Marijuana, Mothers, Morals, and the Military:

Rhetorical Motifs and Epistemic Authority in Pro-Medical Cannabis Testimonies

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Introduction

Cannabis is being legalized across the United States at an astounding pace, both for medical and recreational purposes. As of March 2017, 28 states and DC have legalized medical cannabis in some form (ProCon.org). However, as individual states march ahead, questions still linger about the true efficacy of the botanical plant and its extracts as treatment for various medical conditions. The lists of these qualifying conditions vary from state to state, sending and reinforcing an inconsistent message about cannabis' effectiveness (Hoffman and Weber 2010; Troutt and DiDonato 2015). Advocates and patients claim that cannabis helps manage a wide variety of conditions and can even replace prescription drugs in some instances, so discerning the truth about cannabis is crucial to addressing an increasingly prominent topic in public health (Ilgen et al. 2013; Lucas et al. 2016; Osborn et al. 2015; Walsh et al. 2013). However, the evidence of cannabis' efficacy – much of it anecdotal – is guilty of self-selection bias, among other flaws that make it difficult for some corners of the scientific community to take seriously (Ilgen et al. 2013; Press et al. 2015). The result is a situation of "medicine by popular vote," in which powerful political and financial interests (on both sides) influence policy more than a neutral appraisal of existing literature (Thompson and Koenen 2011).

Complicating matters is the fact that the United States federal government prevents most medical cannabis research from taking place due to its regulations, limited number of strains, and "paradigm of prohibition" (Harris 2010). This federal paradigm cites the abuse potential and "crudeness" of the substances in the botanical plant (as opposed to the refined, synthetic versions used in pharmaceuticals like Marinol), rendering it unfit for serious medical usage (Chapkis and Webb 2008). Therefore, medical cannabis advocates in the US must sometimes resort to methods outside the realm of evidence-based medicine to reframe the consumption of cannabis as a necessary medical act. This work of discursive analysis compares the epistemology of the federal government's paradigm against advocates' relative privileging of anecdotal evidence in the form of individual testimonies and personal narratives. While researchers using well-established and widely accepted methods are increasingly frustrated by federal restrictions, advocates invent new avenues for evidence to reframe medical cannabis for public policy and perception (University of New Mexico 2016). In their narratives, advocates deemphasize or omit information about the psychoactive features of the drug while emphasizing their own various positions of respectability (e.g., veteran status or parenthood) to distance themselves from stereotypical potheads (Chapkis 2007).

Paradigm of Prohibition

In 1970, US Congress passed the Controlled Substances Act, which was later used to classify cannabis as a Schedule I drug, or highly addictive with no medicinal properties (Bostwick 2012). In the name of protecting the public, the federal government also shut the door to future cannabis research. The bureaucracies of the Food and Drug Administration (FDA), Drug Enforcement Administration (DEA), and National Institute on Drug Abuse (NIDA) have been known to cause delays in cannabis acquisition lasting from months to years, with disastrous results for scientific studies already underway (Harris 2010). Furthermore, NIDA's implicit agenda to highlight the study of negative consequences of drug use (they are the institute of "drug abuse," after all) generates a conflict of interest between it and the scientists who would like to investigate the potential positive benefits of responsibly used medical cannabis (Bostwick 2012). Political factors play a crucial role in what kind of research can be done, how it can be done, and which conclusions are "permitted" or expected, as shown by the following

quote from a NIDA spokeswoman (Harris 2010):

> As the National Institute on Drug Abuse, our focus is primarily on the negative consequences of marijuana use … We generally do not fund research focused on the potential beneficial medical effects of marijuana.

What little research is authorized is of poor quality due to the difficult of performing double-blind studies with an obviously psychoactive drug, as well as its irrelevance to the concerns of real-life patients (Noonan 2016). The limited and weak cannabis strains NIDA provides for studies are highly deficient in THC and CBD compared to the strains that many patients use (National Institute on Drug Abuse 2016; University of New Mexico 2016). Research on other compounds in the cannabis plant, such as terpenes, is practically nonexistent (Lupkin 2016; Russo and McPartland 2003). Some past scholars have even expressed skepticism at the notion that the currently accepted scientific method can be properly applied to problems of this nature (Kalant 1968; Mikuriya 1973).

