request for access was legitimate. They were also invested in the legitimacy of the system. Some expressed concern that the point of entry and the specialty market presented opportunities for illegitimate entry to the medical cannabis program. Because patients in this study saw themselves as legitimate, they were bothered by this. It detracted from their own patient status and its legitimacy in a controversial climate where such concerns are commonly in the media spotlight. Patients expressed these concerns *even though* many were supportive of recreational uses. Perhaps this is exactly because medical advice derives legitimacy to the degree that it maintains a sense of objective neutrality.

Patients believed that there were important differences between medical and recreational use, and preferred a clear system boundary between the two. However, they were reticent to accuse others of "cheating" the system. Even though several patients made comments about young, male, recreational users as the stereotypical "cheaters," they were often quick to qualify such comments, acknowledging that it is unfair to base an estimation of legitimacy on appearance of health or illness. The patients I interviewed understood that seemingly healthy young people could indeed have PTSD, or other unseen injuries or illnesses that were completely legitimate.

Many patients thought the doctors in the specialty market accepted marijuana as a safe option with many healthful benefits, including uses for pain conditions that are moderate or

intermittent, or for conditions not specified in the registry. Turner (2004) points out that all modern medical practices engage a form of interpretation based on current nosology, and the legitimacy of diagnoses and plans for treatment often rely on a sense that medicine is a neutral representation of fact. Doctors may feel they are working within the system to maintain their own medical judgment when interpreting diagnoses and treatment plans in the evaluation. They also may enact a kind of “constructive medicalization,” allowing patient who felt it would help them into the system, in part because they saw little harm created by doing so.

With so much difference in the legal consequences between legitimated medical use and illegal recreational use, the incentive to seek out a card for legal protection is strong, and provides incentives for both patients and physicians to act on motivations other than those that are tightly defined through the state. Few participants in this study reported stories of nonmedical motivations, and those who did ultimately had a secondary reason driven by a qualifying condition. This helps to highlight the difference between using marijuana and becoming an official marijuana patient.

Medical marijuana lacks acceptance among a broad range of physicians, and includes pressures that inhibit many doctors from providing official recommendations. If more physicians come to accept a medicalized definition of cannabis or perceive less threat in providing recommendations, it might improve many boundary problem.

The media tends to focus on individuals who do not have legitimate medical reasons to access medical cannabis, but still gain access to the system. Although there are likely to be some “illegitimate” patients who fit this type, just as there are illegitimate prescription drug users, these behaviors were not the focus of this study. I would argue that such formulations are oversimplified. Examples of “cheating” within this study seemed less about medical qualification and more about official expedience. Patients worked around obstructions in the system when doctors failed to recommend by accessing the specialty evaluation market. At least among these

midlife patients, the choice to use the “doctor mill,” had little to do with any doubt that their condition was “qualifying,” or intentions to subvert the system to use cannabis recreationally. The reasons that patients seek access are often more complex than a simple dichotomy of recreational versus medical use, and as the next chapter will show, their use is often not that simple either. Some but not all patients in this study admitted that their use at least occasionally included social rather than medical uses, or at least blurred the line, but interpretations differed due to the presence of a qualifying reason for use.

It is also important to recognize the gap between choosing to use cannabis, recreationally or medically, and choosing to become an officially registered patient through the state. There are two decisions here, but they are often treated as one. Patients who are legitimately qualified and decide to use cannabis may still choose not to register with the state. Cannabis remains widely available on the black market, allowing other options. However, accessing marijuana outside of the system relies on networks, and some patients reports make it plain that they simply do not have resources to make this a viable option.

Also, registry cards are renewed annually, so patients have the opportunity to change their minds about participating in the system. Some feel that the first entry means they are “already on the list,” but decisions to exit the system are also often based on perceived changes to risk based on the rules by which the system operates, which may include changes to fees, or other changes to the law. All but one patient in this study said that, now knowing how cannabis can be used in their medical treatment, they would not stop using it, even if the laws were rolled back. The system has often connected patients with others in the system and also given them opportunities to learn more about cannabis, and many take measures to ensure they could be self-sufficient by growing should the system fail.

Many patients base their registration status on a refined assessment of legal risks and vulnerabilities, or on the sense that the cost to participate in the system is reasonable and fair,

beyond their ability to qualify. With the passage in 2012 of Amendment 64, which legalizes all adult use in Colorado, the boundaries and incentives related to participation in the medical program will inevitably change. Boundary issues in the medical system may become less important to the public. Access also removes much of the incentive for nonmedical users to pursue a medical designation, and may make other questions related to medical legitimacy less relevant, while foregrounding other issues about public health such as driving issues and controls over public use, which is prohibited, as well as ensuring that cannabis is not diverted or accidentally given to children.

Once patients gain access as legitimate patients through the doctor evaluation, use is predominantly self directed and managed independent of medical advice or oversight. Colorado patients resemble other states, and even other societies, in this respect. Patterns of medical use in everyday life have similarities across settings. In this way, knowledge about how patients utilize cannabis includes some elements that rely on specific organizational structures, but also transcends the specific system. The next chapter will address use in everyday life.

CHAPTER 5: Medical Cannabis Use in Everyday Life

After patients receive a physician's recommendation, their interactions with the formal system of medicine are largely complete. Routines of medical cannabis use are typically self-generated, self-managed, and self-regulated, a quality they share in common with many forms of complementary and alternative medicine (CAM) (Chapkis and Webb 2008; Ruggie 2004). However, medical cannabis use also has dynamics that are unique from CAM. The prominence of marijuana's nonmedical, recreational use, which remains subject to criminal penalties, overshadows and muddles its interpretation as a medicine. The incomplete medicalization of cannabis affects patterns of patient use. Because cannabis has not been fully incorporated into mainstream biomedicine, patients typically work out how to "medicalize" their use of cannabis independent of specific medical advice.

This chapter looks at how medical cannabis patients use cannabis in everyday life. To date, no studies have examined how patients utilize medical cannabis within Colorado's system, and few have provided in-depth information about how patients engage in medical cannabis use, or considered this use in the context of incomplete medicalization. In this chapter, I draw from classic sociological literature on recreational marijuana use by Becker (1953) and Zinberg (1984) to outline the effects that medical reframing has on use behaviors and interpretations of cannabis's effects. Reframing cannabis use extends beyond simply renaming "getting high" to "medicating." It changes how individuals use cannabis, including the form in which cannabis is used, the method by which it is consumed, the amount consumed, the context in which it is consumed, and the expectations and outcomes attached to use.

These medical behaviors take place in what Britten (2008) has termed the “popular sector” of self-care. Understanding how individuals make decisions about self-care may be one of the most important yet unexamined aspects of health today (Goldstein 2004; Hughner and Kleine 2008; Vuckovic and Nichter 1997). According to distinguished health researcher Michael Goldstein (2004) and others (Dean 1989; Vuckovic and Nichter 1997), Americans treat between 70 and 95 percent⁵ of all illness episodes without seeking formal medical care. Self-care draws on resources in the lifeworld and incorporates the domains of meaning that abide in the lifeworld (Britten 2008). Lay beliefs are not just “watered down” versions of expert beliefs, but incorporate other dimensions (Hughner and Kleine 2008), including normative life course expectations, and balancing the effects of illness with the effects of medicine in a way that prioritizes the ability to function as “normally” as possible in daily life (Britten 2008). Much care in the popular realm is based on naive theories of health, the body, and its functioning, favoring pragmatism over system imperatives that require scientifically rigorous evidence. Individuals often pay little attention to contradictions between different health philosophies (Backett 1992; Beck 2007; Kleine, 1999 #1112; Hughner and Kleine 2008; Turner 2004). Studies on self-care suggest that individuals seek healthcare options in a way that favors minimal interventions, more natural forms of care, and the ability to exercise control (Britten 2008). This chapter extends the understanding of medical cannabis as a self-care practice. It complements survey studies and ethnographies that have begun to describe medical cannabis use in other locations (Ogborne et al. 2000a; Reiman 2006; Reinerman et al. 2011; Swift et al. 2005).

INTERPRETING CANNABIS EFFECTS

As a drug, cannabis produces a predictable range of effects, but the interpretation of these effects matters. Becker’s (1953) now-classic article, “On Becoming a Marijuana User,” captured this labeling and learning process. Based on 50 interviews with marijuana users in the

⁵ According to Goldstein (2004), this figure has been consistently supported by a vast amount of empirical work using different methods and measures.

1950s, Becker outlined the process by which individuals learned the routines of use associated with the recreational marijuana consumption. New users not only learned from other more experienced users how to smoke cannabis, and how to gauge the right amount to smoke, but they also learned how to interpret marijuana's bodily effects as a recreational pleasure. According to Becker, users learned to discern bodily sensations and label them "getting high." The sensations associated with consumption are not automatically pleasurable; while new recreational users enter the experience with an anticipation of enjoyable effects, not all users will come to interpret the experience in this way. As Becker explains, continued use relies on a perception of enjoying the effects of cannabis, but this is related to the ability to gauge and control dosage so that the substance's effects are noticeably felt, yet not so intense that the experience is unpleasant. In a later article, Becker (1973) points out that "what a person knows about a drug influences the way he uses it, the way he interprets its effects and responds to them, and the way he deals with the sequelae of the experience. What he does not know affects his experience, too, making certain interpretations and actions impossible" (26). The overwhelming predominance of recreational framing around cannabis use has encouraged individuals to interpret cannabis use in one way and to one purpose. This interpretation emphasizes the immediate sensory experience, but it has obscured connections between cannabis use and medical or health-related outcomes that one many only realize when they shift their outlook.

Zinberg (1984) built on Becker's understanding. He looked at the use of marijuana, psychedelics, and opiates for recreational uses through interviews with drug-using subjects. He proposed that drug experiences are created from a combination of "drug, set, and setting." According to Zinberg (1984), drug effects are not fully determined by the drug itself, but always involve interpretation. This is true of the effects of all drugs, whether they are used for recreational or medical purposes. Drug effects rely not only on the drug itself but on "set and

setting.” Zinberg defines “set” as something akin to “mindset,” or in other words, the characteristics of the consumer. In his description, Zinberg includes enduring qualities such as personality and physiology, and more ephemeral aspects of psychological and physiological state, such as the mood the person is in, or whether they have recently eaten. “Setting” refers to the social context. Again, this concept incorporates a more enduring frame of cultural meaning and an immediate sense of the term based on the imminent circumstances surrounding use. Zinberg (1984) referenced the phenomenon of “placebo effects” as an illustration of the powerful role played by the drug consumer in influencing drug effects. The user’s interpretation affects not only the immediate experience while taking the drug, but may also affect its physiological outcomes. This chapter is structured based on Zinberg’s (1984) categorization scheme. It examines how each factor—drug, set, and setting—are modified when cannabis use is adapted to a medical context.

Models for Medical Behavior

Reinterpreting cannabis use from a recreational framework to a medical one happens at the individual level. Similar to Becker’s (1953) account on how individuals learn to use cannabis recreationally, patients often learn routines of use through others. This is also a model by which people learn to implement and assess various self-care health behaviors (Cameron and Leventhal 2003). For medical cannabis, information may come through medical marijuana centers, friends and family, or online networks. The widespread, socially approved model to claim cannabis use as a form of medical “self-care” is relatively new, leading patients to experiment in order to arrive at best practices. Even when individuals have used cannabis recreationally before and were accustomed to its effects, they still engage in experimentation when imposing new medical criteria for evaluation.

Medical cannabis routines are determined in the realm of self-care, where patients privilege lifeworld concerns. Because patients engage in self care within a medically pluralistic

environment, they have multiple models from which to draw in order to define “medical behavior.” They are influenced by models of pharmaceutical use from the formal sector of biomedicine and by therapeutic uses of other herbs or natural remedies from the informal sector of complementary and alternative care. As it is currently organized, medical cannabis spans the formal, informal, and popular sectors, and patients do not model themselves solely after formal or informal models for medical behavior in their routines of use. Instead, patients borrow from available resources across healthcare sectors, with little concern for contradictions in the theories that underlie treatments, and a strong reliance on pragmatic criteria for “what works” (Britten 2008). When cannabis use becomes a medical behavior, patients apply criteria common to other medical contexts. They apply strategies to minimize interventions while optimizing life functioning and “normality.” This includes minimizing health risks or harms that come from medication use. “Natural” treatments are seen as safer options with fewer side effects and lower risk from use over time (Britten 2008; Ruggie 2004).

Even though patient’s self-regulation is inherently social and relies on models from structured care, “individuals hold different views about their health and the nature of their health conditions than do their family members and the health professionals with whom they consult” (Cameron and Leventhal 2003). This is because individuals have access to subjective information about symptoms and emotional states that cannot be discerned by others (Cameron and Leventhal 2003). Patients may also link moral meanings to health behaviors or to health outcomes.

An intriguing 2008 interview study of CAM users by Bishop and colleagues (2008) found that CAM users report CAM use as a “treat,” and as a treatment. When CAM therapy is used as a “treat,” it is an enjoyable luxury not aimed at a specific health need, but often interpreted as an adjuvant form of care for wellness purposes broadly defined, especially as a form of stress reduction and relaxation. When CAM therapy is used as a “treatment,” the purposes include

alleviation, cure, or prevention of specific health problems. Even when CAM patient narratives identified one of these areas as their primary motive, they often shifted to include others fluidly (Bishop et al. 2008). This relationship between therapy as a “treat” or “treatment” was negotiated by CAM patients and in part determined by their own views of what medical reasoning was acceptable. While some saw “treat” definitions of stress reduction as conforming to the logic of medicine, others saw it more as a luxury than a health treatment (Bishop et al. 2008). Medical cannabis use also shows a spectrum of use ranging from a pharmaceutical type regimen to the spectrum of treat and treatment seen among CAM use.

ADAPTATIONS OF DRUG, SET, & SETTING IN MEDICAL USE

Reinterpreting Cannabis the Drug: The Expansion of Cannabis Formulations

Dale: Yeah, you know, it's not the pot of the 70s anymore, it's uh, it's come a long way, it really has. You know and there is medical stuff about it, because, you know, when I smoked a joint back 20-30 years ago, hey—this is some good Mexican. But now they got, you know, even strains that target certain symptoms. Like if you have muscle spasms, you're supposed smoke one strain. If you've got headaches, you're supposed to smoke this kind. You know, it's kind of neat, the way that it's come along.

The above quote from Dale captures the expression of many patients in this study. When marijuana transitions out of a black market and enters a regulated system, cannabis itself undergoes some important changes that should not be underestimated in their significance. Black market marijuana was by and large undifferentiated as a product. However, the regulated medical market has created many distinctions. Most patients have gained “lay expertise” in their knowledge of cannabis as a plant and learned about the expanded range of products available to them.

Cannabis has two variants: indica and sativa. These correspond to different effect profiles that have implications for social and medical uses. Indicas are associated with body effects and more sedate qualities, and Sativas are said to be more mentally stimulating, uplifting, and creative, but may also increase anxiety for some. Strains are often a cross of both subspecies, but some are well known by their variety name. Most patients in this study were aware of general and specific strain information.

As a substance, cannabis is also medicalized through the development of the plant's medical rather than its recreational traits. THC is the main psychoactive constituent of the plant, and has been the focus of the recreational market. In the medical market, other constituents of the plant are considered for their medical effects. In particular, the non-psychoactive cannabinoid, Cannabidiol, or CBD, has gained prominence for its health effects with no "high." Strains and products touting high CBD and low or no THC have been developed to offer whole-plant medicinal products that minimize or eliminate the "high."

Cannabis is a plant with natural variation, but the regulated market increases control over growing conditions that lead to plant material with greater consistency and safety as a result of food-grade gardening practices. Even as the number of products and strain options increase, these "products" become more internally standardized. New extraction processes capitalize on state-of-the-art labs and improved scientific knowledge about cannabis' biochemical properties to produce whole plant extractions with impressive levels of standardization approaching whole plant medicines.

Finally, cannabis is medicalized through the proliferation of standardized products that expand the methods by which cannabis can be consumed. Some of these products are familiar variations on traditional products. Hashish, infused oils, and tincture formulations have lengthy histories that predate the modern era, going back hundreds and thousands of years (Booth 2003). However, in combination with the other forms of medicalization—better information, knowledge of specific strains, improved consistency, knowledge about other plant components, greater product safety, and improvements in standardization—these products exist in updated and modernized versions of traditional products. From lozenges to lotions, beverages to candy chews, derivative products become standardized and the composition and dosages are better defined and included on product labels, allowing patients to self-monitor their dosage with more accuracy.

One product in particular, Phoenix Tears, is worth mentioning. This product is basically a concentrated type of hash oil, and it is typically available in a tube. It looks a bit like anchovy paste. This product was developed by Canadian advocate Rick Simpson, who also disseminates information on how to make it and offers a protocol for its medical use. Simpson's website features anecdotal accounts of great success in treating a variety of serious conditions including MS, cancer, Parkinson's, and Crohn's disease among others. Other publicity, including a movie about this product called *Run from the Cure*, has led to an awareness of Phoenix Tears among the medical cannabis community.

In the interviews for this study, I did not ask patients questions about specific cannabis knowledge, but over two-thirds of participants offered information about specific varieties and their sativa and indica contents. Another third mentioned the balance between THC and CBD, and just under one-quarter of patients mentioned Phoenix Tears. Over 80% of patients mentioned one of these factors or discussed a specific cannabis variety for medical use. In his recent study of 100 Norwegian medical marijuana patients, Pedersen and colleagues (2013) also found that medical cannabis users had knowledge about the cannabis plant, current science, and medical properties as well as physiological effects, and that these were more substantial among those patients with more serious medical conditions.

All patients had some familiarity with the ability to ingest cannabis using different methods, but medical cannabis users had different responses to the array of available products. Although they talked about cannabis in medical language, a significant minority had a Willie Wonka moment when they visited their first dispensary, and many compared it to feeling like "a kid in a candy shop."

Jason and Leo provide useful examples:

Jason: When I first got my card and I walked into a dispensary, any dispensary, it was surreal. It was like, is this really going down? Am I seriously standing here and this guy has got ten pounds of weed back there? Is this actually happening? It was totally surreal.

Many patients, like Jason, had a surreal moment when they first stood in a shop that sold cannabis products. Up to that moment, the changes to the law were largely abstract. Standing in a legitimate store that sells medicinal cannabis creates a disjuncture; it is a first glimpse into a new reality in which the laws take shape. In this moment, many people become a bit dumbstruck as they realize the mundane facticity of this change and see its “thisness,” its concrete existence, so long prohibited and hidden but now part of the everyday landscape. Among previous recreational users, the ideal of decriminalizing cannabis has existed mostly as a vague concept that they had never envisioned; for those with little experience, it is a strange new world.

However, as Jason points out, this feeling eventually wears off as the sense of something profoundly new transitions into a more regular feature of life. Most agreed that this sensation wore off within a time frame ranging from a few visits to many months but less than a year. At first, patients are often tempted to try everything, but patients often tire of this pursuit and end up identifying a strain or a product that proves medically effective for them, and interest in sampling new products recedes. Instead, the goal becomes to ensure that the specific product that works well for them is consistently available. Leo captures this sentiment well. A self-proclaimed long-time regular cannabis smoker, Leo, now in his 60s, is retired. He sought a medical card when a disintegrating disc in his back led to severe chronic back pain. When I ask him what he thought the first time he went into a dispensary, he says,

I was speechless. I was... Oh my God, ya know... I'd only seen stuff like this underground in Guido's trunk in the back alley up on the Hill and shit like that, ya know. It was amazing ... and... not only that, but they know the difference between sativa and indica, and what it does for certain diseases. Now I use indica because mine's a pain killer, that happy bullshit that you take and go to Woodstock with does not do anything except draw your attention to the pain. So the less THC in it the better, the more CBDs, the more CBNs the better, because it kills the pain.

Leo spent some time at this point in the interview recounting past recreational use of cannabis at length, including some memorable exploits from his early 20s. Like many patients, Leo clearly possessed a lot of insider knowledge and wisdom relating to recreational use.

Experiencing a legitimate cannabis store was an emotional experience that was linked to his recreational past, and the longstanding hope that the laws would change. Yet like many other patients, Leo very quickly shifted gears from recounting his emotional response to translating its relevance for his use of cannabis as a medicine. Leo and Jason were not the only ones to almost immediately realign their responses to a more medical outlook by shifting to a discussion about scientific or medical information about the plant and its derivatives. Many patients shifted flexibly between recollections of their recreational use in early adulthood to specific details about finding appropriate medical products currently on the market.

CHANGING THE SET: MEDICAL ROUTINES OF CANNABIS USE

When individuals adopt medical cannabis use, it engages many of the criteria by which patients judge other medicines or courses of treatment. Patients determine routines of medical cannabis use based largely on considerations and concerns of health that are grounded in the lifeworld. Patients experiment and establish routines based on the desire to “live a normal life and meet their social obligations” (Britten 2008:57). While medical systems often focus on symptom control and adherence, lifeworld considerations often seek to balance symptom management with the management of drug side effects to maximize functioning, or what Britten (2008) terms a “minimax” strategy. Patients often formulate their method, timing, and frequency of cannabis use to correspond to these goals, a strategy also used to manage prescription pharmaceuticals. Cannabis’s unique properties allow patients to treat the “high” flexibly. At one time, it may be a side effect to be minimized in order to avoid disruptions; at another it is desired, but in a way that is balanced with other medically beneficial outcomes to improve mood, creativity, or other perceptions of functioning and mental state. Sometimes it is an effect to be sought out and emphasized in order to best enjoy its enhancement to the senses. This section looks at how patients determine their routines of use.

Methods of Ingestion

Most patients experiment with inhaling and eating cannabis, the two most popular forms of ingestion. About two-thirds of the 40 patients in this sample consider smoking or the inhalation method called “vaporizing” as their primary method of ingestion. The remaining third report they primarily ingest cannabis through edibles or alternate between edibles and smoking. Nearly all say they smoke or vaporize occasionally. To arrive at their preferred method, experimentation is often involved. Patients try multiple methods and products to identify the best form for use. When use is framed as medical, it evokes a dialog about the health or harm from methods of intake. All patients mentioned health considerations as a factor when determining their routines for use.

A handful of patients reported universal dislike for specific methods, or cited reasons that some methods are not possible for them based on reasons other than medical effectiveness. For instance, Andy says, “I detest smoke. I detest smoking. Both my parents smoked [tobacco] and I hated it.” As a result, Andy avoids this method and relies primarily on edibles. Beth, a Jehovah’s Witness in her 60s, suffers from chronic pain as a result of injuries from a succession of accidents. Her religious beliefs prohibit her from causing intentional harm to her body. She only uses natural medicine. She accepts cannabis as a helpful herb, which enables her to use it, but she does not smoke it because smoking is harmful. Instead, she primarily uses vaporization. On the other end of the spectrum is Ken. Ken suffered a serious back injury resulting in damage to his spine. He says,

I pretty much can only smoke it. I used to be able to eat it and then for some reason I wasn’t able to. I’m thinking that’s because of the fat in the brownies and other edibles, because my gall bladder was removed. I’m hoping I can get back to eating it, but for right now, the only way I can use it is to smoke it.

Ken, Beth, and Andy illustrate the different constraints that limit some patients’ choices around medical cannabis use. Others begin with few limitations, but discover their preferences and dislikes through experimentation. Patients often base these evaluations on two criteria. The

first criteria is related to the aesthetic experience. Some patients found they really disliked the taste of edibles, for instance. The second criteria is about the perception of control. When patients report that they did not like specific methods, they often attribute their aversion to a lack of predictable results, which arises from difficulties with gauging dosage. Others liked the same methods because they had learned how to get consistent results.

Jason represents these concerns well. A GERD patient, Jason smoked recreationally for years. He is more comfortable with dosage control through smoking than with other methods. He tried other methods, but says, “I tried candy. It just tasted horrible. They’re awful. Then I bought a vaporizer because I heard that it was much better for you. But the vaporizer just, it’s way too powerful.” Jason’s exemplifies how both aesthetics and control affect patient choices.

For many patients, cost was also a concern. This was an especially important criteria for patients on fixed incomes, either due to disability or retirement, or based on budgets due to limitations in their ability to work. Smoking is widely considered to be the most cost-effective form of use. Plant material is cheaper to purchase than formulated products, and many patients claim that smoking stretches supply the farthest. Patients with more expendable income worried less about cost, but even they remarked on how expensive everything was at the beginning. Generally speaking, prices have lowered since the industry first emerged, but prices still reflect the risks and financial demands of participating in the industry, and can still be prohibitive.

Smoking. Even though smoking is commonly identified among physicians and patients as the greatest risk associated with cannabis use, it is still the most common method of use in this study and others (O’Connell and Bou-Matar 2007; Ogborne et al. 2000a; Swift et al. 2005). Many patients with significant past recreational use expressed sentimental attachments to smoking cannabis. Patients such as Brett, Dale, Eileen, Karen, Tim, and Jason were among those who said they still liked to smoke, often calling it “traditional,” or “old-school” to do so.

While some evidence suggests the risks associated with smoking cannabis have been

overestimated (ProCon.org 2013; Tashkin et al. 2005), concerns with smoking are a common theme across other medical cannabis patient studies. Smoking is arguably the most illicit, nonmedical “street” form used for many drugs—opium, cocaine, and speed have all been smoked in their recreational street forms. In addition, the easiest analogy is with smoking tobacco, which is now clearly understood to be antithetical to health, and is associated with enormous costs to public health. For these reasons, smoking on the whole seems incompatible with medicine, and in fact, may have influenced marijuana’s stigma greatly.

Even though many patients see smoking as a relevant concern, inhalation methods also have benefits that patients acknowledge. The main benefit is that smoking or inhaling produces immediate effects. This is useful feedback because it helps patients titrate medical and psychoactive effects. Additionally, patients with conditions such as migraines, nausea, and epilepsy benefit from a substance that can bypass the digestive system.

Many patients in this study were previous or current tobacco smokers. Cigarette smokers tended to worry less about smoking cannabis. They did not see it as compounding their health risks. Instead tobacco was seen as riskier, so it was the behavior that patients prioritized for change. Some expressed no intention to quit smoking tobacco, so there seemed little point in worrying about the dangers of smoking marijuana.

Surprisingly, patients in this study who had the least concerns with smoking were Devon and Aaron, both of whom were previous asthma patients. These patients were aware of studies that showed cannabis smoking had not been correlated with respiratory diseases. Both reported that their asthma stopped in their teen years when they started using cannabis, and never returned. They both attributed this directly to cannabis. Asthma is one of the few conditions for which inhaled medications are used, and this may help to more easily link cannabis inhalation with legitimate medicine. While attributions stopped short of seeing smoking as “healthy,” especially when compared with other available methods, patients often viewed it as less harmful

that it had been characterized in popular media, and also in relation to tobacco. Those who still engaged in smoking as a primary method often mitigated risks by using pipes or other forms of smoking that lessen the harshness on the throat and lungs. About a quarter of patients transition from smoking to vaporization, citing it as the healthier option.

Edibles. About one-third of patients in this study preferred edibles. This was often related to the type of illness or symptoms being treated. Effects from edibles are not as immediate as smoking or vaporizing. Their benefit is in their slow and steady effects, which suits patients who wish to maintain a steady level of cannabinoids in the system over time. However, because the effect is delayed, dosing can present a problem. By the time the patient realizes they have taken a stronger dose than needed, they generally have a longer wait for the psychoactive effects to subside than is the case when using inhalation methods. Patients most commonly reported taking edibles in the evening or just before going to bed, so they slept through the high. They also worked to achieve a specific milligram level of dosage that produced medical effects—pain control, tremor control, or seizure control—that lasted for an entire day without additional intake. In this way, edibles resembled taking a medication once a day before bed, and controlled symptoms with minimum disruption of productive daytime hours.

Mark is one patient who primarily uses edibles. He tried other methods, but found that edibles offered far superior control of his neuropathic pain. When he tried smoking, the effects weren't as enduring. Worsening symptoms caused disruption, but so did additional smoking since spikes in cannabinoids, introducing a "high" feel with its mental distractions and possible drowsiness. Mark likes edibles because the pain relief lasts longer and requires fewer interventions throughout the day. Prior to medical use, Mark was not a recreational user, and even though he does not dislike being high, it was not his primary objective. He and many other patients treat the high as a side effect to be managed in the course of everyday life. Patients may flexibly decide when it is a desirable effect to emphasize rather than downplay.