As the American medical cannabis movement began to gain steam in the late 1980s, it generated vigorous debate and concern from anti-drug advocates and many governmental figures, who saw it as a subversion of federal authority and antithetical to the War on Drugs. This was exemplified at a hearing on October 1, 1997 before the Subcommittee on Crime – that the issue even went to this committee indicates how cannabis consumption was still framed at that time. There, officials and lawmakers alternately called existing medical cannabis research insufficient, while denying that it should even be allowed in the first place, as cannabis' illicit status, countercultural associations, "crude" and botanical nature, and generally pleasurable effects made it antithetical to much of American medicine (Chapkis and Webb 2008). General Barry R. McCaffrey, Director of the Office of National Drug Control Policy, criticized Arizona and California's 1996 medical cannabis referenda for "bypass[ing] the rigorous scientific approval process required of all medicines" and called for "science [to] prevail over ideology." Meanwhile, Representative Bob Barr of Georgia considered even the suggestion of medical cannabis research "a counterproductive message" and declared: "You talk about that [sic] the medical use of marijuana ought to be decided by doctors and scientists, it already has been: that's why it's in Schedule I" (Subcommittee on Crime 1997). The complications of this rhetoric would restrict funding and tie up medical cannabis researchers in red tape for years to come.

Instead of relying solely on the evidence of doctors and scientists (among whom open supporters of medical cannabis were a small number at the time), the medical cannabis movement encouraged patients and their families themselves to directly testify about the plant's effectiveness. As if to anticipate these arguments, the responses from the Subcommittee on Crime were both admonishing and mocking. Representative Bill McCollum of Florida accused the medical cannabis movement of "cynically exploit[ing] the suffering of the terminally ill," stripping those patients of their agency. McCaffrey and Barr belittled patients themselves by accusing them of insincerely malingering or exaggerating minor health concerns as an excuse to obtain psychoactive drugs under the aegis of medical care. For example, McCaffrey joked about the "element of humor in growing pot in your own backyard … for amnesia or writer's cramp," making patients' complaints seem insignificant. As Barr said (Subcommittee on Crime 1997):

> One of our other witnesses is positing that marijuana can be effective against aging; that it can be effective against phantom limb pain; it can be effective against violence. There is a – you have to take some of this stuff with a large grain of salt or some other substance. It is goofy what these folks are proposing, and one would think that they would have, at least, enough intelligence to not put out silly stuff like this, because it would help their credibility, marginally, perhaps, if they didn't, but maybe it's good that they do, because it illustrates very graphically how goofy their ideas are.

Taking up the banner where conventional science has struggled, medical cannabis advocates – experts on nothing besides their own bodies and those of their loved ones – find themselves facing a prohibitive paradigm whose effects reverberate through cannabis discourse today.

Deserving Victims, Discreditable Identities, and the Social Self

Medical anthropologists and sociologists have filled in many gaps in knowledge with critical appraisals

of recreational drug use and clinical medicine. However, little ethnographic information about medical cannabis patients exists. An important counterexample is Chapkis and Webb's (2008) ethnography of a Californian medical cannabis collective. Among other topics pertaining to cannabis' social status, they also discuss the categories of "deserving victims" and "discreditable identities":

> Medical marijuana users … become divided in the public mind between patients … who have never used marijuana except as medicine, and pretenders who have a social relationship to the drug. As with other discreditable identities (like the prostitute, the poor person, or the single mother), a line can be drawn between a small class of deserving "victims" and a much larger group of the willfully bad who are unworthy of support.

Although such divisions are "illusory and dangerous" due to the blurring of medical and social identities and usages in real life, that does not stop medical cannabis advocates from framing the debate in a way that pits patients (deserving victims) against users who are not. However, Chapkis and Webb omit examples of what deserving victims and discreditable identities might look like in the case of medical cannabis discourse. Therefore, to expand upon their theory, it is necessary to look for themes in the types of testimonies to which they refer. This discursive analysis is based off 30 testimonies from state and federal hearings on medical cannabis, hailing from 15 states and DC between 1987 and 2016. Materials were discovered by extensive database and web searches and the top results selected only if they included stories about a medical cannabis patient told from the standpoint of a non-expert. (Although two testimonies were given by family members who happened to be medical doctors, neither discussed the patient's story as a medical case study.) All sources for materials can be found in Appendix A. As this analysis will demonstrate, seemingly extraneous details that testifiers like to add to their testimonies, such as veteran status, parenthood, and moral background, can be meticulously unpacked for hidden discursive meaning. Mobilization of certain identities not only reveals how advocates construct themselves and other patients as deserving victims, but also how they avoid being labeled with discreditable identities.