Like Mark, Julie uses edibles to control Restless Leg Syndrome, but her doses are heavier and she combines them with other methods. Restless Leg Syndrome is a neurological disorder that causes burning pain in one's legs and often interferes with sleep. For Julie, taking cannabis at night helped to manage both problems. Because Julie works as a teacher, the ability to treat her disorder at night but function normally without the need for other prescriptions or additional cannabis during the day helps her to maintain normal routines and fulfill her roles. Julie had initially been prescribed drugs for her disorder. While they worked to manage her symptoms, they caused side effects for which her doctor prescribed additional pharmaceuticals. When Julie reached three pharmaceuticals, she decided “no more.” She did not want to take that many medications; it seemed like a dangerous spiral to keep adding medications in order to treat side effects from other medications.

Julie has consistently used recreational cannabis since her teens, but her recreational use patterns and levels of intake did not control her condition. It was only after she tried high-dose edibles, often combined with smoking a bowl before bed, that cannabis effectively eliminated symptoms and allowed her to maintain an asymptomatic state. Julie's choice to use cannabis as a medicine for her condition also serves as a form of harm reduction, since she accurately perceives cannabis to be a much safer treatment for long-term use than the prescriptions. Even at high doses, she does not worry about overdose or harmful effects during sleep, and there is no “hangover” from use in the morning. Many other patients, like Julie, also saw cannabis as a way to reduce or replace prescription drugs. This was seen as harm reduction based on perceived relative dangers of drugs versus cannabis, and also as a way to reduce troubling side effects.

Like Julie and Mark, many patients benefited from a consistent routine, and often only discovered that cannabis could offer significant medical benefits after exploring different intake methods and amounts. Mark and Julie existed on opposite ends of the range of tolerance that people exhibit—both had to adjust routines to fit their tolerance and optimize their use for

medical purposes.

Others, like Anita, found that symptoms were not as easily managed by taking one large dose at night, but instead were more amenable to small doses spread throughout the day. Anita, the MS patient introduced in a prior chapter, is currently in remission from MS, an outcome she attributes to her medical use of cannabis. Directly after her MS diagnosis, Anita was overmedicated with prescriptions, and reported that she lived in an unpleasant state of mind with little quality of life or functioning. Anita had to adjust to the fact that her diagnosis meant lifetime management. She realized that the prescription medication was lowering her functionality, rather than improving it, and did not represent a long-term solution. She began to phase out medications, eventually phasing out every other drug, one at a time, except for cannabis. She tried to phase cannabis out as well, but when she did, her symptoms started to return. Of her routine with cannabis use, she says,

I don't smoke during the day at all. I just don't like feeling any level of high during the day. I like to be completely clearheaded and in control. So in the morning I have these little medicinal crackers. I pop three or four of them in the morning. They don't cause me to feel high, they don't cause me to feel intoxicated, but they do have a calming effect. Then at lunch, I will pop another couple of crackers. And then at night before I go to bed, I either smoke a little or vaporize a little bit before bed because that's when my symptoms are the worst, at night when I'm trying to sleep.

Mark, Julie, and Anita all used edibles in various ways—alone, with smoking, at night, or at intervals. These three cases also show how patients' decisions about medical cannabis are also considered in relation to experiences with prescription drugs. While they suffered from different conditions, all were managing chronic disorders that required long-term treatment. While Mark's prescription medications were not causing problems for him, they presented unacceptable long-term risks. Julie's prescriptions worked, but caused side effects that cascaded into more pharmaceuticals than she felt comfortable taking. For Anita, the experience was the most dramatic. The prescription drugs for her MS, in combination with the abrupt onset of her disease, brought her life to a complete halt, rendering her unable to fulfill work or family roles over an extended period of time. For her, cannabis turned out to be a path back to a normal life.

Anita transitioned her medical care slowly. At first it was largely pharmaceutical but by the end, it was largely based in self care. This in part reflected a change in her understanding that the problem was not acute but chronic, and required approaches that looked at the big picture and the long term. She added self-care regimens including diet and exercise routines that helped her manage her disorder. Now in remission, it would be nearly impossible to identify her as ill if you did not know her personally. Other studies on medical marijuana patients found similar patterns among preferred methods (Coomber et al. 2003; Ogborne et al. 2000a; Reinerman et al. 2011; Swift et al. 2005).

Amounts & Managing Effects

In contrast to recreational contexts where the goal is often to overindulge, nearly all medical consumers report using small, controlled doses. Most worked to minimize the amount they used to the lowest level that resulted in medical effects. Small doses “suboptimize” the high. Patients develop tolerance, allowing them to adapt and function with little disruption from cannabis. The high becomes familiar, like background noise, that patients learn to integrate into daily life. This is not so different than many standardized prescription medications, where new drug takers experience initial symptoms of sleepiness or excitability from introducing a drug, but as their bodies adapt, the side effects often subside. The primary distinction may be in the unique mental effects from cannabis, and the balance required to manage a whole-plant based medicine that is not fully standardized.

This approach aligns with Britten’s (2008) account of how patients manage other types of medicines. Prescription drug users often try to reduce medication use to the minimal effective dosage. This approach to medications in general is often seen as “responsible” because it lowers risk of dependence, and minimizes side effects or potential health hazards. Patients also prefer to avoid complicated or demanding regimens, and minimizing interventions can help keep medical routines simple. Britten (2008) calls this a “minimax” strategy. In addition, medicine

takers often have difficulty separating disease or illness symptoms from drug side effects. They tend to experiment even with drugs that have specific protocols, tapering on and off of medications to see what illness symptoms return, or what symptoms turn out to be medication side effects (Britten 2008). This gives patients experiential information that can be useful if symptom profiles shift.

Many patients in this study expressed clear medical strategies that minimized the amounts of cannabis used and timed intake to work around other activities in order to maximize role functioning. Even though the high was considered a pleasurable effect at times by most, context mattered. Patients often work toward routines that give them the most control over the “high” effects. Some cannabis product developers understand this and have begun to create lines of products, such as CBD-only lines, that are meant to support such needs and goals of patients by minimizing the high so that patients have a greater buffer to manage effects.

As I explained with edibles above, patients who needed strong dosages to control or treat disorders often timed their intake at the end of the day. Many patients who smoked also waited for the evening to take a dose large enough to produce any psychoactivity. The reasoning given for this was often based on role functioning. Cannabis was best taken after work, parenting, or other activities that required focus had been completed. Across methods, a majority of patients reported this strategy for using cannabis. While routines of use were generally restricted to medical criteria, patients often blurred the line with use that could be considered “recreational,” because they were more likely to experience the effects with evening smoking. A handful of patients compared it with having a glass of wine after dinner. Interestingly, many patients did not enjoy alcohol, and saw cannabis as a flexible substance that could be used for similar relaxation purposes, but with less negative effects. A few patients with spouses reported that they would often join their spouse for a private nightcap where the spouse had a glass of wine and they had a puff of cannabis before bed.

Paul, a retired lawyer, suffered injuries as a college athlete. As he aged, these injuries developed into a severe back condition. He consulted with a top back surgeon, who said Paul's spinal stenosis could be corrected, but the fix would only be temporary. He was told that he would likely experience chronic pain, and would gradually lose mobility. He would probably be confined to a wheelchair within a decade. Paul sought pain management with his regular doctor, who prescribed Neurontin, but he found it to be "like somebody hitting me over the head." Other pharmaceuticals were no better. They were just too intense.

Paul had been a regular cannabis user in his teens, and still toked on occasion when cannabis was available at social gatherings. He liked cannabis and since it was legal to use medicinally in Colorado, he decided to give it a try for pain management. At first he smoked it, but he ended up finding that tinctures worked best for him. Around 5 o'clock every afternoon, Paul takes a dropperful of a standardized tincture that he purchases through his dispensary. He says,

I have titrated the dose pretty well so that amount doesn't make me stupid. I can still function pretty well and it lasts. It helps me sleep through the night, and the pain relief will last for about 24 hours, pretty close. So if I take it other than at that time, it's either because the pain is worse—I've been out shoveling snow, or something, so then I increase the dose, and sometimes I do get stupid. Sometimes if I'm going out to a concert, I'll have a little extra or take some along.

Paul has found a routine that works, and in many ways, he takes cannabis as he would a prescription drug. However, he admits that he likes to indulge in the recreational effect at times. Paul chooses when to ingest cannabis at a level that will produce a more pronounced effect for enjoyment, as a "treat." As with many patients, he also reports that cannabis is helpful for sleep. This was one of the most common non-qualifying medical purposes for which patients use cannabis. Paul characterizes the high disparagingly, as being "stupid." Most of the time he prefers to minimize effects. When I ask him about what he means by that, he says, "You know I don't want to be, pinwheels shooting out of my eyes every day." Most patients with serious pain conditions want to control pain so they are more functional, and often the preferred result is to

be out of pain with as few other side effects as possible.

Patients also reported many types of dosage measurement techniques, from carefully measured capsules employed by Lance, to Gary and Arthur's use of a designated small measuring spoon to parcel out the day's set dosage of plant material, to reports common among women such as Eileen, Karen, and Carmella of using a small-capacity pipe or vaporizer to limit the plant amount used, accompanied by taking only small hits until symptoms were managed. Neil also counted vaporizer puffs and says he did not hold in his breath for medical use, whereas he might increase the amount of hits he took and how long he held it in his lungs when he desired a stronger, recreational effect.

Concerns with functional ability and dependence were salient in patient's descriptions of their use routines. Frank is in his late 60s. A retired professor, he has a flair for the artistic and the entrepreneurial, and has helped to build a small but successful specialty software company since entering retirement. He has advanced stage cancer and is using chemotherapy treatment. He says that the chemo has aged him in ways that are still challenging to adjust to, despite his weathered face, he looks youthful, energetic even in his t-shirt and jeans. Cancer and chemotherapy is a huge imposition on functioning that has forced Frank to adapt. Because he has already been through a round of chemo, he knows that there are days when he will be highly symptomatic and other days when he will not have energy. When I ask about his routines of cannabis use, he says:

Frank: It depends on the day. Today is a do-nothing day.... that's why I scheduled you today.

Me: So [your use] depends on how you're feeling that day?

Frank: And what you've got to do, how you're feeling, and I mean, some days, you're just going like, I don't want to do anything, so I'll just go to the garage [where he smokes marijuana] early." Usually I try to stay [working and not take any cannabis] until three or four o'clock in the afternoon and sort of pick it up then, because that's kind of shut-down time on whatever I could do that day.

Frank's routine attempts to balance the effects of cancer, the effects of chemotherapy, and the effects of cannabis such that his use of cannabis begins earlier on days when chemotherapy has already limited his ability to work or think, and he needs more symptomatic

control from increased nausea or exhaustion. He also points out that sometimes it is impossible to separate the effects between everything clearly:

You don't know whether it's the marijuana or is it the chemo, but I found that chemo brain is really a real side effect. You have a hard time reading, a hard time comprehending, you have a hard time doing a lot of stuff... if you don't make a list every day and get it crossed off, then you will tend to not get a lot of stuff done that needs to be done. I try to get up early in the morning when I'm fresh and make a list of what I'm going to do today, then try to get that done, and then I'll feel like I've had a good day if I can cross a few things off the list.

Frank's description really shows the priority given to functional ability. In her study of terminally ill medical cannabis patients in California, Chapkis (2007) found similar results, a finding she put in the context of productivity and the stereotypes of "amotivational syndrome," also discussed in chapter 1. She found that many seriously ill patients found that far from being amotivational, cannabis often "enhances one's ability to function in the world," running counter to popular culture's amotivational narrative (449). Rather than being absolute, marijuana's contribution or detracting from functioning is a matter of context.

Not all patients followed the same routines. Just under a third of patients said they took cannabis first thing in the morning and used it in small amounts to control symptoms throughout the day. Others simply took cannabis as needed and did not use it daily. Eileen and Karen, for instance, both suffer migraines. They reported smoking cannabis when they sensed a migraine coming on. Similarly, other patients with conditions that varied in pain level or only involved intermittent symptoms did not form daily use habits but instead gauged frequency of use based on the need to control symptoms.

Patient reports suggest that those with more serious progressive conditions, or multiple serious conditions, tend to take medical cannabis with more frequency and consistency, and enforce their routines with more rigor than those who had conditions with intermittent symptoms, or that varied in pain levels on any given day. When patients treated cannabis as a palliative analgesic used to reduce pain from injuries or surgeries, their use seemed to correspond more closely to forms of self-care, such as taking aspirin, or with CAM routines,

which are often driven by patients perceived needs based on symptoms. Aside from migraines, this might be used to increase appetite, reduce nausea, or eliminate or reduce other types of pain.

While CAM or self-care is more fluid and driven by the patient's perception of need, many biomedical routines require stricter adherence to be successful. Those with serious progressive conditions used cannabis in a way that more closely mimicked pharmaceutical medications. These uses were more likely to be seen as a way to treat or even potentially cure a disease. When using cannabis with curative or ameliorative goals, relaxation or symptom relief may be experienced, but patient use is less linked to expectations of a pleasant experience. Whether they want it or not, and sometimes they say they do not want to take it, they still do in the service of a larger health goal. In this way, it shared with biomedical treatments a sense of unpleasant necessity that needed to be taken regardless of current experience of symptoms.

Ron takes Phoenix Tears as his sole treatment for cancer. He has no other form of health care. Ron is relying on Phoenix Tears to control the spread of his cancer, and to potentially cure it. His decision to follow this protocol is based on newly emerging scientific research that show cannabinoids can induce a form of targeted cell death known as "apoptosis" (Guindon and Hohmann 2011; NCI 2013). This is also backed by anecdotal reports. Ron has conducted research to formulate his routine. At first, he knew almost no one who could help him, but he met a few cannabis specialty physicians who are knowledgeable about the science on cannabis and cancer and know about Phoenix Tears as a treatment, and he occasionally consults with them informally.

Ron: I had a 60 to 70% chance to live eight years. The nature of the disease is that when it goes from chronic, whatever that is, to acute, there really isn't anything they can do. They say that they will aggressively treat it. I have cancer in my whole body—how are you going to treat it? I'm treating it [with cannabis] at the cellular level. I'm telling each cancer cell in my body to kill themselves! Without collateral damage from chemotherapy and radiation.

Ron's estimation of cannabis as an effective medicine rests primarily on its ability to help

him beat cancer, but is enhanced by its long record of safety, and its lack of “side effects” beyond the high itself, especially in comparison with chemotherapy, which he calls poison and says he would refuse. As he puts it:

Ron: I don't have to take something else to counteract what this is doing. You know, this, this uh... There's no harmful things going on in my body as a result of marijuana. Marijuana is benign, it can't hurt you. It can't hurt you! There are experiences that you can have with marijuana that will (he pauses and chuckles), that you go through when you do the [high level] dosages that I'm doing. You just have to graduate to it. And the level that I have in me, you know, is, I can't get down off of the level that I have now or I start going back into the symptoms, and it's not a very pretty thing to have happen.

Me: Do you have an intense psychoactive effect?

Ron: No. I don't even get high anymore. The nature of cannabis, of THC... is the body has dosages that are—it's not exactly saturation, but it's like, when it gets to a saturation point, the body itself goes into a chemical reaction that transforms the [THC] from a tetra-delta 9 to 11, and tetra delta 11's properties work against the psychotropic effect. You can't get stoned anymore. You can't get stoned.

Ron's experience also brings up another important factor that is often overlooked in public dialog. Cannabis has its own pattern of tolerance. As with many other substances, the “side effect”—in this instance, the state of being “high”—tends to diminish when cannabis is used at the same dosage over time, but effects easily return when use is discontinued for a time and then resumed. While recreational users may want to avoid developing a high tolerance so they continue to experience the high more profoundly, medical users often rely on developing a tolerance from regular use, because it allows them to use cannabis to control symptoms with significantly less disruption.

Ron claims that he cannot get “high.” He uses a sophisticated, scientific argument related to marijuana's biochemical properties and its transition in the body to a metabolite, which reflects his intensive lay education about his treatment. It is unclear whether his subjective sense would match others' observation of his behavior, and how either of these would correlate to a physiological observation of effects on this patient's mental functioning, but from a sociological point of view, it harkens all the way back to Becker's (1953) description of marijuana use and the importance of subjective interpretation to the experience of the high. Chapkis and Webb (2008) and Coomber and colleagues (2003) also found rhetoric among interviews with patients in which a significant minority reported the lessening or abatement of the “high” effects

altogether, usually after a few months of consistent dosage. Patients claim habituation to effects that were at first intoxicating, although it is impossible to tease out exactly which part of this is physiological, interpretive, or rhetorical. However, widespread reports of this type suggest that patients who adopt medical behaviors of use, in which the high is not the top priority, often learn to mitigate these effects considerably.

“Off-label” Medical Uses

Nearly all patients in this study claimed to use cannabis to treat conditions other than those for which they were deemed “qualifying.” This finding also conforms to findings in other research, both in the general sense that patients in other studies have reported “off-label” uses, and more specifically that patients across studies report using cannabis medically for many of the same non-qualifying conditions (Aggarwal et al. 2012; Chapkis and Webb 2008; Reiman 2007). Unapproved uses of medical cannabis included headaches, insomnia, other types of pain, and digestive issues. However, the most significant off-label use of cannabis is for the treatment of mental health conditions, especially anger, depression, severe anxiety, post-traumatic stress disorder (PTSD), bipolar disorder, and attention deficit/hyperactivity disorder (ADHD). For patients who use cannabis for mental health, the high might not be as separable as a “side effect.” Often a mental shift is a desirable effect when affecting mood or focus are the goal. The consideration becomes more concerned with producing the most lucid and least disruptive mental effects to accomplish the desired goals. This can sometimes be accomplished by selecting the best strains of medication that give the best lucidity and uplifting effects. For conditions that require consistent treatment such as PTSD, cannabis might be treated similarly to those who were treating serious physical conditions. Patients adopted consistent routines of use, regardless of current symptom status, to mitigate the onset of PTSD symptoms. Others with more episodic bouts with depression, anxiety, or—for a few men in the study—anger, use as not in a routine but was as-needed similar to episodic physical conditions such as migraines or pain. Mental

health uses mirrored physical health treatment routines in this respect, but sometimes with a different interpretation of the role of the psychoactive effects.

Lance is an example of a patient who uses cannabis for mental health reasons. He is managing a traumatic brain injury, but has also suffered with severe PTSD. A young, highly decorated military veteran, Lance had never used cannabis at all before his medical use. As a medically retired soldier, Lance retains his appreciation for preciseness, a quality he applies to his routine. Lance's primary method of ingestion is hash oil capsules. Rather than spending a premium for prepackaged capsules, he buys the hash oil and gelatin caps, and then packages the capsules himself at his set dosage. He says, "I take it in the morning and I take it at night. Just one pill. They're premeasured out so I know exact dosages. I keep a log of what I've done so I don't make myself sick or give myself diarrhea."

Although Lance has adopted a strict medicalized regime, even going so far as to take cannabis in a pill form, he is one of only a small group of patients in this study who claims that marijuana has never had a psychoactive effect on him. He does not know for certain why, but he theorizes that it is either due to his traumatic brain injury or perhaps due to other antidepressant prescriptions that he takes. Because Lance never experimented with cannabis recreationally, he has no point of comparison that can help him determine the reason.

While Lance's claim to have never experienced psychoactivity from cannabis, Carmella does. Carmella's story began in her early 40s. She was working as a stocker in a big department store, and noticed a burning pain in her extremities that intensified until she finally decided to see a doctor about it. Carmella claims that she was prescribed very high doses of Gabapentin, a drug used for some forms of neuralgia and seizures, and it induced bipolar disorder, which is now irreversible despite discontinued use of this drug. She had many difficulties after this diagnosis, and was ultimately found to qualify for disability by the state. Carmella lives in northern Colorado with her adult daughter, who is also disabled due to a seizure disorder. They

are on a very tight budget and have no car. Carmella only recently applied to register with the state after her neurologist recommended cannabis for her. Since her problems began, she has also developed severe anxiety, which also limits her mobility around town. She is still working out her routines for marijuana use, but she has found that it greatly assists with the anxiety problems.

Carmella: I had anxiety really bad, and they don't prescribe marijuana for mental illness, but since I had the pain, they could prescribe it for the pain and it helps with the anxiety.

Me: How much does it help. Like if you were at a ten, anxiety wise, how much would it help in controlling that? Does it just lower it a little or take it away?

Carmella: It takes it away completely, because I can... catch it in my head before I have a panic attack and stop the panic attack. And only because I'm stoned am I thinking that way. You think different when you're stoned.

Me: How do you think differently?

Carmella: I'm just more aware of things when I'm stoned, and I'm not so—I'm not so stressed out about what I'm aware of.

Carmella does experience the high from cannabis, but for her, this is the part that is helpful, and it is a better state of mind than the anxiety. Rather than attributing the lack of anxiety to cannabis, she sees cannabis as giving her the ability to control or stop the symptoms herself. At a later point in the interview, Carmella says that she used cannabis regularly as a teen before her daughter was born and that part of her life was filled with good memories of the years before her mental health problems started. Cannabis, she said, makes her feel like herself as she was back then. The mental state is like a memory of an earlier version of herself, before she suffered from anxiety, and she also finds this connection to be helpful now in lowering her anxiety; it connects her to a less anxious version of herself.

Patients' experiences of medical cannabis use, tolerance, and the role of the "high" are based on multiple factors: the method, timing of intake, consistency of intake, the disorder from which they suffer, and their sensitivity to marijuana's effects. Many patients were able to find an optimal dose in which the high was diminished but the medical effects were still experienced.

Applying Medical Models across Drug Types

In my interviews, I noticed that a small subgroup of patients reported prior use of other

drugs, or current use of alcohol in ways that I at first struggled to understand until I realized that some patients define drugs very flexibly and may use any drug, licit or illicit, in ways that conform to medical behavior. This trend was also noted by Reiman (2006), who reported that most research on this phenomena has interpreted such drug use as a way of treating emotional or psychological pain rather than physical pain or as a type of coping mechanism. However, while an association had been found between other illicit drug taking and unmet mental health need, this association was not present with recreational marijuana use (Reiman 2006). In general, studies have found that those who used alcohol and recreational marijuana at more consistent levels were also more likely to self-medicate, or to rely on treatments in the popular and informal sectors, than those who did not use alcohol or marijuana.

Patients reported past use of recreational drugs that varied from none at all to extensive experimentation with all recreational drugs. No one reported current use of illicit drugs, and a majority reported that they did not drink. Some patients had experienced dependence problems in the past due to recreational drug use; others had experienced dependence problems or severe side effects from prescribed pharmaceutical drugs. It seemed that some patients did not draw clear lines between drugs based on their classifications that conformed to the either criminal or medical institution's definitions. Medical behavior meant more than medical classification—just as people could misuse prescription drugs for recreational purposes, occasionally, people used illicit drugs in ways that conformed more closely to medical behavior. One such as Arthur. Arthur is a gay man in his late 50s. He has HIV/AIDS and also suffers from a series of other chronic pain conditions. Arthur tells me that he served in the army straight out of high school, a tradition of service that was common among his family members. While in the service he experienced two vicious rapes by other men in his company, and these events in many ways overshadowed the rest of his life. He reported the incidents to his superior, who basically implied that he deserved what he got and did nothing to help him. Arthur said he had dreams

about his future career in forestry before that event, but after that, his dreams left him: “When I went into the military I had a set vision of what I wanted to do... but after getting raped in the army, I came out not knowing—I had no sense of direction. I had no self-worth, no self-anything.” For decades, Arthur never told anyone about this, even as it defined many things about his life. He abstained from sex for a long time, and says, “it wasn’t until I started doing drugs that—especially acid—that allowed me to allow someone else to touch me. I wouldn’t let anybody touch me. Even my sister and niece.... And taking the acid made that all go away.”

Arthur says that he spent the next 20 years taking LSD every day. He set a dose and never increased it. I asked him if he was hallucinating every day and he says “No, not at all. The sun was shining, everything was. I was happy.” He took it every morning with his coffee, “just like a vitamin,” and no one in his life was the wiser. Arthur says he did not feel he was addicted to it because he could stop at any time, but he didn’t because,

I didn’t want to go back to where I was before, how I felt before. This was keeping me from being there. I had times in my dreams, they [the men who raped him] were there. But it kept me from thinking about it all the time. It kept me from not letting myself feel it. It wasn’t until [a few years ago] that I finally, it just all came out [about the rape]. Because I hadn’t let it come out. I just—couldn’t do it. So [two years before I said anything], I stopped taking LSD, and then [two years later], that’s when it all came out.

Arthur ended up telling his doctor during an appointment. To Arthur, LSD had allowed him to live with the trauma he experienced, connect with others, and have romantic relationships, something that he felt would not have otherwise been possible. His use lacked social context but was taken alone, and he told no one about his use.

Arthur’s situation is more extreme than others reported, in duration and in the symptoms he was attempting to self-medicate to treat. However, others such as Carl and Leo, both reported using alcohol in combination with Advil or other pain medications to manage severe chronic pain. Both reported drinking specifically in response to physical pain, in an effort to numb their attention to the sensation. While Arthur perceived his LSD use as presenting few issues with harm or dependence, Carl, who has major back issues and is in recovery from kidney

cancer, knew that it was not beneficial for his overall health or for his specific condition, to drink. He says, “I never really drank until all of this started, but then I started drinking quite a bit of whiskey....Lots of stress, you know? And to be able to take your mind out of the loop, so you can actually get some rest and have a little peace of mind, which is kind of hard to say when you’re drunk, but it just takes away a lot of stuff, so, not like—in you know you’re not supposed to mix pain pills with alcohol, but when the pain is intense enough that you’re screaming, you need to do something.”

Carl said for a while, he drank two or three “strong drinks” of whiskey daily. He knew in the long-term that it was terrible for his kidneys, and he acknowledges that it can even present immediate dangers when mixed with pain pills, but the experience of pain can be a convincing argument that leads individuals to make self-medication choices that doctors or family would not be likely to endorse. Carl qualifies that he has recently cut back and is only drinking at most every other day now, but he makes a point of saying that he was not a drinker before his health problems, and in his current state of recovery, he almost never goes out or drinks with others.

Finally, Carmella reported beginning use of meth after pharmaceutical drugs prescribed at high doses to treat severe neuropathic pain induced irreversible bipolar disorder. After this occurred, her doctors changed her medications several times, but she was allergic to some drugs and it took some time to find a regimen. She took prescribed Oxycontin, but she found that it kept her awake and instigated a manic state in which she had difficulty coping. While she has been on many heavy hitting pharmaceutical drugs, she had only smoked marijuana during her teen years before her daughter was born, and had not tried it again until very recently when she became a registered patient. When she mentions prior experiences with dependence, I ask her what she was dependent on, she admits that meth was her drug of choice. She quit using meth two years ago, but says that she still craves it. Carmella has severe anxiety, so her adult daughter, with whom she lives, came to the interview with her. Of her meth use, Carmella says:

Carmella: That started after the Neurontin made me feel bipolar. Because I started doing meth and the meth made me feel normal. So I was self-medicating with the meth.

Me: Did it become a problem?

Carmella: Yeah, it got out of control. It was getting high for high's sake and it was out of control.

Although Carmella and her daughter's husband used meth, the daughter did not. Since Carmella had quit over a year prior to the interview, I asked how she had quit. She says that one of her parents died, "And I had a total breakdown. I went to see the doctor. And when the doctor came in and asked me how I was doing, I just started crying and telling him how I was doing, because I was falling apart. And he told me to calm down, that I was bipolar. And he said it was because of the meth that I was [bipolar], but I know it was because of the Neurontin, because that made me feel it, and it was first [she was taking the Neurontin when she developed the bipolar symptoms, and the meth use came later]."“

Carmella knew that meth was terrible for her health, strongly addictive, and completely inappropriate as a medication. However, she also had first-hand experience with the fact that many perfectly legal, prescribed drugs also present dangers. She attributes the poor judgment in choosing to use meth to her altered judgment due to her mental health issues. The context of use, though still in her own private residence, included others and blurred with a recreational mood and setting. It was the phenomenological experience of being restored to "normal" that led her to use meth and to call that use "self-medication." She still regrets using it in this way because of the toll it has taken on her health, and the sense of craving that still requires discipline to avoid a relapse.

Taken together, these examples show that patients' subjective, bodily experiences may lead them to engage a different logic than another person would recommend in the situation. The formal sector imposes stringent boundaries between medication and nonmedical substances. Expert knowledge and professional experience is meant to allow physicians to give patients appropriate amounts of drugs and monitor their uses such that they help to resolve

illness without creating additional problems. Regardless of the medical status of a drug, all substances can be used by patients in a way that resembles medical behavior, and the distinction between these drugs is not that licit drugs are safe and non-addictive while illicit drugs are not. At least based on Carmella's claims, prescription drugs are responsible for a devastating long-term condition. Patients may engage in a different calculus of risk to reward, and give much less heed to a drug's formal status if, at the practical level, it serves a purpose that has gone unmet. As the next chapter will elaborate, medications, treatments, and health behaviors are not synonymous. Patients may think more along these categorical lines in lifeworld determinations about drug use, while "system" logics rely on different categories based on other evaluative criteria.

Although not all patients might engage in medical behavior with relation to other recreational substances, these cases serve to emphasize the critical importance of patient mindset and their adoption of medical behaviors. This is an important way in which patients participate in medicalization processes. It could be argued that many drugs have the potential to be used in medical or nonmedical ways, and for some drugs such opiates, one of the main differences between its licit and illicit forms may be more with the user's choices than with the drug itself. However, other drugs have more clear lines between their medical drug form and their street form, including the appearance and name. Even as whole plant medical formulations of cannabis begin to create important distinctions between cannabis the medicine and cannabis the recreational drug, at this point, they can also still be identical in form and appearance. Much of the public may not realize the quality or formulation differences currently taking place in medically regulated markets like Colorado. With no clearly visible distinctions in name or formulation that is recognized by culture, individual behavior becomes paramount for defining cannabis use as medical or social. However, as the next section on setting will point out, such distinctions are not always as simple as they sound.

CHANGES TO SETTING

Zinberg (1984) theorized that a drug's effects are determined by the drug itself, the "set," and the setting. Thus far, I have described ways that cannabis as a drug has been adapted from its typical recreational forms to formulations that are meant to align with medicinal uses. I have also described several ways that the "set" of the individual is changed, when individuals change their routines of use to reflect medical goals. The last category that defines the effects of a drug, according to Zinberg, is "setting." Setting can be thought of in an immediate sense and in a larger contextual sense. Because medical use routines are largely determined by patients, the immediate setting in which cannabis use takes place is an important cue that is used to distinguish recreational and medical uses. Perhaps one of the biggest changes to routines of use is that medical cannabis users engage in use alone, by themselves. For most patients, this one criteria largely defines the difference between medical and nonmedical uses. The discussion of using cannabis alone and with others blends naturally leads to the distinctions patients make about their own use as medical or recreational.

Beyond the clear significance of individualized use, I also propose that "setting" encompasses a broader context, and parlays directly into the significance of the life course. Most medical patients had seminal experiences with recreational cannabis use in their teens, or decided not to use cannabis recreationally in their youths. Life course very literally changes the setting in a broad and all-encompassing sense. As Settersten (2004) explains, "lives are socially structured," and age matters as a "social phenomenon" (2004). Life course helps to define the salience of recreational or medical frames, and it affects the meaning of those frames. Aging creates differences across the life course in terms of focus on health and the sense of age-appropriate leisure activities. Individuals at midlife are generally expected to be in different social roles than they were in their teens, which also means many other aspects of setting have likely changed, possibly including how one understands their own identity in the context of their

roles, and the experience of their own bodies. These changes offer a new vantage point from which to interpret cannabis use. Finally, life course consists not only of age, but is related to cohort effects—what was going on in the world at specific ages, and how whole peer groups experienced the world at specific ages. For those currently in midlife, attitudes about cannabis are often grounded in youthful experiences, and cultural ideas at that time.

First I will address the immediate changes to setting, and then I will turn to the larger change of setting related to life course.

Using Cannabis Alone

Aaron is in his early 30s. A cannabis user since his early teens, Aaron says he went through a phase of heavy cannabis use when he was young, then naturally transitioned into a casual cycle of cannabis use over his adult life. As a recreational user, Aaron would go through periods when he would smoke a few times a week, and then segue almost accidentally into six months where he didn't consume any cannabis at all. In 2005, Aaron was in a serious car accident that left him with chronic pain from back and neck injuries. After this accident, he noticed that he had started using cannabis more often, in part because he just felt better when he did—it lowered his pain, put him in a better mood, and improved his sleep. In 2008, Aaron sought a recommendation and became a patient under Colorado's system. Despite his significant history of recreational use, he says, “ I never even smoked alone before I got my card.”

While most patients report recreational cannabis use as a social activity among friends, often becoming more and more associated with special occasions as one ages and social use is less common, patients typically engage in medical cannabis use by themselves. This one factor is often used to help define differences in recreational and cannabis use. Medical uses of cannabis were regularly attributed to the setting, which was intimately connected to the motivation or purpose for taking it. Ingesting cannabis alone, often timed around other role requirements such

as work, parenting, driving, or simply daytime productiveness, helped to define the setting as intended for “treatment,” rather than as a “treat.” Medical routines of use change the setting by largely shifting cannabis use from a group activity to an individual one. It was when patients departed from their set routine of medical use, especially when this involved using it with others, that setting was used as a marker to help define whether use was medical or not.

Setting and the Distinction between Medical and Recreational Uses

Cannabis use, writ large, has medical and recreational uses. At the organizational level, these differences have important consequences for how cannabis is researched, what products are developed, and for where cannabis appears in society. However, at the level of the individual and each specific instance of use, the boundaries between medical and recreational use begin to blur and break down. Once patients understand use as being not harmful, and maybe even as being healthful, that understanding often carries across all uses, regardless of the reason. Similarly, even when use is to mitigate pain or other symptoms, there is no clear line that can distinguish the difference of relief of pain and pleasure—these become two sides of the same coin.

Some patients define recreational use as any deviation from routine, or any increase in dosage meant to enhance the psychoactive effects. However, because medical cannabis use routines are self-determined, use is often viewed flexibly. Many patients base their determinations on the setting or other contextual cues to identify whether any specific use of cannabis is “recreational” or “medical.” When asked to explain the difference, patients would say things like, “recreational is something you do with friends,” or make reference to social activities such as use before attending concerts or going to the movies with others.

Patients were not all the same in how they drew the boundaries for medical and recreational use. Some made few contextual distinctions. Gary for instance, simply said, “to me the only difference between a recreational user and one that uses it for medicine would be that

they have a medical condition, whatever that may be, that they would benefit from it.” Gary’s definition is vague and makes no context distinctions. If someone has a medical condition, their use is medical, with no qualifications on how it is used. No medical condition, no medical use; but if the person has a medical condition, cannabis confers medical effects for that person, regardless of the context in which it is taken. However, to be fair, the contexts often thought of as social use, where youthful groups engage together in cannabis use in the context of a party or other social event, were not typical Gary’s social circles were not using cannabis when they socialized, and Gary was not engaged in other scenes where this was common. For Gary, the social context had been a context from his youth, but his current use may have created little need for making contextual distinctions.

Gary’s definition fit with many patients who were contending with serious, ongoing, or progressive diseases, many of whom also made few distinctions based on context. In the presence of serious illness *all* use is medical. Often in such cases, the “patient” role claimed a much larger and more part of the person’s lifeworld, and interfered with role functioning in many ways. They often had to adapt to new limitations, which sometimes removed roles, such as going from work to disability, or significantly revised expectations about what one could do, or how much one could do on any given day. When illness affects all facets of life, and the patient role is hard to escape, it is easy to interpret cannabis use across all circumstances as “medical.” It may also be the case that others in middle age with serious disorders were unlikely to maintain a social life that included scenes where use was purely social, without any medical overtones.

For instance, Arthur is the patient, mentioned above as the regular LSD user, who suffers from multiple conditions including HIV/AIDS. Medicalized LSD use aside, Arthur claims to have indulged in his fair share of substances for recreational purposes over the years, but when I ask if any of his marijuana use is recreational at this point, he says no.

Me: Now - how would you decide that it is or isn't?

Arthur: Because I'm not using it to get high. Um, I'm not sitting here constantly smoking—it's like two or three hits and I'm fine for hours. So for me, that's what it's for, you know. I don't need to constantly smoke it, it's not recreation for me. It's more medicinal.

When I ask Arthur if he uses cannabis in social settings or with other people, he says, he does use it with his neighbors, but he lives in a subsidized apartment building where his neighbors are also on disability and have serious health conditions.

My neighbors, we get together and we all smoke together because we—because smoking by yourself, you tend to smoke more than you need. When you're with a group of people, everybody's having a good time. We're all there for the same reason. We need to eat, you know? We want to eat so we've got to give ourselves the "munchies." So—being that the three of us are poor, and you know, being hippies—what do hippies do? You *share*. When one doesn't have one and the other one does, so we all get together and we share.

For Arthur, even social smoking took place among others who were using for medical purposes, so in his thinking, the use remained medical. It is interesting to note that Arthur and many other people in this type of circumstance were likely to note that a person had a condition that could benefit from cannabis use, but especially among people in their regular social circles, they were often unconcerned with the other person's status as an "official" patient with the state. At the individual level for patients in the lifeworld, system distinctions that seem to offer access unevenly and treat people differently who have similar "valid" reasons may begin to seem arbitrary and even ridiculous to try to apply in real settings with friends or family. If a person accepts that cannabis is medical and someone has a medical condition that would benefit from use, the "rules" are often seen as an improper fit. They have not caught up to the reality of people's experiences.

In fact, once patients accept that cannabis is a medicine, some conjecture that "all use is medical," meaning not just for themselves, but for all cannabis consumers. A subset of patients proposed that many recreational users are inadvertent "medical users," who just don't recognize this purpose for their attraction to cannabis. This type of definition is essentially biological. It accepts that cannabis as a substance is a medicine and its ingestion, regardless of circumstance, has physiological effects that are medicinal in nature.

Other patients made more distinctions in social circumstances. When patients were using cannabis as a tool for symptom control rather than an overall strategy for disease management, they were more likely to make distinctions between their own reasons for use. In situations where pain or other symptoms threaten to be disruptive to their other plans, patients may feel conflicted about whether taking cannabis will be less or more of an interference, and often wish they could get the medical benefit without any psychoactive effect, at least some of the time. For instance, Travis uses cannabis to prevent seizures, but he also relies on it to help with appetite and depression issues. Travis receives disability and does not work, but is the main custodial parent of his two middle school–age daughters. The parent role demands that he exert careful management over his routines in order to be the type of parent he wishes to be. As much as he needs to control his cannabis use to be functional, it is at least as important to prevent seizures, which frighten and traumatize his children. For obvious reasons, he sometimes wishes that the medical benefit came without other effects:

Travis: There's times when I don't even want to be high, but I have to smoke to get that appetite back or to get that depression gone or to get that anxiety away, to get that scared feeling of just like, I'm going to have a seizure. To let my girls know that I'm on it just so that they feel relaxed that I'm not going to have a seizure. It's treated like medicine now.

Travis strikes a careful balance and keeps copious records to help him titrate his dosages and maximize his ability to fulfill his role as a parent. He is not casual about recreational cannabis use, and does not use it around his children. Due to the seriousness of his condition, and the seriousness with which he treats his role as a parent, Travis says he no longer sits around with friends using cannabis. He uses his selected medicinal cannabis products only, and does not wish to try other kinds. He sees all of his use as medical.

While most medical patients found they enjoyed the high, some learned to enjoy it and see it as a “treat” as well as a treatment at times. However, this recreational use often does not look like “risky” use or “partying.” At times, recreational use differs very little from medical use, save the patient’s own sense of why they are using it—is it being used to reduce pain or to

enhance pleasure? When patients face this question, they find it difficult to split hairs, since the two seem inextricably tied together.

In the last section of this chapter, I described Paul, a retired lawyer who uses cannabis tincture to control back and leg pain by following a routine in which he takes a specific amount each afternoon. He mentioned that he would increase the dose if he was experiencing more pain than usual, still a medically oriented use. However, he had times when he called his use “recreational” and this was almost entirely characterized by increasing dosage to enjoy a social event or enhance sensory pleasure, and not in response to stronger symptoms. In a context where he planned to engage in a different activity, he would not appreciate “getting stupid,” because it would make that activity harder to accomplish. Beth, a chronic pain patient in her 60s, offers an example of when medical use and recreational use blur. When I ask Beth if any of her use is recreational, she says:

I’m kind of back-and-forth with that. While I would like to be able to tell you that I only medicate when I hurt, I can also tell you that at my age, you pretty much hurt most of the time. So I could always in reality tell you yes I take it for pain and that’s the only reason. But I’ll choose to relieve my pain like 15 minutes before *Frasier* comes on [she starts laughing, and I laugh with her.] Because what do they say about laughter? It’s the best medicine!

Not everyone felt it was necessary to make firm distinctions between recreational and medical uses in their own personal behavior. Dale described the issue as less of an “either/or” situation at times, and more of a “both/and” situation. For instance, when asking Dale about recreational and medical use, he says:

Dale: Well actually I’m using it, I’m doing both now [not meaning right now at this minute, but just the general now] because recreationally, as I said, I don’t drink so I just smoke it to be sociable or whatever, and you know, I do it medically because, it helps, it really does help.

In Paul and Dale’s case, recreational use was an added benefit that could be accessed when it was desirable to do so, but it was not necessarily oppositional to medical use. It was a way to extend treatment to also include a “treat,” but only as the occasion warranted. In everyday life, most of the time productivity ranked over indulgence, and many patients were clear that they didn’t want to be high most of the time. After all, “treats” often rely on being

somewhat special, and that meant it was not constant.

Mike's sense of ambiguity about this captures many other reactions as well: "it's really hard to classify the difference... I don't know. I really don't know. Because I use it all the time, I don't know—If you're using it to expand your mood and the doctor would have you on mood enhancers anyway—am I using it medicinally or recreationally?" This raises some interesting interpretive problems that might help to explain why the medical/recreational line is at times blurry. Is medical use limited to the state-defined reasons for use, and meant to only benefit the body in some physical way? Since competing definitions exist, is use for PTSD only "medical" in a state that acknowledges that use, or only if the person has a formal diagnosis of PTSD or depression? In the lifeworld, these official designations may create difficulties in categorizing uses appropriately, but this is in part because the categories themselves do not adequately capture patient behavior very accurately. These questions also completely sidestep the issue of tolerance. In truth, consistent use of cannabis at low levels often results in gaining a sense of familiarity with its effects. This is a useful tool that allows patients to gauge dosage over time. Patients also learn to navigate the mental effects without experiencing the high as a functional impairment, leading some to claim they cease to get high altogether. Patients may also come to use these effects as an indicator that cannabis is "working." In the literature on medical adherence, patients tend to adapt pharmaceutical use based on experiential cues, largely based on symptoms and their cessation, adapting drug use to adapt to physical cues. Managing medication has been shown to differ based on patient's sense of what their body is telling them. Ironically, the "high" in the context of medical use may come to serve as a cue of effectiveness. While no patients directly interpreted their medical cannabis use in this way, many made comments about "listening to your body" to make determinations of dosage.

However, Yvonne's comment's about using CBD may help to point to the way the discernible effects from the cannabis "high" come to be valued information. Yvonne tried using

capsules that were formulated to be high in CBD (cannabidiol), a non-psychoactive constituent of the cannabis plant that is purported to have many valued medicinal properties, but no high.

Of her experience, she says:

I spent thirty dollars on those [CBD pills] and I didn't see anything from that, I didn't get any relief. But now I'm reading this magazine that says you have to take CBDs over a period of time. So I'm going to try it again and take it over time, keep taking it and see if that helps.

Many medications share the lack of immediate effects that Yvonne reports experiencing with CBD. By contrast, the immediate feedback Yvonne receives from cannabis in terms of both the “high” sensation and the immediate reduction of pain or other symptoms may become conflated such that the high becomes a clear signal that cannabis is having an effect. This unique quality allows patients to exert a great deal of control that cannot be exerted from someone else. It is radically phenomenological. The patient must learn to gauge the subtle differences in effects, determine the correct dosage amount, and many learn to attend to differences between strains. Because patients often desire control, this aspect of direct management and feedback through the immediate discernible effects of cannabis may come to be seen as an indication of effectiveness.

For a few patients, the distinction between recreational and medical was personally meaningless, either because the patient did not experience the high, or had developed such a tolerance through medical use that a recreational “high” was unlikely. In these instances, it was easy for the patient to claim that all use was medical.

It is easy to trouble the waters about these types of distinctions among midlife medical cannabis use. While routines of use do seem to affect how recreational use is attributed, it is likely that these patients also had different levels of acceptance of cannabis as a medicine, and had become patients with different opinions about whether recreational use was an acceptable activity or not. One of the key actors I interviewed, Megan, had worked with patients in advocacy roles and had advised patients as an associate at a dispensary. She has decided to stop

using the term “recreational” altogether, opting for terms like “social,” or “adult” use instead.

When I asked her why, she said:

Well in part because I don't really think that it's the best word to describe what people are doing when they're choosing marijuana socially.... I don't know that I've settled necessarily on the best word for it, but “recreational” implies in the minds of many people, a lack of consideration. A lack of responsible behavior. And I think that you can use marijuana as an adult responsibly, outside of the medical context and inside of the medical context, and I think that people, individuals, are able to do that. You know, I've seen people use marijuana medically and occasionally do so non-medically as well, the same individual, and it works for them. And I think that's okay, you know. I don't think that there's a problem with that.

Whether the appropriate term is “recreational,” “social,” or simply “adult” use, the implication is that the setting matters greatly for whether identical effects are enjoyable or not. When one wishes to carry out work or family related tasks, stronger effects from cannabis can be stressful. On the other hand, when the goal is sociability, sensory enjoyment, relaxation, or even sleep, these effects can enhance the experience, and even enhance health by supporting stress reduction.

THE LIFE COURSE AS SETTING

As I mentioned, individuals enter medical cannabis use from different starting points. This is determined in part because of differences in use over the life course. Of the 40 patients in this study, nearly all had used cannabis recreationally, and of those, almost all had done so primarily during teen or college years. Only two patients never tried cannabis at all; however, another five were practically never-users in that they tried it only once or twice in their early adult years, decided it was not for them, and never engaged in further recreational use prior to becoming medical cannabis users. These numbers are not surprising, given that lifetime use rates for those 30 and over are estimated to be between 65% and 80%. Other studies also found that many patients had tried recreational cannabis use at least once, but the majority were not using cannabis immediately prior to adopting medical use (Hammersly et al. 2001; Reinerman et al. 2011).

Aside from the seven individuals who reported little to no recreational use, the

remaining patients in this study used cannabis recreationally over a period of time in their teens. Pavalko (2011) points out that individuals' life courses are embedded in and shaped by historical times and places. Each cohort has a unique experience and experience the same historical events differently, in part based on one's age at the time they happened.

When recounting cannabis use in their teens and 20s, many patients mentioned how different things were back then. First off, they characterized the 1970s and 1980s as a time when everyone was using weed, but the cops weren't busting everyone. As Dale put it, "you've got to realize—okay, I lived through the '80's when doing drugs was cool [he laughs]." This environment of relaxed cannabis use was still relevant to many patients, who had long held the opinion that cannabis was not dangerous. Many patients in the study who were in their late 40s or older claimed at least a tangential connection to "hippies," even if on further questioning, they admitted that they were not themselves a hippie, but more just proximal to them at a formative age. A small minority of patients, mostly among those who did not use in their teens, expressed a disliking of hippies at that time, an attitude that had mostly softened, although if this was a function of time or of their own cannabis use, it is hard to say. These patients still did not see themselves as identified with the stereotypical cannabis users. A few still felt that they did not want to be around people who typified these groups, but such an attitude was rare.

Not only did this group hold onto stereotypes of marijuana users, they also often volunteered rebuttals to stereotypes about marijuana that were probably more advertised during their use as young adults than they are now. The clear favorite was the gateway drug theory, mentioned by just under half of all patients interviewed. Any patients who brought it up pretty much thought it lacked any merit. A few based this on their own disinterest in any recreational drugs other than marijuana. However, many had tried other drugs, but they insisted that this was unrelated to cannabis use as far as they were concerned. Rather, they attributed a willingness to try many things in their youth as more an expression of a curious attitude and a

sense of invulnerability that characterized youth. Andy, Karen, Aaron, and a handful of others were willing to consider that there was merit to a gateway theory, but said that to the gateway drug was alcohol, not cannabis. Carl said it was a gateway... “to the presidency,” but otherwise, the theory was wrong. This echoes a message that has circulated widely among activists, who point out the self-admission of cannabis use by the last three U.S. presidents, Obama, Clinton, and Bush. Mike and Ken, both of whom had used other drugs, said it was “all about education,” or essentially it was a result of categorizing marijuana as a deviant recreational drug, and leading them to see it in the same category as other, harder drugs. Ken, a chronic pain patient, felt that if teens who tried cannabis found that they’d been lied to about its dangers, then maybe that was the case with other drugs as well. Mike related it to himself, but with a similar message. He said, “the only reason it would be a gateway drug is because the people I went to to get it, I’d get exposed to other drugs that way.” Glenn even went so far as to say that it is not only not a gateway drug, but he thinks we will end up treating other drug addiction with cannabis. In fact, this substitution effect has been found in several studies (Lucas 2012; Reiman 2006).

In addition to these cultural frames that defined cannabis use, about half of the patients in this study had followed an “on-time,” normative trajectory for cannabis use, starting in their teens and discontinuing use in their 20s or 30s, often based on life course transitions such as work, school, or becoming a parent. Hathaway found similar patterns among life course and exiting cannabis use (Hathaway et al. 2011). When marijuana disappeared from social circles, many patients report not seeking it out. It wasn’t a conscious decision; changes to the setting changed use. Women in the sample were especially likely to report stopping use when they had children. Of the nine women interviewed who had children, half reported quitting use of recreational cannabis when they became mothers; two reported quitting before having children, related to college, and it is unclear how motherhood affected their decisions. By contrast men more often reported discontinuation of use due to work and drug testing. Although the sample is

not representative, more men than women in this study reported intermittent and continuous ongoing use over adulthood.

Reintegrating cannabis use at midlife challenged patients' views of on-time use of marijuana over the life course. As Hammersly notes, "cannabis may be more a signifier of the type of social setting than the identity of the participants"; patients expressed concerns with perceptions others might have of their use. In part, they did not want to be subject to stereotypes as "stoners," but I would also suggest that many users did not want to be perceived as acting in a way that was deviant with midlife. These came across as concerns with being perceived as "responsible," or "mature." These perceptions were interconnected with use patterns and frames fitting with medical use. Many made statements about being in control and being mature or responsible. As an example, Beth states, "If you're completely in control of what you're doing, which means that your desires are not controlling you—absolutely you can regulate yourself with no problem."

Some people interviewed had used cannabis more recently and had less concern with stigma because use was normal in their social group. Many of their closest friends and even family already knew they used cannabis occasionally, but their identity and level of use often changed after the medical designation. Patients often verified that they had support in their closest relationships prior to becoming medical cannabis patients. Interestingly, many had spouses who did not use cannabis medically or recreationally, but supported the use of their partners, often because they just wanted the person to feel good/out of pain, "normal."

Many patients made comparisons with their youthful use in order to draw distinctions. In comparison, health concerns had become a more salient concern. Especially among patients in this sample, all of whom had health issues, risk assessments had adjusted since their youthful days. As Backett (1992) points out in her article on lay health moralities among middle class families, health becomes a part of the lifeworld intimately tied to family and the domestic

context. As people age, “over the years, their lives had altered so that supposedly health damaging behaviours such as excessive drinking and smoking or lack of concern about diet were no longer possible, desirable, or appropriate” (Backett 1992:262). It wasn’t that these behaviors were “reproachable” or “unhealthy” at their essence, it was that they were “inappropriate” in the current social context. Midlife health, and perhaps especially for those who have developed significant chronic illness or experienced injuries that permanently change their pain levels or abilities, reconfigure the role of health in making lifestyle determinations.

As Carl says: “You have to regulate yourself. If you have to go to work at seven o’clock in the morning, you know, you can’t just sit there and get totally ripped all night long and then expect to be crisp the next day, like we used to when we were in high school. We’d party all damn night, and we were bulletproof. We’re not bulletproof anymore.”

Many comments relating to maturity, responsible use, regulating one’s self, in contrast to teen behavior, may act as a form of “normification,” defined by Goffman as a way of performing expected behaviors that match the age group setting in order to match expectations and appear non-deviant. In Hathaway’s (2011) article on stigma and cannabis, he found that there were two common “normifying” discursive formulations among marijuana users: “narratives of self restraint and transformation.” When the midlife patients in this study made the transition to medical cannabis use, narratives of restraint and transformation have been at the core of adapting cannabis use to medicine and to midlife. The focus shifts to responsible adult use. This is enabled in part by alterations to the drug form to make consistent dosage easier, but in other ways cannabis use is radically individual, and its responsible medical use is more defined by adaptations to set and setting—it was about being adult, using in responsible amounts, and at responsible times, and only the individual can gauge appropriate moderation.

Patients did not define medical use in moralistic terms in which medical uses are positive but recreational uses are negative. Even though there were clear medical uses for mitigation of

pain, treatment of symptoms, or even preventative and curative purposes, many patients who presented themselves as highly principled medical users whose focus was not on recreational uses of cannabis, most felt that there were appropriate ways to use cannabis for fun, relaxation, and enjoyment. Some felt that because these “fun” forms of use mitigated stress, they were really more on a continuum with medical uses rather than oppositional.

Patients at midlife felt they were capable of making good choices about this based on their responsibility in other aspects of life, and their experience and judgment at midlife. In this chapter, I have argued that neither the pharmacological effects of a drug, nor its legal status, completely define that drug’s effects. Using Zinberg’s (1984) classic trilogy of drug, set, and setting, has provided a structure by which to analyze the shift to medical cannabis use. Medicalization affects drug, set, and setting, opening new forms of interpretation that do not simply change the language from one of “getting high,” to “medicating”; they also change behaviors and experiences. Because cannabis is incompletely medicalized, patients contribute to medicalization through the adoption of self-imposed behaviors, and these behaviors follow patterns that are seen in other self-care, CAM, and pharmaceutical drug regimens. Patients express a preference for natural solutions, seek to minimize use, and form routines that exert control over functioning in the lifeworld by balancing symptom management with drug effects. Some may actually find the high to be useful feedback that indicates the medicine is working. In addition, patient use of cannabis moves to solo settings that conforms to how other medical substances are used. Setting also plays a broader role—midlife patients are often simply not engaged in recreational settings more common to teens and young adults in college. It is more normative for those over thirty, when they do recreate, to do so in more moderate ways, and often in private settings. In its most radical interpretation, medical cannabis use illustrates that substances are neither medical nor recreational until we decide how to incorporate them into our behavioral routines, and what criteria we engage to evaluate them.

CHAPTER 6: Cannabis and Trends of Health, Medicine, and Pharmaceutical Intervention

In the previous chapters, I have contended that medical cannabis is a case of incomplete medicalization and this has effects along two lines. First, it affects the institutional placement of cannabis, such that it spans the formal, informal, and popular sectors. Second, medicalization affects cultural perceptions of cannabis use in ways that are tied to public attitudes about its medical qualities and appropriate uses. In this chapter, I expand beyond medicalization to consider medical cannabis in the context of medicalization's companion concepts, healthicization and pharmaceuticalization. I consider how patients describe their use in relation to health and health behaviors. I also consider how patients understand cannabis as a treatment and as a medicine. In order to understand how patients perceive cannabis use in relation to healthism or healthicization and pharmaceuticalization, it was critical to make distinctions between these societal trends.

DEFINING HEALTHISM AND PHARMACEUTICALIZATION

Healthicization, or healthism, is a term meant to indicate the trend in society by which more elements of everyday life and lifestyle are incorporated under the mandate of health, but not necessarily directly into the domain and authority of medicine. Since formal medicine comprises only small part of the territory claimed by the broader social function of health and healing, researchers beginning with Crawford (1980) offered healthism as a component of medicalization to distinguish those elements of life that come to be associated with health, even if they are not formally medical.

Many researchers on health and medicine have noted the significance of increased attention to health in society, paralleled by rise of health oriented self-help books, fitness centers

and a focus on natural health (Schuster et al. 2004). In an age where the disease burden has shifted from acute to chronic illnesses, health becomes inextricably linked to lifestyle choices, and healthful behavior takes on a moral character of individual responsibility (Cheek 2008; Conrad 2007; Greenhalgh and Wessely 2004; Turner 2004). Health maintenance and to some degree, medical care, moves toward the management of health risks (Cheek 2008; Lewis 2006).