However, when examining political discourse, it is crucial to include the elements of rhetoric and persuasion as part of the process of constructing narratives and the self for others, rather than exclusively focus on the impersonal relationship between political events and speech alone. Duranti (2006) argues that politicians (the subject of his study) utilize personal narratives to construct a social persona he calls the "political self," which impresses voters with its trustworthiness, expertise, and likeability. In the case of medical cannabis, these narrative accounts not only help patients make sense of their own experience, but lets them evaluate those experiences in moral terms, pitting "the acceptable" against "the authentic." This project, building on Chapkis and Webb's (2008) concepts, uses Duranti's (2006) framework to explore the possibility that a similar process of narrative-making is used to construct the persona of the deserving victim.

Veteran Status: Countering the Counterculture

> I also speak before you as a military veteran suffering from health problems associated with my service … I am wondering why Minnesota has turned its back not only on the terminally ill and those who are greatly suffering with debilitating sicknesses, but also the many military veterans who fought for the freedoms that we enjoy today?
>
> Timothy Majerus, MN (2007)
>
> (Minnesotans for Compassionate Care 2017)

Veteran status is a potent force in all kinds of American activism. Entire organizations, such as Weed For Warriors, have sprung up to advocate for combat veterans who use medical cannabis. Advocates are well-aware of the social capital of veterans. As Dr. Sue Sisley, medical cannabis researcher and activist, commented to a reporter, veterans' groups are capable of "persuading even the most conservative Republicans that [cannabis] is medicine," reflecting the intertwined roles of science and anecdote in advocacy (O'Connell 2016). Incidentally, as of April 2017, Dr. Sisley is also undertaking the only federally funded study on the effects of medical cannabis on post-traumatic stress disorder – a study which uses veterans as its study population. As a class of deserving victim, veterans are difficult to oppose; in a society that reveres military service as a sign of patriotism, it is socially and politically risky to be perceived as snubbing someone who has served their country. Therefore, veteran status can be mobilized to

negate cannabis' countercultural associations, and to reframe the debate from one of "justifying" to one of "deserving."

Hippies and the anti-war movement are two prominent symbols linked with cannabis use in American culture. In the United States, cannabis was bestowed the reputation of a uniquely pacifistic and countercultural drug, with implications of opposition to American militarism and even veteran-worship. Despite many of them possessing liberal values themselves, however, medical cannabis advocates work hard to distance themselves from stereotypical potheads, and mobilization of veteran status is an extremely effective way of contradicting cannabis' undesirable associations. Indeed, some veterans were emphatic about their unwavering support of the American military and its actions (Minnesotans for Compassionate Care 2017):

> I'm a Vietnam veteran and my youngest son has recently returned from 18 months in Iraq. We are a family that honors this country, having served it in the military in every conflict since the Revolutionary War.
>
> Joni Whiting, MN (2007)

This directly contradicts the popular stereotypes of recreational cannabis users as being socially liberal and pacifistic. In doing so, it also attempts to portray more "legitimate" medical cannabis as especially deserving of bipartisan support. By stripping cannabis of its political metadata, it becomes possible for observers to evaluate it on their own partisan terms. For many Americans, and particularly conservatives, those terms include the valuation and appreciation of veterans.

The veteran narrative is also effective at shifting the burden of responsibility from the prospective patient to the government. Majerus (see the beginning of this section) effectively mobilizes his veteran status to completely flip the debate. Rather than having to justify their use before gatekeeping doctors, it is the government that finds itself in the awkward position of having to justify its denial of medical care to the people who served it. In the narrative reimagined by veterans, it is not the veterans who are betraying their country by breaking the law, but the government who is unpatriotically betraying its veterans by denying them the medicine they deserve.