By contrast, pharmaceuticalization, as defined by Abraham (2010), is a process by which social, behavioral, or bodily conditions are seen as treatable with pharmaceutical drugs. Medicalization focuses on the domain of medicine, paying attention to doctor-patient interactions, medical categories, and health care institutions. It has given only limited treatment to the pharmaceutical industry, and often treated this industry as secondary. By contrast, pharmaceuticalization proposes that it may be a more central driver of medicalization, especially since the introduction of Prozac in the late 1980s (Abraham 2010; Conrad 2007). Abraham (2010) argues that even though these processes are related, pharmaceuticalization is different than medicalization, and can occur independent of medicalization, as when drugs may become available or more prevalent as a treatment for an existing or established medical condition. In cases such as this, prescription drugs do not always expand the domain of medicine, but they do expand the use of pharmaceutical drugs within medicine.

Medication, Treatments, and Health Behaviors

In this chapter, I argue that healthicization and pharmaceuticalization may have arisen to help address the unstated differences between medications, treatments, and health behaviors. Once we distinguish these overlapping categories from one another, we can see that cannabis may be viewed alternately as a medication, a treatment, or a health behavior. Its inclusion by patients in each of these categories can help to elaborate marijuana's relationship with trends of healthism and pharmaceuticalization, because each category implies certain qualities that influence behavior and attitudes about the appropriate uses of cannabis within medicine.

A medication is a substance, a treatment is a modality or blueprint for behavior, and a health behavior is an enactment of a behavior meant to confer some healthful benefit. Because medicalization groups issues into the medical domain, it corresponds closely to treatments, because medicalization defines a problem as within the jurisdiction of medical treatment plans. More specifically, treatments exist on a continuum from self-care to biomedical care, and are often considered “medicalized” to the degree that they rely on the logic of formal biomedicine and are managed by doctors within the formal sector. Treatments that exist outside the formal sector and its logic are often seen as not fully medicalized. As I have argued throughout this work so far, cannabis is incompletely medicalized, in part because it is not fully incorporated into biomedicine, either in its form as a medication or in terms of treatment regimes.

Treatments are identical with neither medication nor health behaviors. They are the plan of action to be taken to resolve a problem. Treatments may or may not involve medicines. They can also involve surgery, physical therapy, biofeedback, acupuncture, or other bodily manipulation. Typically, treatments are meant to restore or maintain health, but may not, in and of themselves, be “healthy.” Treatments within the biomedical model are often understood to have a discrete, one-to-one relationship with specific illnesses, although chronic problems have increased the need for comprehensive treatment plans that incorporate multiple therapeutic agents in an ongoing treatment plan.

Because medications, as one form of treatment, are separable from treating something within the biomedical domain, they correspond to the concept of pharmaceuticalization. Medications within biomedicine are standardized and synthesized substances, most dominantly presented in pill form, but they may also be given in other ways such as injection, inhalation, or in liquid form. They are used to achieve great benefits in relieving, resolving, or even curing various illnesses, diseases and their symptoms, but they often present dangers as well, due to side effects, interactions with other substances, toxicity, and risk of dependence. In fact, this is

the stated purpose for introducing the controlled substances policies that were nonexistent prior to the twentieth century, but now dominate the handling of all drugs including medications. While some substances are considered innocuous enough that they do not require monitoring and control, over-the-counter and nonprescription formulations are more common to self-care, while biomedical practitioners are tasked with making expert judgments on how controlled substances should be best used. Just as with treatments generally speaking, medications are not inherently healthy. Medications, though used to restore health, may become unhealthy when used improperly, or in the wrong amounts, or over too long a period of time, with some individual variation. Chemotherapy provides a useful example. As a treatment, chemotherapy is meant to restore health by killing cancer, but in and of itself, it is actually quite toxic.

If patients perceive cannabis primarily as a medication and characterize it as not in and of itself healthful, but as providing either short-term or long-term support for maintain or restoring health, or preventing recurrence of another disorder, then medical cannabis may be seen as contributing to pharmaceuticalization. If instead, patients see cannabis as not equivalent to medication, and do not see it as causing the use of more medications, then it may be contributing to de-pharmaceuticalization trends among medical cannabis patients.

Finally, patients can see cannabis as a health behavior. Unlike medications, health behaviors are *perceived* as inherently contributory to health. They may or may not be part of a treatment, or include medication. Health behaviors are often defined in opposition to risk behaviors (Cockerham 2008). Behaviors categorized as “healthy” or “risky” change over time, but they typically address lifestyle factors such as eating habits, ideas about exercise and fitness, and leisure habits, and are often tied to the lifeworld, to identity, and to the life course. They may include many self-imposed medications or treatments, from drinking potions of gold, to taking Echinacea, wearing magnets, drinking aloe vera to taking pill vitamins, or they may focus more on herbs, food, or water as a form of medicine. Healthy behaviors may become more

salient over the life course, and risks may come to seem less acceptable, because the impacts of such decisions gains greater immediacy with age. Health behaviors are also accompanied by moral judgments as health comes to be treated as a practical achievement (Cockerham 2005). Americans believe in the idea of individual responsibility for prevention and management of health outcomes. As Rosenberg (2007) explains, “we want health to make predictive sense, to be based on coherent relationships between behavior and its consequences” (60). Healthicization addresses the increase in health behaviors as distinct from processes of medicalization and pharmaceuticalization. Of the three processes, healthicization is really the only one that addresses behaviors outside of the formal sector. By contrast, health behaviors are healthy. While they may involve moderation, a health behavior confers health benefits.

If patients see medical cannabis as contributory to health, and when used properly, as presenting few dangers in the long term, cannabis may contribute to trends of greater healthism among medical cannabis patients. In this instance, cannabis patients may come to understand their cannabis use as a companion to health practices akin to taking an herbal supplement or vitamin, and may see it as compatible with other health behaviors. In this sense, they may also see little need to discontinue use after a specific health problem has been resolved, but rather see ongoing use regardless of any specific health complaint, as appropriate.

Healthicization and pharmaceuticalization help to tease out different trends from medicalization and these three correspond to differences between treatment, medication, and health behavior. Patients and the public may view the proper category for medical cannabis as being a treatment, a medication, or a health behavior. In order for cannabis to fit within moral ideas of health, its meaning must undergo a revision from being a cause for poor health with no medical uses to one that is understood as either medically beneficial, healthy, or both.

How cannabis is categorized implies different relationships and different appropriate management strategies. However, it is important to clarify that the categories of health

behavior, medication, and treatment are by no means mutually exclusive, and in fact may be better described as mutually constitutive in approaches to health management. In the public mind, cannabis as a treatment is often associated with palliative use, to make one “feel better,” but not necessarily to halt the progress of disease, much less cure it. In truth, medical cannabis is used for a wide diversity of problems and purposes that include palliation but range beyond it, as the patients in this study have shown. In fact, the same patient may use cannabis to treat different types of health conditions at different times. Nearly all patients consider cannabis to be safe, or low in “harm,” but this is generally a more medication orientation, and is not the same as deeming it “healthy.” As I pointed out in the chapter 1, even after the introduction of medical cannabis, the debate still revolves almost exclusively around the issue of more or less harm.

Although in previous chapters I have argued that some patients handle marijuana similarly to pharmaceuticals, my question here is not just whether patient behavior mimics other medical behavior, or whether routines imitate those found in the informal sector; rather, I ask, do patients come to see medical cannabis use primarily in terms of treatment, medication, or health behavior? What do these interpretations tell us about the contribution of medical cannabis use to societal trends toward pharmaceuticalization or de-pharmaceuticalization? Toward healthism or away from it?

HEALTHISM & HARMS

Over the past three decades, health promotion and wellness has expanded greatly in western culture (Conrad 1994; Parusnikova 2000). The “new health morality” transforms health into a more conscious presence outside of the medical encounter. Wellness means making improvements to health through self-control, discipline, lay expertise, self-knowledge, and an aura of morality (Contrada and Ashmore 29). Wellness seekers engage in a discourse that blends moral aims and scientific claims around health promotion to construct a world of goods, bads, and shoulds for healthful living; however, these imperatives and ideals are not always aligned

with other lifeworld desires or goals.

To achieve wellness, individuals must strive to make health improvements, exercise self-control over health and discipline over the self, and learn more about how to maintain health in order to determine the best choices (Lock 1999). According to Scheper-Hughes (1987), Americans face a “double-binding injunction to be self-controlled, fit, and productive workers, and to be at the same time self-indulgent pleasure-seeking consumers” (26). Perhaps this dual mandate rests on a reliance that the two are distinct from one another, although they need not be oppositional. There are places where health and pleasure clearly overlap, such as when sexual activity or wine in moderation are defined as good for both, or how CAM therapies can be described as both indulgence and health maintenance (Prevention 2012; Spector 2013).

Rhetoric about recreational cannabis use has been associated with the polar opposite of the tenets of this health paradigm in popular culture, although among subcultural networks, its safety has long been known (Becker 1953; Ferraiolo 2007; Harrison 1988; Himmelstein 1983; Zinberg 1984). As a recreational substance, cannabis’s associations are linked to those of illicit drug use—instead of self-control, cannabis use is seen as impulsive and seeking a state that lessens self-control (Hathaway et al. 2011). Cannabis use is also characterized as something fun and enjoyable. This runs counter to the lay health supposition that to be healthy, one must employ discipline and self-sacrifice, a notion that Chapkis and Webb refer to as “pharmacological Calvinism” (Chapkis and Webb 2008; Rosenberg 2007). Health becomes a practical accomplishment due to the success of ascetic efforts, discipline and moderation (Scheper-Hughes and Lock 1987). The corollary is that fun or enjoyable things are usually bad for you, lead to unhealthy states of illness or disease, and must be carefully moderated or abstained from altogether (Backett 1992; Chapkis and Webb 2008; Conrad 1994).

Health behaviors, with their strong ties to the lifeworld, are also within the context of one’s social status, domestic context, and family relationships. Lay health theories frame how

consumers define the meaning of “healthy” or “unhealthy.” For example, consumers who define health as an absence of symptoms may make different decisions than those who view health as an optimal goal state (Hughner and Kleine 2008). These determinations are also relative to others in one’s social networks, and to the available resources in one’s milieu. Emotional states—stress, grief, friendship—are intertwined with one’s close ties and social contexts, but may come to be seen as directly related to one’s health. Because healthicization often brings medical concerns into everyday activities and relationships, Lowenberg and Davis (1994) refer to it as the “medicalization of lifestyle” (592).

Cannabis and Healthism

Many patients in this study have adopted a view in which cannabis is seen as minimally harmful or altogether lacking in physical harm to the body. Many express their preference for cannabis based on the sense that it lacks the trade-offs of harm for benefit that many other medications involve. As discussed at length in Chapter 5, the only health harm from cannabis on which the majority of physicians and patients seem to agree are those associated with engaging in smoking. They are not based on marijuana’s physiological interaction with the body. Even when the “high,” is seen as an undesirable consequence, at least under some circumstances, patients see this as a trade-off in productivity rather than an actual physical harm. Most patients were also not concerned with dependence, in part because they had used it as teens and had not problems ending their use. However, a few did express concerns with dependence on use to control pain, a problem they mostly addressed by minimizing the dose, as I detailed in the chapter 5.

Although most patients saw it as minimally harmful or lacking harm entirely, only some patients went beyond that, and claimed that it was making a contribution to health. As an example, Brett insisted that cannabis remained illegal because it was simply “too good,” serving as a healthy, inexpensive medication with no down sides, and also as one of the most

nutritionally dense foods to be found in nature. In Brett's mind, cannabis's illegality was protectionism, plain and simple. Since cannabis the plant cannot be patented, pharmaceutical companies cannot find a way to benefit from it. If it were freely available, this industry would be hard pressed to compete with many of its many superior qualities.

Brett: It is such an amazingly beneficial plant, and that's why it's illegal. It's too good. The competition's too intense. You know, the pharmaceutical industry is set up so that there's a different pill for every ailment. That's profitable. One pill for nausea, another pill for inflammation, another pill for pain, another pill to handle the side effects of the other pills. Uh—cannabis handles all of them, not all, but a wide variety of them. Nausea, inflammation, pain, you know, migraines.... [the pharmaceutical companies,] they don't want a multipurpose medicine.

Claims about cannabis as a medicine often placed emphasis on mind-body connections—the importance of one's mental state or thoughts for health. Patients were careful to distinguish that the medical effect was not a placebo, or based simply in marijuana's capability to mentally distract. While a few conceded that the distraction from pain was helpful, many also agreed with Gary:

Do I think it's a placebo? No. I think there's actual pharmacological effects that it has on the body. There are studies that prove that. And not necessarily studies in the US, but there are studies overseas where it reduces pain or helps you relax or reduces muscle spasms. So I don't think it's a placebo, I don't think it's all in the mind.

Patients rejected the notion that the medical effects of cannabis were “just in your head,” a sentiment reminiscent of medical narratives surrounding contested illnesses (Bülow 2008). Many patients acknowledged that their illness or chronic pain was a complex interaction of mind and body, often linked by stress. Many patients noted how physical symptoms responded to one's state of mind. HIV patient Mike even pointed out that objective measures of his T-cell count, an important indicator for HIV patient health, directly showed mind-body effects:

When I'm in a good mood, I'm healthier. I'm happier and I'm healthier. When I'm down, my T-cells will reflect that....Just like in the summertime. I get depressed early in the summer, and my T-cells will drop 50, 60 points. And then in the wintertime with ski season and all the snow, I just love outside, and I love the snow. My T-cells will go up.

When I asked patients what factor most affects health, many echoed Jason's sentiment:

I think stress will kill you. Stress is the number one bad thing that people have, mentally. If you are stressed out all the time, you are going to have a lot of health issues. Depression. People who are depressed tend to not be very healthy either. So mental health is very important.

Just as patients saw that mental states could have negative effects on the state of the body's health, many patients, especially those with serious chronic pain, also noted that it worked the other way around. Just as depression or stress could increase physical pain, pain or increased illness symptoms could cause mental stress, anxiety, and depression. Many patients in this study reported a period of depression. Among interviews, Ken was one of a substantial subgroup who had experienced multiple, severe bouts with depression. Ken and others associated anxiety or depression with finding out about and living with chronic conditions, due to constant physical pain or discomfort, but also as a result of dealing with newly imposed limitations, the effect these factors had on one's goals or quality of life expectations going forward, and the implications for aging and mortality. A few patients in the sample said that the first prescriptions they were advised to take after receiving a serious diagnosis were antidepressants. Frank has a cancer diagnosis, and he says:

Frank: I mean the first thing they're going to do to you when you go through any type of deal or sickness [mimicking a doctor]: "I'll tell you what we got to do is get you on antidepressants. So let's get you started on some antidepressants."

Me: when you have cancer, that's an automatic thing?

Frank: Uh-huh (agreeing), that's the first thing they tell you right at the start is, oh yeah. You've gone through an operation or you've gone through a situation where you know it's terminal... the first they that's prescribed to you is antidepressants. They will throw that at you. Now they don't tell you, but you better not have sex on your mind because it won't be on your mind with antidepressants.

Me: Oh, I see.

Frank: So they don't tell you and talk you into taking them, and you're going like, "shit, when was the last time I made love? I mean, there's something wrong here. This is not, not normal." So antidepressants, you want to get off of quick, you have to get off of those.

Frank's diagnosis was one among some serious life-threatening illnesses in the study. However, when it interfered with enjoyable life activities he did not find that the mood effects were worth the trade-off for sexual function. Most patients with diagnoses at this level were prescribed antidepressants for some time. Unsurprisingly, patients who had chronic conditions that also involved mental health symptoms of depression, anxiety, or post-traumatic stress

disorder (PTSD) were given antidepressants, and in many cases, were cycled through many different types of antidepressants. Many found that cannabis offered support for depression, anxiety, or anger, without the more serious forms of disorientation, sleep disorder, or drug interaction potential. Ken captures the sentiment of body to mind effects well:

I think cannabis is one hell of a better alternative [than prescription drugs]. I mean, I wake up feeling good every morning, instead of sick.... Because it takes away the pain. Between the migraines and the pain, I mean—I feel sorry for, I have hated pain my whole life. It just disrupts your brain, it disrupts everything in your life. If you could take the pain away, why not? You could be happy again.

Mike, Jason, Frank, and Ken, all express the relationship of chronic pain or other illness with good and bad mental states in a way that is reflexive. The ability of cannabis to intervene in this process extends up and down the chain, improving mood and reducing pain with few costs after the fact. Ken has only used cannabis in his teens, Frank had been an intermittent user over his adult life, and Mike and Jason had been consistent recreational users who enjoyed the “high,” which made this effect seem less of a negative in the trade-off, and at times it was seen as an unmitigated positive contribution. Those who did not enjoy the high and preferred to reduce this effect often still felt it could be managed, and if one got more high than they meant to on occasion, it was seen as a small price to pay compared to the “costs” associated with other options. In fact, many patients were clear that despite the rhetoric that separates medications from marijuana, many medications have mentally disorienting effects that are far more pronounced and less pleasant than those of marijuana, and this is hardly a characteristic that must only be managed with cannabis but not with other medications.

Medicalization processes often entail a negotiation between the individual and the system of biomedicine, but healthicization processes are more firmly planted in the lifeworld, which allows quality of life and enhancement to predominate. Some patients felt cannabis had helped them dramatically, either to experience better quality of life in the face of possible death, or that it had literally kept them alive in a time when role loss and pain may have caused them to mentally give up. Carl, seriously ill with kidney cancer, gets a little philosophical about it:

Well, you look at, everyone's going to die, sooner or later. And you start looking at quality of life, how you want to live, and yeah you get down sometimes. You know, when I had a little skin cancer, a little skin deal, it was malignant, and you know, they got it all. And that was before all of this started. I freaked out. "Should I just kill myself now?" "Should I do this, should I do that?" And, "oh my God my dog's going to outlive me." You know, you really start going through this "Oh me, oh my. I feel sorry for myself" crap. And that's very normal, now—it's very natural. So [stutters a little] it's, it's—you need to kind of live your life how you want to live. You know? Treat people how you want to be treated. And smoking pot doesn't hurt anybody, there should not be a damn thing wrong with it.

Carl found that cannabis helped him cope in a holistic way—it helped with physical pain, but this was not the extent of it. It also helped him experience psychological relief and reflect on his experience in a way that managed not only his illness, but his fears about whether cancer would cause his quality of life to deteriorate. It helped him to stop "freaking out," and shift from feeling sorry for himself to a perspective of savoring his experience and come to some grips with his mortality. Others with life-threatening illnesses in this study expressed similar sentiments, characterizing cannabis as a type of holistic medicine. Cannabis was neither "all in your head," nor could it be reduced to a simple one-to-one correspondence with pain alleviation or physical treatment.

Patients with less serious conditions also saw cannabis as compatible with a self-care approach in which one privileges subjective experience as a relevant indication of one's health needs. Several offered some version of Mark's explanation that:

I listen to my body. That's number one. I don't take anything routinely or say, It's 10 o'clock in the morning so I've got to take a dose. It's not like that. You really have to be in tune with your body. After a time, anybody who has chronic pain, they learn to tune it out for a little bit, but I would say, to manage your pain really well, you have to be open to it. You have to accept it. You have to say, okay, I know this is going to hurt like hell but I've got to feel it to kind of know how to manage it.

Although Mark's condition is not as seriously life threatening as Carl's, he still managed to express that cannabis helps not only with the management of discrete mental or physical symptoms. Instead, it helps the patient to be attuned to their symptoms and reach acceptance in relation to them, a quality that not only treats the symptoms directly, but helps in some holistic sense for managing those symptoms going forward.

HEALTHISM AS A PLURALISTIC SPACE

The truth is, people tried lots of different types of treatments to manage health from the space outside of formal health care. The most reported treatments outside of the formal sector included using hypnosis to quit smoking, incorporating various herbs and vitamins, and chiropractic care.

Lance: Fish oil and coconut oil have been curing my depression. I'm not a clinician and neither are they. They're herbalists and naturopaths, and so I'm not going to do anything foolish. Because I'm aware that the state can order me on those drugs too so I mean. So let's play it safe.... the first thing I did through the homeopathic thing was I started with valerian root a passion flower and that got me to sleep for the first time in a long time, in about three years and I slept for about sixteen hours. When I woke up I felt like a train hit me. I was like, Jesus, what happened! I do other things too, whole food and a whole bunch of other things. also tried both meditation and yoga to manage symptoms. but I can't focus anymore after the TBI so they don't help.

Lance has moved as much of his regimen of care into the natural and self-controlled realm as possible. After being on medications that really scared him. Lance shows a clear preference for healthicization over medicalization. Even though his traumatic brain injury represents a lifelong problem, and he will have to maintain some formal medical care, he seems much more happy to trade in the “patient” identity for the “healthy lifestyle” one. Others like Devon, manage pain, and other lifestyle choices are not as closely related to direct care of the same condition for which cannabis is being used. Like many people in this study, Devon expressed an aversion to unnatural substances and pills—his skepticism and dislike extended not only to pharmaceuticals and over the counter medications, but also include vitamins. His idea of a healthy lifestyle was very much based in a clear preference across lifestyle choices for the raw and the natural.

Devon: Most of the multivitamins out are just loading you full of stuff you don't need or way too much of stuff that your body is just going to kick out anyway. With me, it's more my diet. I try to eat organic. Was a veggie for a long time, not anymore. But I still try to lean toward a raw-ish organic diet if I can. Yeah, well, statistics show that people that use cannabis recreationally instead of alcohol are much more intelligent. And I think that just coincides with the way you live your life. We are usually healthier and more conscious.

A few reported significant dietary changes or food restrictions, yoga and meditation, and a few idiosyncratic and obscure practices. For instance, Jehovah's Witness Beth had also

experienced great relief from using a form of electrotherapy. While these practices were used to promote a healthy lifestyle, they were not particularly associated with specific political views or cultural behaviors. Cannabis users in this sample tried many other lifestyle changes and treatments from the popular or informal sectors, but these were not based on political views—the many republicans and libertarians as well as the democrats and independents sought out health care solutions wherever they could find them.

Me: Have you ever tried any other types of treatments outside of Western medicine, like acupuncture or chiropractic?

Mindy: “Yeah, chiropractic, acupuncture, Chinese medicine, biofeedback, physical therapy, things like that.”

Me: What was your experience?

Mindy: Just that I didn’t get any long-term relief and it was really expensive. I had to keep going back and back and back and it wasn’t really changing any of my injuries so I just gave up on it.”

The ones with constant chronic pain or multiple conditions that basically took over their lives did not get much out of most CAM options. It was too expensive and even if they thought it was modestly helpful, they just couldn’t afford to do it enough for it to seem worth it. Most people had tried at least one CAM modality. The few exceptions who had never tried any such treatments just kind of shrugged and said they didn’t object to it, they just never did it. While some people tried cannabis as a larger form of experimentation, others felt that cannabis served as a catalyst to other changes:

Brett: Cannabis encourages a healthy lifestyle.

Me: Why is that?

Brett: I don’t know, but I’ve noticed that. I think it’s because I’m actually more conscious of what I’m putting in my body. Not just food wise. I’ve noticed that I’m more into meditation. More conscious of what I’m thinking. Oh wait, I know why! I’ve thought of this numerous times. I think that because when you’re under the influence of cannabis, it heightens your senses; it heightens your level of awareness.

In these accounts, cannabis becomes a tool almost for enlightened health. It enhances healthful activities by inducing mindfulness and awareness, which can be directed toward health choices. Rather than impairing mental function, Brett and Devon clearly feel that it provides them with a tool that helps them make smarter choices.

However, some patients interpreted the goal of health as striving toward a normatively

healthy body. Some did not strive for this, but maintained choices to smoke cigarettes, or rarely but for some, to drink, and to not pursue other health behaviors such as an exercise regimen or health conscious diet. If a person was going to engage in only mild attempts at healthy behavior, they usually claimed it to be eating a healthy diet. Nearly all patients pointed out that they drank very little alcohol, and too great delight in pointing out how very unhealthy drinking was compared with cannabis use, again—it was another way that patients expressed their stigma as superiority when it came to a healthy lifestyle.

Others were less resistant to change, but felt their illness or disease had rendered a normative version of “healthy” impossible. Chronic, acute, and cyclic diseases and their severity might have influenced this. One smaller group was very focused on marijuana as part of a larger, holistic view of health. But most were not focused on this, perhaps didn’t have money to consider eating organically. Most were normative (no extremes). It was more about maintaining quality of life than engaging in a healthy lifestyle.

While many patients clearly related to health as a moral issue, a few expressed strong reactions to any suggestion that marijuana fit a spiritual frame. About a fifth of patients in the sample, most who considered themselves religiously involved Christians, vehemently insisted on separation between cannabis use or other health practices and their religious practices. On the other side, three people who were not religious but considered themselves spiritual in other ways described cannabis as a well-defined part of their spiritual practices. Most simply saw the idea as irrelevant and didn’t relate to it at all, but they were fine if others did.

CANNABIS, PAIN, AND BIG PHARMA

Andy: You know what my respect for that is as an engineer? My respect for that is: the human body is genetically designed by the ascent of man to respond to its environment. And cannabis is a part of that environment. Pharmaceuticals are not a part of that environment. They’re wildcards. You don’t know what they’re going to do. The body has already figured out that that stuff exists ... And you probably saw this coming, but I see a naturopathy, if that is the right word, and pharmacology as being not separate, they’re only separate in scientific terms. Your business, either way. That’s the way I look at it for myself, like I may get an Aleve, and I may eat a [cannabis] cookie. It’s whichever works for me, whenever it works for me, and it’s not what pops into my head – oh geez, this is the pharmaceutical. Oh geez, this is natural.

Despite huge gaps in care, widespread chronic conditions that include chronic pain, and concerns with prescription drugs, biomedicine still treats medical cannabis as a controversial last resort. It is understood as an option that should only be explored after other options have been tried, or when no treatment is available. By contrast, patients often see cannabis as safer and more natural than pharmaceuticals, or even many over-the-counter drugs. Many patients feel that cannabis is overregulated and monitored more than is necessary. However, they also recognize that overregulation is an imperative from the political system. The transition of cannabis to a new category and a new moral standing, has required strict definitions and unambiguously medical boundaries.

Patients in this study were greatly concerned with pharmaceutical safety. They often felt that doctors do not show enough discernment and are influenced by pharmaceutical companies. The concern over doctor bias may increase their worry about prescription drugs. Prescription drugs were the source of much skepticism among patients, and especially those who had lots of experiences with them. In most cases, these patients had already been disabused of the notion that pharmaceuticals could be a magic bullet for their illnesses. They had proven to be useful but sometimes only moderately so, and often came with a cost in the form of intense side effects or scary warnings for increasing risk of stroke or damage to organs. Prescriptions also have dangers of interaction effects, but cannabis can supplement most drugs without this issue.

Patients worried about taking pills in the first place. They worried about multiple drugs and the cumulative effect, of being overmedicated or being treated as guinea pigs:

Lance: Do I have concerns with pharmaceutical drugs? Yes. All of them. All of them have terrible side effects. All of them have side effects that include stroke, death; I mean all of the ones they have given me. Every last one of them. Seizures, I mean, and a lot of that, like that Abilify, I almost had a seizure in Home Depot, I fell on the ground, and they were like what happened. I was like, nah man, don't worry about it. I was like I'll be all right; I'm going to the hospital.

While not all patients had horror stories, the number who did have stories of overmedication were striking. Carmella had induced bipolar disorder from an overly potent

prescription of Gabapentin; Arthur had adult-onset asthma that was misdiagnosed as a seizure disorder, which sent him to the emergency room multiple times. He says the medication they put him on to treat the misdiagnosed condition made him crazy. By the end of Tina's experience with fibromyalgia and chronic pain, they had her on a toxic cocktail of pills that ended with methadone; she was sleeping constantly, and despite being unable to eat anything substantial, she ballooned up from her petite size to almost double her normal weight and required a cane for assistance. She claims that despite the serious nature of the drugs her physician placed here on, no one was monitoring her case. For her, the turning point was when Michael Jackson died. She cried out of fear for her own life, and felt desperate when she saw his grief-stricken children and thought of her own kids. Certainty if she stayed on the path she was on, she would meet the same end as he had. She began to taper off the drugs. The list goes on: Ken, Anita, Travis, Karen's husband, Beth's mother, Devon... all reported being overprescribed serious pain medications. These patients and others reported currently being on multiple prescriptions such as Gabapentin, Tramadol, Hydrocodone-based drugs, Flexeril... six patients were recommended methadone and five were briefly on it—none had good experiences to report. These patients all reported struggling back from a state of overmedication that was genuinely ruining their lives. Some felt that the very experience of medicines came to be associated with negative emotions:

Travis: I could smell the pills, I could feel them, the way they caused my stomach, just the acid in it, the more pills I put in me, the more I could feel it. It was just nasty. I could feel them, I can smell them, I can taste them. I take so many pills for my stomach just from the acid, some of them it's just nasty. So if I can stay away from some pills that keeps down some of the acid. And if I can smoke, instead of taking that pill, then it's just a whole lot better.

With first-hand or second-hand knowledge of cases like these, many patients were wary of the industry on the whole. They felt like pharmaceutical industry was a corrupting influence on biomedicine that dented its image.

Gary: Yeah. I think that there is a pharmaceutical industry I think peddles a lot of stuff that may not be necessarily good for you but yet there is such an incentive for the doctors to take this and pass this out to the patient or diagnose the patient has this particular problem that way they can dose this stuff out. And I'm not against pharmaceutical medications, they have their place. They make a lot of people's lives easier to deal with. So for me I think that pharmaceutical medications, also corporate pollution. And I'm not a big

ecologist. You know I'm saying? But I know enough to know that there is a lot of corporate pollution going on.

Frank's colon cancer metastasized, and he has taken multiple courses of chemotherapy as a result. When cancer metastasizes, it is considered to be in an advanced stage, in which it is replicating.

Frank: [I have] colon cancer. I had it operated on. They did the transection, and it mutated, or metastasized. So I got it on the lung and on the liver. Once you start studying cancer though, it's real funny. It's a mutant, and so what happens is it starts growing on its own, and it can sit there for a long time and decide not to do anything.

Me: the cancer?

Frank: yeah. There's no such thing as remission. What happens is once you got a mutant, it'll go and just sit: "Don't feel like growing today," you know? Then, all of a sudden when it hits, it's gonna go real quick. So I got into it and started chemo, and they will blast you with all kinds of – what you do in chemo is, you're always treating the side effects, I mean you don't – they don't give a shit, I mean the guys are killing cancer, I mean all of these fucking side effects: throwing up, uh, loss of weight, no appetite, on and on and on and on. They will just throw any pharmaceutical at you that you want. So they get you on Oxycontin, and they get you on painkillers, and geez man, you can't hold nothing down.

Me: Why would they give you Oxycontin or painkillers?

Frank: Fuck, you're gonna die, girl! What you want? [I laugh because of the way he says it.] You want anything, you know? Shit, dude. Shit. When I was in the hospital, I mean they would have these nurses come in and I mean it would be like a drug salesman who's opened their coat [imitates opening a trench coat like a guy on the corner selling watches]. "This one's really good"... and I was going like "damn!" I've never seen a drug deal like this in my life! But they'll throw anything at you that's on the market.

Frank's description of the pharmaceutical arsenal presented to him seems to illustrate the point in serious life-threatening illness when the calculus usually used to balance risks and benefits to health has transformed. The dire situation of advanced cancer, the difficult experience of chemotherapy, and the level of pain, discomfort, nausea, and other side effects warrant simply offering the patient whatever they want. However, in the way that Frank tells it, it almost seems like Frank's disease is out of his own control, but the inability of biomedicine to exert control seems almost like a desperate response. It is in this dire circumstance that biomedicine cedes control to the patient and offers them "anything" they want.

Williams and Calnan (1996) claim that evidence suggests "an increasing degree of 'ambivalence' amongst the lay populace regarding the risks and benefits of modern medicine" (1614). Britten's (2008) work in *Medicines and Society* concurs: patients are concerned with dangerous drug side effects, problems with addiction and dependence, and risks from

technological interventions. They often feel ambivalent toward “medical progress,” and remain skeptical about “expert” medical advice on health and lifestyle.

Some patients started with a trusting attitude, but after first-hand experiences in which doctors introduced dangerous treatments or overmedicated them without adequate monitoring, their concession to the authority of medicine shifted to a wary, almost frightened attitude. These patients often began with hope that advancements in biomedicine might resolve their health problem, but soon found it had greatly compounded their problems, reducing their functionality even further and resulting in endangering side effects. In previous chapters, Anita, Lance, and others reported such outcomes. Tina was perhaps one of the most severe cases of overmedication. Tina has multiple disorders, including fibromyalgia, PTSD, and severe digestive issues. After going through several increases in medication, she was placed on methadone. At her worst, she was in bed all day and unable to care for her children. While Tina has a slight frame and probably weighs just over 100 pounds at her normal weight, she says at the height of her overmedication,

I was 198 pounds. My hair... fell out. I looked sick. My kids told me, mom, you were an odd shade of gray. I had severe daily nausea. Daily. I found myself at 33 years old walking with a cane because of my treatment for fibromyalgia. Not because of my ailment. Fifteen pills at bedtime alone. And sometimes I would not be able to sleep after that dose... It's really hard to say without crying.

Tina says that she was sure she was going to die from the medication. The turning point for her, she says:

Michael Jackson died and I was scared. I'm not going to lie. That scared me. And it wasn't just him and his story, it was seeing his kids on TV and then looking at my kids.... I went on a tapering list. I started my detox on my own, and then went back to [my doctor] for a tapering list... This was 2009. I was treated by the nurse practitioner. I had never seen the doctor once through all of my treatments there. These are the people that you go to because you're supposed to be able to trust. That's what this society tells us. But they didn't monitor anything. They didn't monitor anything! I was not going to multiple pain specialists and asking for different meds, I was seeing one doctor, one office.

Tina's experience was extreme. Tina had worked in a healthcare setting in the past, offering patient support to cancer patients, a job she found hugely rewarded. Overall, she still aspired to work in a capacity where she could work in a healing and supportive role related to

healthcare. While she did not blame the entire institution of biomedicine, and she knew that not all doctors would behave in the unethical ways that hers had, the experience of being progressively overmedicated took years to recover from, and her attitude toward pharmaceuticals remained highly skeptical and even fearful. To her marijuana was a great antidote, offering a natural, nontoxic treatment that she could exert significant control over, and use to effectively manage much of her pain.

While several patients I interviewed had had a negative overmedication experience with biomedicine, others had not but feared such a scenario. Patients expressed a strong sense of being offended by the ability of the system to push much more dangerous drugs while prohibiting or failing to recognize the incredible safety record of cannabis:

Leo: you want to know what really makes me angry? I'll sit here and I'll watch commercials about a drug made by Pfizer or whoever... and they'll sit there and go, "well it'll help your calluses on your feet but it might do this and that and that and that and that and that and that, and kill you." So I'm going, you know, all the shit that happens on the side is worse than what the fuckin' thing cures. Two years later and you look on the TV and here's Sockloff and Sockloff [attorneys at law], saying call us because if you ever took this drug, we're suing the hell out of those people. This makes me angry as hell. When the same drug in this bowl (pointing to marijuana in his glass pipe on his end table) will work! And the federal government tells me that I can't use it because of their buddies in the drug companies? That makes me angry!

Most patients cared deeply about safety, and made estimations based on this. They felt cannabis was exponentially safer than all of these drugs. Brett brings up the minimum lethal-to-dose ratio, which is a comparison of the dosage at which a drug offers medical benefits compared to the dose at which it is considered lethal (Gable 2006). Although the standard for alcohol is usually reported as 10:1, and Brett overestimates it at 4:1, he is still correct that of the most commonly known recreational drugs, only heroin is rated above alcohol. Brett notes how much safer cannabis and psychedelic drugs are by this metric:

Brett: So alcohol... is four to one. ... Heroin is the only [recreational] drug above alcohol, it's two to one. And that's extremely toxic, way up there. The reason I'm bringing this up is, you know, it goes right on down the line, and then at the very bottom of the lethal-to-dose ratio scale, is all the psychoactive drugs, meaning Ayahuasca, peyote, psilocybin, cannabis. And so what that tells me is that nature intentionally, you know, these are the safer drugs. The ones that are not psychoactive have way higher lethal-to-dose ratios and the drugs that are psychoactive are way safer. So, for whatever reason, I think that what's happening there, and we're having a hard time with it, but I think we're starting to get it, especially with everything that's happening right now in our era.

In every estimation that patients made about cannabis's relative safety, its potential for drug interactions, or its other side effects, they adamantly expressed their belief that cannabis was far superior choice. For instance, when asked about side effects, Ken says, "I have been thinking about that question. I don't think I have any side effects. I mean, I feel a little spacey now and then. But compared to the opioids, my side effects are nada. Seriously." While many reported no serious side effects, a few noted that they sometimes experienced anxiety, which was probably the most serious among the side effects reported. Patients such as Andy and Mark had experienced anxiety with marijuana on occasion, and they were more cautious in their approach to experimentation. They found that the strain mattered a lot for this effect. A second side effect noted by pain patients was that some strains could actually increase the awareness of pain rather than relieve it. Patients such as Eileen and Leo, found that this was often caused by using sativa-dominant strains, because they had a stronger effect on attention. While this effect on focusing attention could at times be useful, when the focus was directed at pain, it was incompatible as a medicine.

Most patients interchanged cannabis with pharmaceuticals quite readily. A majority were also quick to point out what a healthier recreational choice cannabis was over alcohol, which many explicitly stated they did not use or prefer. In fact, this perception of marijuana's inherent safety was often the main justification for changing drug policies related to cannabis but not for other drugs that were harmful or presented potential for addiction. Lance even went to far as to suggest that he would be fine with swapping the legal status of cannabis for alcohol, even though he does not get high from marijuana, and so does not engage in any recreational use.

It would be fine if they got rid of alcohol. It would be a fair trade to get rid of alcohol because there is a lot of violence in alcohol. I've given up alcohol altogether because I can't drink because if I drink, I'll be in jail. PTSD patients should not drink.

Others, such as Devon, spoke more generally: “Yeah, I’ve known since I was like 18 that tap water is more dangerous than cannabis.” These estimations create a sense of comfort about cannabis that lessens fear of any effects that are perceived as unpleasant. Whether that is an overly stoned experience, rapid heart flutters, or some other effect considered unpleasant, patients know the effect has never been shown to result in death. In response, many patients, like Lance, worked to taper off other drugs when cannabis could be used effectively in its place:

Lance: Currently I am on Effexor, Lamictal, some Zyrtec, and some Nexium. That’s about it.... With herbalism and medical marijuana I have gotten down, and I am pretty comfortable with [the ones I’m still on], because one’s a protein pump inhibitor for your stomach and ... I’m allergic to dust mites and there is nothing you can really do about that. And the other two were just like an antidepressant and anti-anger thing or anxiety type thing and I don’t think they do shit but I am not going to stop taking them just yet.

Lance, like other patients such as Anita (described earlier), reduced medicines one by one until they felt the medicines they were taking could not be replaced by cannabis but were still necessary for symptoms. If taking a drug out resulted in a return of symptoms, they would simply add it back in. Cannabis was used to substitute for other drugs, to wean off other drugs and to supplement other drugs, for which cannabis improved effectiveness, allowing patients to lower dosages with the same level of effectiveness.

Carl: I have a prescription for Percocets, which I try not to take unless I absolutely have to. And Valiums. And [my doctor] said, “I have no problem giving you Valiums. “ Because he says, “I can’t even imagine what you’re going through.” Actually the Valium will help me sleep when basically I just need to be knocked out, to deal with my hip pain. So I roll and toss, wake up in pain probably every 5 to 10 minutes all night long, all the time.

Many patients in this study had been on or were currently on regimens of other drugs, and had experience with other side effects. All saw the occasional accident of getting “too high,” as mildly inconvenient but ultimately far, far superior to the side effects of other drugs. In addition, while many prescription drugs have counter-indications and do not mix well, cannabis can be taken with most prescription drugs without problems. Many patients were aware that cannabis did not have interaction effects with other drugs, and found that it could be an adjuvant to pharmaceutical painkillers, allowing patients to take fewer narcotics but maximize the effects of those taken. Darrell talked about his appreciation that cannabis was a more flexible

therapeutic substance than many pharmaceuticals, allowing patients greater control over use routines because it is possible to skip days without side effects:

Darrell: [Cannabis] makes the Percocet more effective. But the problem with opiates is, if I'm not hurting, marijuana, I don't have to take. I don't have to do it, it doesn't matter. Even if you want to for your head, it's not breaking your body down. If my Fentanyl patch is working really well when I first put it on, it kicks butt. And I really don't need Percocet, and I don't need the rest of my pills that day. But I've got to take them for maintenance. Or you get sick.

Patients largely understood proper dosages of cannabis as subjective—they know that the amount working for them might not be the same amount another person needs, or might be much less than another person requires for benefit. Ultimately, cannabis was safe to experiment in this way. As Brett puts it: “I take one puff, wait five or ten minutes. And then gauge it. I mean, you know, it requires us to be mature adults. And then if you take too much, you end up taking a nap. So. Big deal.”

Dependence. Because of marijuana's safety, patients were free to experiment to arrive at a happy medium that controlled symptoms but did not induce a state that lowered functionality. Most patients did not believe that cannabis caused physical dependence, but some worried about forming a habitual dependence. When asked about dependence, Andy said he was not addicted to marijuana, he was “addicted to not being in pain.” In this sense, he made it clear that his habits had more to do with pain management than the particular treatment, but he also says “freedom and responsibility should go hand-in-hand. Others, like Karen and Anita, noted how they monitored their use and cut back on use if they seemed to be “going overboard.”

Karen: there's been times where I could feel that I was maybe using too much. And I thought whoa, back off. Because there's times where I'm going like, I really just don't have the energy to do anything. and I could feel that happening within myself, and I'm like, no. I'm going to go back to being more conservative with it. Because I don't want it to not work some day. Because just like anything else, your body is going to build a tolerance. And instead of one, you're going to need two, instead of two, you're going to need three. And I don't want that at all.

While many times, limitations on use were self-imposed, overall, patients appreciated that cannabis was a forgiving and durable medication that posed few dangers, even if one experimented and this led to taking more than was needed, and even when a person was on

multiple other medications. Cannabis is perceived as “safe,” prompting patients to prioritize personal responsibility as an important criteria in self-care regimens. Karen summed up the “set” associated with marijuana routines and risks well: “it really does boil down to you only taking what you think you’re going to need. Just like anything else, it can be abused, just like anything else out there....[Cannabis] is like anything else. You could drink one Pepsi a day, or you could drink a six-pack, you know? Food... anything can be abused, just about, if you’re not careful.”

Gary also talked about monitoring his drug use to minimize dangers from prescription pain medication:

I don’t take it twice a day for one thing. Number two I have dropped to, I don’t want to misrepresent this, instead of taking the pink pill which I don’t remember what the milligram is, I’m taking the blue one which is a lower milligram dosage. Which has really been great because narcotics or narcotic opiate-based medications for me it was affecting my memory. Because at that time I was going to, I had been on it for years and I was finishing up my bachelors degree and I had a hard time concentrating. I had to read things three or four times to get it to stick. My mind was fuzzy. I used to be real sharp, real quick. Quick witted or quick with a reply or whatever. And it affects you mentally if you are on this for a long period of time.

With Gary, the concern with prescriptions was not only with its physical dangers, but also with its mental effects. In his estimation, the mental effects from medical cannabis, in comparison with other options, were much more manageable in day-to-day functioning.

PATIENT’S OPINIONS OF PHARMACEUTICALIZING CANNABIS

On the whole, patients do not see cannabis as contributing to pharmaceuticalization. They also do not want to see cannabis pharmaceuticalized into standardized pills. Some reflected on the uselessness of Marinol: it was just not very effective. Dale talks about Marinol:

In its pill form, like Marinol, okay that’s synthetic THC, but it doesn’t contain any of the CBNs or CBDs that marijuana contains, and so will when you take the Marinol, just have the THC, it does not have the CBNs or CBDs, it’s like making a peanut butter and jelly sandwich than just saying two pieces of bread or peanut butter and jelly so much without putting the peanut butter and jelly on it.

Other patients clearly doubt that you *can* effectively standardize what the whole plant can do. This reflects the experiences of Carl and Mark, in feeling that cannabis as a whole plant offered more holistic health assistance than any pharmaceutical compartmentalization of the

plant was likely to offer. The rejection of pharmaceuticalization also reflected the desire for more natural forms of substances. Some thought that turning it into a pill form would actually make it more dangerous, and much more expensive. Another point that patients raised was that pharmaceuticalization removed cannabis from the control of the patient, who can at this point grow their own medicine. Finally, the idea of pharmaceuticalization may be perceived as a huge loss of diversity.

If a biomedical logic is imposed upon cannabis, the subtleties of whole-plant cannabis effects and their variations over strains is lost. So are other subtle enjoyments that are perhaps less strictly “medical,” but in fact may simply be the “treat” in the treatment; similar to what make CAM enjoyable but is lacking in medicine taking, making most people think of it as an unpleasant necessity. Patients compared these qualities of cannabis enjoyment and discernment to craft beers, fine wine, or other products with connoisseurship. This patient-centric perspective of enjoyment would be forced to yield to divisions based not on the consumer’s appreciation, but to the one-to-one equation of biomedical medicines, in which cannabis becomes subdivided into components based on condition. Some patients simply found many of these changes undesirable and unneeded.

It is clear that cannabis is not one medicine but is an entire class of medicines, just as the opium plant is the basis for an entire swath of widely used pharmaceuticals. Cannabis may challenge medicine to an epistemological shift, for the same reasons that it initially resisted cooptation at the turn of the 20th century. Cannabis is simply not processed in the body using the same processes as other substances. As more is known about the system of receptors in the body, which affect the activation of inhibitory and excitatory neurons in the brain—cannabis may rather ask biomedicine to conform to it, or catch the wave of interest in neuromedical developments, and may be more accepted as cognitive science and our scientific understanding of neurotransmitters improves. Cannabis may have a role to play in the rise of neuro-

medicalization that many neurologists think could advance medicine on the whole.

Another reason patients don't want it co-opted by big Pharma is simply because they don't trust big Pharma, a theme I will develop more in chapter 7. In the context of this chapter, patients see a profit motive that ultimately spells a value-added cost to the patient, and greater restrictions to access, without a corresponding improvement in value.

Patients also suspect situations in which pharmaceuticals derived from cannabis could be made legal, while whole plant cannabis continues to be restricted. Lest this sound farfetched, some parts of cannabis are already Scheduled in Schedule III, separate from the whole plant which remains in Schedule I, and there are already prescriptions under development that are poised to benefit from this difference. However, just as patients see cannabis as distinct from pharmaceuticals on many important dimensions, they also seemed puzzled by the idea that it aligned with the informal sector treatments, such as chiropractic, acupuncture, or even other herbal, homeopathic, or Chinese medicine regimens. A few patients described a dream of a world in which cannabis simply became its own full-fledged branch of accepted specialty medicine rather than being subsumed into any system as it exists. In this vision, specialty cannabis doctors and dispensaries would remain, but professionalize and become more accepted within biomedicine and society as properly medical.

CONCLUSION

Rosenberg (2007) lists conditions that demand long term multidimensional care or that have been resistant to available treatments as sleep disorders, arthritis, depression, migraine, irritable bowel syndrome, and chronic back pain (128). It may come as no surprise that these very conditions are among the most commonly reported conditions for which patients seek use of medical marijuana. Certainly this context lends some perspective to the patient-driven policies allowing for medical marijuana use.

Medical marijuana patients face a situation of incomplete medicalization, but in many

ways, the medical use of cannabis is a form of harm reduction, used as an adjuvant or substitute for medicines with greater side effects and dangers of toxicity. Doctors express reluctance not only based on incomplete medicalization but because marijuana is not completely pharmaceuticalized. As Nunberg's (2011) article to a medical audience states, "For physicians who make medical marijuana recommendations, the risk of being deceived is not dissimilar to the risk of deception faced by those who prescribe oxycodone and other painkillers; however, those prescribing the latter can limit the number of pills and refills" (12).

Many patients express a preference that cannabis remain in its "natural" state as a whole plant or minimally processed, whole-plant derivative. Even when patients expressed an appreciation for biomedicine, person after person reiterated that he or she was "not a pill person," and disliked taking medications. By contrast cannabis in its natural form allowed more individual control, and because of their knowledge that cannabis had an incredibly low level of toxicity and presented only mild risks for dependency, patients felt more comfortable grouping it with other "health behaviors" in the lifeworld, such as eating organic food, taking herbs, and sleeping properly.

Even as cannabis is medicalized, its current role contributes to depharmaceuticalization for most patients. However, when it comes to healthism, marijuana's management in the realm of self-care often leads some patients to group it with other health behaviors, but not all patients make the leap from calling it minimally harmful to actually healthful. This may be more a reflection of the larger cultural narrative than any other specific cause for this view.

Marijuana's reported benefit to those with widespread, undertreated chronic pain, and its ability to counterbalance trends toward pharmaceuticalization make the debate over marijuana's harms seem puzzling and irrational, especially given the serious harms associated with many approved legal prescription drugs (Cohen 2009a). However, the final chapter on stigma, may help to shed light on why the battle over cannabis has remain so entrenched.

CHAPTER 7. Cannabis & Stigma

INTRODUCTION

Cannabis use has an interesting relationship to deviance, stigma, and stereotypes. Although dabbling in cannabis experimentation has become statistically normative, regular cannabis use is not. The continued criminalization of cannabis enforces society's evaluation that its use is a form of deviance punishable by arrest and imprisonment. In spite of this, cannabis use is seen by many as a relatively mild form of deviance. Deviance is always defined relative to norms, so more conservative or strongly religious groups may perceive it more harshly. The estimation of its seriousness as a norm violation also increases when use is heavy, is combined with other deviant lifestyle behaviors, or when a person gets caught and is punished by the authorities.

Perceptions of deviance are also relative to setting. Recreational cannabis use can be found across many private social settings, and even in a few public ones such as music concerts, and within these social circles, use may be neither deviant (non-normative), nor stigmatizing (discrediting). Hammersly and colleagues (2001) refer to recreational cannabis use as “a signifier of any style that is ‘conventionally unconventional’” (139). In fact, in many social situations, cannabis may have few ties to individual identities, but instead be more anchored to the setting and its intended atmosphere (Hammersly et al. 2001).

Individuals who consume cannabis occasionally, and whose consumption is largely based on social availability, may feel little personal connection to cannabis. For many people who use cannabis casually, cannabis use is often only deviant at the moment of the “vulnerable present,” when an individual is in the midst of engaging in the behavior. Once that moment is

over, so is the act of deviance, although concerns with being caught may linger depending on whether someone possesses any amount of marijuana or paraphernalia, or feel at risk to be tested for drugs, primarily as a part of employment. Episodic cannabis use does not generally lead individuals to include cannabis consumption as a relevant feature of identity that carries across social situations (Hammersly et al. 2001). Often the decision to use cannabis is a spontaneous one made in the moment. For occasional or episodic users, especially those who do not maintain any personal supply, use is nearly always in the frame of the past. Future use is not planned, so such users may not see themselves as a current cannabis user.

Unproblematic past use is also not stigmatizing, especially if use was “on time” in the life course during teen or college years. It is commonplace for individuals to recount youthful, recreational use of cannabis as a signifier indicating that one was open-minded, fun-loving, mildly subversive, or otherwise culturally hip in their earlier years, and such tales are rarely accompanied by the threat of stigma. Only current and consistent cannabis use is subject to an ongoing threat of negative social judgment on a person’s identity. Even this may vary considerably depending on the social network and social situation. Marijuana use can be concealed, but how vigilantly someone must conceal it often depends on their sense of threat from judgment in their own social groups, in the form of interpersonal sanctions, as well as their sense of threat from the law or other institutional sanctions. Interpersonal sanctions may seem more severe when use is “off time” with normative life course expectations, when views of one’s social network judge cannabis use more harshly or disparagingly, or when one’s other role expectations such as profession or parent, represent value conflicts. Concealment may be more or less challenging based on frequency of use and whether use level is light, moderate, or heavy to the point of impairment that interferes with functioning.

In her article on concealable stigmas, Quinn (2005) suggests that an oft-repeated behavior is more likely to translate to an element of social identity. Unlike recreational users

who may opt to only use cannabis intermittently, and whose identities are only weakly and situationally tied to cannabis, medical cannabis patients have stronger ties to a cannabis identity. First, they adopt a consistent, ongoing routine of cannabis use, such that use is not isolated nor is it driven by factors of social setting. Second, when patients register with the state, they establish a formal identity as a cannabis user. They are essentially now card-carrying members of a cannabis community. These two factors create stronger associations between cannabis use and identity for medical cannabis users, making flexible transitions in and out of this identity less possible.

Because medical cannabis users consume cannabis frequently, and also see their use as ongoing, concealment may be more difficult and the threat of stigma may be stronger for medical cannabis users than for many recreational users. However, the medical designation serves to weaken the connection between cannabis use and cultural stereotype, and invokes the value-neutrality of medicine. While we may see recreational cannabis use as an adjunct to a lifestyle aesthetic that is subject to negative social judgment, medications are generally understood to be directed at the state of one's physical body and not dependent on one's cultural tastes, but may be subject to different moral determinations related to one's responsibility for health.

The introduction of a medical cannabis identity challenges the narrow framing of cannabis use and users that has dominated for most of the last century. Because taking medicine is considered in a much more value-neutral way than recreational drug-taking, the medical designation has the power to deflect or maybe redirect many of the stigmas that are applied to cannabis use. However, claims to medical cannabis use rest on one's claim to a legitimate medical condition. When it comes to patients with serious, objectively determined diagnoses, such as cancer and HIV/AIDS, cultural attitudes about medical cannabis use are often strongly sympathetic as shown in the polls, and patients are clearly exempted from cultural "stoner"

stereotypes, or interactional stigmas (Eddy 2010). However, as cases become less convincingly “medical,” the extension of a sick role exemption to medical cannabis also fades.

To varying degrees, illnesses may also be concealable and subject to stigma. People with many different types of disorders may seek to use medical cannabis. Some of these medical conditions are visible while others are undetectable in casual social interaction. Some are objectively diagnosed while others are diagnosed more subjectively, and may be vulnerable to contest and face legitimacy questions themselves. Ironically, most illnesses or diseases are less concealable when they are untreated and patients become symptomatic or the disease progresses. When cannabis or other treatments are successful, medical conditions may be less evident to others.

The ability to conceal either cannabis use or illness depends on one’s relationship with others. In casual interactions, it may be easy to conceal even very serious illnesses or medical conditions, but as interaction becomes more frequent and intimate, it quickly becomes more difficult or even impossible to maintain such concealment, and may require considerable effort to be secret in order to accomplish this goal, which can invoke undesired feelings of guilt or detachment (Quinn 2005).

Because it is directly tied to another stigmatizing identity, medical cannabis use presents some interesting complexities. Patients may be fine with disclosing their cannabis use, but wish to keep the illness with which it is linked hidden. The continued criminal status of cannabis use at the federal level also introduces risks that influence patients’ choices to disclose use regardless of their personal level of comfort with this identity. Patients may choose not to engage in political activity, advocacy or public speech, based on fears of arrest or the loss of other highly valued roles. It is legal to fire employees for use, and a drug arrest can also remove the ability to get funding for school or disqualify a person from other benefits. In extreme cases, it may result in the removal of one’s children by Child Protective Services, or hurt one’s

arguments for child custody. Patients must often weigh their willingness to speak out publicly about their use against the significant repercussions they might face if they do so. This influences not only public speech, but disclosure to networks of family, friends, and acquaintances.

In considering patient reports about their decisions to hide or disclose use, this chapter hopes to expand the literature by gaining insight on patient responses to stigma and stereotypes. Finally, the chapter considers the role of collective identity in the medical cannabis community. I propose that medical marijuana patients form a “thought community,” that has a group style. A thought community is a collection of actors who are linked by their shared occupation of a social role. Unlike a social movement, a thought community is more loosely connected through a shared, intersubjective interpretation, but may not be based on in-person relationships where actors know one another. These acts of interpretation include shared elements that come to reflect a group style, and offer tools on which individuals can draw to support their position (Arksey 1994; Eliasoph and Lichterman 2003; Rose 2007; Zerubavel 1997). I argue that the group style among medical cannabis patients emphasizes antiestablishment views, and invokes an almost libertarian approach in which individuals should be free to do what they want without government interference so long as it does not harm or disrupt others, with an especially strong emphasis on the fundamental rights of individuals to their own bodies. Lastly, I argue that this group style may discourage coordinated, collective action by medical cannabis users, but instead support the “to each his own” mentality even in social actions, and possibly to the detriment of the issue overall, because the results lack the strengths that come from coordination. However, group style encourages proud identification with cannabis use, and this transition from shame to pride has proven to be a more significant and effective tool for the social and political change of spoiled identities.