Some veterans who are not patients also draw connections between the sacrifices they made for their country and the sacrifices they make for their loved ones in an attempt to transfer respectability to cannabis use (Georgia Care 2016):

> When friends and strangers thanked me for my military service, I would make sure they understood that it's my family that was essentially part of that same commitment, that they made some sacrifices for me to be able to go serve my country, especially when I was called to Iraq. So I refer to [my wife's] illness as a family disease. Not her illness alone, but a family disease because we all make sacrifices to support her.
>
> Warren Tannenbaum, GA (2016)

Here, the testifier compares his loyal care for his wife to his service to his country. The ill, cannabis-using wife corresponds to the innocent nation whose security the veteran-husband defends. And, just as he put his own life on the line for his country, he is also prepared to risk everything for his wife (Georgia Care 2016):

> As law-abiding citizens, and as a 28-year Navy veteran, we always follow the law. When it comes to helping improve my – my wife's MS symptoms, I'll risk everything to help her. I will give up my security clearance if I ever get arrested in an attempt to help her.
>
> Warren Tannenbaum, GA (2016)

Caring for one's loved ones by obtaining medical cannabis is neither criminal conspiracy nor simply a compassionate act, but a patriotic and laudable duty.

Moral Approval and the Politics of Pleasure

> Most people who smoke marijuana … constantly talk about the marijuana "high." To be honest, I never had the slightest clue what these people were talking about … I didn't like smoking. I do not smoke tobacco and smoking marijuana makes me cough … When people talked about being "high," I didn't know what they meant. I still don't.
>
> Irvin Rosenfeld, FL (1987)
> (Randall 1989)

Of course, only a minority of cannabis-using patients are veterans. Many more are ordinary civilians who cannot bolster their identities with military service, and are thus much more likely to be socially diagnosed as

addicts or potheads. The key distinction in the public mind, as Chapkis and Webb (2008) mentioned, is the separation between medical cannabis patients as deserving victims, and recreational users as discreditable ones. Testifiers tread a fine line between conveying what is "appropriate" (what they know their audience wants to hear) and what is "authentic" (what parts of their story are true reflections of their experience). However, the argument testifiers use to distance patients from potheads is a simple one: if potheads smoke cannabis for pleasure, then the natural counterpoint would be that medical users get no extraneous enjoyment out of using cannabis at all. Whether from the psychophysiological effects of the drug or the moral and legal guilt of obtaining it, cannabis is portrayed as an un-pleasurable but necessary experience for testifiers.

Detractors of the medical cannabis movement frequently accuse it of exploiting the suffering of ill patients to bring legal cannabis in through the backdoor. The rising medical cannabis movement has also had to contend with anti-drug movements spearheaded by parents and aided by the federal government (Brown and Fee 2014). Allowing medical cannabis use for only a few supposedly deserving victims, they say, would open the floodgates for anyone to use minor health complains as excuses to obtain an illicit drug for recreational purposes alone. Even in states where cannabis is currently legal, it remains in an awkward social limbo: unlike other medicines, like opiates, its recreational uses are increasingly accepted. Therefore, to legitimize their own use in places where cannabis use is more restricted, medical cannabis users downplay or deny the potentially pleasurable effects cannabis has for them (Chapkis 2007). Many, such as Donald Spear of Michigan, appeal to their personal upbringing or background as proof they would never partake in drugs for recreational purposes (Randall 1989):

> I was very reluctant to smoke marihuana [sic] not only because it was illegal but also because I did not like to use drugs of any kind. Years earlier I briefly drank alcohol and smoked cigarettes, but decided I did not like them and gave them up … I come from a strict, moral background and using drugs of any kind, even aspirin, is not really right.
>
> Donald Spear, MI (1987)

For cannabis to be medicine, it must not subvert American biomedical expectations that medical treatment be devoid of pleasurable side effects, or even that it must be painful. Generally, positive side effects are to be avoided because of their "addictive" potential, and evidence of enjoying a drug (such as an opiate) is justification to suspect patients of addiction, malingering, or drug-seeking (Chapkis and Webb 2008).

Other testifiers not only deny the pleasurable effects of cannabis in themselves, but morally condemn recreational users altogether (Minnesotans for Compassionate Care 2017):

> My work history includes 26 years with the Minnesota Department of Corrections. Twenty of those years were spent as a Lt. and two as a caseworker. I was security director for the Treatment Unit at Minnesota Correctional Facility Oak Park Heights from 1982-1984, giving me much exposure to the negative effects of the illicit use of drugs. I was also a licensed part-time police officer in Hastings for eight years. Our daughter is presently a Sgt. with the Madison, Wisconsin Police Department and has been employed there for 13 years. I give you this background to assure you that we're not at all supportive of the illicit use of recreational drugs. But that's not what this issue is about.
>
> Jerry Petersen, MI (2007)

But despite the testifier's disclaimer, that is exactly what this issue is about: separating the deserving from the undeserving, the patients from the potheads. The existential conflict of being a law-enforcer and a law-breaker is neatly resolved by shifting the discreditable identity of "recreational user" onto another, more criminal class of others.