STEREOTYPES & STIGMAS

Many unfavorable stereotypes surrounding cannabis use circulate through American culture, characterizing users in predictable ways, and reinforcing associations with specific subcultural groups. Stereotypes are generalizations that operate as mental schema, offering us biased associations that can be applied to the world (Zerubavel 1997). They are created and circulate at the level of the group or larger culture. By contrast, stigma is a process of labeling that takes place at the level of the interaction, in which norms are applied to a specific person or group.

The stereotypes associated with recreational cannabis users are widely known. When the accoutrements are stripped from them, they echo stereotypes that have been formulated and applied to many marginalized groups, including those who identify as gay and lesbian, and to racial minorities. Most revolve around a sense of being “dirty,” unproductive, and lazy or incompetent. However, because cannabis use is associated with the young adult phase of the life course, stereotypes of cannabis users also exaggerate qualities associated with this particular phase of life to emphasize lack of experience and irresponsibility, while also implying that those who have aged out of this part of the life course are immature or “burnouts” because they have maintained inappropriate behaviors relative to their age. Stereotypes often include associations with particular subcultures, and these associations endure, but new associations are added as new youth cohorts create their own subcultures. Although there are various subcultural groups that have an association with marijuana use, the most salient one for those in midlife, and for Baby Boomer groups in particular, is the “hippie.”

Nearly every patient in my sample treated the question about stereotypes as if it were self-evident and as such, unnecessary to discuss. When asked, most offered some variation of “dirty, unproductive hippie,” as the most predominant social stereotype of cannabis users.

Karen was a little more detailed and colorful:

The whole reefer madness scenario.. you know—the way the government has portrayed it, and in the movies too, you know. *Cheech and Chong* and *Pineapple Express* movies, and all those others... [Cannabis users] are portrayed as just a bunch of losers, that they don't do anything and they're not productive to society or whatever. Well, I'll tell you, I know a lot of people who are cardholders, and they are amazing people, taxpaying, productive, you know, careers, doctors, lawyers, computer geeks.

Even as Karen elaborates the stereotypes, she illustrates one of the more adept uses of rhetoric evident throughout the medical marijuana community, to first point out *who* is doing the stereotyping—the government, and the media—and second, to immediately claim countervailing evidence that shows the stereotype is unfair and inaccurate. Karen also provides a good account that captures stereotype threat:

You know, there's all those little names that are out there. I've even had a guy say that, "well I don't want my customers to know that I'm going to get my [medical cannabis] license." Oh no! But yet, that the man who has had numerous back surgeries, always in pain, done all the other drugs, saw they didn't work, and still he doesn't want anybody to know. Because there's that mindset, and people are judgmental.

Stereotype threats occur when individuals are concerned that specific, culturally available stereotypes will be applied to them. This does not require an interaction; rather it consists of a fear of experiencing stigmatization based on being viewed through the lens of a negative stereotype (Steele 1999). Individuals may reflexively imagine that such labels will be applied to them, and adjust their appearance or visible behavior to avoid this possibility, even though no actual interaction has taken place. By contrast, stigmatization occurs when individuals experience an actual interaction in which another person does actually apply stereotypes or norms to pass a negative social judgment on the individual. While many patients in this study were able to avoid stigma, in part because their own social circles did not apply these stigmas, but in part because they could conceal their identity as they chose in other potentially stigmatizing social settings.

ILLNESS AS STIGMA

Most of the medical marijuana patients who volunteered to participate in this study are contending with serious chronic illnesses, which are stressful and stigmatizing. Medical cannabis programs are generally structured such that a legitimate claim to medical cannabis

relies on a legitimate claim to an illness. The legitimacy of an illness may be related to fulfilling the normative role expectations attached to “the sick role.” Parson’s concept of “the sick role,” introduced in 1951, has been foundational to the sociology of health and illness. The sick role indicates a socially acceptable suspension of normal social role expectations, but comes with the “price” of recognition that illness is “undesirable, and the sick person should be working to recover “as expeditiously as possible” (Conrad and Schneider 1998 [1980]:247). However, some health researchers have suggested that the sick role has become “increasingly contingent” in the current environment where chronic illness has increased and medical pluralism abounds (Rosenberg 2009). The ongoing nature of chronic illness revises the sick role. Chronic illnesses often span a long period of time, and may not be resolvable without continuous treatment. This creates a dynamic in which the sick role is not clearly defined. (Burnham 2012; Rosenberg 2009; Turner 2004; Varul 2010).

When stigmatized identities are forced to be hidden due to a combination of criminality and ridicule through stereotypes, they become tied to feelings of shame. However, medical marijuana use has created a legitimate pathway for reclaiming cannabis use without tainting one’s identity and, much like the gay rights movement, medical marijuana users have approached the revision of this “tainted” and legally prohibited identity, in part by shifting from the shameful secrecy to claims of pride. In order to challenge persistent negative cultural stereotypes, medical marijuana patients challenge the law and risk arrest by the simple act of claiming the medical marijuana patient identity. When patients identify as cannabis users, they participate in revising the language and meanings associated with cannabis use. Research on the gay rights movement has shown collective identity to be fundamental for enabling political engagement (Britt and Heise 2000).

Negotiating Chronic Illness

Just as one could not look at patients in this sample and know their affiliation with

cannabis use or cannabis culture, only two patients out of the forty had any visible illness or disability. Zane was confined to a wheelchair due to an amputation, and Wes was legally blind and used a cane for walking assistance. Of the other 38 patients, none appeared to be ill upon casual acquaintance. It took knowing their stories and their willing disclosure to understand the invisible presence of HIV, cancer, epilepsy, multiple back surgeries, or other conditions.

As with Karen's story about her husband Marcus from chapter 1, many patients described a process of adjustment to chronic illness conditions, in which they slowly come to terms with the meaning of their illness or injury. In this sense, the "sick role," was not only an external label, but one by which patients formed their own expectations. Many expected to inhabit the "sick role" for a short amount of time, identify what was wrong, treat it, and go back to normal. It took time for patients to realize that they were not "going back to normal," but were faced with finding a new normal, and with potentially inhabiting the sick role, or cycling in and out of it with much greater frequency, perhaps for the rest of their lives. This was especially true for some who became officially designated with a disability status through the state. Forty percent of my sample qualified for some form of disability, but qualifying for such benefits is often a lengthy process, and psychologically taxing because it involves accepting the designation and the limitations it signifies.

Billy exemplified this gradual acceptance of disability very clearly. On the weekend that Billy graduated from high school, he and his closest friend from school went out to celebrate, but the night would change the rest of both of their lives. Billy got behind the wheel drunk, and wrecked his car horribly. His injuries were very bad, and although his friend lived, he was also permanently changed by the accident. After months in a coma, Billy spent over a year in rehab, learning to do everything over again. He lives with a traumatic brain injury that limits his abilities in many ways. Nevertheless, he was brought up in a hardworking farm family and taught a spirit of Midwestern perseverance, and he stubbornly put his mind to relearning many

skills, and to living independently from the care of his loving family. Billy pushed against the disability label for years. He got a culinary degree from a prestigious school. But he just could not hold a job. He could not manage the amount of multitasking under time constraints that was required. After nearly ten years and according to him, over 100 jobs, Billy finally conceded. He had a disability as a result of his accident, and he was not capable of working like others. It was on one hand a relief and on the other, a huge blow that he counterbalances with his pride in his college degree and in his success at maintaining an apartment independently. He says:

You know, I have accepted the fact that I am disabled. I went through and I fought for so long, you know every time I got back up to fight, they would knock me down and, “oh, you’re not disabled.” So I had to hit that wall where I was just done. I couldn’t go anymore.

For many years, Billy fought against the disability label, even though his inability to hold a steady job left him constantly struggling economically. Even now, his funds are very meager, and he has to work to make his money last, but he says that since going on disability, his life has stabilized a great deal.

You know. I am happy getting what I do. I don’t have to move every month or two. I have stuff. I have a bed. I have a couch, I have, you know? TVs. I’ve always had TVs, you can stick a TV in the back of your vehicle. But couches, loveseats, dishes. I have a home, you know?

Billy’s struggles to make ends meet and meet his basic needs were formidable. Despite living marginally and struggling constantly, and even despite the accident that made his injuries plain, it was very hard for him to accept being disabled, a designation that seemed to indicate that he could never live a normal life. Perhaps more importantly, as a young man, admitting disability had seemed like giving up on his aspirations to achieve many of the same normative life course milestones that many hope to reach.

Yvonne’s illness came later. By the time she became ill, she had already been married, had children, and worked in a career. Rather than stopping her short of her dreams for a normal adult life, Yvonne saw disability more as a sign that her productive adult life was coming to an end, and middle age was giving way to prematurely becoming “old.” Yvonne not only resisted

the disability label, but she initially rejected her diagnosis altogether.

Yvonne: For years, I have burning in my neck and shoulders. I thought it was from sitting at the computer, and it's fibromyalgia. So I got diagnosed back in, gee, it was probably 2008 or 2009. I apparently had it a long time, they said. I never related the pain to anything except sitting at the computer too long....I didn't believe in fibromyalgia, to be honest. I didn't believe it was really anything more than an excuse to be lazy. I kept saying "no, it's not," to anything [my doctor said], that's why she sent me upstairs to get tests ... because I didn't believe it. I said, "no, it's not that." [My doctor] she was like, yeah, I think it is. I said, "no." ...

Although resistant, Yvonne eventually begrudgingly accepted her diagnosis. Her fibromyalgia prevented her from returning to a normal work life, but her resistance to accepting her new situation of living with chronic illness was also evident in her resistance to applying for disability. She also says that she often opted to not take medications, even though she was in pain, preferring to manage on her own, citing concerns with becoming dependent on medications.

It took me a good year before I would consider signing up for disability, it took my cousin, a nurse, to talk me into it.... I didn't want to use it as an excuse, you know, I wanted to—well, it was a lot to say you were disabled. That was hard for me.

In addition to fibromyalgia, Yvonne has been diagnosed with Crohn's disease. Like Billy, she also attributes her eventual willingness to apply for disability to difficulties maintaining a job due to illness symptoms.

I lost my job because....basically I was up in the bathroom all the time. But you know, half the time, they did not even know I was gone it was so fast there and back and the bathroom was there by my desk, so at the same time, I was very tired. I was so tired. It hit all at once.

While Yvonne had worked for most of her adult life as a self-professed driven high achiever, her illness interfered with her job. But it was the culmination of several crises among family members, including the death of a parent, that pushed her to the point of accepting that she was in a situation where normal functioning was not possible. Chronic illness or consequences from serious injury often combined with unrelated factors or created obstacles to maintaining roles in such a way that patients could not continue to maintain appearances that they were fulfilling the work role. Others, like the stories of Karen's husband Marcus in chapter 1 and the story of Anita in chapter 5, interfered with not only the ability to hold a job, but also

with the ability to maintain a parenting or spousal role, until they had found solutions for managing their illnesses. Role disruption was an important part of the process when redefining life after serious injury or chronic illness. Often these role difficulties became difficult to hide from close networks, but are invisible struggles to others. These patients often fought very hard to maintain these roles, and feared being seen as “lazy” or incapable.

In some ways, the fear of being stigmatized as ill or as a cannabis user both include fears of being labeled as lazy and unproductive. These negatively impact the ability to be proud and to gain the respect or favorable estimation of others. In fact, in Billy’s and Yvonne’s accounts, their attachments to being perceived as hard working, honest, productive and avoiding being labeled helpless or victims led them to cling tenaciously to work roles, and suffer economically as a result.

MEDICAL CANNABIS AND STEREOTYPES OF THE CANNABIS USER

With medical cannabis, and perhaps especially those engaged in other normative role functioning at midlife, there has been an increasing convergence in important respects between the ways in which cannabis users understand and identify themselves—as non-deviant, ordinary citizens—and in how they are externally categorized (Hammersly et al. 2001:142).

Categorization includes an “external” aspect of social identification and an “internal” self-identification. Often internal self-categorizations rely not only on the types of social anxiety Mary Anne felt about “coming out” in support or marijuana in specific interactions, but they are couched in the fact that the patient and those with whom the patient interacts are aware of the negative cultural stereotypes that can be invoked in such interactions. For many patients who had used cannabis recreationally before, the adoption of the medical cannabis identity allowed them to be more open about their use because it buffered these stereotypes. Jason had regularly used cannabis over his adult life. When I asked if using marijuana medically had changed how he looked at his cannabis use, he said, “Not really. The only thing it’s really done is made me a

little more comfortable and not feel like I'm just hiding something. I just feel more comfortable now. That it's more accepted."

Jason had never identified very closely with any lifestyles stereotypically associated with cannabis use. A fiscal conservative in the financial industries, Jason looks very clean cut and businesslike, from his haircut to his tie, to his choice in shoes. Like about a quarter of the participants in this study, Jason had pretty much always voted republican, "except for Obama." He expressed disdain for hippies and for the Occupy Wall Street movement that was actively protesting in Denver at the time of his interview. In response to Occupy, Jason offered,

Jason: All these protestors out there are just killing me.

Me: How so?

Jason: Because—get a job! Go get a job. Instead of sitting around in the park moaning about how you don't have anything. Go get a job. There are jobs out there. You can go flip burgers.

Nothing about Jason's attitude conformed to stereotypical expectations. Even though he had regularly used cannabis over his entire adult life, over 16 years, he felt it had had no influence on his political views, or outlook toward others, other than his views on the specific issue of marijuana laws. Like most people in this study, Jason had no trouble easily coming up with the most common stereotypes applied to cannabis users. In fact, nearly all of the patients in my study identified hippies, being dirty, being lazy, and being unclean or unsuccessful as the most common stereotypes. A few patients in my study who maintained identification with "hippie" ethics, strongly left-leaning politics, or clothing and hairstyle choices that could be associated culturally with this group were concerned with stereotyping, but most knew that neither they, nor any cannabis users they knew, fit this profile. However, those among my interviews who adopted lifestyle accoutrements that reflected "hippie" culture and those like Jason, who did not, appeared to be an indicator of those who might embrace recreational cannabis culture, but it was not. While some, like Valerie, were very hippie in fashion and also in their cultural and political affiliations, others like Yvonne, who claims to "wear a lot of hippie garb, even to church," had a clear disdain for much of cannabis culture. She chalks her clothing

choices up to comfort and retirement from work, relieving her from the requirement to dress professionally. However, she describes her personality in more of an overachiever fashion, a fact that made it very hard for her to accept the limitations of fibromyalgia. She says that before she “got her wings trimmed” from the physical mobility limitations that fibromyalgia creates, she had been “really judgmental... after being around people in Oregon” who she says she saw as “lazy potheads” who didn’t want to work. Overall, she was disapproving of using cannabis as a way to make claims that you could not do other things. Using it to be more functional was the appropriate moral outlook.

By contrast, others such as Julie, a school teacher, or Aaron, who worked in a job that dealt with the criminal justice system, had appearances that suited their career choices, yet both embraced participation in recreational settings and had an affinity to cannabis culture. Ultimately, even as patients were aware of the stereotypes about cannabis users, their own personal style choices did not clearly indicate their relationship to the recreational or medical cannabis communities and their cultures.

Frank, a patient with advanced cancer, was the oldest patient in my sample. He lived in an artsy house, and told stories of his advanced education, college experiences, travel, and living abroad that conformed in some respects to a more “bohemian” lifestyle and outlook. When I asked about his views about marijuana user stereotypes, and whether he believed that any of them were accurate, he said, “No, that would almost as stupid as making comments about ethnicity. Some of it’s true, but you can’t just make a broadcast and have that hold up.” Frank underlines my observation above; by lumping stereotypes about cannabis users together with other types of stereotypes now considered inappropriate, he capitalizes on the idea that stereotypes, generally speaking, are simply an ignorant way to think about people.

IDENTIFYING WITH CANNABIS: PRACTICAL RISKS

Even as medical cannabis is portrayed as easy to access by the media, there are many ongoing practical risks associated with its use. Growing cannabis or providing it to others increases risk of police interventions. Workplaces are not required to accommodate use, but can drug test employees, and marijuana use is likely to be detected in such tests. If employers learn of a patient's medical marijuana use, they may choose to enforce these rules; so far, the courts in these cases have sided with employer's rights. Media and policymaking have increased concerns with driving after cannabis use, and tried to set a new, but scientifically conjectural limit on THC in the blood, and patients worry about criminal charges from driving. According to an attorney who handles many medical cannabis cases in Colorado, Child Protective Services are no longer basing child removal in Colorado solely on cannabis use, but it can be a determining factor in the removal of children from parental custody.

These factors influence patients' choices to disclose use to family, friends, or mainstream medical professionals. It may influence their political activity, causing patients to become more active on the medical cannabis issue. Alternately, it can cause some patients to avoid political activity or association with medical marijuana in order to lower their level of risk of losing jobs, kids, or being raided or robbed, a situation to which many patients may feel particularly vulnerable given that many lack the strength and may be easily injured in the event of such high-stress incidents. Finally, it may influence their decisions about how and when to use medical marijuana.

Trade-offs

While medical cannabis use can sometimes mitigate role loss by improving functioning, and reducing pain or depression, in some respects its controversial role as medicine also can make one feel more threatened to lose these roles if their cannabis use is revealed. Several patients in this study expressed their careful concealment of cannabis use in relation to their

employment. Job threats extend beyond concerns about drug testing. For instance, consider Andy's case. Andy worked in IT. He had to go on a business trip with his boss, and travel often caused pain associated with his degenerative disc disease to flare, causing his upper back to knot up and, if left untreated, he got an excruciating headache. He would usually use cannabis for flare-ups, which reduced or removed the symptoms without significant loss of functional time, but the travel and the presence of his boss made cannabis a difficult option, so he concealed a tiny amount of tincture in an Ambesol bottle and brought along Vicodin, just in case he had any difficulties. Andy tended to have pretty bad side effects from using Vicodin, so he hoped that he would not need it. The situation was compounded by the fact that Andy had worked to conceal his illness from his company because he feared it would prevent him from being promoted, or they might phase him out. He had seen this happen to someone else. Andy says:

[This was] the first time [my boss] ever saw me with a bad day [from illness]. I actually – we were in a hotel, we have adjoining hotel rooms. Actually did take an Ambesol bottle, dump the Ambesol out, and put tincture in the Ambesol bottle. So that's all that I had. Then usually that's not enough for long-term pain problems. I also had Vicodin, with me. Because I couldn't take my [regular cannabis] medicine. So I have the Vicodin, and you'll recall I hate the crap. So I woke up on a bad day, they were under a lot of pressure, and I had to excuse myself about an hour into the day. I said, "I've got to take a break." And I told [my boss]. I didn't want to tell him, hey look, I'm basically handicapped. I'm going to have bad days for the rest of my life. I'm going to not be able to work some days. I don't want to tell him that, because I don't want the negative backlash that exists in the real world. Do I say, "now I'm covered by the Americans with Disabilities Act"? Well I'm not that kind of person. I'm not going to push that kind of crap down somebody's throat. I just expect to be treated like a human being, right?

Andy, much like Yvonne and Billy, does not want to invoke any special privilege or be seen as incapable as a result of illness, but for Andy, this means he feels compelled to hide his illness altogether. He would prefer not to invoke "rights," but simply be extended decent treatment. He points out that, because pain is not visible to others, they are often lack understanding and are not very sympathetic:

[He pretends to be an unsympathetic coworker, in a whining voice]: "Ohhhh, he's got a headache."
[back to normal voice] People who have never had serious pain don't understand it. And so I – well, I had a bad day, and I had to excuse myself... He saw me in pain, and I went to the room and I sat there, just having a fit [of painful back spasms]. And I took that Vicodin. It made me feel worse. That's what happens sometimes, with opiates for me, they don't help. I don't like taking them anyway because they screw up the receptors in your brain and all that, and I just don't want them. Anyway. I had a bad day. And two weeks

later he told me, I'm going to have to switch you over to contractor's tasks. And after that point I practically didn't hear anything from him again. He wouldn't ever directly, um, address me or anything, it was all like standoffish, and so on, and so forth. Then after about six months he said, "I don't have any more work for you." I think it was entirely because of that event.

The management of two concealed identities in Andy's case created an untenable situation, in which his inability to take medicinal cannabis due to several limiting factors left him in a situation where he could not manage, and therefore could not conceal, his medical condition. Because he had made a strategic decision to conceal his medical problems at work, his boss had little context to understand his response, and ultimately, Andy felt it was directly responsible for losing his job.

Other patients recounted similar situations where legal limitations on cannabis combined with the desire to maintain the appearance of non-illness in social situations created impossible trade-offs.

Legal Problems as Institutional Sanctions

Most people who use cannabis recreationally will do so without experiencing problems with dependency. In fact, the most negative consequence from cannabis use is often as a result of getting arrested. Medical cannabis has created new pathways, but the co-existence of criminalized marijuana is found by many patients to be the most dangerous aspect of medical cannabis. It may lead to harassment or arrest, and in towns or cities where local government or law enforcement are less supportive of the state's laws, it may lead to blocked access.

This has been a concern for Ron. Because he is treating cancer and using a highly concentrated product that is not commercially produced, he has to maintain access to substantial plant material, grow his own, or find a source. He says, "the only problems I've had with the medicine is, one is, not having access to it." Ron also experienced harassment and arrest. Ron's legal difficulties included interference with his access to cannabis and created intense stress while he worked through the legal complications. He had difficulty maintaining

cannabis access while also managing the legal complications and expenses from his arrest, and the potential of going to jail.

[the District Attorney] took my medicine and told me to die. I said, I have a doctor's recommendation to do exactly what I'm doing. He said, I don't even care about that. That's what's going on. So every day, I fight for my right to fight for my life. It'd be nice if all I had to go was get up every morning and fight cancer. They've got my medicine! They won't give it to me. I have to beg people on the street to have enough medicine. It puts me in situations when I run out where I think I'm gonna die, and then, and the symptoms that I go through—it's not, it shouldn't happen. And these people just continue to refuse to accept the facts! The science! Because of greed... because of misinformation. And de-education.

After this interview, Ron's case was dropped and his medicine was returned to him, but it had not been properly stored and was useless. Six months after this interview, Ron contacted me to say his blood tests had improved considerably and the numbers were cut in half from when I'd seen him—halfway back to normal readings.

Ron's case was particularly egregious, but he was far from alone. Of the patients in the sample, about a quarter reported some form of police intervention or burglary of plants. Two other patients faced charges and court battles at the same level of seriousness as Ron's case. Other patients reported less serious issues, but these incidences clearly raised fears of vulnerability. For instance, Darrell had an interaction with the police that represented dangers to his health, when the cops raided his garden based on an anonymous tip, even though the garden was found to be within the guidelines and no files were charged:

I was well within my rights. I was not charged. There are no pending charges. But my house got raided and they knocked my door down, they threw a flash grenade into my house. They knew I had dogs. They burnt the tail on one of my older dogs...and they hurt my little dog....They made them poop themselves, literally...after the flash grenade went off, they were running in and saying "get down, get down!" [I said,] "okay. I'm disabled. I'm disabled, I'm not going to fight you...nobody's going to fight you, just settle down...They had 13 SWAT members in my house with automatic weapons pointing in my face, screaming "get down!" I'm petrified for my animals. They [the SWAT team] ended up pushing me down to the floor and they ripped my shirt off of me and told me to crawl. I had [injured] my leg back [over the summer] and ... my knee is trashed, and my other knee [had a major injury a few years before] as well. They grabbed me by my fingertips and were dragging me across my kitchen floor, scarred my knees up... I have pins and screws in my lower back with a cage. I've got four long bolts that are this long [indicates 6-8 inches] and look like they belong in a fence... I have to get three MRIs now. I've got pain shooting down, my neck is numb and my arms hurt because I can't stretch like they had me stretched. And I kept telling them, I am not going to fight you... they said they were there for an "overgrow." They kept us detained in handcuffs for 25 minutes until the detective got there, and then they go down and they had already been down in the basement. They knew I was well within my rights, the rights of my medical card. They tore half of my Mylar [a type of reflective material] down off my one room so they could look to see if anything was behind it. I was dumbfounded for what happened. And scared to death, too....I didn't even get an

apology....Nobody's fixing my door. My house is trashed...And we're still cleaning it up. We were at 22 plants and I'm allowed 24. I have a license for 24. So they ended up just leaving and I haven't heard anything else.

For Darrell, it was not only the stress and fear of the raid, but their actual physical handling of his dogs, his belongings, and most importantly, him, without concern for his disability. Ultimately, they presented much more danger to him than he felt marijuana ever would. He feared the ease with which something like this could happen, and he suspected that he knew the person who had called in the anonymous tip for malicious personal reasons, but he could not prove it. He worried that, were another raid to happen, they would injure him, his home, or his dogs further, perhaps irreparably. In the end, he considered pressing charges, but decided against it, in part because he is chronically ill and poor, and he lacked the energy or funds that is required by such a protracted battle.

A few patients, like Karen and Beth, went above and beyond to show they were cooperative toward law enforcement. In a story I mentioned in chapter 1, Karen recounts her run-in with the DEA. In our interview, Karen begins to describe her rationality for deciding to grow a cannabis garden—in essence, cannabis from the dispensaries is expensive. Like many budget-conscious patients in this study, Karen decided to try growing to reduce costs.

there was one day where I was down here, you know, taking care of the garden and all. There's a knock on the door and the drug enforcement agency was knocking on the door. The DEA, you know? That was really scary. I think what happened, and I can't be sure, but I'm almost positive that—we had done some remodeling done on our house, and we got a government subsidized loan to do that. And I'm pretty sure that the guy who is in charge of that program saw what we were doing and called the feds. Because it was government federal monies that we used to do the upgrades on the house, and I'm pretty sure that he was very old school and didn't agree with any of it, you know? And felt like, he was just going to call.

This part of the Karen's story corresponds with other patients' concerns that even when one is careful, unforeseen situations can still lead to legal problems.

So I'm downstairs and I can hear my husband upstairs going, "yes, yes sir. No sir." And they thought, "who's here, who's he talking to?" And so I come upstairs, and there are two officers with bulletproof vests, and they're all in dark blue. They've got badges, and I'm thinking okay, these are not regular police officers, who are they? And they introduce themselves as drug enforcement agents, you know. And I thought, "okay..." ... I was too shocked to be scared. When we first started growing, everybody always told us if you're going to grow, you don't have to let them in, you just put your card in the window and say bring me a warrant and I'll let you in, but without a warrant, bye. Well, we open the door and let them in.

And I thought, you know, I'm doing it legally, I'm under my [allowable plant] numbers. If I don't have anything to hide, you might as well let them in, and we'll cooperate.

Karen decided to cooperate and ultimately after doing a “good-cop, bad-cop” routine by her account, the officers questioned her politely, took photos, counted the plants and left, but before they did,

They basically gave me a thumbs-up and said well you're doing it the way you're supposed to be... So that was a very huge relief and a huge shock because I just thought— “I'm going to jail! My God!” Because I really did think that—that's it. It's done. Because again still it's a federal offense. But it was such a small operation that I don't think they just felt that, you know what? [she makes a kind of pssh sound like dismissing] ... before the DEA left, they said, “well, we are going to go talk to your local law enforcement to let them know what's going on around here.” I said [huffs], “Fine.... Go ahead,” you know, whatever. But I thought, “god.” The next morning I woke up and I thought, maybe I should go and talk to them myself first. Because I thought well if they're going to go talk, because they told me, they said, we're going to go and tell them. And I thought, Fine, whatever. Because I really didn't want them to know. I just, I didn't want them to know what I was doing. Because again, there is the stigma of, it's an illegal operation. Even though I have my card. Even though I had a recommendation, even though...

More than half of patients had an interaction with officials that led them to fear criminal action or other sanction and often this drove home the tentative legal status of being a patient. Even if patients think that the risk of arrest or jail is minimal, this fear still runs deep, because these situations often reveal the lack of protections that many patients feel they have once such a charge has been brought forward. For many patients, such scenarios caused an attitude of defiance and outrage. Patients resented being placed in a position of fear from the police. The police often only managed to further entrench divisions and emphasize who was in the right and who was in the wrong based on current policies. Patients were undeterred from their moral position. I found it interesting that those who had experienced these run-ins persisted without being deterred, and often were only more stubbornly determined to exercise their rights after such incidences. By contrast, those who had not experienced any such threats of arrest or other negative consequences seemed unconcerned, and estimated the likelihood of such an event occurring as very unlikely.

“COMING OUT” FOR CANNABIS: STIGMA & DISCLOSING CANNABIS USE

Although there are serious risks associated with disclosure, cannabis medicalization can be a force for “normalization” because taking medicine is often seen as morally neutral. We do not typically associate taking medications with a particular cultural identity or lifestyle. This affects the stigmas and stereotypes that often co-occur with deviance. Stigmas are addressed to a person’s identity or character and entail an assignment of discrediting qualities assigned by others. Unlike some stigmas, which are visible, cannabis use is a concealable stigma, and as such, it requires individuals to make decisions about hiding or disclosing their use to others. Medical drug-taking is often considered an activity that is appropriate to keep private, except perhaps among one’s closest friends or family. However, because recreational drug behavior is often also concealed, medical users may wish to distinguish their use as medical by lowering the barriers of concealment. Disclosing medical cannabis use within interactions becomes a way of declaring its legitimacy, while also allowing the patient to show they have nothing to hide from significant others. In a sense, cannabis users “come out of the closet,” often in stages of disclosure, starting with those to whom they are closest—spouses, children, parents, siblings, and best friends. Some will stop there, but others continue to expand the coming out process to weaker networks until it is an undifferentiated, public identity claimed by the person.

This has an interesting effect of creating the possibility for much more interconnected and self-aware networks. As McKenna and Bargh (1998) point out, stigmatized individuals may like to connect with others who share their identity, but when the identity is “concealable and potentially embarrassing,” due to cultural devaluation, it may be hard to look around and identify others, and it is often an act of bravery to be the first to disclose, and these factors become barriers to group formation. As a result, this notion of “coming out” has been used not only in the context of identifying as gay or lesbian, but the literature has examined it as a behavioral process among those with other concealable, stigmatized and stereotypes identities,

including those with mental illness, depression, autism spectrum disorder, or as an undocumented immigrant (Corrigan et al. 2010; Davidson and Henderson 2010; McKenna and Bargh 1998; Ridge and Ziebland 2012). With medical cannabis, the “coming out” framework is not solely a model imposed by researchers, but is occasionally used in the rhetoric found among medical and recreational cannabis use advocacy, heard at multiple events I attended. At one in particular, Mary Anne spoke. Her husband was involved in cannabis legal matters through his profession. She decided to become active in cannabis advocacy after changing to a job serving cannabis patients. In her first public speech among the cannabis community, on stage with a microphone, Mary Anne began by calling it her “coming out speech,” the first time she had announced publicly that she was a proud supporter of cannabis use. She described how even after attending meetings, where members discussed these issues, she had been afraid to say it was normal and okay to smoke marijuana, and had been content to sit on the sidelines and “watch other brave people do the work.”

This speech explicitly drew on the terminology of “coming out,” but it went further than that, using the process of coming out as a model, and acknowledging that disclosure requires a significant amount of deliberation, in which individuals anticipate the reactions of others, and deciding to disclose is often frightening and requires one to “be brave.” Mary Anne described her experiences before coming out: “medical marijuana exploded, and regulations were in the news every day. At my job, there were stoner jokes every day, and people would roll their eyes, but I said nothing. Every once in a while I would be brave enough to share something, but my coworkers would just make more jokes.”

She goes on to say that people would be surprised if they knew who uses marijuana. Once she was free from that job, she felt liberated to talk about it without the threat of losing her job. She ended up choosing to work to help run a cannabis-related business that served patients. After she took that job, she says, “I started thinking about how would I come out in other areas

of my life—to my son, to his school, to other parents? How would I tell people what I do? It was scary and uncomfortable, so I over-thought and over-planned it.” Then one day, Mary Anne found herself with the mother of her child’s good friend. This mother was one of those seemingly “perfect” women, and Mary Anne was sure she would be judged disfavorably through her disclosure, but “when the topic came up and, she [the mother] simply said, ‘wow, that’s great. What do you tell your son about it?’” Mary Anne says that in all of her imagined conversations with acquaintance, she had never thought of someone asking her this question. In response, she said “my son understands the importance of patients having medications, but he’s six, that’s all he needs. But when he’s older, I expect to tell him the truth.” In response the mother said, “that makes sense.” And, Mary Anne recounts, that’s when he realized that in this normal location, she had “come out” to someone as a marijuana advocate, and she had not been subject to stigma. The person had not reverted to cultural stereotypes. She goes on to talk about taking more opportunities after that to come out. She ended her talk by exhorting other to “tell the truth. In every conversation you have. You know that you are on the side of right. Help spread the message that it is normal to smoke marijuana.”

Other speakers made direct comparisons between being a cannabis consumer and being gay. Others emphasized that it was important for women in particular to claim this issue and to come out of the closet, emphasizing the moral authority of women as mothers. It was also implied that women were less subject to the more insidious stereotypes of marijuana use, a suggestion that was supported in at least one recent study (Looby and Earleywine 2010).

CANNABIS: FROM SHAME TO PRIDE

In their chapter “From Shame to Pride in Identity Politics,” Lory Britt and David Heise (2000) discuss how social movements help members redefine stigmatized identities in more positive or prideful terms. This may also apply to health-related identities that are contested. Pia Bülow(2004), for instance, describes how patients with Chronic Fatigue Syndrome were able to

collectively create a narrative about their experience, and through the transformation from a personal narrative to a collectivized one, experience a sense of confirmation, which serves to support the identity as valid. This process may serve a positive purpose for the individual, as well as building a stronger base to challenge scientific or medical authority (Brown et al. 2010). Medical marijuana users also tend to tell a narrative that borrows from the larger medical marijuana community and an alternative explanation of marijuana-related science and history, in order to revise the affiliation with marijuana from one of shame and embarrassment to one of pride.

Me: Have you ever felt embarrassed?

Anita: In the beginning, for sure. In my line of work, people seem to be so hardline against it. so I am the one in like hundreds of my peers that don't believe that way. It's hard to feel alone. Yeah, it is a very lonely place to be in the work environment. When you can't be outspoken about what you do to alleviate your symptoms. Especially when they saw me getting better. That was really difficult. Well, what are you doing? Diet and exercise. What else are you doing? Getting rid of my prescription medication, doing a lot of herbs. I mean, you finding ingenious ways to say it without saying it.

Anita shares with many patients an initial sense of embarrassment that slowly turns to an acceptance, and then a more confident claim to the medical cannabis patient identity.

Others, like Julie, were unexpectedly “outed” through participation in activities, which forced them to have the conversation with employers or others when they might have otherwise chosen not to disclose this information:

Julie: You know my boss knows when I did the marijuana driving study I was teaching here and uh the night before the news was on I went into my bosses office and I' m like alright I got to tell you something. You might want to fire me? He said we' re not going to fire you over this. Uh my father is a minister and he supports what I do uh he love the fact that it; I have a brother that' s an alcoholic and my father has seen firsthand the difference between who' s on weed and my son who' s an alcoholic and my brother still works at a restaurant and I have a master' s degree.

Lots of patients expressed initial embarrassment or uncertainty, but most patients claimed they had a lot of pride in being involved with medical cannabis now, and also with that pride came a willingness to talk about it with anyone who didn't present a direct threat to practical resources. This dynamic fit with the concept from LeBel (2008) that some patients would be proactive and pre-empt threats of stigma by adopting an advocacy role. For instance,

Andy calls himself a “good poster child for cannabis.” He testifies at government hearings and participates in politics. When he was employed in the IT industry, he was very careful with the disclosure of his medical marijuana identity in order to avoid being challenged or fired on this basis. Now, he is unemployed, and this led him to decide to use his time to be active on the issue. Many other patients expressed a sense of pride, especially with the recent strides in Colorado’s medical marijuana program as a frontrunner in the country. For instance, when I ask Brett, he says, “ I’m very proud. I’m extremely proud about what I’m doing. I have zero apologies or shame or anything of that type. AND I’m very proud of Denver.”

A few patients feared reprisals, and did not publicly identify. For instance, Gary lives in public housing, and he feels that speaking publicly or acting politically on this issue could cause him to lose his home, so he is very discreet, and his only point of disclosure is through a pseudonym online. Even though many patients claimed to be “out and proud” about their medical cannabis identity, there were situations where disclosure was more challenging or seemed inappropriate. Disclosure is not only an “either/or” or a “yes/no” proposition. Individuals must decide not only whether to disclose the marijuana use, but when and how to hide that same information, and how to frame that information, and these factors vary across situations.

For instance, while most people disclosed use in some situations, there were instances where they felt it was important to be discreet, especially when children were involved. For instance, when I ask Frank if there is any situation in which he would hid his medical marijuana use, he says,

Frank: Uh, yeah. I, I’ve got this decision to make here in about a week from Thursday because all of the, all of my kids are bringing in their kids and so they’re going to go stay at [a hotel] and the kids are going to stay here. So I’ve got four of them, but I don’t want to go—I mean, the oldest is 15, and the youngest is 1. So I don’t see how trying to convert them into any type of knowledge that—
 Me: because they’re kids?
 Frank: Yeah, and I don’t think that they have enough information to make a logical decision. Is grandpa just crazy or what?

Others were concerned not only about whether children could understand medical cannabis use, but they worried about spillover of stigma to their children. For instance, Jason says he is comfortable that his friend and family know about his use, but he would not want his medical cannabis use to be known by his kid's friends parents. In addition, even though his in-laws know about his medical cannabis use, he would feel uncomfortable having a direct discussion about it:

Me: In what situation would you feel uncomfortable if somebody outed you as a medical marijuana user?
Jason: At my kid's school. Or in front of my in-laws. But they all know. All of them know anyway but it's not something that I feel comfortable talking to them about.
Me: Do you think it would change their impression of you in some way?
Jason: No, because they've known me since I was 16, or since I was in the fourth grade. So they know me anyway. But my kid's friends' parents don't. And I don't want them to think, oh gee, I can't let my kid go over to their house because their dad is a stoner.

Jason's preferred not to discuss his use, which aligned with his desire to minimize the medical cannabis identity as a significant part of his personal story. Even though he relied on cannabis, he says,

I have never really considered marijuana to be that influential in anything really in my life, except for making me happy. Or not stressed. It's really more of a stress reliever than anything, for me. I don't have an upset stomach when I use it, I don't have heartburn, I don't get pains in my side....I don't agree that it's illegal. I don't think it should be.

Even though Jason had political views about it, he did not desire to relate to the issue as an important part of his political identity. Likewise, even though he found it to be incredibly useful medicine for GERD, he did not want his use of cannabis to overshadow areas that he valued more for his sense of identity. discussing his use with acquaintances felt like it identified him with the issue in a way that made him uncomfortable.

Some patients lost relationships over their medical cannabis use, usually due to religious or political beliefs that could not accommodate this practice within their ideologies.

Dale: Well actually, my daughter, she's way into the religious stuff and goes to church every Sunday and teaches Sunday school, you know... She was raised up with a stereotypes of marijuana. You know, she found out I have my card, and I haven't talked to her since.
Me: Is that the reason why (the medical marijuana)?
Dale: I imagine that's the reason why. But that sounds to me like it's a personal problem of hers because hyena, it helps me. You know that's her personal problem.

Unlike Jason, Dale was very outspoken about his use. Instead of controlling the identity by not talking about it, he felt it was the responsibility of others to be tolerant of views even if they were different than their own. He felt like honesty was important, and being a patient was an important part of his experience that had created many positive effects in his life. If his daughter could not accept this about him, she was unable to accept him. Dale did not feel he should change his behavior based on his daughter's disapproval. A handful of patients reported relationship conflicts over their use, but it was usually in more distant relationships. A few patients compartmentalized the medical cannabis identity similarly to Jason, usually based on their lack of connection with cannabis culture and its aesthetics. However, many more placed at least some importance on the medical cannabis patient identity, and felt it was important to take a stand on the issue.

Like many others, Brett told a story of losing his best friend from high school over his involvement with the medical cannabis issue, and his attitude was much the same, but in part because the relationship was not close enough to him. Like nearly all other patients, Brett checked in with his immediate family. He says that he would not have gotten involved if his children had objected. Others reported making a "family" decision with spouses, and say they would probably not have decided to use cannabis had their spouse rejected the idea. A few patients were married to other medical cannabis patients with serious disorders, but the majority had spouses who did not use cannabis medically or recreationally, despite the opportunity to do so.

While a small group of patients in my study preferred to fly completely under the radar and did not discuss medical cannabis with anyone outside of their closest relationships, the majority had adopted a proactive, educational approach and expressed a willingness to talk to anyone. Again, Brett captured the willingness to discuss the issue in a way that also highlights the "group style" discussed in the next section:

You know, I try very much to gauge where the people are at. If they're completely uh, not ready for the information and the wall is up, you know, I'm not going to frustrate them or myself. I've learned how to gauge and, not try to force, or you know it just depends, if they don't want to hear it, but you know the one thing I won't allow anybody to do, is to put any kind of judgment on me or to try to give me information that's not accurate. Like what happens a lot of the time is that people will make up real quick, off-the-cuff remark, like, oh, well that's bad, or – and I won't let that stand. I have to correct the inaccuracy. But if they don't have the information and they don't want it... god bless you. Then "so be it." But I won't allow anybody to put wrong information out there.

Brett's comment shows the adamant refusal to allow stereotypes to go unnoticed, while simultaneously avoiding "frustrating" situations where someone is "not ready for the information." Brett's comment shows the shift to pride in knowing that he is right, factually and morally, but aside from not allowing the perpetuation of stigma, he does not need to preach to anyone, reflecting the group style that says, "to each their own."

MEDICAL MARIJUANA AS A "THOUGHT COMMUNITY"

Collectivities are collections of actors linked together through particular social relationships, such as kinship, work, religion, and politics. Their shared norms, values, ideals, and social perspectives constitute intersubjective "thought communities" beyond individual subjectivity that reflect a particular collective world view (Zerubavel 1997). The notion of thought communities is akin to Mead's (1934) concept of the generalized other in that both are abstractions of the perspectives of social collectivities that enter into the thinking of the individual. (Cockerham 2005:59).

After attending many events in this community, the attitudes of patients do seem to reflect a general, anti-establishment group style. In other respects, users in this study ran the full spectrum. They were roughly one-third republican and libertarian, one-third democrat, and one-third independent, uncertain, or unaffiliated. Culturally, they ranged from old hippies to ex-military, completely secular to devoutly religious, and well-off to abjectly poor, one clear thread ran through attitudes: a disdain for government interference in this issue and most other ones too. Patients did not want to be told what they could or could not do in the privacy of their own homes. But this attitude extended beyond an opinion about the role between the government

and people's rights; this ethic of autonomy extended to the treatment of others—which often meant deferring judgments upon others. Not all patients subscribed to a strong version of this but many patients seemed to subscribe to a “to each his own” kind of mentality about life in general. Just as patients did not care for what they perceived to be the government's illegitimate role as medicine cop, most showed a clear desire to avoid roles that involve enforcing the rules of the system upon others.

Antiestablishment as a “Group Style”

This position of “to each his own” was bolstered by patients' concerns with government decisions about pharmaceutical drugs. As individuals, patients may be accused of using cannabis illegitimately; but many have had direct experience with pharmaceutical drugs, and in their estimation, the government's motives could not be more clearly nonmedical. Patients get very heated and angry on this topic. Many had experienced effects ranging from unpleasant to catastrophic with the use of multiple prescriptions. They often felt that a useful medicine had been denied them and their loved ones in the name of greed, profit, and power, rather than in the interest of the people. That others are suffering from this as well; and that they must continue to fight in order to get access under conditions of risk and uncertainty. Finally, they feel that none of this is motivated by the stated motives—they do not believe the current laws are effective or keep anyone more safe. Rather, they see it all as motivated by money, power relationships, and greed—the height of corruption in the system.

Many patients might agree with Waitzkin's (2011) perspective that governmental duties of protection and public health have been subsumed by corporate interests—essentially the developments of corporation power are such that “in policy decisions, the interests of US-based corporations and the US government became substantially identical” (67). It was interesting that this antiestablishment perspective spanned all political outlooks from left to right, although those who were left progressives tended to invoke the language of civil rights, while those on the

right tended to link these attitudes with small government, money, politics and other more libertarian-leaning sentiments in which the government had not right to overstep into its citizen's personal lives. There was no mistaking that, regardless of one's politics, the cannabis issue created strong negative emotions about the government overstepping their bounds and should not be allowed to determine a person's right to their own body.

For instance, Eileen, who identifies as a centrist independent with a progressive lean, characterizes is as:

It has been so many years since the Seventies, and we're even more repressed than ever in many ways. Why is the federal government still against this, and refused medicinal value?... It just doesn't make sense, and it's disheartening when you feel like it's so hard to make change.... But I just follow my heart with what I felt was right, and for me it became a civil rights issue more than anything else, where how much involvement should government have in our personal lives and in what we put in our body, things like that.

Eileen couches her point of view in frames that are probably more typical of the rhetoric found among democrats and left-leaning politics. By contrast. Others, like Carl, who identifies as a lukewarm libertarian, feels that the laws are not designed at all to serve in the interest of the people but are instead driven by money:

It's political. It's all it is, is political. They're trying to justify their existence. They fought it [the drug war] for so long that they will go to any extremes to make sure it remains that way. The pharmaceutical companies want to own it [cannabis], because they're losing out big. Monsanto, different people, want to control it. So I think that it's all politics and control. And it's about money, there's tons of money being brought over the Mexican border and marijuana and cocaine and other drugs- It's all money. And I want to say the biggest thing, the reason the government is against it, the reason they're fighting...everything they do is about the money. It's not about being right or wrong. It's about the money.

Interestingly, patients did not hesitate when I asked them if they would stop using cannabis medically were the law to change. Patients were adamant that this would only effect their discretion, but they would be undeterred. Only one patient said she would stop using cannabis if the law were reversed and medical cannabis use was no longer legal. Beth, as a Jehovah's Witness, felt that she was obligated to obey the laws, no matter how stupid, in order to be in accord with her faith.

Privacy and the Body

Both “cannabinated” states and illnesses or diseases are embodied. According to Bobel and Kwan (2011) “Cultural theorists have long asserted that social relations of power produce bodies that are disciplined and resistant” (2). Both illness and cannabis use may be considered forms of “unruly bodies.” Medicalization is meant to transform their deviance through the social control of medicine. The exclusion of marijuana from the formal corpus of medicine is as much as about this plant’s possibility to create “unruly bodies,” as it is about any other factor. Even as medicalization brings some control over the issue of cannabis into the medical domain, it remains layered with the control of cannabis through the legal system (Medina and McCranie 2011). The intersection of legal, social, and medical categorization of medical cannabis plays out and intersects on the body, engaging norms that surround bodies, medicine, and health. As with other norms governing our bodies and embodiment, we can attempt to conform or at least appear to, or we can flaunt our differences (Bobel and Kwan 2011).

Cannabis states may be considered “unruly,” but this characterization may rely more on different norms related to drug, set, setting, and life course uses than it does to a more simplistic focus on the drug’s pharmacological capability to intoxicate . In a world where the use of anti-depressants, Ritalin, and other mood altering prescription drugs have become commonplace, the argument against marijuana’s particular intoxication and mood altering capabilities becomes more based on cultural categorization and context than physiological effects. Reframing cannabis to be “medical,” and to be normative across the life course offer clear pathways out of legacy of the twentieth century and into a new way of integrating cannabis into society in a more sensible way.

Whatever the sentiment about cannabis intoxication, one thing was very clear among the patients in my study. They all felt strongly that they should have rights to their own bodies, and to what they put in them. Most agree that this is true, no matter the reason you are doing it, but

Andy captures why the medical designation changes things:

Andy: basically it's "you don't have a right to tell me I can't enjoy pot," and "how dare you tell me I can have my medicine." So I guess the indignation level is higher on the medicine.

Andy's comment on this points out that many see it as frustrating and absurd to ban a leisure activity that poses so few damages or harms compared with tobacco, alcohol, and even coffee, but it defies common sense and borders on criminality to ban a substance when it can relieve pain, slow the progress of certain diseases, prevent seizures, and perhaps even resolve some diseases for which we have no current effective treatments. Like Andy, Frank focuses on the illegitimacy of the government in telling people what they can do privately with their bodies in the name of their own health, wellness, and survival:

If you've got a goddamn debilitating disease, who is the government to tell you what you should be taking or not taking? I mean if I firmly believe that chocolate syrup would make me feel better, I'd go drink chocolate syrup. But don't make a law that says I can't do that—I mean, that's bullshit. Even if you believe the science or don't believe the science-- which there's very little science.

According to Frank's view, expert guidance is the prerogative of the individual, but is supposed to be a choice and an option that serves the individual, rather than a method by which the individual loses the option to choose and incurs punishment from the state. In many ways Gary agrees with both Andy and Frank, when he says,

Why does the state have to be somebody's nanny? I don't see the purpose in that. I'm an adult. I've been around for a while. So if I find legitimate use for a particular substance, in my case, medical cannabis, then I don't want some bean counter or some government official telling me that's bad for my health when what I have read tells me something different.

However, his comment also points to the relevance of life course. By using terms like "nanny," and "I'm an adult," Gary's comment emphasizes the importance of responsible adult use. His statement implies that, in trying to prevent teen use of cannabis, we treat everyone like teenagers who are not yet capable of exercising judgment.

People are greatly angered and disgusted by the notion that the state should take a private decision out of their hands and reduce choices. They are doubly offended when this actually makes criminals out of people who choose not to follow the government's expert health

advice. But it becomes intolerable absurdity when the state imposes such rules based on information that patients deem patently and verifiably untrue. Many patients conclude that at least on this matter, the government is acting illegitimately. Some feel this is just one example of many such wrong actions on the part of the government, typically driven by monetary greed. Many patients expressed strongly patriotic views, not without some rhetoric of God and country. However, when it came to the government, this issue was a catalyst for forming strongly anti-establishment tenor among patients. In this context, most medical cannabis patients feel that they hold the moral high ground and the more intelligent and well informed opinion on the matter, and history will prove them to be right.

SHIFTING THE GAME: FROM STIGMA TO PREJUDICE

The group style found among medical cannabis patients emphasizes individual autonomy, one's fundamental right to his or her own body, and specifically emphasizes the illegitimacy of a government that encroaches on individual privacy. Although this "group style," with its "to each his own" mentality, tends not to support traditional collective efforts through social movement organization, it promotes a moral agenda that establishes an alternate narrative in which cannabis patients have the moral high ground and the government's actions are illegitimate, greedy, and guided by inappropriate motives. Many explained cannabis's ongoing illegal status, despite proof that it had medical value, as being due to the system feeling "threatened" in terms of profit and power. Nearly every patient mentioned some version of either industry or government, or both, having a vested financial interest in maintaining cannabis illegality. They saw business and government as willing to say and do nearly criminally irrational things to protect their financial interests and their control. The mantra from patients on this topic was, "follow the money." In essence, they were arguing that the system's interests in maintaining profit, or customers, was largely against the interest of people and their health.

For instance, Beth captures what many express when she says:

Beth: There is more regulation in this one little industry than there is on Wall Street!

Me: Why do you think they're doing that?

Beth: For the same reason that they stop every kind of a cure that comes around that they can't patent, "they" being the medical world, the drug world, so be it. I mean doctors are not doctors in the true sense of the word anymore. They only know how to prescribe meds... I mean, I can't remember when doctors actually fixed you, when they didn't just give you drugs and say "go home, and if that doesn't work, we'll try another drug." So that industry, the medical prescription industry, is against anything that is going to take patients away.

From a system perspective, curing patients is losing customers. Treatments are designed to be ongoing to assure the continued business of customers, even if it is to the consumer's detriment. By contrast, cannabis aligns with lifeworld goals for health. It is natural, cheap to produce, and nontoxic. Beth contrasts it by saying: "Cannabis in my opinion, based on my knowledge, experience, and extensive—and I mean extensive—research, other people's research, reading other people's research. It is absolutely most human friendly plant on the planet." This distinction was made over and over again in patient interviews, in which the "establishment" or system's goals were antithetical to goals to wellness in the lifeworld, and cannabis was portrayed as an almost heroic antidote to many of these problems. Many, like Ron, express great outrage at not only the lack of care, but the moral violation of placing money ahead of life:

Because I think that the conspiracy is insidious. It is wrapped up into the God of this earth, money. Our society has sold its soul for money. We don't care about life anymore. We only care about money! And after we get money, we want to have power to protect the money. So that's what's going on in our country now. We don't have medicine to help people, we've got medicines to addict people on multiple medicines that continually get one more to take care of the last symptom that the last med gave you, and then you need one more and one more. My mother, 90 years old, must have a 150 different prescriptions that she has to take for chrissakes. And how do you ever stop doing any of them because nobody knows. The doctors don't know, and pharmaceutical companies don't care because it's just ka-ching, ka-ching, ka-ching. It's all about money.

Patients also take the government to task for basically serving as the handmaid to industry rather than protecting the interests of the people. For instance, Tina connects government and the pharmaceutical industry in her critique when she says:

The government knows what is in these pills. They also know the good that medical marijuana, that marijuana does. They know it's medicine. They've known for years. Our founding fathers [used cannabis and hemp], this is research that I have looked into since I've gotten sick. And it infuriates me, not just the marijuana but hemp. Hemp provides enzymes that keep diseases out of our body, like the one I have. What's going on, really? To me, the whole reason I see behind it, I can't think of any other humane reason--and you can't put money on a human life—but that's what it is, it's about money. When they realized the money they can make off these pills? You're going to get longevity with marijuana, you're going to kill

these people with the pills. When they are dead in the ground are you still going to get money from them? No, you're going to go after the next generation. Last night Walgreens was hit again [robbed] for their pharmaceuticals. It's not just these people that are taking them that it's prescribed to, [pharmaceuticals are] on the streets. And they're worried about the marijuana being on the streets?!

Carl also captures a point in this argument that many patients make. Many believe cannabis has remained illegal because the pharmaceutical industry has not yet figured out how to turn it into a commodity. He says:

If they can't replicate it, they can't control the market, they can't have a patent on it. And that comes right down to money and money only. For pharmaceutical companies. I think pharmaceutical companies put more money into campaigns and more money in to fight it [marijuana legalization] just for the reason of money. Follow the money. If we can grow a plant for ourselves, they can't tax it, other than charging us a fee to have a license to be able to do it, they can't sell it, they can't – just follow the money. My idea is just follow the money. Because it's the big pharmacies, it's getting all the politicians to fight it, uh, that should be banned, all these contributions should be banned, totally, from unions, from pharmacies, because its— what do they call it when you can't try a case because you're involved with it or whatever? Conflict of interest—it's a total conflict of interest, everything they're doing, every law they're making, because they're either drawing their paycheck by doing this, or they want to draw their pay check. Ten million dollars a year is going into enforcement from our licenses.

Many believe that once cannabis is seen as capable of meeting the system's demand for making money, either through product development that the pharmaceutical industry can profit from, or through government fees and taxes on use, the laws will change. HIV patient Hugh starts by discussing the pharmaceutical industry's direct-to-consumer advertising, but points out that as the system begins to draw profits from medical marijuana, the changes to the law will cascade in favor of medical marijuana. He says:

Hugh: [The direct-to-consumer advertising of pharmaceuticals?] —It cheapens it badly. It's like when you see these, when lawyers and doctors started being able to advertise—

Me: Like the ambulance chasers ads?

Hugh: Yeah. I first saw that in California, but they're still not allowed in New York. You still can't do it [have those types of ads]. But what *really* got to me was to see how some of the politicians behave.

Actually... in general, not just about marijuana. They all want to be on the bandwagon, and they smell the cash. The taxation money. They smell it. I know we've hit the point of no return [on medical cannabis becoming accepted] because they've got all this extra [tax] money [collected from fees to the marijuana industry] earmarked. They've already raided the patient medical marijuana annual fee [fund] several times. They've diverted it to the general fund.

Me: Do you think that's true of all politicians, or are there some who [will still oppose it]?