When testifiers acknowledge that they have broken the law, they underscore their shame and bewilderment at having to go through the experience. As with the argument from legal authority above, a clear line is drawn between criminals who willingly break the law for selfish purposes, and medical cannabis supporters who reluctantly break the law out of necessity (Minnesotans for Compassionate Care 2017; Randall 1989):

> My husband and I came to resent the fact that Keith's marijuana therapy was illegal. We felt like criminals. We are honest, simple people and we hated

having to sneak around.

Mae Nutt, MI (1987)

I couldn't imagine how to obtain marijuana. The most serious crime I'd ever committed was speeding when I was in college. Was I supposed to go downtown to some alley in the middle of the night and just stand there, hoping not to get shot?

Ron Oveson, MN (2007)

Not all the gritty details of a patient's authentic story may be acceptable to observers. Some even risked legal consequences by testifying about their experiences. But by selectively choosing their utterances about pleasure and crime, they construct a persona for themselves that falls safely between the two categories.

"Mother Knows Best": Maternal and Scientific Authority

My name is Angie Weaver. I am a stay-at-home mom from Hibbing, MN. I earned my bachelor's degree in Family Consumer Science from Minnesota State University, Mankato. Before I had my daughters, I worked with children and families in a variety of settings including daycares, an elementary school, and also for Lutheran Social Services. I have always loved children, and could not wait to have my own. My husband … and I have been married for 13 years. We have two daughters, Amelia, age 7, and Penelope, age 3. I would like to tell you about my daughter Amelia.

Angie Weaver, MN (2007)
(Minnesotans for Compassionate Care 2017)

Some demographic patterns in the data were distinctly gendered. 16 of the 30 testifiers were speaking on their own behalf as patients, with 13 of that subset being men. This is consistent with the known demographics of medical cannabis users in various states, where men predominate regardless of differing qualifying conditions (e.g., Aggarwal et al. 2009a; Braitstein et al. 2001; Troutt and DiDonato 2015). 8 of the 30 testifies were patients testifying on behalf of their children who were cannabis patients; although women (5/8) only slightly predominated men (3/8) in this category, among women as a whole (10/30) there was a greater number of women testifying for their children (5/10) than for their parents (1/10), spouses (1/10), or themselves (3/10). (Men, in comparison, focused mainly on themselves [13/20], followed by children [3/20], spouses [2/20], and non-related others [2/20].) This suggests that women play a unique role in medical cannabis testimonies as the caregivers of children over any other group. What mothers say about their children's cannabis use is highly relevant, since mothers who use drugs themselves (let alone provide drugs to their children) are vilified for having broken a strict tenet of "good mothering" (Springer 2010). Mothers' narratives adhere to stereotypical gender roles as the primary caregivers to children, while also drawing upon said status to portray their knowledge of cannabis' effectiveness as self-evident.

Gender roles in testimony place the testifier within the realm of what is "acceptable" for men and women. Women, in this instance, underscore their experiences with powerful feelings of love and affection for their children, something devoid from (or at least less pronounced) in the collected testimonies of fathers. For example, Weaver (see the beginning of this section) introduces herself as a "stay-at-home mom" who, starting from at least university onward, has been fulfilling her culturally expected role as a woman by being enthusiastic about children and pursuing their care at every opportunity. Such a persona contradicts the popular image of mothers who purchase drugs (or allow their children to use drugs), which is usually a portray of an irresponsible or drug-addicted parent.

Mothers also used their maternal authority to assert cannabis' effectiveness as medicine (Randall 1989):

As a mother, nothing seems more important to me than a strong appetite … Eating together helps to bind families together. When Josh regained his ability to eat, he rejoined our family. He could come to dinner without vomiting. We could talk and he could eat. As a mother it is impossible for me to put into words how wonderful it is to watch your son eat a mouthful of mashed potatoes.

Janet Andrews, ID (1987)

One of the more common claims of the American anti-drug movement is that using drugs is anathema to the nuclear family, and that using them results in the dissolution of healthy parent-child relationships. The argument in this quote contradicts

that in a counterintuitive way: rather than supplying drugs to children being the opposite of good mothering, it is exactly what family-building requires. Later in the same testimony, this mother also mobilizes her status as "mother of Josh" to claim medical cannabis' effectiveness is self-evident (Randall 1989):

Is marijuana effective? It was for Josh. When your kid is riding a tricycle while his other hospital buddies are hooked up to IV needles, their heads hung over vomiting buckets, you don't need a federal agency to tell you marijuana is effective. The evidence is in front of you, so stark it cannot be ignored.

Janet Andrews, ID (1987)

As with veteran narratives, this rhetorically challenges governmental authorities to question a "good mother's" authority over her own children and her rightful place as caretaker of the family. Mobilizing one's identity as a mother to project a "maternal self," even reifying gender roles in the process, is a rhetorical strategy that helps families defend the nature of the medicine their children receive, even when those children are technically adults in charge of their own care. This was the case with the parents of Keith, who was diagnosed with cancer in his 20s and died at the age of 24 (Randal 1989):

As a parent, I once had to confront a stark choice – obey the law and let my son suffer or break the law and provide my son with genuine relief from chemotherapeutically induced misery. I chose to help my son. Faced with the same choice again, my husband and I would help our son again. We are confident any parents confronting such circumstances would make the same decision.

Mae Nutt, MI (1987)

Parenthood, particularly motherhood, reframes the medical cannabis debate by casting parental authority against governmental authority and constructing the persona of the "responsible parent" to challenge dominant anti-cannabis narratives.

Conclusion

Each type of narrative functions in a slightly different way, but all have the same overarching goal: to separate medical cannabis users from recreational ones. Veterans' narratives emphasize the difference between deserving victims and the countercultural hedonists who purportedly popularized the drug, while reaching across party lines and rhetorically appealing to observers' sense of patriotic obligation. Innocents' narratives dissociate medical users from recreational users by highlighting the former's distaste at using cannabis or being involved in its criminal acquisition. Mothers' narratives also draw boundaries of protection around faultless, suffering children (regardless of their actual age) while privileging their own self-reported medical miracles. Testifiers with intersecting identities – a veteran who is also a mother, a veteran who is also a devout Christian, and so on – may use any combination of these narratives to construct their own version of an identity for themselves (or others) that constitutes the deserving victim. Multiple kinds of narratives can have similar goals and results, but have slightly different methods of accomplishing them. What matters is the consistency of the overarching narrative, its coherence to its audience, and the degree to which it helps the testifiers process and make sense of their own experiences (Duranti 2006).

But the testifiers who construct their personas as deserving victims – veterans, the innocent, and children and their good mothers – also cast a shadow. That shadow is the conglomeration of discreditable identities in the background, the things they deny about themselves and condemn in others. This category includes the bad patriots, bad parents, criminals, addicts, and people who have a recreational relationship to cannabis. In addition, the cannabis patients in these testimonies were not representative of users as a whole: although one-third of testimonies referred to cancer, only around 5% of the entire medical cannabis-using population in the United States has acquired cannabis for that diagnosis (McVey 2016). Furthermore, as Chapkis and Webb (2008) noted, for many of the patients who were part of the collective they studied, there was no clear boundary where recreational use ended and medical use began (and vice versa). The medical cannabis movement has been hugely successful at propagating its divisional narrative, but the deliberate blurring of nuance has unfortunate implications for how cannabis use is studied.

When medical cannabis is legalized and studied based on the false binary between deserving and discredited users, inequities in patient access and further stigmatization of certain "undesirable" classes of drug

users may result. For instance, many studies on cannabis use do not account for users who fall between or across categories, such as recreational users who discover that their cannabis use helps them manage symptoms of a disease, or medical users who discover and pursue the pleasant effects of a cannabis high. By failing to investigate the multifactorial motivations for cannabis use, these studies risk reproducing the same stigmatizing dichotomy between patients and potheads. The impact of this discourse may also affect certain demographic groups over others; while the race of testifiers could not be determined from this sample, further qualitative and quantitative research could elucidate details about the intersections of this divisionary discourse with race and doctor-patient or patient-dispensary interactions. However, some effects of this discourse are more immediate and apparent. For instance, even in states where cannabis is legal, prisoners do not have the right to access medical cannabis (Matthews 2014). Because they hardly fall into the category of "innocent victim," their motives are considered less sincere, and their pain less legitimate. The possibility that other stigmatized identities, perhaps those related to race, disability, and class, may encounter similar struggles, should not be dismissed. Although "medicine by popular vote" has triumphed where federal regulatory stonewalling has stifled progress, it may ultimately trump the rights and liberties of society's most vulnerable individuals.

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