Hugh: Very few exceptions who oppose it. But those, once they smell the cash, they turn too.

These recriminations against the system and the actions of people within it, to kowtow to money and power against the interest of human values, left patients feeling righteously defiant

and stubbornly proud. Marijuana use became almost an act of civil disobedience against unjust and morally bankrupt laws. This political stance enables the cultural shift from shame to pride.

Medical cannabis has been subject to stereotypes that, when stripped down, look identical to those imposed on other marginalized groups. These stereotypes translate to stigma when they are used to evaluate individuals, but they can also serve as ‘threats’ that, when internalized, lead individuals to respond to them with shame without the need for their actual enforcement.

The first step from shame to pride involves the simple act of incorporating the medical cannabis patient identity into one’s self-concept, and through speech or behavior, to serve as a countervailing case to the stereotypes. Patients often express pride in being involved with medical cannabis, but the issue of identity with medical cannabis—and this may be true of other stigmatized identities—is not to bring more attention to that category *as an identity*. Stigma, as classically defined by Goffman (1986 [1963]), allows one characteristic of a person to overshadow all others in a discrediting way. The identity struggle with medical cannabis is not aimed at placing more emphasis on this identity, but in de-emphasizing it, allowing people to be proud medical cannabis patients, but only as one component of their personality, and to allow the recognition that just as all members of a racial group, gender, sexual orientation are not alike, neither are medical cannabis patients all hippies or delinquents, but rather can be recognized as diverse as the adult American population. Even as patients claim pride rather than shame, in many ways they aren’t seeking recognition—in some ways, they just the opposite—they are seeking to be treated “just like everyone else.”

Tina illustrates this identity issue well. When I ask her if there is anywhere outside of work where she would feel uncomfortable identifying herself as a medical cannabis patient, she says:

Tina: No, it's who I am, and it's part of my life.

Me: Do you feel like it's become an important part of your identity to say that you are a medical cannabis patient?

Tina: Yes, but it's not my identity. I have more identities I would say to me that I would rather identify myself as being attached to me. It's my medicine. When I was taking Vicodin or Percocet or methadone I didn't run around saying, making that part of my identity. However it was obvious it was part of my identity. It was pretty bad. But no, because I think with the younger generation, it is a big part of their identity. Just the younger generations, until people grow and mature in life and find out what their true purpose and identity in this life and on this world is that, yeah, they do grab those superficial things. And to me that would be a superficial identity.

Me: The medical marijuana identity?

Tina: Yes, but then again, it is part of who I am because—look at how much it has changed my life.

Tina brings up many interesting points that were echoed in part in some other statements, but she articulates something that many others seemed to find hard to articulate. While some patients simply said they were comfortable or even proud of their association with medical cannabis, others, like Jason, or Mike, seemed indifferent, and said things like Mike. After being diagnosed with HIV in his early 20s, during the late 1980s, Mike lived much of the last 30 years expecting to die. In terms of his identity with medical cannabis, Mike says: “it doesn't affect my life in any way—I've always lived my life how I want.”

Most patients said they would identify themselves as a patient to discuss or educate others on the issue, many did not want to push their views on others, and, like Brett in the quote above, did not feel they needed to convert anyone who “wasn't ready.” However, Tina also points out how the identity of a cannabis patient at midlife is fundamentally different than it is when one is in their teens, in part because of life experience, but also because individuals are not engaged in as much identity experimentation as is found in the life course stage of young adulthood. They are more secure in their identity, and medical cannabis is simply not as important as their role as a spouse, parent, or as their career.

It may be that the true shift in movements like medical cannabis, gay rights, and others, comes when the stereotypes, rather than being accepted as normative, are redefined as unjust. When stereotypes are no longer accepted within culture, but are linked to their messengers, such as the government, and their basis is seen as flawed or based on improper motivations,

then applying those stereotypes to evaluate a person and discredit them is not longer stigma—it transforms into prejudice and flips the game. The once-stigmatized person is now defined as a person being unfairly discriminated against. The scrutiny turns from the person stigmatized to those who impose the judgment, and the labeling process becomes socially unacceptable—even stigmatizing and shameful as being bigoted.

CONCLUSION

In this chapter, I have argued that patients face unique challenges when they balance the linked, concealable stigmas of being a medical cannabis patient and a person with a serious or chronic illness. Juggling these identities can present trade-offs, but in both circumstances, patients often work hard to maintain a positive self image and to maintain their claim to role functioning.

Patient strategies for managing concealable stigmas may involve completely hiding the identity, selectively disclosing, or proactively claiming the identity but shifting its meaning from shame to pride. However, the issue of restoring a stigmatized identity is complex, because it often does not involve a demand for greater public attention to that identity, and yet relies in part on establishing the identity as sympathetic. The desire to shed the overshadowing importance given to a stigmatized identity may make it a harder political point around which to rally social movement support.

The group style amongst medical cannabis patients leads patients to present arguments that base their moral claims in antiestablishment and fundamental rights to one's body. Stigma and stereotype threats rely on norms, and medical cannabis presents a serious challenge to the narrow discourse that has dominated the U.S. over the last fifty years, in part because it provides a basis from which to dismantle stereotypes and reveal their underlying prejudice, and this process is key to transforming a stigmatized identity and allowing a move from shame to pride.

CHAPTER 8: Conclusion

SUMMARY OF FINDINGS

Despite its status as an illegal substance, recreational marijuana is the most popular illicit drug worldwide. Its use has been statistically normative among US adults for most of the last half-century. Most adults have chosen to try cannabis at least once, and even more have been exposed to the opportunity to do so. As previous chapters have described, this use is closely tied to the life course, with the highest prevalence of use among those in their late teens and early twenties. Use tapers with age, from over 20% who report recent (30-day) use of cannabis in their 20s, down to 6-7% of those over 40 who report recent usage (Johnston et al. 2012). This association has led to a concentration of concern on adolescent marijuana use, and especially on the role of cannabis in negative life outcomes, often theorized in terms of the gateway theory or amotivational syndrome. However, well-founded arguments have been raised against these theories (Chapkis and Webb 2008; Iversen 2008; Joy et al. 1999; Stolick 2009; Zimmer and Morgan 1997). Many discount them altogether; some see them as almost entirely deriving not from any unique properties of cannabis, but as a consequence of the laws (Lucas 2012; Werner 2011).

Where medical cannabis laws are liberalized, it often sets in motion a cascade of moral panic-style community concerns about adolescent drug use and other related risk behaviors. Some claim that teen marijuana use will escalate. Others warn that alcohol use will go up, or impaired driving incidents will increase. However, preliminary research on all three has shown that medical cannabis laws have the opposite effect. Research by Anderson, Hansen, and Rees (2012a) analyzed data from several medical marijuana states, and found that marijuana use

among teens has declined slightly. Additional research found that traffic fatalities decreased, alcohol consumption declined, and suicide rates went down (Anderson et al. 2012a; Anderson and Rees 2011; Anderson, Rees and Sabia 2012b). While a separate study by Chu used different data modeling techniques and showed modest increases in teen use by (5-15%) in medical marijuana states; however this researcher also found 10-20% decreases in arrests or treatment admissions for cocaine and heroin in those same states (Chu 2012a, 2012b).

Although marijuana has a low risk of harm, its long theorized relationship as a stepping stone to hard drug use, and its purported role in demotivating or derailing our youth has in many ways been the fear that fuels the drug war. In many respects, the core of the drug war is marijuana policy. Cannabis is the only substance with widespread enough use to justify drug war budgets (Rosenthal and Kubby 2003). Marijuana arrests account for roughly half of all drug arrests annually and disproportionately target marginalized groups (Facts 2012; King and Mauer 2006) Drug war policies are largely seen as a failure, and the lynchpin is the inappropriate handling of cannabis through policy and scheduling (Aggarwal 2010; Barnes 2000; Gwynne 2011; Riggs 2012)

While considering the children and young adults in the name of public health and safety is an important concern, drugs laws has gone too far by basing its entire strategy for cannabis policy on the fear of teen experimentation and use. Not only this, but it does so in a misguided fashion, assuming that prohibition-style criminalization will produce the desired results of deterrence, when there is little proof that this is so. As states and countries break free of the drug warrior mentality that has driven late twentieth century drug policy and experiment anew, evidence mounts that these types of policies do not accomplish their stated goal, and at a financial cost and a cost to human lives that is unacceptable.

Cannabis & Social Construction

In the introduction of this work, I argued that the social constructions surrounding cannabis use may be among the most interesting and consequential of the twentieth century. These constructions have relied on the ability, despite contest, to forcefully constrain the definition of cannabis to its use as a deviant recreational substance. Cultural dialog is limited to claims of more or less “harm.” These policies has stood for fifty years, even as chronic pain conditions escalate, prescription drug overdoses double and then double again, and meanwhile cannabis fails to ever kill a single person.

The successful introduction and expansion of medical cannabis has challenged this narrowed discourse. Anecdotal accounts of medical successes with cannabis accumulate, and consistent profiles begin to emerge across settings, where cannabis help many types of pain, nausea, brain traumas, multiple sclerosis, epilepsy, cancer, HIV/AIDS, Parkinson’s disease, Autism, stomach disorders. Some view the range of illnesses and diseases treated with cannabis skeptically, yet drugs based on the opium plant run the gamut across an equally large span.

Incomplete Medicalization

Throughout this dissertation, I have argued that medical cannabis is a case of incomplete medicalization. Marijuana has not been fully integrated into the medical domain, institutionally or culturally, and this affects every aspect of the medical cannabis patient experience. Incomplete medicalization has consequences in the doctor-patient interaction, creating challenges for patients in accessing the system. It affects the institutional management of cannabis, which spans the formal, informal, and popular sectors of medicine, and leaves much of the medicalization process in the hands of the individual patient. It affects the conceptualization and distinctions made between medical and recreational uses, which patients often feel pressured to monitor and define. It interacts with the cultural interpretations, stereotypes, and stigmas where the patients must navigate threats to identity, but the greater

demographic diversity among cannabis patients, and the greater value-neutrality of medicine relative to recreational drug settings has the capacity to drive a wedge between stereotypes and realities. Finally, incomplete medicalization contributes to an environment of uncertainty, in which medical and legal forms of social control overlap but also become unpredictable, placing patients in a tenuous position where their access to cannabis as a medicine and their protection from legal repercussions become a moving target.

Medicalized Patterns of Use

While naysayers have contended that medical marijuana is a ruse begun with the nothing more than the intent of decriminalizing use for recreation, the progression of medicalization, and its expansion across states and countries suggests that medical cannabis has a basis that is authentically different than recreational use. The findings of my study support that medical uses of cannabis shift individual behavior in many important ways.

In my interviews with midlife medical cannabis patients in Colorado, I found that patients were not simply using medicalized rhetoric to reframe recreational behaviors as medical ones. Rather, they employed strategies that were surprisingly consistent with behavioral patterns in the use of all types of medications. This entailed a shift in use that placed emphasis on the health goals of the lifeworld, in which balancing one's symptoms with one's medical treatments and health regimens sought to minimize risks of toxicity and dependence while maximizing the ability to maintain role functioning and live a normal life.

It can be argued that some individuals gain access to the medical cannabis system, most likely through the doctor recommendation, in order to use cannabis for purposes other than the medical ones which the system intends. It is also possible that after patients grow or purchase plants within their allowed limit, they may share it with others not registered as "legitimate" patients. The focus on cheaters and diversion is a popular topic in the news media, but it does not invalidate the presence of legitimate patients who benefit from cannabis medically. In fact,

any regulated system that confers benefits on some while subjecting those excluded to punishment has the need for effective gatekeeping and is vulnerable to admitting illegitimate users. In other cases, we are often equally concerned with blocking those not meant to gain access, who we often vilify. I call this the “welfare mom effect,” but it includes prescription drugs, underage drinking, and illegal immigration, among others.

While gatekeeping often serves an important function, our views of how it operates are often overly simplistic. It is more complex than it might seem at first glance to distinguish those who meet the criteria of legitimate “patients” from those we consider illegitimate “drug users.” This may be due in part, to our tendency to reify concepts that are in fact constructed, such as the laws governing which conditions qualify for medical cannabis, which differs across states, and even in our treatment of diagnosis itself as objective and unproblematic. Several chapters have illustrated some of these difficulties.

As chapter 4 showed, the concept of “cheating” often conflates the idea of using marijuana with registering as a patient, when these decisions are separable. Possessing a qualifying medical condition is not the only criteria that patients employ when deciding whether to enter the official state system. They also consider the protections and risks that come with being identified by the state as a cannabis user, and weigh them against the risks of the black market. Considerations included potential risk of arrest or other legal action, concerns about privacy and who has access to the registry, the convenience or difficulty of getting a consistent supply of an appropriate medical-grade cannabis product, the costs involved for registering or for purchasing product, and the stability of the system as a whole based on the political atmosphere. Examples, especially in chapter 7, showed that becoming a legitimate patient did not ensure physician cooperation or legal protection. Decisions to participate in Colorado’s regulatory system were motivated by different factors than the decision to use medical cannabis to manage one’s medical condition.

Focusing on Life Course & Lifeworld

By focusing on midlife medical marijuana patients in Colorado, I have attempted to foreground the importance of life course for behavior around cannabis use. Medical cannabis patients at midlife focus on responsible adult forms of use, which includes exercising moderation, minimizing the amount used, timing use to maximize productivity, and monitoring use as a form of self-discipline. Medical cannabis use at midlife shifts the focus from “getting high” to “getting well.” Patients expressed a range of responses when discussing distinctions between their own personal use as recreational or medical. Some patients viewed all use as medical, while others felt the lines to be fluid and based on primarily on whether the context of use was social or individual.

Because cannabis is used medically to treat a range of conditions, not all use was directed at immediate symptom management. While many patients used cannabis to control pain in many forms, other use was not intended for such immediate goals, but worked to prevent seizures, maintain remission from multiple sclerosis, or even recover from cancer. Even though all patients in this study had a condition that legitimately qualified as Colorado’s law is currently written, nearly all claimed to use cannabis for “off-label” purposes as well, the most common of which were related to depression, anxiety, anger, PTSD, and other dimensions associated with mental health. Patients saw these uses as legitimately medical, perhaps in part because their use still conformed to medicalized behavior to treat a condition—even if these conditions were not yet recognized in Colorado, some are recognized in other states, or consistently reported in anecdotes from all corners of the world.

System and Lifeworld. To understand how patients utilize medicine, including medical cannabis, I have followed Britten’s (2008) lead, using Habermas’ concepts for two basic spheres of sociality, the “system” and the “lifeworld.” Systems operate to coordinate the capitalist economy and administer for the state and include institutions such as biomedicine, government,

and the law. By contrast, the lifeworld corresponds to what we think of as everyday life, constituted of and organized by our shared lives with others. The system and the lifeworld employ different logic, require different types of evidence, and strategize action based on different goals (Britten 2008).

In the context of medical cannabis, the system requires that patients have a legitimate condition, to qualify through application to the state, and to follow the rules of the system such as possessing an amount of marijuana under the limit set by the state, in order to meet the goals of limiting cannabis use to only eligible individuals. Physicians have discretion to override the state's standard amount if they deem a patient to need a larger supply, which the state then can approve or reject, but these are the rules and limits with which the system is most concerned. Beyond entry qualification and plant amount limits, there is little oversight over how patients use their allowed allotment of cannabis.

Patients take a more flexible view of use that is consonant with the lifeworld and its goals of role functioning, relationships, norms, and values. This applies to how patients manage their own use, but it also view use by others through the lens of the lifeworld. Most patients were adamant and explicit in their position that they had not nor would they assist in the diversion of medical cannabis to the recreational market, or selling to nonmedical friends or acquaintances, but they had no qualms about social use among friend without making any system distinctions about who was legitimate and who was not. On the whole, most patients expressed a strong sense of ethical obligation, but no one was interested in playing a cop and enforcing system rules on others.

About half of the forty patients in this study had experimented with medical cannabis use prior to seeking out a qualifying recommendation. Many of these had done so based on the suggestion and help from close friends or family members. Once they were patients, they often perpetuated this behavior. System rules seemed arbitrary in the face of a friend, loved one, or

parent who was in pain. The idea that it was legal for them to use it, but not legal for an elderly parent suffering with arthritis based on state of residency or other limiting factors, quickly came to seem ludicrous. Patients were often initiated into a medical interpretation of cannabis use through the guidance of some member in their strong network, and many paid this forward, quelling the fears of others, and providing them with advice.

Patients and Doctors

Incomplete medicalization has affected the institutional structuring of medical cannabis such that it is spread across the formal sector of biomedicine, the informal sector of CAM, and the popular sector where self-care happens. The implications of this structural choice seemed nowhere more clear than in the interaction between doctors and patients over the official cannabis recommendation. To help make sense of this, I borrowed Broom and Woodward's (1996) model for doctor-patient interactions around Chronic Fatigue Syndrome. This model suggested that doctors take three lines when it comes to negotiation of contested areas of medicine. The first, "doctor knows best," privileged medical expertise and scientific evidence over patient's phenomenological experience. The second, characterized by uncertainty, balanced these two forms of evidence, but when they did not match, tended to side with scientific expertise. The last, "constructive medicalization," more closely resembled care in the informal CAM sector, where patient's experiential knowledge is valued and a physicians see patients as collaborators.

Because Broom and Woodard's (1996) model addressed a contested diagnosis rather than a contested treatment, I sought to expand the application of this model. I argued that doctor's prior views on medical cannabis mattered in their willingness to recommend, regardless of which of the three approaches they took in interactions with patients.

I was surprised to find that 80% of patients ended up getting recommendations through specialty evaluation doctors, or "the doctor mill." Even when a patient's physician informally

suggested medical cannabis use, many still were unwilling or claimed to be unable to sign official paperwork. Doctor's reasons for not signing patient paperwork were sometimes based on their medical opinion, but just as often, it was due to political pressures from their employer, or from the federal government. This dynamic suggests a different understanding of the "doctor mill." This specialty practice has been characterized as shady, and doctors have been disparaged for this work because it is "easy money," but if regular physicians will not sign paperwork on legitimate cases due to nonmedical pressures, the specialty evaluation market provides a valuable service, and acts a form of "constructive medicalization" that supports the medicalization of cannabis, with a few caveats. The first is that it must still meet the expectations of professionalism. Guidelines have been instituted on this from the system perspective; from the lifeworld perspective it is really about the face-work in the recommendation. Doctors who maintain an appropriate professional doctor's appointment help to bolster legitimacy, while those who do not can harm the legitimacy project of medical cannabis.

Cannabis, Stigma & Identity Reclamation

In the final part of this dissertation, I proposed that medical cannabis, even in its incompletely medicalized form, presents challenges to the cultural stereotypes and their application through stigma. Medical cannabis relies on the dissemination of information by strong networks of friends and family. The support of close family and friends is an essential ingredient for most medical cannabis patients. When medical cannabis successfully helps loved ones, word travels. I also propose that medical cannabis patients face many of the same challenges and even many of same stereotypes faced by other marginalized groups.

Patients are brave to adopt the medical cannabis identity. Doing so is in itself a politically meaningful act because it initiates the reclamation of cannabis use as a spoiled identity. Because cannabis laws continue to shift but cannabis use remains federally illegal for all use, patients

risk sanctions simply by claiming this identity.

As greater networks have formed and patients are more interconnected with one another, medical marijuana has become more akin to a “thought community” than a social movement. In “Culture in Interaction,” Eliasoph and Lichterman (2003) say that “people always make meanings in specific social settings—large or small, face-to-face or virtual—and they make those meanings in relation to each other as they perceive each other,” which they refer to as a “group style” (736). Group styles are not neutral, but communicate relying on shared assumptions and enact elements of culture that are not invented but are already “patterned and durable.” (737). In Colorado’s medical marijuana community the group style included what I have called “to each his own,” which fits with the status of medical cannabis as a controversial identity. It may also help to explain difficulties in creating a more cohesive social movement or seeking out allies from other movements. While activism is common, it is often individualistic rather than communal. Other group style characteristics include a value placed on the claim that each person has to the rights of his or her own body and what goes into it. Last, there is support for antiestablishment thinking, regardless of left-right identification on the political spectrum. Just as the body should be radically autonomous for each individual, the territory of the lifeworld should not be encroached upon by the government or other systems of power.

Medical cannabis recognizes the process of “coming out,” and identity “pride,” that come with reclamation of a spoiled identity. These processes are critical components to the ongoing political successes of medical cannabis, in part because, when these facets are combined with a strong moral argument that undermines the normative acceptance of entrenched stereotypes and reveals their prejudicial nature, it provides a pathway out of stigma. The cultural gaze turns from the stigmatized to the stigmatizer as a perpetrator of prejudice, and the identity once spoiled has the potential to be reclaimed.

LIMITATIONS & RECOMMENDATION FOR FUTURE RESEARCH

As with all studies, this dissertation is only one piece of work and has inherent limitations. I have focused on patients in midlife in Colorado, and explored themes regarding their medical use routines of cannabis, their attitudes about recreational and medical cannabis, their experience navigating the Colorado system, and their choices regarding hiding or disclosing the medical patient identity. While I was inspired by the work of others before me and those working as contemporaries—Amanda Reiman and Wendy Chapkis in California, and Sunil Aggarwal in Washington State—this dissertation is the first work that looks in-depth at medical cannabis use in Colorado. It is also unique in its focus on midlife. While I believe this focus served an important purpose, it did so at the expense of excluding other groups. For instance, this work does not consider cannabis use among the oldest generation beyond the Baby Boomers, nor does it consider the experiences of those under 30 who came after Generation X. Future research that compares and contrasts cohorts over the life course might build on many of the observations found here and determine if certain practices, attitudes or styles differ by age or stage in life.

While this work captured a fascinating window in Colorado's medical marijuana history—from right after the advent of the “green rush” to right before the passage of Amendment 64—much work is needed that observes the effects Amendment 64 has on medical cannabis patients and on the medical marijuana industry in Colorado. In particular it will be interesting to see how it affects patient's entry into the system, and how it shifts attention away from gatekeeping or diversion from the medical to the recreational market, and turns its eye to controlling access to minors.

This work focused primarily on patients, but in the process I became fascinated with what was happening on the industry side as well as curious to know more from the perspective of medical professionals. Future work could round out many of the findings here by exploring

the themes I have discussed from the point of view of other actors within the medical marijuana system.

While medical cannabis has been around for 15 years now, the opportunities for research are vast. It is also dizzyingly dynamic and continues to undergo palpable change, which makes the value of ongoing research efforts critical for capturing events as they happen.

This work is not representative of the Colorado patient population, which limits its generalizability. However, it provides insights that might serve as the basis for larger scale studies that could investigate these trends for their generalizability among patients in Colorado or across other states and countries. When I reviewed work from Australia, the United Kingdom, the United States, and Canada, I was struck by some of the distinct patterns among cannabis patients, from attitudes to use patterns, to conditions treated. Comparative work is my final suggestion for future research to pursue in order to better understand these similarities as well as find where they depart.

In addition, the recruitment for this study required patients to opt in to participate. This protected the privacy rights of patients, but made it more difficult to reach the full spectrum of those who have interacted with the medical cannabis system in Colorado. For instance, it was unlikely to appeal to those who had tried medical cannabis, found it did not work for them, and exited the system. Also, even though recruitment materials attempted to be inclusive, those who did not have legitimate reasons for participating the medical cannabis program may have lacked any interest or motivation to participate. Finally, it may not have been successful in reaching those who are the most fearful of stigma and reticent to voluntarily disclose their use to any stranger, even in the context of research. Additional work might benefit by targeting these particular groups to understand the similarities and differences in behavior based on these factors.

Implications for Sociological Research

Incorporating medical cannabis into the models and literature from the sociology of health and medicine has implications not only for how to understand the transitions around the social construction of cannabis in our society, but it also suggests implications for ongoing research in the sociology of health and illness. First, it offers an interesting case of incomplete medicalization that expands theories related to medicalization, contested illnesses to include a contested treatment. An especially provocative area for which this research may be relevant is in considering the intersection of medicalization and politicized health identities. Conditions or treatments that are in the process of medicalization but are not yet completely medicalized are often not simply transitioning in relation to the medical domain; because institutional social control is layered, the process of medicalization often involves redefinition in other domains, but especially in the domain of law and criminal justice. This work touches on these intersections, and this also serves as a useful direction for other studies on medicalization, and for theories about medicalization processes, to consider.

Second, this work has suggested that individuals utilize medical cannabis much as they do other medications. The significance of self-care behaviors is paramount for understanding many health outcomes, yet this area has yet to be fully explored. The case of medical cannabis suggests some interesting directions for exploring how people regulate health behavior, and what factors lead them to follow a more formal routine or to adopt a flexible routine that more closely parallels the informal sector.

Finally, this work contributes to our understanding of controversial identities. Medical cannabis and gay and lesbian rights may be two of the largest issues that we as a society are currently contemplating and revising our views. Both issues contend with fundamental questions about our rights to our own bodies and what we do with them in private. These stigmatized identities share much in common with those that gained prominence in the civil

rights era, but they differ because they are based on behavioral choices that are inherently concealable, and that have been and in many places remain legally prohibited and punishable by law. This dissertation suggests some important themes about concealable stigma, and its relationship to identity, shame, and pride. Finally, it suggests how stereotypes and their relationship with norms, and our shifting assessments of their social acceptability matters for whether certain groups are seen as stigmatized or as the subjects of unfair discrimination. This idea has implications that would be interesting to study further on marijuana users in additional contexts, in the gay rights issue, and in any other issue that involves similar stigma designations.

CONCLUSION

Through in-depth interviews with medical cannabis patients at midlife, this dissertation has raised many interesting themes and original ideas worthy of further exploration. First, I believe this work has made a strong case for acknowledging the underlying significance of the life course for the use of cannabis. While protecting children and encouraging teens to make good decisions are laudable goals, these concerns need to be addressed not with heavy moralism and crude prohibitions that seem to satisfy some consciences but accomplish little else.

Policies should balance these concerns with the convincing scientific evidence, and with humane considerations for needs and benefits created by laws that consider medical use as well as responsible adult use. Cannabis criminalization has relied on the stubborn perpetuation of improper drug scheduling and the regular rallying of moral panic through exaggerated claims to harm. Even with all of the obstacles placed in the way of progress, these policies are in need of modernization to better reflect current scientific knowledge, better policy design, and more common sense. I believe that cannabis laws suffer from a fundamental error in logic that can be found across many policies governing behaviors we wish to regulate. People behave as if regulating a behavior is the same as condoning it, while prohibiting it is regulating it. In truth, regulation offers much greater control than prohibition ever can.

Conrad and Schneider (1998 [1980]) say that “in modern industrial society, only law and medicine have the legitimacy to construct and promote deviance categories with wide-ranging application” (23). The institutional control of cannabis may not be moving wholesale from one jurisdiction to another—but like opiates, its regulation may continue to be managed across the criminal justice system and the medical institution. However, the expansion of medical cannabis may help to shift these policies into a more sensible balance that acknowledges the radical truth that cannabis at its most basic is a humble plant, and the rest we have constructed. One of the most interesting things I learned in this study was that—even though various substances—from opiates to coffee to yes, cannabis—have different profiles of benefits and risks that humans can exploit for their own purposes or use at their own peril, medicine is more an orientation towards those substances rather than inherent in them. Once patients adopted medical use of cannabis, they also acted medically toward it in ways that were strikingly similar to how other medications are used.

Marijuana may in some ways be the most radical medicine of all, with its low toxicity, negligible risk of dependency, and its in-built “side effect” that can only be gauged in a subjective, autonomous, and individualized way. These unique qualities make it amenable to self-regulation, if only we can handle that responsibility. From interviews with patients, it became clear that many took this responsibility seriously.

As Reiman (2006) said, while we debate our ability to handle this responsibility, “millions of patients are in need of an effective, convenient method of obtaining their medicine, and this method should be subject to the same consideration, description and evaluation as any other health service being provided to the public” (1). As a society, we have already begun to research and mainstream other forms of alternative medicine through the expansion of research. Recent, promising findings suggest that cannabis may contribute positively in the treatment of many disorders, including halting the progress of cancer, ALS, and MS, as well as

controlling seizures and helping with nausea. It seems we need to lower the barriers for research and allow cannabis to be explored as a medicine. The laws now place cannabis in a category where its only cultural role is associated with harm. It is time to explore cannabis's potential to have whatever positive influence on the world and on medicine that it proves capable to have.

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